Chapter 45

COMMUNITY MENTAL HEALTH CENTER COST REPORT
FORM CMS-2088-17

4500. GENERAL

The Paperwork Reduction Act of 1995 establishes the requirement that the private sector be informed why information is collected and how it will be used by the government. In accordance with §§1815(a), 1866(e)(2), and 1861(v)(1)(A) of the Social Security Act (the Act), providers of medical and other healthcare services as defined under §1861(ff), participating in the Medicare program are required to submit annual information to achieve settlement of costs for health care services rendered to Medicare beneficiaries. Community mental health centers (CMHCs) providing partial hospitalization program (PHP) services must file cost reports in accordance with 42 CFR 413.24(f). The data submitted on the cost reports supports management of federal programs. The information reported on Form CMS-2088-17, must conform to the requirements and principles set forth in the Provider Reimbursement Manual, CMS Pub. 15-1, as well as those set forth in the Medicare Benefit Policy Manual, CMS Pub. 100-02, chapter 6, §70.3.

Form CMS-2088-17 must be used by all freestanding CMHCs for cost reporting periods beginning on or after October 1, 2017. CMHCs that file as part of a hospital healthcare complex must use the Form CMS-2552. Cost reports are due on or before the last day of the fifth month following the close of the period covered by the report. For cost reports ending on a day other than the last day of the month, cost reports are due 150 days after the last day of the cost reporting period, in accordance with 42 CFR 413.24(f)(2). The CMHC cost report must be submitted to your Medicare administrative contractor (MAC) (hereafter referred to as contractor) electronically in accordance with 42 CFR 413.24(f)(4).

The CMHC cost report provides for the determination of allowable costs which are reasonable and necessary and the calculation of an overall cost-to-charge ratio (CCR). CMHCs are paid under the outpatient prospective payment system (OPPS) for furnished Medicare PHP services. The OPPS incorporates an outlier adjustment to ensure that outpatient services with variable and potentially significant costs do not pose excessive financial risk to providers. For CMHCs, CMS determines whether billed PHP services are eligible for outlier payment using the CMHCs CCR. The outlier payment is a percentage of the difference between the cost estimate and the multiple threshold. OPPS high cost outlier payments may be reconciled upon cost report settlement to account for differences between the overall ancillary CCR used to pay the claim at its original submission by the provider, and the CCR determined at final settlement of the cost reporting period during which the service was furnished.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0037 (Expires 09/30/2020). The time required to complete this information collection is estimated average 90 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to:

Centers for Medicare and Medicaid Services
PRA Reports Clearance Officer
7500 Security Boulevard
Mail Stop C4-26-05
Baltimore, Md. 21244-1850

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

4500.1 Rounding Standards for Fractional Computations.--Throughout the Medicare cost report, required computations result in the use of fractions. The following rounding standards must be employed for such computations:

1. Round to 2 decimal places
   a. Percentages
   b. Averages
   c. Full time equivalent employees
   d. Per diems, hourly rates

2. Round to 6 decimal places
   a. Ratios (e.g., unit cost multipliers, cost/charge ratios)

If a residual exists as a result of computing costs using a fraction, adjust the residual in the largest amount resulting from the computation. For example, in cost finding, a unit cost multiplier is applied to the statistics in determining costs. After rounding each computation, the sum of the allocation may be more or less than the total cost being allocated. Adjust this residual to the largest amount resulting from the allocation so that the sum of the allocated amounts equals the amount being allocated.

4500.2 Acronyms and Abbreviations.--Throughout the Medicare cost report and instructions, a number of acronyms and abbreviations are used. For your convenience, commonly used acronyms and abbreviations are summarized below.

A&G	-	Administrative and General
CAP REL	-	Capital-Related
CCN	-	CMS Certification Number
CFR	-	Code of Federal Regulations
CMHC	-	Community Mental Health Center
CMS	-	Centers for Medicare & Medicaid Services
COL	-	Column
ECR	-	Electronic Cost Report
FR	-	Federal Register
FTE	-	Full Time Equivalent
HCRIS	-	Healthcare Cost Report Information System
HFS	-	Health Financial Systems
KPMG	-	Klynveld, Peat, Marwick, & Goerdeler
OPPS	-	Outpatient Prospective Payment System
PHP	-	Partial Hospitalization Program
PPS	-	Prospective Payment System
WKST	-	Worksheet

4501. RECOMMENDED SEQUENCE FOR COMPLETING FORM CMS-2088-17

Step	Worksheet	Instructions
1	S	Read §§4502 through 4502.2. Complete Part I.
2	S-1	Read §4503. Complete entire worksheet.
3	S-2	Read §4504. Complete entire worksheet.
4	A	Read §4505. Complete columns 1 through 3, all lines.
5	A-6	Read §4506. Complete entire worksheet.
6	A	Read §4505. Complete columns 4 and 5, all lines.
7	A-8	Read §4507. Complete entire worksheet.
8	A-8-1	Read §4508. Complete entire worksheet, if applicable.
9	A-8-2	Read §4509. Complete entire worksheet, if applicable.
10	A	Read §4505. Complete columns 6 and 7, all lines.
11	B & B-1	Read §4510. Complete entire worksheets.
12	C	Read §4511. Complete entire worksheet.
13	D	Read §4512. Complete lines 1 through 15.
14	D-1	Read §4513. Complete entire worksheet.
15	D	Read §4512. Complete lines 16 through 19.
16	S	Read §4502.3. Complete Part II and III.
17	F	Read §4514.1. Complete entire worksheet.

4502. WORKSHEET S - COMMUNITY MENTAL HEALTH CENTER COST REPORT

4502.1 Part I - Cost Report Status.--This section is to be completed by the provider and contractor as indicated on the worksheet.

Provider use only.--The provider completes lines 1 through 4.

Line 1.--Indicate if this cost report is being filed electronically by checking the box in column 1. If this is an electronically filed cost report, enter the creation date and time in columns 2 and 3, respectively. The date and time are archived in the ECR as an identifier for the file. This file is your original submission and must not be modified.

Line 2.--Indicate if this cost report is a manual submission by checking the box in column 1. Only complete this line if this is an approved low utilization cost report in accordance with CMS Pub. 15-2, chapter 1, §110 or the provider's demonstrating financial hardship in accordance with §133.

Line 3, column 1.--If this is an amended cost report, enter the number of times the cost report has been amended.

Line 4, column 1.--Enter an "F" if this is full cost report, an "L" for a low Medicare utilization cost report or an "N" for no Medicare utilization. A provider that has not furnished any covered services to Medicare beneficiaries during the entire cost report period may file a no Medicare utilization cost report in accordance with CMS Pub. 15-2, chapter 1, §110(A). Providers must obtain contractor approval prior to submitting a low Medicare utilization cost report. (See CMS Pub. 15-2, chapter 1, §110(B).)

Contractor use only.--The contractor completes lines 5 through 12.

Line 5, column 1.--Enter the Healthcare Cost Report Information System (HCRIS) cost report status code that corresponds to the status of the cost report: 1=as submitted; 2=settled without audit; 3=settled with audit; 4=reopened; or 5=amended.

Line 6, column 2.--Enter the date (mm/dd/yyyy) an accepted cost report was received.

Line 7, column 2.--Enter the contractor number.

Lines 8 and 9, column 2.--If this is the very first cost report for this provider CMS certification number (CCN), enter "Y" for yes on line 8. If this is the final (terminating) cost report for this provider CCN, enter "Y" for yes on line 9. If the cost report is not a first or a final cost report for this provider CCN, enter "N" for no on each respective line.

Line 10, column 3.--Enter the Notice of Program Reimbursement (NPR) date (mm/dd/yyyy). The NPR date must be present if the cost report status code is 2, 3, or 4.

Line 11, column 3.--Enter the software vendor code of the cost report software used by the contractor. Enter "3" for KPMG or "4" for HFS.

Line 12, column 3.--If this is a reopened cost report (response to line 5 is "4"), enter the number of times the cost report has been reopened. This field is only to be completed if the cost report status code in line 5, is 4.

4502.2 Part II - Certification.--The certification statement is read, completed, and signed by an officer or administrator of the provider after the cost report has been completed in its entirety.

