

CHAPTER 49

SKILLED NURSING FACILITY AND SKILLED NURSING
FACILITY HEALTHCARE COMPLEX COST REPORT
FORM CMS-2540-24

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4900 GENERAL

In accordance with the Paperwork Reduction Act (PRA) of 1995, CMS must inform the private sector why information is collected and how it will be used. Under the authority of §§1815(a) and 1833(e) of the Social Security Act (the Act), CMS requires each provider of services (hereafter “provider”) participating in the Medicare program to submit annual information, the Medicare cost report, to determine costs for healthcare services rendered to Medicare beneficiaries. In regulations at 42 CFR 413.20 and 413.24, CMS presents the requirements for adequate cost data and annual provider cost reports. Accordingly, this chapter presents Form CMS-2540-24 and instructions, effective for cost reporting periods beginning on or after October 1, 2022, and ending on or after September 30, 2023, to be completed by each freestanding skilled nursing facility (SNF) and SNF healthcare complex, both hereinafter referred to as SNF. The information reported must conform to the requirements and principles set forth in the Provider Reimbursement Manual, Part I (CMS Pub. 15-1).

Only an independent (also known as freestanding) SNF and, if applicable, a home health agency (HHA) or hospice reported as part of the SNF healthcare complex, completes Form CMS-2540-24.

In regulations at 42 CFR § 413.24(f)(4), CMS presents the requirement that each SNF submit an annual cost report to the Medicare Administrative Contractor (contractor) in an American Standard Code for Information interchange (ASCII) electronic cost report (ECR) format. The provider must submit the cost report on or before the last day of the fifth month following the close of the period covered by the report unless the contractor grants an extension in accordance with 42 CFR 413.24(f)(2)(ii). When a provider, voluntarily or involuntarily, ceases participation in the health insurance program or experiences a change of ownership, the provider must submit a cost report no later than 150 days following the effective date of the termination of the participation agreement or the change of ownership.

The Form CMS-2540-24 also provides for the computation of reimbursable costs applicable to titles V and XIX. Complete the worksheets and portions of worksheets applicable to titles V and XIX only when claiming reimbursement from those programs and only to the extent, your State program requires these forms.

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 OMB control number for this information collection is 0938-0463. The expiration date of this information collection instrument is [month, day, year]. The time required to complete this information collection is estimated to average 202 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Direct any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form to: Centers for Medicare and Medicaid Services, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records, or any documentation 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.

4900.10 Reporting Standards.

Electronic reporting requires standards for reporting certain types of data. Apply the following standards to the SNF cost report:

Positive and Negative Numbers--Enter positive values without plus signs. Enter negative values with a minus sign in front unless the field is defined as negative on the schedule.

Rounding Computations--Where a computation results in a fraction, present the result written in decimal form and round as follows:

- Round to two decimal places:
 - Percentages
 - Averages, standard work week, payment rates, cost limits
 - Full time equivalent employees
 - Per diems, hourly rates
- Round ratios (e.g., unit cost multipliers, cost-to-charge ratios, days-to-total-days ratios) to six decimal places

Round computations to two decimal places unless otherwise specified. If a residual exists as a result of computing costs using a fraction, adjust the largest absolute value resulting from the computation by the residual amount. For example, in cost finding, a unit cost multiplier (UCM) 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 to be allocated. Adjust the largest absolute value resulting from the allocation by the residual amount so that the sum of the allocated amounts equals the amount to be allocated.

Percentages--Express percentages as decimal equivalents, i.e., 8.75% as .087500.

Decimal Numbers--Express decimal numbers as follows:

- include the decimal point
- exclude leading zeroes to the left of the decimal
- include trailing zeroes to the right of the decimal

Dates--Enter dates in the mm/dd/yyyy format unless otherwise specified.

Yes/No Responses--Where a question requires either a yes or a no response, enter Y for yes or N for no.

Shading--Where shading appears on a line or in a column, no response is permitted.

4900.20 Acronyms and Abbreviations.

Commonly used acronyms and abbreviations in the Medicare cost report include:

A&G	Administrative and General
BBA	Balanced Budget Act of 1997 (Pub. L. 105-33)
CAP-REL	Capital-Related
CBSA	Core-Based Statistical Area
CCN	CMS Certification Number
CFR	Code of Federal Regulations
CMS	Centers for Medicare & Medicaid Services
CMS Pub.	Centers for Medicare & Medicaid Services Publication
CNA	Certified Nursing Assistant
COL	Column
CPA	Certified Public Accountant
FFS	Fee for Service
FR	Federal Register
HCHC	Hospice Continuous Home Care
HGIP	Hospice General Inpatient Care
HIRC	Hospice Inpatient Respite Care
HRHC	Hospice Routine Home Care
HHA	Home Health Agency
HSPC	Hospice
HO/CO	Home Office/Chain Organization
ICF/IID	Intermediate Care Facility for Individuals with Intellectual Disabilities
IOM	Internet Only Manual
IV	Intravenous
LCC	Lesser of Reasonable Cost or Customary Charges
LOC	Level of Care
LPN	Licensed Practical Nurse
MSA	Metropolitan Statistical Area
NF	Nursing Facility
NPI	National Provider Identifier
NPWT	Negative Pressure Wound Therapy
OBRA	Omnibus Budget Reconciliation Act
OT	Occupational Therapy
PDPM	Patient-Driven Payment Model
PEP	Partial Period Payment
PPS	Prospective Payment System
PRM	Provider Reimbursement Manual
PS&R	Provider Statistical and Reimbursement Report (or System)
PT	Physical Therapy
RCE	Reasonable Compensation Equivalent
RN	Registered Nurse
RT	Respiratory Therapy
SLP	Speech Language Pathology
SNF	Skilled Nursing Facility
QA	Quality Assurance
UCM	Unit cost multiplier
WKST	Worksheet

4900.30 Instructional, Regulatory, and Statutory Effective Dates.

These instructions present effective dates as needed when implementing instructions and referencing related regulations and/or statutes.

Where applicable, dates in parentheses at the end of select paragraphs and/or sentences indicate the effective date, generally the end of a cost reporting period. However, a “b” following the date indicates an effective date for cost reporting periods beginning on or after the specified date, e.g., (10/01/2022b). An “s” following the date indicates an effective date for services rendered on or after the specified date, e.g., (04/01/2023s). Instructions not followed by a date are effective for cost reporting periods beginning on or after October 1, 2022, and ending on or after September 30, 2023.