4502.3 Part III - Settlement Summary.

Line 1, column 1.--Enter the balance due to or from the CMHC. Transfer the settlement amount from Worksheet D, line 19.

4503. WORKSHEET S-1--COST REPORT IDENTIFICATION DATA

4503.1 Part I - Identification Data.--The information required on this worksheet is needed to properly identify the provider.

Line 1, columns 1 through 4.--Enter in the appropriate column the site name, Provider CCN, core based statistical area (CBSA) code (rural CBSA codes are assembled by placing the digits "999" in front of the two digit state code, e.g., for the state of Maryland the rural CBSA code is 99921), and certification date (mm/dd/yyyy).

Line 1, column 5.--Indicate the type of control under which the CMHC operates by entering a number from the list below:

1 = Voluntary Nonprofit, Church
2 = Voluntary Nonprofit, Other
3 = Proprietary, Individual
4 = Proprietary, Corporation
5 = Proprietary, Partnership
6 = Proprietary, Other
7 = Governmental, Federal
8 = Governmental, City-County
9 = Governmental, County
10 = Governmental, State
11 = Governmental, Hospital District
12 = Governmental, City
13 = Governmental, Other

Line 2, columns 1 and 2.--Enter the street address and P.O. Box if applicable.

Line 3, columns 1 through 4.--Enter the city, state, ZIP code, and county for this CMHC.

Line 4.--Enter in column 1, the cost report beginning date and enter in column 2, the cost report ending date.

Lines 5.--Indicate if this CMHC is part of a chain organization as defined in CMS Pub. 15-1, chapter 21, §2150 that claimed home office costs in a home office cost statement. Enter “Y” for yes or “N” for no. If yes, complete lines 6 through 8. Otherwise, skip to line 9.

Lines 6 through 8.--If line 5 is yes, enter the name of the chain organization, the street address, P.O. Box (if applicable), the home office CCN, city, state, and ZIP code.

Line 9.--Indicate if your CMHC is legally required to carry malpractice coverage. Enter “Y for yes or “No” for no. Malpractice insurance premiums are money paid by the CMHC to a commercial insurer to protect the CMHC against potential negligence claims made by their patients/clients.

Line 10.--If line 9 is yes, indicate if your malpractice insurance is a claims-made or occurrence policy. A claims-made insurance policy covers claims first made (reported or filed) during the year the policy is in force for any incidents that occur that year or during any previous period during which the insured was covered under a “claims-made” contract. The occurrence policy covers an incident occurring while the policy is in force regardless of when the claim arising out of that incident is filed. Enter 1, if the malpractice insurance is a claims-made policy. Enter 2, if the malpractice insurance is an occurrence policy.

Line 11.--Enter in column 1, the total amounts of malpractice premiums. Enter in column 2 the total amount of paid losses, and enter in column 3, the total amount of self-insurance premiums.

Malpractice insurance premiums are money paid by the provider to a commercial insurer to protect the provider against potential negligence claims made by their patients/clients. Malpractice paid losses is money paid by the healthcare provider to compensate a patient/client for professional negligence. Malpractice self-insurance is money paid by the provider where the healthcare provider acts as its own insurance company (either as a sole or part-owner) to financially protect itself against professional negligence. Often providers will manage their own funds or purchase a policy referred to as captive insurance, which provides insurance coverage they need but could not obtain economically through the mainstream insurance market.

Line 12.--Indicate whether malpractice premiums paid, paid losses, or self-insurance are reported in a cost center other than the A&G cost center. Enter “Y” for yes or “N” for no. If yes, submit supporting schedule listing cost centers and amounts.

Line 13.-- Did this facility participate in any payment demonstrations during this cost reporting period? Enter "Y" for yes or "N" for no. If column 1 is yes, enter the type of demonstration in column 2. If the CMHC participated in more than one demonstration, subscript this line accordingly.

4503.2 Part II - Statistical Data.--This section collects unduplicated days data.

Columns 1 and 3.--Enter on the appropriate lines the number of Medicare visits in column 1 and total visits in column 3, by type of service. If more than one treatment was furnished to a patient in the same visit, record a separate visit for each different treatment rendered to the patient.

Column 2.--Enter on the appropriate lines the number of visits by type of service for all other patients by subtracting Medicare visits reported in column 1 from total visits reported in column 3.

Columns 4 and 6.--Enter on the appropriate lines the number of Medicare patient days in column 4 and total patient days in column 6, who received services during the cost reporting period, regardless of the number of visits for each individual patient. For example, if a patient receives multiple services on the same day, he or she is counted once for each service rendered in accordance with billing guidelines.

Column 5.-- Enter on the appropriate lines the number of patient days by type of service for all other patients by subtracting Medicare patient days reported in column 4 from total patient days reported in column 6.

Columns 7 through 10.--Enter on columns 7 through 10 the number of full-time equivalent employees (FTE) for each cost center. The average number of FTEs for the period may be determined either on a quarterly or semiannual basis. When quarterly data is used, add the total number of hours worked by category for all employees using the first week of the first payroll period for each quarter, and divide the sum by 160 (4 times 40). When semiannual data is used, add the total number of hours worked by category for all employees using the first week of the first payroll period for the first and seventh months of the cost reporting period. Divide this sum by 80 (2 times 40).

Line 11.--Enter the sum of lines 1 through 10 for all columns as appropriate.

Line 12.--Enter in the appropriate column (columns 4 through 6) the unduplicated census count for Medicare patient days and all other patient days provided by employees of the provider or provided under contract during the reporting period. Count each patient day only once for each day of care they received at this facility. The total unduplicated census count may not equal the total patient days reported on line 11.

4504. WORKSHEET S-2--COST REPORT REIMBURSEMENT QUESTIONNAIRE

The information required on this worksheet (formerly Form CMS-339) must be completed by all CMHCs submitting cost reports to the contractor under title XVIII of the Act. Where the instructions for this worksheet direct you to submit documentation/information, mail or otherwise transmit to the contractor with submission of the electronic cost report (ECR). The contractor has the right under §§1815(a) and 1883(e) of the Act to request any missing documentation.

NOTE: The responses on all lines are "yes" or "no" unless otherwise indicated. When the instructions require documentation, indicate on the documentation the Worksheet S-2 line number that the documentation supports. Lines 1 through 14 must be completed.

Line Descriptions

Line 1.--Indicate whether the CMHC has changed ownership and this is the first cost report filed under this new ownership? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the date the change of ownership occurred in column 2. Also, submit the name and address of the new owner and a copy of the sales agreement with the cost report.

Line 2.--Indicate whether the CMHC has terminated participation in the Medicare program. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the date of termination in column 2, and "V" for voluntary or "I" for involuntary in column 3.

Line 3.--Indicate whether the CMHC is involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the CMHC or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", submit a list of the individuals, the organizations involved, and a description of the transactions with the cost report.

NOTE: A related party transaction occurs when services, facilities, or supplies are furnished to the provider by organizations related to the provider through common ownership or control. (See CMS Pub. 15-1, chapter 10 and 42 CFR 413.17.)

Line 4.--Indicate whether the financial statements were prepared by a certified public accountant; enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter "A" for audited, "C" for compiled, or "R" for reviewed in column 2. Submit a complete copy of the financial statements (i.e., the independent public accountant's opinion, the statements themselves, and the footnotes) with the cost report. If the financial statements are not available for submission with the cost report enter the date they will be available in column 3.

If you answer "N" in column 1, submit a copy of the financial statements you prepared, and written statements of significant accounting policy and procedure changes affecting Medicare reimbursement which occurred during the cost reporting period. You may submit the changed accounting or administrative procedures manual in lieu of written statements.

Line 5.--Indicate whether the total expenses and total revenues reported on the cost report differ from those on the financial statements. Enter "Y" for yes or "N" for no in column 1. If yes, submit a schedule reconciling the financial statements with the cost report.

Line 6.--Indicate whether you are seeking reimbursement for bad debts resulting from Medicare deductible and/or coinsurance amounts which are uncollectible from Medicare beneficiaries. (See 42 CFR 413.89(e) and CMS Pub. 15-1, chapter 3, §§306 through 324 for the criteria for an allowable bad debt.) Enter "Y" for yes or "N" for no in column 1. If you answer "Y" in column 1, submit a completed Exhibit 1, or internal schedules that at a minimum duplicate the documentation requested on Exhibit 1, to support the bad debts claimed.

Exhibit 1 requires the following documentation:

Columns 1, 2, 3, 4 - Patient Names, Health Insurance Claim (HIC) Number, and Dates of Service (From - To).--The documentation required for these columns is derived from the beneficiary's bill. Furnish the patient's name, health insurance claim number, and dates of service that correlate to the filed bad debt. (See CMS Pub. 15-1, chapter 3, §314 and 42 CFR 413.89.)

Columns 5 & 6 - Indigence/Medicaid Beneficiary.--If the patient included in column 1 has been deemed indigent, place a check in column 5. If the patient in column 1 has a valid Medicaid number, include this number in column 6. See the criteria in CMS Pub. 15-1, chapter 3, §§312 and 322 and 42 CFR 413.89 for guidance on the billing requirements for indigent and Medicaid beneficiaries.

Columns 7 & 8 - Date First Bill Sent to Beneficiary & Date Collection Efforts Ceased.--This information should be obtained from the provider's files and should correlate with the beneficiary name, HIC number, and dates of service shown in columns 1, 2, 3 and 4 of this exhibit. The date in column 8 represents the date that the unpaid account is deemed worthless, whereby all collection efforts, both internal and by an outside entity ceased, and there is no likelihood of recovery of the unpaid account. (See CFR 413.89(e) and (f), and CMS Pub. 15-1, chapter 3, §§308, 310, and 314.)

Column 9 - Medicare Remittance Advice Dates.--Enter in this column the remittance advice dates that correlate with the beneficiary name, HIC number, and dates of service shown in columns 1, 2, 3, and 4 of this exhibit.

Columns 10 & 11 - Deductibles & Coinsurance.--Record in these columns the beneficiary's unpaid deductible and coinsurance amounts that relate to covered services.

Column 12 - Total Medicare Bad Debts.--Enter on each line of this column, the sum of the amounts in columns 10 and 11. Calculate the total bad debts by summing up the amounts on all lines of column 12. This "total" must agree with the bad debts claimed on the cost report. Attach additional supporting schedules, if necessary, for bad debt recoveries.

Line 7.--If line 6 is yes, indicate whether your bad debt collection policy changed during the cost reporting period. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", submit a copy of the policy with the cost report.

Line 8.--If line 6 is yes, indicate whether patient deductibles and/or coinsurance amounts were waived. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", ensure that they are not included on the bad debt listings (i.e., Exhibit 1 or your internal schedules) submitted with the cost report.

Line 9.--Indicate whether the cost report was prepared using the PS&R report only. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" enter the paid through date of the PS&R in column 2. Also, submit a crosswalk between revenue codes and charges found on the PS&R to the cost center groupings on Worksheet C of the cost report. This crosswalk will reflect a cost center to revenue code match only.

Line 10.--Indicate whether the cost report was prepared using the PS&R for totals and provider records for allocation. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" enter the paid through date of the PS&R used to prepare this cost report in column 2. Also, submit a detailed crosswalk between revenue codes and charges on the PS&R to the cost center groupings on Worksheet C of the cost report. This crosswalk must show dollars by cost center and include which revenue codes were allocated to each cost center. The total revenue on the cost report must match the total charges on the PS&R (as appropriately adjusted for unpaid claims, etc.) to use this method. Supporting work papers must accompany this crosswalk to provide sufficient documentation as to the accuracy of the provider records. If the contractor does not find the documentation sufficient, the PS&R will be used in its entirety.

Line 11.--If you entered "Y" on either line 9 or 10, indicate whether adjustments were made to the PS&R data for additional claims that have been billed but not included on the PS&R used to file this cost report. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", include a schedule which supports any claims not included on the PS&R. This schedule should include totals consistent with the breakdowns on the PS&R, and should reflect claims that are unprocessed or unpaid as of the cut-off date of the PS&R used to file the cost report.

Line 12.--If you entered "Y" on either line 9 or 10, column 1, indicate whether adjustments were made to the PS&R data for corrections of other PS&R information. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", submit a detailed explanation and documentation which provides an audit trail from the PS&R to the cost report.

Line 13.--If you entered "Y" on either line 9 or 10, column 1, indicate whether other adjustments were made to the PS&R data. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", include a description of the other adjustments and documentation which provides an audit trail from the PS&R to the cost report.

Line 14.--Indicate whether the cost report was prepared using CMHC records only. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", submit detailed documentation of the system used to support the data reported on the cost report. If detail documentation was previously supplied, submit only necessary updated documentation with the cost report.

The minimum requirements are:

- Internal records supporting program utilization statistics, charges, prevailing rates and payment information broken into each Medicare bill type in a manner consistent with the PS&R report.

- A reconciliation of remittance totals to the provider's internal records.

- The name of the system used and system maintainer (vendor or provider). If the provider maintained the system, include date of last software update.

NOTE: Additional information may be supplied such as narrative documentation, internal flow charts, or outside vendor informational material to further describe and validate the reliability of your system.

EXHIBIT 1
LISTING OF MEDICARE BAD DEBTS AND APPROPRIATE SUPPORTING DATA

PROVIDER _____ PREPARED BY _____
CCN _____
FYE _____ DATE PREPARED _____

(1) Patient Name	(2) HIC. No.	(3) Dates of Service		(4) Indigence /Medicaid Beneficiary (Check if applicable)		(5) Date First Bill Sent to Beneficiary	(6) Date Collection Efforts Ceased	(7) Remittance Advice Dates	(8) Deductible *	(9) Co-Insurance	(10) Total Medicare Bad Debts*
		From	To	Yes	Medicaid Number						

*These amounts must not be claimed unless the CMHC bills for these services with the intention of payment. See instructions for columns 4 - Indigence/Medicaid Beneficiary, for possible exception. These amounts must not be claimed if they were included on a previous Medicare bad debt listing or cost report.

4505. WORKSHEET A - RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

Worksheet A provides for recording the trial balance of expense accounts from the CMHC's accounting books and records. It also provides for reclassification and adjustments to certain accounts. The cost centers on this worksheet are listed in a manner that facilitates the combination of the various groups of cost centers for purposes of cost finding. Cost centers listed may not apply to every provider using these forms. Complete only those lines that are applicable.

If the cost elements of a cost center are separately maintained on the accounting books, reconcile the costs from the accounting books and records with those reported on this worksheet. The reconciliation is subject to review by the contractor.

Standard (i.e., preprinted) CMS line numbers and cost center descriptions cannot be changed. If additional or different cost center descriptions are needed, add (subscript) additional lines to the cost report. Where an added cost center description bears a logical relationship to a standard line description, the added label must be inserted immediately after the related standard line. The added line is identified as a numeric subscript of the immediately preceding line. For example, if two lines are added between lines 5 and 6, identify them as lines 5.01 and 5.02. If additional lines are added for general service cost centers, add corresponding columns for cost finding.

Submit the working trial balance of the facility with the cost report. A working trial balance is a listing of the balances of the accounts in the general ledger to which adjustments are appended in supplementary columns and is used as a basic summary for financial statements.

Cost center coding is a methodology for standardizing the meaning of cost center labels as used by health care providers on the Medicare cost report. Form CMS-2088-17 provides for preprinted cost center descriptions on Worksheet A. In addition, a space is provided for a cost center code. The preprinted cost center labels are automatically coded by CMS approved cost reporting software. These cost center descriptions are hereafter referred to as the standard cost centers. The CMS approved cost reporting software also accommodates cost centers that are frequently used by health care providers but not included as standard cost centers, hereafter referred to as the nonstandard cost centers.

This coding methodology allows providers to continue to use labels for cost centers that have meaning within the individual institution. The four digit cost center codes that are associated with each provider label in the ECR provide standardized meaning for data analysis. Providers are required to compare any added or changed label to the descriptions offered on the standard and nonstandard cost center tables. A description of cost center coding and the table of cost center codes are in §4495, table 5**.**

Column Descriptions

List on the appropriate lines in columns 1, 2, and 3 the total expenses incurred during the cost reporting period. Any needed reclassifications and adjustments must be rendered in columns 4 and 6, as appropriate. Blank lines are provided for additional cost centers, as required.