4900.40 Recommended Sequence Of Completion.

Part I - Departmental Cost Adjustments and Cost Allocation

<u>Step</u>	<u>Worksheet</u>	<u>Instruction</u>
1	S-2	Read §§4901.30. Complete worksheet.
2	S-3, Part I	Read §4901.41. Complete worksheet.
3	A	Read §4902.10. Complete columns 1 through 6, lines 1 through 100.
4	S-3, Parts II, III, & V	Read §§4901.42, 4901.43, and 4901.45. Complete all worksheets.
5	A-6	Read §4902.70. Complete, if applicable.
6	A	Read §4902.10. Complete columns 7 and 8, lines 1 through 100.
7	A-7	Read §§4902.80 through 4902.82. Complete entire worksheet.
8	A-8	Read §4902.90. Complete entire worksheet.
9	A-8-1, Parts, I & II	Read §§4902.100 through 4902.102. Complete entire worksheet.
10	A-8-2	Read §4902.110. Complete, if applicable.
11	S-3, Part IV	Read §4901.44. Complete entire worksheet.
12	A	Read §4902.10. Complete columns 9 and 10, lines 1 through 100.
13	B, Parts I & II; B-1; B-2	Read §§4903 through 4903.30. Complete all worksheets entirely.

Part II - Departmental Cost Distribution and Cost Apportionment

<u>Step</u>	<u>Worksheet</u>	<u>Instruction</u>
1	C	Read §§4904 through 4904.10. Complete entire worksheet.
2	D	Read §§4905 through 4905.10. Complete entire worksheet. Complete a separate worksheet for each applicable healthcare program for the SNF and the nursing facility (NF).
3	D-1	Read §4905.20. Complete entire worksheet. Complete a separate worksheet for each title V and XIX, as applicable.

Part III - Calculation of Reimbursement Settlement

<u>Step</u>	<u>Worksheet</u>	<u>Instruction</u>
1	E, Parts A & B	Read §§4906 through 4906.20. Complete both worksheets.
2	E-1	Complete lines 1 through 4. See §4906.30.
3	E-2	Complete entire worksheet. See §4906.40.
4	G; G-2, G-3	Read §§4908 through 4908.40. Complete the worksheets.

Part IV - Calculation of Reimbursement Settlement of SNF Based-Facilities

<u>Step</u>	<u>Worksheet</u>	<u>Instruction</u>
1	S-4, Parts I, II, III, & IV	Read §§4901.50 through 4901.54. Complete this worksheet when applicable.
2	H	Read §§4909 through 4909.10. Complete this worksheet when applicable.
3	H-1, Parts I & II	Read §4909.20. Complete this worksheet when applicable.
4	H-2, Parts I & II	Read §§4909.30 through 4909.32. Complete this worksheet when applicable.
5	H-3, Parts I, II, & III	Read §§4909.40 through 4909.43. Complete this worksheet when applicable.
6	H-4, Parts I & II	Read §§4909.50 through 4909.52. Complete this worksheet when applicable.
7	H-5	Read §4909.60. Complete this worksheet when applicable.

<u>Step</u>	<u>Worksheet</u>	<u>Instruction</u>
8	S-5, Parts I & II	Read §§4901.60 through 4901.62. Complete this worksheet when applicable.
9	K-1, K-2, K-3, & K-4	Read §4912.20. Complete these worksheets when applicable.
10	K	Read §4912.10. Complete this worksheet when applicable.
11	K-5	Read §4912.60. Complete this worksheet when applicable.
12	K-6, Parts I & II	Read §§ 4912.70. Complete these worksheets when applicable.
13	K-7	Read §4912.80. Complete this worksheet when applicable.
14	K-8	Read §4912.90. Complete this worksheet when applicable.

Part V - Additional Data

<u>Step</u>	<u>Worksheet</u>	<u>Instruction</u>
1	S, Parts I, II, & III	Read §§4901.10 through 4901.13. Complete Part III; then complete Parts I and II.

4901 S SERIES

On the S series of worksheets, the SNF reports identifying information and data about the SNF and if applicable, its SNF-based HHA and/or hospice. The S series consists of the following worksheets:

- Worksheet S - Skilled Nursing Facility and Skilled Nursing Facility Healthcare Complex Cost Report Status, Certification, and Settlement Summary
- Worksheet S-2 - Identification Data
- Worksheet S-3 - Statistical Data
- Worksheet S-4 - SNF-Based Home Health Agency Statistical Data
- Worksheet S-5 - SNF-Based Hospice Statistical Data

4901.10 WORKSHEET S - SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTHCARE COMPLEX COST REPORT STATUS, CERTIFICATION, AND SETTLEMENT SUMMARY

Worksheet S collects the cost report status, the provider certification of the cost report, and the summary of the cost report settlement.

4901.11 Part I - Cost Report Status.

This section is to be completed by the provider and contractor as indicated on the worksheet.

Line 1.--If the provider prepared the cost report electronically, enter Y in column 1 and, in columns 2 and 3, enter the date and time, respectively, the provider created the electronic cost report (ECR).

Line 2.--If the provider prepared the cost report manually, enter Y in column 1. Only providers submitting manually prepared cost reports, 1) reporting low Medicare utilization in accordance with CMS Pub. 15-2, chapter 1, §110, or 2) after demonstrating financial hardship in accordance with §133, may enter Y, and the provider must obtain contractor approval to submit a low utilization cost report in accordance with CMS Pub. 15-2, chapter 1, §110, or demonstrate financial hardship in accordance with 42 CFR 413.24(f)(4)(v).

Line 3.--If this is an amended cost report, enter the number of times the provider amended the cost report.

Line 4.--Enter the Medicare utilization level for the cost reporting period in column 1 by selecting one of the following options:

- Enter F for a full cost report.
- Enter L for a low Medicare utilization cost report (requires prior contractor approval; see CMS Pub. 15-2, chapter 1, §110).
- Enter N for no Medicare utilization cost report.

If column 1 is L, enter the date the contractor approved the written request in column 2.

NOTE FOR LINES 5 THROUGH 12: Contractor use only.

Line 5.--Enter the Healthcare Cost Report Information System (HCRIS) cost report status code that corresponds to the cost report status: 1=As-submitted; 2=Settled without audit; 3=Settled with audit; 4=Reopened; or 5=Amended.

Line 6.--Enter the date an accepted cost report was received from the provider.

Line 7.--Enter the 5-position contractor number.

Line 8.--Is this the initial cost report, i.e., the very first cost report for the CMS certification number (CCN) reported on Worksheet S-2, line 3, column 3, enter Y. Otherwise, enter N.

Line 9.--Is this the final cost report, i.e., terminating cost report for the CCN reported on Worksheet S-2, line 3, column 3, enter Y. Otherwise, enter N.

Line 10.--Enter the Notice of Program Reimbursement (NPR) date. The NPR date must be present if the contractor enters a cost report status code of 2, 3 or 4, on line 5.

Line 11.--Enter the ADR vendor code for the software used by the contractor to process this HCRIS cost report file. Use "4" for HFS MCRIF32.

Line 12.--For a reopened cost report (response to line 5 is 4), enter the number of times the cost report has been reopened.

4901.12 Part II - Certification.

An administrator or the chief financial officer completes this certification section to comply with the regulations set forth in 42 CFR 413.24(f)(4)(iv)(A) and (B) after the cost report is completed.

LINE DESCRIPTIONS

Line 1.--The signatory (administrator or Chief Financial Officer) must:

- when signing electronically through the ECR software, sign in column 1 as provided in 42 CFR 413.24(f)(4)(iv)(C)(1); and enter Y in column 2 to check the electronic signature checkbox to transmit the SNF cost report electronically with an electronic signature; or
- when signing outside the ECR software, sign in column 1 as provided in 42 CFR 413.24(f)(4)(iv)(C)(1); and enter Y in column 2 to check the electronic signature checkbox to submit the SNF cost report with an electronic signature; or
- sign in column 1 as provided in 42 CFR 413.24(f)(4)(iv)(C)(2); and make no entry in column 2 to submit the SNF cost report with an original signature.

Lines 2, 3, and 4.--Enter the signatory name, the signatory title, and the date signed, respectively.

4901.13 Part III - Settlement Summary.

Enter the balance due to or due from the applicable program for each applicable component of the program. Transfer settlement amounts as follows:

<u>Line - Component</u>	<u>From</u>			
	<u>Title V</u>	<u>Title XVIII Part A</u>	<u>Title XVIII Part B</u>	<u>Title XIX</u>
Line 1 - SNF	Wkst. E-2, Line 26	Wkst. E, Part A, Line 16	Wkst. E, Part B, Line 19	Wkst. E-2, Line 26
Line 2 - NF	Wkst. E-2, Line 26	N/A	N/A	Wkst. E-2, Line 26
Line 3 - ICF/IID	N/A	N/A	N/A	Wkst. E-2, Line 26
Line 4 - SNF-Based HHA	Wkst. H-4, Part II, Line 29	N/A	Wkst. H-4, Part II, Line 29	Wkst. H-4, Part II, Line 29

4901.30 WORKSHEET S-2 - IDENTIFICATION DATA

The information reported on this worksheet is needed to properly identify the provider, who controls it, as well as, to provide information on its operations.

Line 1.--Enter the SNF street address and, if applicable, the post office box number.

Line 2.--Enter the SNF city, state, ZIP code, and, if applicable, county, in columns 1 through 4, respectively.

Line 3 through 8.--For each applicable line, enter the component name, CCN, core-based statistical area (CBSA) code for the physical location of the SNF, the rural/urban designation (R for rural or U for urban), Medicare certification date (if applicable), and Medicaid certification date (if applicable), in columns 1 through 7. If reporting a component name on line 8, column 2, enter the component type in column 1.

Descriptions for lines 3 through 7.--

Line 3.--This is an institution that meets the requirements set forth in 42 CFR 483.1 that has been issued a CCN indicating that it meets the requirements of §1819 of the Act.

Line 4.--This is an institution or distinct part of an institution that meets the requirements set forth in 42 CFR 483.5 that has been issued a separate identification number indicating that it meets the requirements of §1919 of the Act.

Line 5.--This is an institution or distinct part of an institution that meets the requirements set forth in 42 CFR 440.150 that has been issued a separate identification number indicating that it meets the requirements of §1905 of the Act.

Line 6.--This is a SNF-based HHA that has been issued a CCN and meets the requirements of §§1861(o) and 1891 of the Act.

Line 7.--This is a SNF-based hospice that has been issued a CCN and meets the requirements of §1861(dd) of the Act.

Line 8.--Other (specify).--For any component type not identified on lines 3 through 7, enter the required information in the appropriate column. Subscript this line accordingly to accommodate multiple SNF-based CORFs (lines 8.00-8.09), OPTs (lines 8.10-8.19), OOTs (lines 8.20-8.29) and OSPs (lines 8.30-8.39).

Line 9.--Enter the cost reporting period beginning date and the cost reporting period ending date in columns 1 and 2, respectively. In accordance with the regulations at 42 CFR 413.24(f), providers must submit periodic reports of operations which generally cover a consecutive 12-month period of operations. See CMS Pub. 15-2, chapter 1, §§102.1 through 102.3, for situations when you may file a short period cost report.

Line 10--In column 1, enter the type-of-control code from the list below that indicates the type of ownership or auspices under which the SNF operates.

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

*Where an "other" item is selected (column 1 equals 2, 6, or 13), specify type-of-control in column 2.

SNF ORGANIZATION AND OPERATION

Line 11--Is the SNF a distinct part SNF that meets the requirements in 42 CFR 483.5? Enter Y or N.

Line 12--Is the SNF a composite distinct part SNF that meets the requirements set forth in 42 CFR 483.5? Enter Y or N. If Y, complete line 13 and subscripts as needed.

Line 13--If the response to line 12 is Y, enter the component name, street address, post office box number, city, state and ZIP code for the non-contiguous component in columns 1 through 6, respectively. For multiple non-contiguous component locations, subscript line 13 as needed to report each location.

Line 14--Did the SNF terminate participation in the Medicare program? Enter Y or N in column 1. If column 1 is Y, enter the termination date in column 2, and enter V, for voluntary termination, or I, for involuntary termination, in column 3.

Line 15--Did the SNF change ownership immediately prior to the beginning of this cost reporting period? Enter Y or N in column 1. If column 1 is Y, enter the date the change of ownership occurred in column 2. Submit documentation of the name and address of the new owner and a copy of the sales agreement with the cost report.

Line 16--Is the SNF part of a home office/chain organization (HO/CO) as defined in CMS Pub. 15-1, chapter 21, §2150? Enter Y or N in column 1. If column 1 is Y, enter the number of HO/COs allocating cost to the SNF in column 2. If column 1 is Y and column 2 is greater than or equal to 1, complete line 17, and Worksheet A-8-1.

Lines 17--If line 16, column 1 is Y, enter the HO/CO name, street address, post office box number (if applicable), city, state, ZIP code, HO/CO CCN, and HO/CO contractor number, in columns 1 through 8, respectively. If line 16, column 2, is greater than 1, subscript this line as needed to report each HO/CO allocating costs to the SNF.

Line 18--Did the total number of available beds permanently maintained for lodging inpatients change from the prior cost reporting period? These beds must be available for use and be housed in patient rooms or wards (i.e., do not include beds in corridors or temporary beds). (See 42 CFR §412.105(b) and CMS Pub. 15-1, §2200.2.C.) Enter Y or N in column 1. If column 1 is Y, and the change resulted in an increase or decrease in the number of Medicare certified beds, submit with the cost report a copy of the approval from the Regional Office for a change in Medicare bed size required under CMS Pub. 15-1, §2337.2.

Line 19--Did the SNF operate a ventilator care unit? Enter Y or N.

SNF OWNED SERVICES

Line 20.--Did the SNF and/or SNF-based HHA operate a Medicare approved laboratory with its own Clinical Laboratory Improvement Act (CLIA) number or CLIA certificate of waiver that meets the requirements in 42 CFR 493? Enter Y or N in column 1. If column 1 is Y, enter the CLIA number in column 2.

Line 21.--Did the SNF operate a radiological department that meets the standards required of a hospital furnishing such services under the program at 42 CFR 482.26 or the standards to provide portable x-ray services. Enter Y or N.