Column 1.--Salaries are the gross salaries paid to employees before taxes and other items are withheld. Salaries include deferred compensation, overtime, incentive pay, and bonuses. (See CMS Pub. 15-1, chapter 21.) Enter salaries from the CMHC's accounting books and records.

Column 2.--Enter all costs other than salaries and contracted purchased services from the CMHC's accounting books and records.

Column 3.--Enter all the costs of contracted purchased services from the CMHC's accounting books and records.

Column 4.--For each cost center, add the amounts in columns 1 through 3 and enter the total in column 4.

Column 5.--For each cost center, enter the net amount of reclassifications from Worksheet A-6. The net total of the entries in column 5 must equal zero on line 100. Show reductions to expenses as negative numbers.

Column 6.--For each cost center, enter the total of the amount in column 4 plus or minus the amount in column 5. The total on column 6, line 100 must equal the total on column 4, line 100.

Column 7.--For each cost center, enter the net of any increase and decrease amounts from Worksheet A-8, column 2. The total on Worksheet A, column 7, line 100 must equal Worksheet A-8, column 2, line 50.

Column 8.--For each cost center, enter the total of the amount in column 6 plus or minus the amount in column 7.

Transfer the amounts in column 8, lines 2 through 100, to the corresponding line on Worksheet B, column 0.

Line Descriptions

The Worksheet A segregates the trial balance of expenses into general service cost centers, reimbursable cost centers, and nonreimbursable cost centers to facilitate the transfer of costs to the various worksheets.

GENERAL SERVICE COST CENTERS

General service cost centers include expenses incurred in operating the CMHC as a whole that are not directly associated with furnishing patient care such as, but not limited to mortgage, rent, plant operations, administrative salaries, utilities, telephone, and computer hardware and software costs. General service cost centers furnish services to other general service cost centers and to reimbursable and nonreimbursable cost centers.

Lines 1 and 2 - Capital Related Costs-Buildings & Fixtures and Capital Related Costs-Moveable Equipment.--These cost centers include the capital-related costs for buildings and fixtures and the capital-related costs for movable equipment including depreciation, leases and rentals for the use of the facilities and/or equipment, interest incurred in acquiring land and depreciable assets used for patient care, insurance on depreciable assets used for patient care and taxes on land or depreciable assets used for patient care. Do not include in these cost centers the following costs: costs incurred for the repair or maintenance of equipment or facilities; amounts included in the rentals lease payments for repairs and/or maintenance; interest expense incurred to borrow working capital or for any purpose other than the acquisition of land or depreciable assets used for patient care; general liability of depreciable assets; or taxes other than those assessed on the basis of some valuation of land or depreciable assets used for patient care.

Line 3 - Employee Benefits.--This cost center includes the costs of the employee benefits department. In addition, this cost center includes the fringe benefits paid to, or on behalf of, an employee when a provider's accounting system is not designed to accumulate the benefits on a departmentalized or cost center basis. (See CMS Pub. 15-1, chapter 21, §2144).

Line 4 - Administrative and General.--The administrative and general (A&G) cost center includes a wide variety of provider administrative costs that benefit the entire facility. Examples include fiscal services, legal services, accounting, data processing, taxes, and malpractice costs. Marketing and advertising costs that are not related to patient care, fundraising costs, and other nonreimbursable costs are not included here, but are reported in the appropriate nonreimbursable cost center.

If the physician is paid a salary that compensates him or her for both provider services and professional services, then include the salary in this cost center. The cost attributable to the professional services is subsequently removed by an adjustment computed using Worksheet A-8-2. See Worksheet A-8-2 for the instructions on that adjustment.

The professional services of physicians, physician's assistants (PA) and clinical psychologists (CP) are not considered as provider services and are not includable as an element of cost in the provider's cost report. These services are billed directly to a carrier for payment. A provider must distinguish between professional services and provider services of the physicians, PA, and CP. The provider services are includable on the cost report. The payment for services of a physician to providers is discussed in CMS Pub. 15-1, chapter 21, §2108. Not all provider services of physicians are entered as an administrative and general cost, i.e., if a physician supervises a revenue cost center such as physical therapy, then the physician's salary or part of it is a cost of the physical therapy cost center.

Line 5 - Maintenance & Repairs.--This cost center includes the maintenance of the facility grounds such as landscaped and paved areas, streets on the property, sidewalks, fenced areas, fencing, external recreation areas, and parking facilities. In addition it may include routine painting, plumbing, and electrical repairs, mowing and snow removal. The costs of maintaining the safety and well-being of personnel, visitors, and the provider's facilities are also included in this cost center.

Line 6 - Operation of Plant.--Plant operation costs include utility systems such as heat, light, water, air conditioning and air treatment.

Line 7 - Laundry and Linen Service.--This cost center includes the cost of routine laundry and linen services whether performed in-house or by outside contractors.

Line 8 - Housekeeping.--This cost center includes the cost of routine housekeeping activities such as mopping, vacuuming, cleaning restrooms, lobbies, waiting areas, and otherwise maintaining patient and non-patient care areas.

Line 9 - Cafeteria.--This cost center includes the cost of preparing food for provider personnel, physicians working at the provider, visitors to the provider.

Line 10 - Central Services and Supplies.--This cost center includes the costs for minor medical or surgical supplies. These are supplies for which patients are not separately charged, and for which the recording of use by each individual patient is extremely time consuming and costly for providers. Examples include cotton balls and alcohol prep.

Line 11 - Medical Records and Library.--This cost center includes the direct costs of the medical records cost center including the medical records library.

Line 12 - Professional Education and Training (Approved).--This cost center includes training and educational services related to the care and treatment of a patient's disabling mental health problems.

Line 13 - Other (Specify).--Use this line to report the costs of other general service costs not previously identified on lines 1 through 11. If more than one other general service is offered, subscript this line and provide an appropriate description and cost center code.

Lines 14 through 22.--Reserved for future use.

Line 23 - Drug and Biologicals.--This cost center includes drugs and biologicals that are (1) prescribed by a physician and administered by or under the supervision of a physician or a registered professional nurse; and (2) not excluded from Medicare Part B payment for reasons specified in 42 CFR §410.29.

Line 24 - Occupational Therapy.--This cost center includes the costs of purposeful goal-oriented activities in the evaluation, diagnosis, and/or treatment of persons whose function is impaired by physical illness or injury, emotional disorder, congenital or developmental disability, or the aging process, in order to achieve optimum functioning, to prevent disability, and to maintain health. Occupational therapy services may be provided for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

Line 25 - Behavioral Health Treatment Services.--This cost center includes the costs for staff for providing care and services to psychiatric patients. Administrative services, such as supervisory duties, rendered by these individuals are includable in the administrative and general cost center. Any services by these individuals which are nonreimbursable activities, such as diversionary activities, social, or recreational therapies, custodial or respite care, vocational trainging, etc., shall be entered in the appropriate nonreimbursable cost center.

Line 26 - Individual Therapy.--This cost center includes the costs for individual therapy with physicians, psychologists, or other mental health professionals to the extent authorized under State law. Do not include professional services of physicians, PAs, or CPs if billable to a Medicare carrier.

Line 27 - Group Therapy.--This cost center includes the costs for group therapy with physicians, psychologists, or other mental health professionals to the extent authorized under State law. Do not include the expenses of professional services of physicians, PAs, or CPs if billable to a Medicare carrier.

Line 28 - Activity Therapy.--This cost center includes the costs for individualized activity therapies that are not primarily recreational or diversionary.

Line 29 - Family Therapy.--This cost center includes the costs for family counseling services, the primary purpose of which is treatment of the beneficiary's condition.

Line 30 - Psychiatric Testing.--This cost center includes costs for psychological and neuropsychological tests which includes tests performed by technicians and computers in addition to those performed by physicians, clinical psychologists, independently practicing psychologists, and other qualified non-physician practitioners.

Line 31 - Education Training.--This cost center includes the costs for patient training and education to the extent the training and educational activities are closely and clearly related to the beneficiary's care and treatment.

Lines 33 through 41.--Reserved for future use.