Line 22.--Did the SNF operate an institutional-based ambulance service. Enter Y or N in column 1. If column 1 is Y, enter the ambulance provider number in column 2.

Line 23.--Is the SNF involved in business transactions, including management contracts, with individuals or entities (e.g., drug or medical supply companies) that are related to the provider 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 or N. If Y, submit with the cost report a list of the individuals, the organizations involved, and a description of the transactions.

Lines 24 through 28--Reserved for future use.

PROFESSIONAL SERVICES PURCHASED BY THE SNF

Line 29.--Did the SNF or its sub-providers (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter a Y or N. If column 1 is Y, were the majority of the expenses (i.e., greater than 50 percent of the total professional services expenses) for services purchased from an unrelated organization located outside of the SNF's local area labor market (CBSA)? In column 2, enter Y or N.

SNF-BASED HHA THERAPY COSTS

Line 31.--Did the SNF-based HHA contract with outside suppliers for physical therapy (PT) services (see CMS Pub. 15-1, chapter 14)? Enter Y or N.

Line 32.--Did the SNF-based HHA contract with outside suppliers for occupational therapy (OT) services (see CMS Pub. 15-1, chapter 14)? Enter Y or N.

Line 33.--Did the SNF-based HHA contract with outside suppliers for speech language pathology (SLP) services (see CMS Pub. 15-1, chapter 14)? Enter Y or N.

MEDICAL MALPRACTICE

Line 34.--Is the SNF legally required to carry malpractice coverage? Enter Y or N. Malpractice insurance premiums are money paid to a commercial insurer to protect against potential negligence claims made by patients/clients.

Line 35.--If line 34 is Y, is the malpractice insurance coverage a claims-made or an occurrence policy? Enter a 1 for a claims-made insurance policy that covered claims first made (reported or filed) during the year the policy was in force for any incidents that occurred that year or during any previous period that the insured was covered under contract. Enter a 2 for an occurrence insurance policy that covered an incident occurring while the policy was in force regardless of when the claim arising out of that incident was filed.

Line 36.--If line 34 is Y, enter the total amount of malpractice premiums paid in column 1, the total amount of paid losses in column 2, (paid losses is money paid to compensate a patient/client for professional negligence), and the total amount of self-insurance paid in column 3, (self-insurance is money paid by a SNF or SNF healthcare complex whom acts as its own insurance company; see §2162 of CMS Pub. PRM 15-1).

Line 37.--Are malpractice premiums and paid losses reported in other than the Administrative & General (A&G) cost center? Enter a Y or N. If Y, submit with the cost report a supporting schedule listing cost centers and amounts.

Lines 38 and 39.--Reserved for future use.

LOWER OF COST OR CHARGE EXEMPTION

Line 40.--Did the SNF qualify for exemption from the application of the lesser of cost or charge (see 42 CFR 413.13)? Enter Y in column 1 if the exemption applies for Medicare Part A and in column 2 if the exemption applies for Medicare Part B; otherwise, enter N.

Line 41.--If the complex includes a SNF-based HHA, did the SNF-based HHA qualify for exemption from the application of the lesser of cost or charge (see 42 CFR 413.13)? Enter a Y or N in column 1 if the exemption applies for Medicare Part A and in column 2 if the exemption applies for Medicare Part B. No response required if no SNF-based HHA.

Lines 42 through 49.--Reserved for future use.

FINANCIAL STATEMENTS

Line 50.--Were the financial statements prepared by a certified public accountant (CPA)? Enter Y or N in column 1. If the response is Y in column 1, enter "A" for audited, "C" for compiled, or "R" for reviewed in column 2. Submit with the cost report 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 column 1 is N, submit a copy of the SNF-prepared financial statements and written statements of significant accounting policy and procedure changes affecting Medicare reimbursement that occurred during the cost reporting period (or submit the changed accounting or administrative procedures manual in lieu of written statements of significant accounting policy and procedure changes).

Line 51.--Do the total expenses and total revenues reported on the cost report differ from those on the filed financial statements? Enter Y or N. If Y, submit a reconciliation with the cost report.

BAD DEBTS

Line 52.--Is the SNF seeking reimbursement for bad debts resulting from Medicare deductible and coinsurance amounts that are uncollectible from Medicare beneficiaries? (See 42 CFR 413.89, for the criteria for an allowable bad debt.) If Y, submit a completed Medicare Bad Debts Listing (see Exhibit 1 on page 49-22) to support the bad debts claimed. If the SNF complex includes a SNF-based HHA or SNF-based hospice, complete a separate Medicare Bad Debts Listing for the claimed bad debts of each.

Line 53.--If line 52 is yes, did the SNF bad debt collection policy change during this cost reporting period? Enter Y or N. If the response is Y, submit with the cost report a copy of the changed policy.

Line 54.--If line 52 is yes, did the SNF waive beneficiary deductibles and/or coinsurance? If Y, ensure that waived deductibles and/or coinsurance are not included on the Medicare Bad Debts Listing.

PS&R REPORT DATA

Line 55.--Is this cost report prepared using only the Provider Statistical & Reimbursement Report (PS&R) for Medicare Part A and Part B? For Part A, enter Y or N in column 1; and, if column 1 is Y, enter the paid-through date of the PS&R used to prepare the cost report in column 2. For Part B, enter Y or N in column 3; and, if column 3 is Y, enter the paid-through date of the PS&R used to prepare the cost report in column 4. Also, submit with the cost report a crosswalk of revenue codes and charges on the PS&R to the cost center groupings on the cost report.

Line 56.--Is this cost report prepared using the PS&R for totals and provider records for allocation for Medicare Part A and Part B? For Part A, enter Y or N in column 1; and, if column 1 is Y, enter the paid-through date of the PS&R used to prepare the cost report in column 2. For Part B, enter Y or N in column 3, and, if 3 is Y, enter the paid through date of the PS&R used to prepare the cost report in column 4. Also, submit with the cost report a crosswalk of revenue codes, departments and charges on the PS&R to the cost center groupings on the cost report. The crosswalk must include which revenue codes were allocated to each cost center. Supporting work papers must accompany this crosswalk to provide sufficient documentation as to the accuracy of provider records.

Line 57.--If you entered Y on either line 55 or 56, columns 1 and/or 3, were adjustments 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 or N in columns 1 and 3. If either column 1 or 3 is Y, include a schedule that supports the adjustments made to the PS&R. This schedule must include totals consistent with the breakdowns on the PS&R and must include claims unprocessed or unpaid as of the paid-through date of the PS&R used to prepare the cost report.

Line 58.--If you entered Y on either line 55 or 56, columns 1 and/or 3, were adjustments made to the PS&R data for corrections of other PS&R information? Enter Y or N in columns 1 and 3. If either column 1 or 3 is Y, submit a detailed explanation and documentation that provides an audit trail from the PS&R to the cost report.

Line 59.--If you entered Y on either line 55 or 56, columns 1 and/or 3, indicate whether other adjustments were made to the PS&R data. Enter Y or N in columns 1 and 3. If either column 1 or 3 is Y, include a description of the other adjustments and documentation that provides an audit trail from the PS&R to the cost report.

Line 60.--If the cost report was prepared using only provider records for Part A, enter Y in column 1; otherwise, enter N. If the cost report was prepared using only provider records for Part B, enter Y in column 3; otherwise, enter N. If column 1 or column 3 is Y, submit with the cost report detailed documentation of the system used to support the data reported on the cost report. If detailed documentation was previously supplied, submit updated documentation only (if any).

Detailed documentation must include, at a minimum, the following:

- Copies of input tables, calculations, or charts supporting data elements for prospective payment system (PPS) operating rate components and other PRICER information covering the cost reporting period.
- Internal records supporting program utilization statistics, charges, prevailing rates and payment information broken into each Medicare bill type in a consistent manner with the PS&R.

- Reconciliation of remittance totals to provider records.
- The name of the system used and indicate how the system was maintained (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.

Lines 61 through 69.--Reserved for future use.

COST REPORT PREPARER INFORMATION

Line 70.--Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.

Line 71.--Enter the employer/company name of the cost report preparer.

Line 72.--Enter the cost report preparer's contact information. Enter the telephone number in column 1 and email address in column 2.

EXHIBIT 1
LISTING OF MEDICARE BAD DEBTS AND APPROPRIATE SUPPORTING DATA
INSTRUCTIONS AND FORM

Exhibit 1 requires the following information: Enter the provider name, CCN, sub-provider CCN (if applicable), cost reporting period (CRP) beginning and ending dates, whether the listing represents Medicare bad debts for inpatient or outpatient services, the name of the preparer, the date prepared, the total of Medicare allowable bad debts (sum of column 15), and the total of dual-eligible Medicare bad debts (sum of amounts entered in column 15 where column 6 has an entry).

Columns 1, 2, 3, 4, and 5.--From the Medicare beneficiary's bill, enter the beneficiary's name, dates of service, and MBI or HICN, that correlate to the claimed bad debt. (See 42 CFR 413.89(f).)

Column 6.--Enter the Medicare beneficiary's Medicaid number if the beneficiary was dually eligible (eligible for Medicare and some category of Medicaid benefits). If there is an entry in this column, there must be an entry in column 9.

Column 7.--Enter "Y" if the Medicare beneficiary was not eligible for Medicaid but the provider deemed them to be indigent; otherwise, enter N for no. (See 42 CFR 413.89(e)(2)(ii).)

Column 8.--Enter the Medicare remittance advice date for the Medicare beneficiary information in columns 1 through 5.

Column 9.--Enter the Medicaid remittance advice date or, when the provider does not receive a Medicaid remittance advice, enter "AD" for alternate documentation used to determine state liability (42 CFR 413.89(e)(2)(iii)(B)), that corresponds to the Medicare beneficiary information in columns 1 through 6.

Column 10.--Enter the date that the first bill was sent to the Medicare beneficiary. If the beneficiary is a QMB, enter "QMB."

Column 11.--Enter the date all collection efforts ceased, both internal and external, including efforts to collect from Medicaid and/or from a state for its cost sharing liability.

Column 12.--Enter the Medicare deductible from the Medicare remittance advice (before any payments received from any party). Report deductible amounts only when the provider billed the patient with the expectation of payment. See 42 CFR 413.89(e)(2) for possible exception.

Column 13.--Enter the Medicare coinsurance amount from the Medicare remittance advice (before any payments received from any party). Report coinsurance amounts only when the provider billed the patient with the expectation of payment. See 42 CFR 413.89(e)(2) for possible exception.

Column 14.--Enter the date the uncollected deductible and coinsurance amounts were written off as a Medicare bad debt. In order to be considered written off for Medicare purposes, the amount must be written off as a bad debt in the provider's own accounting system, all collection effort against the patient or other third parties (internal and external) must have ceased, and a valid Medicaid RA must have been received from the State for Medicaid beneficiaries.

Column 15.--Enter the allowable Medicare bad debt amount. This amount must be less than or equal to the sum of the amounts in columns 11 and 12 less any payments received from the beneficiary.

Column 16.--This column is for informational purposes. Enter any comments or additional information as needed.

EXHIBIT 1

TITLE	MEDICARE BAD DEBTS LISTING
PROVIDER NAME	
CCN	
SUBPROVIDER CCN	
CRP BEGINNING DATE	
CRP ENDING DATE	
INPATIENT / OUTPATIENT	
PREPARED BY	
DATE PREPARED	
TOTAL COLUMN 15	
TOTAL DUAL ELIGIBLE	

PATIENT LAST NAME	PATIENT FIRST NAME	DATE OF SERVICE FROM	DATE OF SERVICE TO	MBI OR HICN	MEDICAID NUMBER	PROVIDER DEEMED INDIGENT	MEDICARE REMITTANCE ADVICE DATE
1	2	3	4	5	6	7	8

MEDICAID REMITTANCE ADVICE DATE	DATE FIRST BILL SENT TO BENEFICIARY	DATE COLLECTION EFFORT CEASED	MEDICARE DEDUCTIBLE AMOUNT	MEDICARE COINSURANCE AMOUNT	MEDICARE WRITE-OFF DATE	ALLOWABLE BAD DEBT AMOUNT	COMMENTS
9	10	11	12	13	14	15	16

4901.40 WORKSHEET S-3 - STATISTICAL DATA

In accordance with 42 CFR 413.20(a) and 42 CFR 413.24(a), you are required to maintain statistical records for proper determination of costs payable under the Medicare program. The statistics reported on this worksheet pertain to the SNF, the NF, and the ICF/IID. The statistical data to be maintained, depending on the services provided by the component, include the number of beds, the number of bed days available, the number of inpatient days, the number of discharges, the average length of stay, and the number of admissions by payer source.

4901.41 Part I - Visits and Census Data.

This part provides for the reporting of the number of bed days available, inpatient days, discharges, average length of stay, and admissions by program, by level of care and payer source.

Column Descriptions

Column 1.--Enter on the appropriate line the beds available for use by patients at the end of the cost reporting period. For line 1, enter the number of beds available for use by patients reported for SNF - FFS and SNF HMO inpatient days reported on lines 1 and 2. For line 3, enter the number of beds available for use by patients reported for NF - FFS and NF HMO inpatient days reported on lines 3 and 4.

Column 2.--Enter the total bed days available. Bed days are computed by multiplying the number of beds permanently maintained for lodging inpatients throughout the cost reporting period by the number of days in the cost reporting period. If there is an increase or decrease in the number of beds permanently maintained for lodging inpatients during the cost reporting period, multiply the number of beds permanently maintained for lodging inpatients for each part of the cost reporting period by the number of days for which that number of beds was available.

NOTE: An institution or institutional complex can only change (increase or decrease) the bed size of its SNF (number of beds certified) and/or its NF no more than two times per cost reporting period in accordance with the requirements set forth in CMS Pub. 15-1, chapter 23, §2337.