NONREIMBURSABLE COST CENTERS

Nonreimbursable cost centers include costs of nonreimbursable services and programs. Report the costs applicable to nonreimbursable cost centers to which general service costs apply. If additional lines are needed for nonreimbursable cost centers other than those shown, subscript one or more of these lines with a numeric code. The subscripted lines must be appropriately labeled to indicate the purpose for which they are being used. However, when the expense (direct and all applicable overhead) attributable to any non-allowable cost area is so insignificant as to not warrant establishment of a nonreimbursable cost center, remove the expense on Worksheet A-8. (See CMS Pub. 15-1, chapter 23, §2328.)

Line 42 - Sheltered Workshops.--This cost center consists of programs to provide remunerative employment or other occupational activities of an educational, therapeutic nature for individuals whose earning capacity is impaired by physical, mental, and/or social handicaps. Workshops may provide job training, vocational evaluation, sheltered employment, and/or work adjustment services.

Line 43 - Recreational Programs.--This cost center includes the costs for programs which are primarily recreational.

Line 44 - Resident Day Camps.--This cost center includes the costs incurred by residential day camps.

Line 45 - Diagnostic Clinics.--This cost center includes the costs incurred by the operation of diagnostic clinics.

Line 46 - Physicians' Private Offices.--A nonreimbursable cost center must be established to accumulate the cost incurred by you for services related to the physicians' private practice. Examples of such costs are depreciation costs for the space occupied, movable equipment used by the physicians' offices, administrative services, medical records, housekeeping, maintenance and repairs, operation of plant, drugs, medical supplies, and nursing services.

Line 47 - Fund Raising.--This cost center includes the costs of services related to fund raising (see CMS Pub. 15-1, chapter 21, §2136).

Line 48 - Coffee Shops & Canteen.--This cost center includes the costs incurred for the operation of a coffee shops and/or canteen.

Line 49 - Research.--This cost center includes the costs incurred by research.

Line 50 - Investment Property.--This cost center includes the costs incurred by owning investment properties.

Line 51 - Advertising.--This cost center includes the costs incurred by advertising.

Line 52 - Franchise Fees and Other Assessments.--This cost center includes the costs incurred by franchise fees and other assessments.

Line 53 - Pro Ed & Training (Not Approved).--This cost center includes the costs incurred by professional education and training (Not Approved).

Line 54 - Meals & Transportation.--This cost center includes the costs incurred by providing meals and transportation.

Line 55 - Activity Therapies.--This cost center includes programs which are primarily recreational or diversional.

Line 56 - Psychosocial Programs.--This cost center includes community support groups for chronically mentally ill persons for the purpose of social interaction. Partial hospitalization programs may include some psychosocial components, and to the extent these components are not primarily for social purposes, they are covered.

Line 57 - Vocational Training.--This cost center includes the costs of services related solely to specific employment opportunities, work skills, or work settings.

4506. WORKSHEET A-6 - RECLASSIFICATIONS

Worksheet A-6 provides for the reclassification by cost centers of certain amounts necessary for proper cost allocation.

Some providers may charge some of these amounts to the proper cost centers before the end of the accounting period. Therefore, use Worksheet A-6 only to the extent that expenses have been included in cost centers that effect improper cost allocation.

Any expenses that are includable in the administrative and general or capital related cost centers, e.g., insurance or lease expense, but which were recorded in other cost centers on Worksheet A, must be reclassified on Worksheet A-6.

It may be necessary to reclassify certain expenses pertaining to buildings, fixtures, and movable equipment. These expenses must be directly assigned or allocated on the same basis as the depreciation expense for the respective buildings, fixtures or movable equipment. Examples of these expenses include insurance, rent on buildings, fixtures, or movable equipment, real estate taxes, and personal property taxes. Interest on funds borrowed to purchase buildings, fixtures, or movable equipment are included in these expenses. Interest borrowed for operating funds is not included. Interest on funds borrowed for operating funds must be allocated with administration and general expenses.

Employee health and welfare costs must be considered as part of each employee’s compensation and charged to the various cost centers in the same proportion that the salary is charged.

Column 1.--Identify each reclassification adjustment by assigning an alpha character (e.g., A, B, C) in column 1. Do not use numeric designations.

Columns 2, 3, 4 and 5.--For each increase reclassification, enter the corresponding cost center description in column 2, the Worksheet A cost center line number reference in column 3, and reclassification amount in columns 4 and 5.

Columns 6, 7, 8 and 9.--For each decrease reclassification, enter the corresponding cost center description in column 6, the Worksheet A cost center line number reference in column 7, and reclassification amount in columns 8 and 9.

For line 100, the sum of all increases in columns 4 and 5 must equal the sum of all decreases in columns 8 and 9. Submit (with the cost report) copies of work papers used to compute the reclassifications.

Transfer the amounts on Worksheet A-6, to Worksheet A, column 5, line as appropriate.

4507. WORKSHEET A-8 - ADJUSTMENTS TO EXPENSES

In accordance with 42 CFR 413.9(c)(3), where operating costs include amounts not related to patient care, specifically not reimbursable under the program, or flowing from the provision of luxury items or services (i.e., those items or services substantially in excess of or more expensive than those generally considered necessary for the provision of needed health services), such amounts are not allowable. This worksheet provides for the adjustments in support of those listed on Worksheet A, column 7. These adjustments, required under Medicare principles of reimbursement, are made on the basis of cost or, only if the cost (including direct cost and all applicable overhead) cannot be determined, amount received (revenue). If the total direct and indirect cost can be determined, enter the cost. Adjustments to expenses based on cost cannot be based on revenue in subsequent cost reporting periods. Indicate the basis used in column 1. There are, however, items on the worksheet which are adjusted on one basis only. For these items, the basis for adjustment is printed in column 1. Line descriptions indicate the more common activities which affect allowable cost or result in costs incurred for reasons other than patient care and thus require adjustments.

If any of the adjustments you make on Worksheet A-8 flow from Worksheets A-8-1, complete that worksheet before completing Worksheet A-8.

Line Descriptions

Lines 1 and 2.--If depreciation expense computed in accordance with the Medicare principles of reimbursement differs from depreciation expense per your books enter the difference on lines 1 and/or 2. (See CMS Pub. 15-1, §100ff.)

Line 3.--Enter the amounts received for rendering administrative services to others, including physicians and therapists. For example, you may arrange to process billings and collect the proceeds on behalf of such specialists and charge a fee for these services. Reduce allowable costs by the amount of such fees.

Line 4.--Reduce interest expense by investment income, except investment income earned by:

- Grants, gifts and endowments, (whether restricted or unrestricted),
- Funded depreciation,
- Pension funds, and
- Deferred compensation funds.

The offset of investment income against interest expense cannot exceed the total interest expense included in allowable cost.

Lines 5 and 6.--Enter these discounts, rebates, and refunds on these lines only when such receipts have not already been netted against the appropriate expense in the accounting records.

The recommended offset of these amounts against the administrative and general cost center is appropriate only if the related expense cannot be identified. (See CMS Pub. 15-1, §804.)

Line 11.--If the expense applicable to these activities is insignificant, make the adjustment on this line. However, these and similar activities are normally set up as nonreimbursable cost centers on Worksheet B since the amounts involved are usually significant.

Line 15.--Obtain any amount entered on this line from Worksheet A-8-1.

Line 16.--Enter the amount obtained from Worksheet A-8-2, column 18, the total line.

NOTE: Make the adjustments on Worksheet A, column 7 for the various cost centers affected by provider-based physicians by referring to the adjustments for the corresponding cost centers on Worksheet A-8-2, column 18. Reasonable compensation equivalent limits do not apply to a medical director, a chief of medical staff, or to the compensation of any physician employed in a capacity not requiring the services of a physician, such as a controller.

Lines 17 through 49.--Enter any additional adjustments which are required under the Medicare principles of reimbursement. Appropriately label the lines to indicate the nature of the required adjustments.

Line 50.--Enter the total of lines 1 through 49. Transfer all the amounts on lines 1 through 49, column 2, to the appropriate lines on Worksheet A, column 7.

4508. WORKSHEET A-8-1 - STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS

Worksheet A-8-1 provides for the computation of any needed adjustments to costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control. In addition, certain information concerning the related organizations with which the provider has transacted business must be shown. (See CMS Pub. 15-1, chapter 10, §1004.)