Columns 3 through 7.--Enter the number of inpatient days for all classes of patients for each type of care by program and payer type, in columns 3 through 6. The total in column 7 must equal the sum of columns 3 through 6. Column 6 (Other) includes, but is not limited to, private pay, and commercial insurance.

Columns 8 through 12.--Enter the number of discharges, including deaths, for each type of care by program and payer type, in columns 8 through 11. A patient discharge, including death, is a formal release of a patient. The total in column 12 must equal the sum of columns 8 through 11. Column 11 (Other) includes, but is not limited to, private pay, and commercial insurance.

Columns 13 through 17.--The average length of stay is calculated for each line as follows:

- a. Column 13, lines 1 through 5 = Column 3 divided by column 8
- b. Column 14, lines 1 and 2 = Column 4 divided by column 9
- c. Column 15, lines 1 through 5 = Column 5 divided by column 10
- d. Column 16, lines 1 through 5 = Column 6 divided by column 11
- e. Column 17, lines 1 through 5 = Column 7 divided by column 12

Columns 18 through 22.--Enter the number of admissions (from your records) for each type of care by program and payer type. Column 21 (Other) includes, but is not limited to, private pay, and commercial insurance.

Columns 23 and 24.--The average number of employees (full-time equivalent) for the period may be determined either on a quarterly or semiannual basis. When quarterly data are used, add the total number of hours worked by all employees on the first week of a payroll for the beginning of each quarter and divide the sum by 160 (four times the number of hours in the standard work week). When semiannual data are used, add the total number of hours worked by all employees on the first week of a payroll period for the first and seventh months of the period, and divide the sum by 80 (two times the number of hours in the standard work week). Enter the average number of paid employees in column 23 and the average number of non-paid workers in column 24 for each component, as applicable.

Line 1.--Enter SNF FFS inpatient days where the patient received skilled nursing care as defined at 42 CFR Part 409, Subpart D.

Line 2.--Enter SNF HMO inpatient days where the patient received skilled nursing care as defined at 42 CFR Part 409, Subpart D.

Line 3.--Enter NF FFS inpatient days where the patient received nursing care as defined at 42 CFR 440.155.

Line 4.--Enter NF HMO inpatient days where the patient received nursing care as defined at 42 CFR 440.155.

Line 5.--Enter inpatient days associated with health or rehab services provided to individuals with intellectual disabilities and receiving active treatment as defined at 42 CFR 440.150.

Line 6.--Enter inpatient days associated with patients that occupied a hospice bed that is permanently maintained for lodging hospice inpatients.

Line 7 - Columns 1 through 12.--Enter the total for each column.

4901.42 Part II - SNF Wage Index Information -- Direct Salaries.

This part provides for the collection of SNF data to in accordance with the Social Security Act Amendments of 1994 (P.L. 103-432). This data may be used to develop a SNF wage index and must be completed by all SNFs.

NOTE: Any line reference for Worksheets A and A-6 includes all subscripts of that line.

Line 1.--Enter the sum of salaries and wages paid to employees from Worksheet A, column 1, line 100.

Line 2.--Enter physician Part A salaries paid to employees which are included on Worksheet A, column 1, line 100.

Line 3.--Enter physician Part B and physician Part B assistant salaries and wage related costs that are related to patient care and are included on line 1. Under Medicare, these services are billed separately under Part B.

Line 4.--If you are a member of a chain or other related organization, as defined in CMS Pub. 15-1, §2150, enter the allowable wages and salaries and wage related costs for HO/CO personnel from your records that are included in line 1.

Line 5.--Enter the sum of lines 2 through 4.

Line 6.--Subtract line 5 from line 1 and enter the result.

Line 7.--Enter the total of Worksheet A, column 1, *line 70*. If this line is subscripted to accommodate more than one HHA, also enter the total of the subscripted lines.

Line 8.--Enter the amount from Worksheet A, column 1, *line 72*. If this line is subscripted to accommodate more than one hospice, also enter the total of the subscripted lines.

Line 9.--Enter the sum of amounts from Worksheet A, *column 1*, lines 73, 74, 81, 90, 91, 92, and 93.

Line 10.--Enter the sum of lines 7 through 9.

Line 11.--Enter the result of line 5 minus line 10.

Line 12.--Enter the amount paid (include only those costs attributable to services rendered in the SNF), rounded to the nearest dollar, for contracted direct patient care services, i.e., nursing, therapeutic, rehabilitative, or diagnostic services furnished under contract rather than by employees and management contract services as defined below. For example, you have a contract with a nursing service to supply nurses for the general routine service area on weekends. Report only those personnel costs associated with these contracts. Eliminate all supplies and other miscellaneous items. Do not apply the guidelines for contracted therapy services under §1861(v) (5) of the Act and 42 CFR 413.106. Contracted labor for purposes of this worksheet does **NOT** include the following services: consultant contracts, billing services, legal and accounting services, Part A CRNA services, clinical psychologists and clinical social worker services, housekeeping services, planning contracts, independent financial audits, or any other service not directly related to patient care.

Include the amount paid (rounded to the nearest dollar) for contract management services, as defined below, furnished under contract rather than by employees. Report only those personnel costs associated with the contract. Eliminate all supplies, travel expenses, and other miscellaneous items. Contract management is limited to the personnel costs for those individuals who are working at the facility in the capacity of chief executive officer, chief operating officer, chief financial officer, or nursing administrator. The titles given to these individuals may vary from the titles indicated above. However, the individual should be performing those duties customarily given these positions.

For purposes of this worksheet, contract labor does **NOT** include the following services: other management or administrative services, consultative services, unmet physician guarantees, physician services, clinical personnel, security personnel, housekeeping services, planning contracts, independent financial audits, or any other services not related to the overall management and operation of the facility.

Contract labor is reported on Worksheet A, column 2. If you have no contracted labor as defined above or management contract services; enter a zero in column 1. If you are unable to accurately determine the number of hours associated with contracted labor, enter a zero in column 1.

Line 13.--Enter from your records the amount paid under contract for physician services for Part A only related directly to the SNF. This includes Part A physician services from the home office allocation and/or from related organizations.

Line 14.--Enter the salaries and wage related costs (as defined on lines 15 and 16) paid to personnel who are affiliated with a home office and/or related organization, who provide services to the SNF, and whose salaries are not included on Worksheet A, column 1. In addition, add the home office salaries excluded on line 4. This figure is based on recognized methods of allocating an individual's home office salary to the SNF and/or NF. If no home office/related organization exists or if you cannot accurately determine the hours associated with the home office/related organization salaries that are allocated to the SNF and/or NF, then enter a zero in column 1. All costs for any related organization must be shown as the cost to the related organization.

NOTE: All wage-related costs, including amounts related to excluded areas and physician services, should be included on lines 15 and 16.

Line 15.--Enter the total core wage related costs as described in Part IV. Only the total cost of the wage related costs that are considered fringe benefits may be directly charged to each cost center provided the costs are reported in column 5 and not column 1, of Worksheet A. For purposes of determining the wage related costs for the wage index, a facility must use generally accepted accounting principles (GAAP). Continue to use Medicare payment principles on all other areas to determine allowable fringe benefits. Do not include wage-related costs applicable to the excluded areas reported on line 10. Instead, these costs are reported on line 16. Also, do not include the wage-related costs for physician Parts A and B, non-physician anesthesiologists Parts A and B, interns and residents in approved programs, and home office personnel.

Line 16.--Enter the total wage-related costs applicable to the excluded areas reported on line 10.

Line 17.--Enter the total wage-related costs applicable to Part A physicians. Do not include wage-related costs for excluded areas reported on line 16.

Line 18.--Enter the total wage-related costs applicable to Part B physicians. Do not include wage-related costs for excluded areas reported on line 16.

Line 19.--Enter the total adjusted wage related costs, line 15, minus lines 16 through 18.

Column 2.--Enter on each line, as appropriate, the **salary** portion of any reclassification made on Worksheet A-6.

Column 3.--Enter on each line, as appropriate, the **salary** portion of any adjustment made on Worksheet A-8.

Column 4.--Enter the result of column 1 plus or minus columns 2 and 3.

Column 5.--Enter on each line the number of **paid** hours corresponding to the amount reported in column 4. The hours must reflect any change reported in columns 2 and 3. On-call hours are not included in the total paid hours. Overtime hours are calculated as one hour when an employee is paid time and a half.

Column 6.--Enter on line 1 through line 14 the average hourly wage resulting from dividing column 4 by column 5.

4901.43 Part III - SNF Wage Index Information - Overhead Cost - Direct Salaries.

This part provides for the collection of SNF wage data for overhead costs to properly allocate the salary portion of the overhead costs to the appropriate service areas for excluded units. This form is completed by all SNFs.

NOTE: Any line reference for Worksheets A and A-6 includes all subscripts of that line.

Column 1.--Enter the direct wages and salaries paid on lines 1 through 15, from Worksheet A, column 1, respectively.

Column 2.--Enter on the line, as appropriate, the salary portion of any reclassification made on Worksheet A-6.

Column 3.--Enter on each line, as appropriate, the salary portion of any adjustment made on Worksheet A-8.

Column 4.--Enter the result of column 1 plus or minus columns 2 and 3.

Column 5.--Enter on each line the number of paid hours corresponding to the amount reported in column 4.

Column 6.--Enter on each line the average hourly wage resulting from dividing column 4 by column 5.

4901.44 Part IV - SNF Wage-Related Costs.

The SNF must provide the contractor with a complete list of all core wage-related costs included in Part II, lines 15 through 19. This worksheet provides for the identification of such costs.

For wage-related costs not covered by Medicare reasonable cost principles, a SNF shall use GAAP in reporting wage-related costs. In addition, some costs such as payroll taxes, are not considered fringe benefits for Medicare cost finding.

Enter on each line, as applicable, the corresponding amount from your accounting books and/or records.

4901.45 Part V - SNF Reporting of Direct Care Expenditures.

Section 6104(1) of Public Law 111-148 amended section 1888(f) of the Act (“Reporting of Direct Care Expenditures”) to require SNFs to separately report expenditures for salaries, wages, and fringe benefits for direct care staff (breaking out (at a minimum) registered nurses, licensed professional nurses, certified nurse assistants, and other medical and therapy staff). This form is completed by SNFs and/or NFs.

Complete this form for employees who are full-time, part-time, directly hired, and retained under arrangement (i.e., contract). Do not include employees in areas excluded from SNF PPS (i.e., Worksheet S-3, Part III, lines 7 through 9).

Definitions

Employee Salaries & Wages, Wage-Related Costs, Contracted Labor, and HO/CO Related Party Costs

- Employee Salaries & Wages - Amounts, including salaries, wages, overtime, vacation, holiday, sick, lunch, and other paid-time-off, severance, and bonuses, paid to SNF employees who receive an IRS Form W-2, Wage and Tax Statement at the end of the year.
- Wage-Related Costs - Wage-related costs defined in PRM 15-1, chapter 21, §2144, associated with employees reported in column 1.
- Contracted Labor - Amounts paid to contracted individuals and reported on an IRS Form 1099.
- HO/CO or related party costs - The salaries, wages, and wage-related costs allocated from the HO/CO and reported on Worksheet A-8-1.

Nursing Employees

- Registered Nurses (RNs) - Assess patient health problems and needs, develop and implement nursing care plans, and maintain medical records. Administer nursing care to ill, injured, convalescent, or disabled patients. May advise patients on health maintenance and disease prevention or provide case management. Licensing or registration required.
- Licensed Practical Nurses (LPNs) - Care for ill, injured, convalescent, or disabled persons. LPNs monitor patients’ health, administer basic nursing care, including changing bandages and inserting catheters, discuss health care with patients, listen to their concerns, report patients’ status to RNs and physicians, and maintain medical records. LPNs may work under the supervision of a registered nurse. LPNs supervise certified nursing assistants. Licensing is required after the completion of a State-approved practical nursing program.

- Certified Nursing Assistants (CNAs) - A certified nursing assistant is an individual providing nursing or nursing related services to residents in the facility, (i.e., basic patient care under direction of the charge nurse including taking vital signs, feeding, bathing, dressing, grooming, moving patients, or changing linens). This term may also include an individual who provides these services through an agency or under a contract with the SNF, who has completed the NATCEP and been certified as a CNA. CNAs do not include those individuals who furnish services to residents only as paid feeding assistants as defined in 42 CFR §488.301. Completion of the Nurse Aide Training and Competency Evaluation Program (NATCEP) is required of all certified nurse aides who work full time within 4 months of employment.

Technical/Professional Employees

- Physical Therapist (PT) - A qualified PT provides skilled rehabilitation services and must meet the requirements set forth in 42 CFR Part 484.
- Physical Therapy Assistant (PTA) - A qualified PTA provides skilled rehabilitation services under the supervision of a qualified PT and must meet the requirements in 42 CFR 484.115.
- Occupational Therapist (OT) - A qualified OT provides medically prescribed treatment concerned with improving or restoring function that has been impaired by illness or injury or, where function has been permanently lost or reduced by illness or injury, to improve the individual's ability to perform those tasks required for independent functioning. A qualified OT must meet the requirements in 42 CFR Part 484.
- Occupational Therapy Assistant (OTA) - A qualified OTA provides skilled rehabilitation services under the supervision of a qualified OT and must meet requirements set forth in 42 CFR Part 484.
- Speech-Language Pathologist (SLP) - A qualified SLP provides those services necessary for the diagnosis and treatment of speech and language disorders that result in communication disabilities and for the diagnosis and treatment of swallowing disorders (dysphagia), regardless of the presence of a communication disability. An SLP must meet the requirements set forth in 42 CFR Part 484.
- Therapy Aides and Students - Therapy aides perform set-up preceding skilled therapy provided by the qualified therapist and must be supervised personally by the qualified therapist (PT, OT or SLP) in such a way that that the qualified therapist has visual contact with the aide at all times. A qualified therapy assistant cannot supervise a therapy aide. A therapy student, participating in field experience, is not licensed or certified for practice in an unsupervised status. The student participates in their field experience under the supervision of the qualified therapist (PT, OT, and/or SLP).
- Respiratory Therapist (RT) - An RT provides those services that are prescribed by a physician for the assessment, diagnostic evaluation, treatment, management, and monitoring of patients with deficiencies and abnormalities of cardiopulmonary function. These services are also provided by RNs and LPNs. Routine administration of oxygen is not respiratory therapy; it is a nursing service.