Part I.--Cost applicable to services, facilities, and supplies furnished to you by organizations related to you by common ownership or control are includable in your allowable cost at the cost to the related organizations. However, such cost must not exceed the amount a prudent and cost conscious buyer pays for comparable services, facilities, or supplies that are purchased elsewhere.

Part II.--Use this part to show your relationship to organizations and/or home office for which transactions were identified in Part I. Show the requested data relative to all individuals, partnerships, corporations, or other organizations having either a related interest to you, a common ownership with you, or control over you as defined in CMS Pub. 15-1, chapter 10, §1004 in columns 1 through 6, as appropriate.

Complete only those columns which are pertinent to the type of relationship which exists.

Column 1.--Enter the appropriate symbol which describes relationship of the provider to the related organization.

Column 2.--If the symbol A, D, E, F, or G is entered in column 1, enter the name of the related individual in column 2.

Column 3.--If the individual indicated in column 2 or the organization in column indicated in column 4 has a financial interest in the provider, enter the percent of ownership as a ratio.

Column 4.--Enter the name of the related corporation, partnership or other organization.

Column 5.--If the individual in column 2 or the provider has a financial interest in the related organization, enter the percent of ownership in such organization as a ratio.

Column 6.--Enter the type of business in which the related organization engages (e.g., medical drugs and/or supplies, laundry and linen service).

4509. WORKSHEET A-8-2 - PROVIDER-BASED PHYSICIAN ADJUSTMENTS

In accordance with 42 CFR 413.9, 42 CFR 415.55, 42 CFR 415.60, 42 CFR 415.70, and 42 CFR 415.102(d), you may claim as allowable cost only those costs which you incur for physician services that benefit the general patient population of the provider. 42 CFR 415.70 imposes limits on the amount of physician compensation which may be recognized as a reasonable provider cost.

Worksheet A-8-2 provides for the computation of the allowable provider-based physician cost you incur. 42 CFR 415.60 provides that the physician compensation paid by you must be allocated between services to individual patients (professional services), services that benefit your patients generally (provider services), and nonreimbursable services such as research. Only provider services are reimbursable to you through the cost report. This worksheet also provides for the computation of the reasonable compensation equivalent (RCE) limits required by 42 CFR 415.70. The methodology used in this worksheet applies the RCE limit to the total physician compensation attributable to provider services reimbursable on a reasonable cost basis.

NOTE: Where several physicians work in the same department, see CMS Pub. 15-1, chapter 21, §2182.6C for a discussion of applying the RCE limit in the aggregate for the department versus on an individual basis to each of the physicians in the department.

Column Descriptions

Columns 1 and 10.--Enter the line numbers from Worksheet A for each cost center that contained compensation for physicians subject to RCE limits. Enter the line numbers in the same order as displayed on Worksheet A.

Columns 2 and 11.--Enter the description of the cost center used on Worksheet A. When RCE limits are applied on an individual basis to each physician in a department, list each physician on successive lines directly under the cost center description line, or list the first physician on the same line as the cost center description line and then each successive line below for each additional physician in that cost center.

List each physician using an individual identifier (not the physician’s name, NPI, UPIN or social security number of the individual), but rather, Dr. A, Dr. B…, Dr. AA, Dr. BB, etcetera. However, the identity of the physician must be made available to your contractor upon audit. When RCE limits are applied on a departmental basis, insert the word "aggregate" (instead of the physician identifiers) on the line below the cost center description.

Columns 3 through 9 and 12 through 18.--When the aggregate method is used, enter the data for each of these columns on the aggregate line for each cost center. When the individual method is used, enter the data for each column on the individual physician identifier lines for each cost center.

Column 3.--Enter the total physician compensation paid by the provider for each cost center. Physician compensation is monetary payments, fringe benefits, deferred compensation, costs of physician membership in professional societies, continuing education, malpractice, and any other items of value (excluding office space or billing and collection services) that a provider or other organization furnishes a physician in return for the physician's services. (See 42 CFR 415.60(a).) Include the compensation in column 4 of Worksheet A or, if necessary, through appropriate reclassifications or as a cost paid by a related organization through Worksheet A-8-1.

Column 4.--Enter the amount of total remuneration included in column 3 which is applicable to the physician's services to individual patients (professional component). These services are reimbursed on a reasonable charge basis by the Part B carrier in accordance with 42 CFR 415.102(a). The written allocation agreement between you and the physician specifying how the physician spends his or her time is the basis for this computation. (See 42 CFR 415.60(f).)

Column 5.--Enter the amount of the total remuneration included in column 3, for each cost center, applicable to general services to you (provider component). The written allocation agreement is the basis for this computation. (See 42 CFR 415.60(f).)

NOTE: 42 CFR 415.60(b) requires that physician compensation be allocated between physician services to patients, the provider, and nonallowable services such as research. Physicians' nonallowable services must not be included in columns 4 or 5. The instructions for column 18 ensure that the compensation for nonallowable services included in column 3 is correctly eliminated on Worksheet A-8.

Column 6.--Enter for each line of data, as applicable, the reasonable compensation equivalent (RCE) limit applicable to the physician's compensation included in that cost center. The amount entered is the limit applicable to the physician specialty as published in the **Federal Register** before any allowable adjustments.

The RCE limits are updated annually on the basis of updated economic index data. A notice is published in the **Federal Register**, which sets forth the new limits. The RCE applicable to the various specialties is obtained from that notice. If the physician specialty is not identified in the table, use the RCE for the total category in the table. The beginning date of the cost reporting period determines which calendar year (CY) RCE is used. Your location governs which of the three geographical categories are applicable: non-metropolitan areas, metropolitan areas less than one million, or metropolitan areas greater than one million.

Column 7.--For each line of data enter the physician's hours allocated to provider services. For example, if a physician works 2080 hours per year and 50 percent of his/her time is spent on provider services, then enter 1040. The hours entered are the actual hours for which the physician is compensated by the provider for furnishing services of a general benefit to its patients. If the physician is paid for unused vacation, unused sick leave, etc., exclude the hours paid from the hours entered in this column. Time records, or other documentation that supports this allocation, must be available for verification by the contractor upon request. (See CMS Pub. 15-1, chapter 21, §2182.3E.)

Column 8.--Enter the unadjusted RCE limit for each line of data. This amount is the product of the RCE amount entered in column 6 and the ratio of the physician's provider component hours entered in column 7 to 2080 hours.

Column 9.--For each line of data enter five percent of the amounts entered in column 8.

Column 12.--The computed RCE limit in column 8 may be adjusted upward, up to five percent of the computed limit (column 9), to take into consideration the actual costs of membership for physicians in professional societies and continuing education paid by the provider.

Enter, for each line of data, the actual amounts of these expenses paid by you.

Column 13.--For each line of data enter the result of multiplying the amount in column 5 by the amount in column 12 and divide the result by the amount in column 3.

Column 14.--The computed RCE limit in column 8 may also be adjusted upward to reflect the actual malpractice expense incurred by you for the services of a physician or group of physicians to your patients.

Enter for each line of data the actual amounts of these malpractice expenses paid by you.

Column 15.--For each line of data enter the result of multiplying the amount in column 5 by the amount in column 14 and divide the result by the amount in column 3.

Column 16.--For each line of data enter the sum of the amounts in columns 8 and 15 plus the lesser of the amounts in columns 9 or 13.

Column 17.--Compute the RCE disallowance for each cost center by subtracting the RCE limit in column 16 from your component remuneration in column 5. If the result is a negative amount, enter zero in this column.

Column 18.--The adjustment for each cost center to be entered represents the provider-based physician (PBP) elimination from costs entered on Worksheet A-8, column 2, line 16. Compute the amount by deducting, for each cost center, the lesser of the amounts recorded in column 5 (provider component remuneration) or column 16 (adjusted RCE limit) from the total remuneration recorded in column 3.

Line 100 - Total Line.--Total the amounts in columns 3 through 5, 7 through 9, and 12 through 18.

4510. WORKSHEET B - COST ALLOCATION - GENERAL SERVICE COSTS AND WORKSHEET B-1 - COST ALLOCATION - STATISTICAL BASIS

In accordance with 42 CFR 413.24, cost data must be based on an approved method of cost finding and on the accrual basis of accounting except where governmental institutions operate on a cash basis of accounting. Cost finding is the process of recasting the data derived from the accounts ordinarily kept by a provider to ascertain costs of the various types of services rendered. It is the determination of these costs by the allocation of direct costs and proration of indirect costs. Obtain the total direct expenses from Worksheet A, column 7.

Worksheets B and B-1 facilitate the step-down method of cost finding. This method recognizes that general services of the CMHC are utilized by other general service, direct patient care service, and nonreimbursable cost centers. Worksheet B provides for the equitable allocation of general service costs based on statistical data reported on Worksheet B-1. To facilitate the allocation process, the general format of Worksheets B and B-1 is identical. The column and line numbers for each general service cost center are identical on the two worksheets. Prepare these worksheets in conjunction with each other.

The statistical basis shown at the top of each column on Worksheet B-1 is the recommended basis of allocation. The total statistic for cost centers using the same basis (e.g., square feet) may differ with the closing of preceding cost centers.

Close the general service cost centers in accordance with 42 CFR 413.24(d)(1) so that the cost centers rendering the most services to and receiving the least services from other cost centers are closed first (see CMS Pub. 15-1, chapter 23, §2306.1). If a more accurate result is obtained by allocating costs in a sequence that differs from the recommended sequence, the CMHC must request approval in accordance with CMS Pub. 15-1, chapter 23, §2313.

If the amount of any cost center on Worksheet A, column 8, has a negative balance, show this amount as a negative balance on Worksheet B, column 0. Allocate the costs from the overhead cost centers to applicable cost centers, including those with a negative balance. If after receiving costs from the applicable overhead cost centers, a general service cost center has a credit balance at the point it is to be allocated, do not allocate such general service cost center. Rather, enter the credit balance in parenthesis on line 100 of the appropriate column, as well as the first line of the column.

This enables you to cross foot column 14, line 100 to column 0, line 100. After receiving costs from the applicable overhead cost centers, if a revenue producing cost center has a credit balance on Worksheet B, column 14, do not carry such credit balance forward to Worksheet C.

On Worksheet B-1, enter on the first line of each column the total statistics applicable to the cost center being allocated (e.g., in column 1, Capital-Related Costs - Buildings and Fixtures, enter on line 1 the total square feet of buildings on which depreciation was taken). Use accumulated cost for allocating A&G expenses.

For each cost center being allocated, enter that portion of the total statistical base applicable to each cost center receiving services. For each column, the sum of the statistics entered for cost centers receiving services must equal the total statistical base entered on the first line. Such statistical base, including accumulated cost for allocating A&G expenses, does not include any statistics related to services furnished under arrangements except where:

- Both Medicare and non-Medicare costs of arranged for services are recorded in the CMHC's books/records; or

- The contractor determines that the CMHC is able to and does gross up the costs and charges for services to non-Medicare patients so that both cost and charges are recorded as if the CMHC had furnished such services directly to all patients. (See CMS Pub. 15-1, chapter 23, §2314.)

Enter on line 101 the total expenses of the cost center being allocated. Obtain this amount from the same column and line number on Worksheet B used to enter the total statistical base on Worksheet B-1. (In the case of buildings and fixtures, this amount is on Worksheet B, column 1, line 1.)

Divide the amount entered on line 101 by the total statistical base entered in the same column on the first line. Enter the resulting unit cost multiplier on line 102. Enter the resulting unit cost multiplier (rounded to six decimal places) on line 102.

Multiply the unit cost multiplier by that portion of the total statistical base applicable to each cost center receiving the services rendered. Enter the result of each computation on Worksheet B in the corresponding column and line.

After the unit cost multiplier has been applied to all the cost centers receiving the services rendered, the total cost (line 101) of all of the cost centers receiving the allocation on Worksheet B must equal the amount entered on the first line. Perform the preceding procedures for each general service cost center. Complete the column for each cost center on both Worksheets B and B-1 before proceeding to the next column for the cost center.

After all the costs of the general service cost centers have been allocated on Worksheet B, enter in column 14, the sum of expenses on lines 23 through 100, columns l through 13. The total expenses entered in column 14, line 101, must equal the total expenses entered in column 0, line 101.

Transfer the totals in column 14, lines 23 through 32 of Worksheet B to Worksheet C, column l. Do not transfer the nonreimbursable cost centers, lines 42 through 100.

NOTE: Whenever an adjustment is required to expenses after cost allocation, submit a supporting worksheet showing the computation of the adjustment, the amount applicable to each cost center, and the cost center balances which are to be carried forward from Worksheet B for cost apportionment to the health care programs.

Column Descriptions

Column 1.--Depreciation on buildings and fixtures and expenses pertaining to buildings and fixtures e.g., insurance, interest, rent, and real estate taxes are combined in this cost center to facilitate cost allocation. Allocate all expenses to the cost centers on the basis of square feet of area occupied.

If a CMHC occupies more than one building, it may allocate the depreciation and related expenses by building, using a supportive worksheet showing the detail allocation and transferring the accumulated costs by cost center to Worksheet B, column 1.

Column 2.--If you do not directly assign the depreciation on movable equipment and expenses pertaining to movable equipment, e.g., insurance, interest and rent, as part of your normal accounting systems, you must accumulate the expenses in this cost center. Allocate all expenses (e.g., interest, personal property tax) for movable equipment to the appropriate cost centers on the basis of square feet of area occupied or dollar value.

Column 3.--The salary statistics used for employee health and welfare cost allocation must be reconcilable to total salaries and salary by department shown on Worksheet A, column 1. Adjustments are necessary to take into account salaries reclassified in column 5 of Worksheet A and the salaries adjusted in column 7 of Worksheet A.

Column 4.--Allocate the administrative and general expenses on the basis of accumulated cost. Therefore the amount entered in Worksheet B-1, column 4 is the sum of Worksheet B, columns 1 through 3, lines as applicable.

A negative cost center balance in the statistics for allocating administrative and general expenses causes an improper distribution of this overhead cost center. Exclude negative balances from the allocation statistics.

Worksheet B-1, Column 4A.--Enter the costs attributable to the difference between the total accumulated cost reported on Worksheet B, column 3A, line 101 and the accumulated cost reported on Worksheet B-1, column 4, line 4. Enter any amounts reported on Worksheet B, column 3A for (1) any service provided under arrangements to program patients that is not grossed up and (2) negative balances. Including these costs in the statistics for allocating administrative and general expenses causes an improper distribution of overhead. In addition, report on line 4 the administrative and general costs reported on Worksheet B, column 4, line 4 since these costs are not included on Worksheet B-1, column 4 as an accumulated cost statistic.

For subscripted A&G cost centers, the accumulated cost center line number must match the reconciliation column number. Include in the column number the alpha character "A", i.e., if the accumulated cost center for A&G is line 4 (A&G), the reconciliation column designation must be 4A.

Worksheet B-1, Column 4.--The administrative and general expenses are allocated on the basis of accumulated costs. Therefore, the amount entered on Worksheet B-l, column 4, line 4, is the difference between the amounts entered on Worksheet B, column 3A and Worksheet B-1, column 4A. A negative cost center balance in the statistics for allocating administrative and general expenses causes an improper distribution of this overhead cost center. Exclude negative balances from the allocation statistics.

4511. WORKSHEET C - APPORTIONMENT OF PATIENT SERVICE COSTS

To determine the allowable costs applicable to the Medicare program, apportion the costs between the Medicare beneficiaries and the other patients. The basis of the apportionment is the gross amount of charges for each reimbursable cost center.

Column 1.--Enter the total cost of each cost center as computed on Worksheet B, column 14, corresponding lines. Do not bring forward any cost center with a credit balance from Worksheet B, column 14.

Column 2.--Enter on each line (from your records) the gross total patient charges for each cost center.

Column 3.--Divide the cost for each cost center in column 1 by the corresponding gross charges in column 2 to determine the ratio of cost to charges for each cost center. Carry the ratio out to six decimal places.

Column 4.--Enter, from your records or PS&R, the Medicare program charges for each cost center If you charge some patients less than the customary charges for services rendered because of the patients' inability to pay or for any other reason, those charges are increased (for apportionment purposes) to reflect the gross amounts.

Thus, for computing reimbursable costs on this worksheet, the individual amounts applicable to Medicare program patients must not differ from the amounts applicable to all other patients for the same services.

When certain services by a provider are furnished under arrangements and an adjustment is made on Worksheet A-8 to gross up costs, the related charges entered on Worksheet C are also grossed up in accordance with CMS Pub. 15-1, chapter 23, §2314.

Column 5.--Calculate the Medicare cost by multiplying the cost to charge ratio from column 3 by the Medicare charges in column 4 for each reimbursable cost center listed for lines 23 through line 32.

Line 50.--Enter the total of lines 23 through 32.

4512. WORKSHEET D - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR COMMUNITY MENTAL HEALTH CENTERS - TITLE XVIII

Worksheet D applies to title XVIII only and provides for the reimbursement calculation of CMHC services rendered to Medicare beneficiaries.

Line Descriptions

Line 1.--Enter the gross APC/PPS payments (includes deductible and coinsurance).

Line 2.--Enter the amount of outlier payments.

Line 3.--Enter the outlier reconciliation amount from line 54.

Line 4.--Enter the sum of lines 1 through 3.

Line 5.--Enter the amounts paid or payable by primary payers when Medicare liability is secondary to that of the primary payer.

Line 6.--Enter the total amount of deductibles billed to program patients (do not include coinsurance).

Line 7.--Enter in the applicable the column the gross coinsurance amount billed to Medicare beneficiaries.

Line 8.--Enter the sum of line 4 minus lines 5, 6, and 7.

Line 9.--Enter the gross reimbursable bad debts, net of bad debt recoveries, applicable to any Medicare deductibles and coinsurance. The amount entered applicable to CMHC PPS must not exceed the discounted coinsurance applicable to Medicare beneficiaries.

Line 10.--Enter the adjusted Medicare bad debt, line 9 (including negative amounts) times 65 percent.

Line 11.--Enter the reimbursable bad debts for dual eligible beneficiaries. This amount is reported for informational purposes and is a subset of the amount reported on line 9.

Line 12.--Enter the result of line 8 plus line 10.

Line 13.--Enter any other adjustments. Enter increases to costs as a positive amount and decreases as a negative amount.

Line 14.--Enter all demonstration payment adjustment amounts before sequestration.

Line 15.--Amount due before sequestration (line 12, minus lines 13 and 14).

Line 16.--Enter the sequestration adjustment amount as follows: (2 percent times (total days in the cost reporting period that occur during the sequestration period, divided by total days in the entire cost reporting period, rounded to four decimal places) times line 15).

Line 17.--Enter all demonstration payment adjustment amounts after sequestration. Enter increases to costs as a positive amount and decreases to costs as a negative amount.

Line 18.--Amount due after sequestration (line 15, minus lines 16 and 17).

Line 19.--Enter the total interim payments applicable to this cost reporting period from Worksheet D-1, line 4.

Line 20.--For contractor final settlement, report the amount from Worksheet D-1, line 5.99.

Line 21.--Enter the amount from line 18 minus the amounts on lines 19 and 20. This represents the amount due to or from the provider. Transfer this amount to Worksheet S, Part III, line 1.

Line 22.--Enter protested amounts.

DO NOT COMPLETE THE REMAINDER OF WORKSHEET D, LINES 50 THROUGH 54 ARE FOR CONTRACTOR USE ONLY.

Line 50.--Enter the original outlier amount from line 2.

Line 51.--Enter the outlier reconciliation adjustment amount in accordance with CMS Pub. 100-04, chapter 4, §§10.7.2.2 through 10.7.2.4.

Line 52.--Enter the rate used to calculate the time value of money. (See CMS Pub. 100-04, chapter 4, §§10.7.2.2 through 10.7.2.4.)

Line 53.--Enter the time value of money.

Line 54.--Enter sum of lines 51 and 53.

4513. WORKSHEET D-1 - ANALYSIS OF PAYMENTS TO COMMUNITY MENTAL HEALTH CENTERS FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Complete this worksheet for Medicare interim payments only. (See 42 CFR §413.64.)

Complete lines 1 through 4. The remainder of the worksheet is completed by your contractor.

Line Descriptions

Line 1.--Enter the total Medicare interim payments paid to the CMHC. Include all Prospective Payment System (PPS) payments for CMHC services. Do not include payments received for services reimbursed on a fee schedule basis. The amount entered reflects the sum of all interim payments paid on individual bills (net of adjustment bills) for services rendered in this cost reporting period. The amount entered must include amounts withheld from the CMHC's interim payments due to an offset against overpayments to the CMHC applicable to prior cost reporting periods. It does not include any retroactive lump sum adjustment amounts based on a subsequent revision of the interim rate or tentative or net settlement amounts; nor does it include interim payments payable. If the CMHC is reimbursed under the periodic interim payment method of reimbursement, enter the periodic interim payments received for this cost reporting period.

Line 2.--Enter the total Medicare interim payments payable on individual bills. Since the cost in the cost report is on an accrual basis, this line represents the amount of services rendered in the cost reporting period, but not paid as of the end of the cost reporting period, and does not include payments reported on line 1.

Line 3.--Enter the amount of each retroactive lump sum adjustment and the applicable date.

Line 4.--Enter the total amount of the interim payments (sum of lines 1, 2, and 3.99). Transfer these totals to Worksheet D, line 19.

DO NOT COMPLETE THE REMAINDER OF WORKSHEET D-1. LINES 5 THROUGH 7 ARE FOR CONTRACTOR USE ONLY. (EXCEPTION: IF WORKSHEET S, PART I, LINE 5, IS "5" (AMENDED COST REPORT), THE PROVIDER MAY COMPLETE THIS SECTION.)

Line 5.--List separately each tentative settlement payment after desk review together with the date of payment. If the cost report is reopened after the Notice of Program Reimbursement (NPR) has been issued, report all settlement payments prior to the current reopening settlement on line 5.

Line 6.--Enter the net settlement amount (balance due to the provider or balance due to the program) for the NPR, or, if this settlement is after a reopening of the NPR, for this reopening.

NOTE: On lines 3, 5, and 6, when an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment, even though total repayment is not accomplished until a later date.

Line 7.--Enter the sum of the amounts on lines 4, 5.99 and 6. The amount must equal Worksheet D, line 18.

4514. FINANCIAL STATEMENT WORKSHEET

Prepare this worksheet from the CMHC accounting books and records. Cost reports received with an incomplete worksheet F are returned to you for completion. If you do not follow this procedure, you are considered as having failed to file a cost report.

4514.1 Worksheet F - Statement of Revenues and Expenses.--This worksheet requires the reporting of total revenues for the entire facility and total operating expenses for the entire facility. If cost report total revenues and total expenses differ from those on your filed financial statements, submit a reconciliation report with the cost report submission.

Line 1 - Total Patient Revenue.--Enter on this line total patient revenues.

Line 2 - Less: Allowance and Discounts on Patient's Accounts.--Enter on this line total patient revenues not received. This includes:

Provision for Bad Debts,
Contractual Adjustments,
Charity Discounts,
Teaching Allowances,
Policy Discounts,
Administrative Adjustments, and
Other Deductions from Revenue

Line 3 - Net Patient Revenues.--Line 1 minus line 2.

Line 4 - Less: Total Operating Expenses.--Transfer from Worksheet A, column 4, line 100.

Line 5 - Net Income from Service to Patients.--Line 3 minus line 4.

Lines 6 through 22.--Enter on the appropriate line 6 through 19 all other revenue not reported on line 1. Obtain these amounts from your accounting books and/or records.

Line 20 - Other (Specify).--Enter all other revenue not reported on lines 6 through 19. Obtain this from your accounting books and/or records. Subscript this line as necessary.

Line 21 - Total Other Income.--Enter the sum of lines 6 through 20.

Line 22 - Total.--Enter the sum of lines 5 and 21.

Lines 23 through 25.--Enter on the appropriate lines 23 through 25, expenses from your books and records.

Line 26 - Other Expenses (Specify).--Enter all other expenses not reported on lines 23 through 25. Subscript this line as necessary.

Line 27 - Total Other Expenses.--Enter the sum of line 23 through 26.

Line 28 - Net Income (or Loss) for the Period.--Enter the result of line 22 minus line 27.

EXHIBIT 1 - Form CMS-2088-17

The following is a listing of the Form CMS-2088-17 worksheets and the page number location.