- Other Medical Staff - Non-nursing employees (directly hired and under arrangement) that provide direct patient care. Do not include employees who work in excluded areas such as a SNF based HHA, hospice, ambulance or other non-reimbursable area; that are not included in the SNF PPS payment; or that function solely in administrative or leadership roles that do not provide any direct patient care themselves. This category must not include occupations such as feeding assistants, physician Part B services and the services of advance practice nurses such as nurse practitioners (NPs), clinical nurse specialists, certified nurse midwives, and certified registered nurse anesthetists that are billable under a Part B fee schedule.

Column 1.--Enter the total paid salaries and wages (staff that are issued an IRS Form W-2) for the specified category of SNF employee including overtime, vacation, holiday, sick, lunch, and other paid-time-off, severance, and bonuses on *lines 1 through 3, and 5 through 12*. Do not include wage-related costs *as defined in §4901.44*.

For contract labor, enter the amount paid (include only those costs attributable to services rendered in the SNF/NF), rounded to the nearest dollar, for contracted direct patient care services on lines 15 through 17, and 19 through 26.

For home office/chain organization, enter the amount paid (include only those costs attributable to services rendered in the SNF/NF), rounded to the nearest dollar, for home office/chain organization direct patient care service costs on lines 29 through 31, and 33 through 40.

Lines 13, 14, 27, and 28 are reserved for future use.

Column 2.--Enter the appropriate portion of wage-related costs corresponding to paid salaries and wages reported in column 1, *lines 1 through 3, and 5 through 12*, as applicable from your records.

For contract labor, report on lines 15 through 17, and 19 through 26, enter the wage-related cost corresponding to the paid salaries and wages reported in column 1, when those cost can be separately identified. If those costs cannot be separately identified report as labor costs in column 1.

For home office/chain organizations, report on lines 29 through 31, and 33 through 40, enter the wage related costs corresponding to the paid salaries and wages reported in column 1, when those costs can be separately identified. If those costs cannot be separately identified report as labor costs in column 1.

Column 3.--Enter the *result of column 1 plus column 2*.

Column 4.--Enter *on each line the number of paid hours by occupational category corresponding to the amounts reported in column 3. Paid hours include regular hours (including paid lunch hours), overtime hours, paid holiday, vacation and sick leave hours, paid time-off hours, and hours associated with severance pay.*

Paid hours are defined as the number of hour's staff members are paid to deliver services for the days worked. Do not count meal break hours or hours paid for any type of leave or non-work-related absence from the facility or for any unpaid time worked. For example, if a salaried employee works 10 hours but is only paid for 8 hours, report 8 hours. If a facility is paying a salaried employee a bonus for additional hours worked, report those hours under the following conditions: The payment must be directly correlated to the hours worked and must be distinguishable from other payments. (e.g., cannot be a performance-based or holiday bonus). Additionally, the bonus payment must be reasonable compensation for the services provided.

Column 5.-- Enter *on each line the average hourly wage resulting from dividing column 3 by column 4.*

4901.50 WORKSHEET S-4 - SNF-BASED HOME HEALTH AGENCY STATISTICAL DATA

Worksheet S-4 consists of the following four parts:

- Part I - Visits and Census Data
- Part II - Employment Data FTEs
- Part III - CBSA Data
- Part IV - PPS Activity Data

In accordance with 42 CFR 413.20 and 42 CFR 413.24, you are required to maintain statistical records for proper determination of costs payable under titles XVIII and XIX. The statistics required on this worksheet pertain to a SNF-based HHA. For Part I, the statistical data to be maintained, depending on the services provided by the SNF-based HHA, includes the number of program visits, total number of HHA visits, number of program home health aide hours, total home health aide hours, program patient census count, total patient census count, program patient unduplicated census count, and total patient unduplicated patient count. Part II collects required FTE data by employee staff, contracted staff, and total staff. Part III identifies the total number of CBSAs where Medicare services were provided. Part IV identifies PPS-activity data. Complete a separate Worksheet S-4 for each SNF-based HHA.

Definitions.

HHA Visits.--A visit is an episode of personal contact with the patient by staff of the SNF-based HHA, or others under arrangements with the SNF-based HHA, for the purpose of providing a covered home health service as described in 42 CFR 409.45 (b) through (g). Medicare type visits generally fall under the definition of Medicare visits as described in 42 CFR 409.48. In counting Medicare type visits, it is critical that non-Medicare visits are of the same type as those that would be covered by Medicare. This ensures that costs of services are comparable across insurers and that costs are apportioned appropriately between Medicare and non-Medicare. A visit is initiated with the delivery of covered home health services and ends at the conclusion of delivery of covered home health services. In those circumstances in which all reasonable and necessary home health services cannot be provided in the course of a single visit, SNF-based HHA staff or others providing services under arrangements with the SNF-based HHA may remain at the patient's home between visits (e.g., to provide non-covered services). However, if all covered services could be provided in the course of one visit, only one visit may be covered. (See 42 CFR 409.48(c)(4)).

Patient Census.--Each patient is counted once for each type of service during the cost reporting period. For example, if a patient receives multiple Medicare covered skilled nursing visits from a registered nurse and multiple Medicare covered medical social service visits, he or she is counted only once in column 2 for the corresponding service. Another example is if a patient receives both covered services and non-covered services, he or she is counted once as title XVIII (for covered services), once as other (for non-covered services), and only once as total.

Unduplicated Census Count.--Each patient is counted only once, no matter how many SNF-based HHA services each receives during the cost reporting period. A patient who receives HHA services throughout the year should be counted and reported no more than one time. The unduplicated census count answers the question: How many patients did the SNF-based HHA serve during this cost reporting period?

Use lines 1 through 10 to identify the number of visits and corresponding patient census count. The patient census count in columns 2, 4, 6, and 8 includes each individual who received each type of service. Include each individual patient only once for each type of service. For example, if a patient receives multiple Medicare covered skilled nursing visits from a registered nurse and multiple Medicare covered medical social service visits, he or she is counted only once in column 2 for the corresponding service. The sum of the patient census counts in column 8 minus columns 2, and 4 will equal column 6. The total of lines 1 through 9 for columns 2 and 4 and the total of lines 1 through 10 for columns 6 and 8 may not necessarily equal line 13, unduplicated census count, since many patients receive more than one type of service. Beneficiaries who experience multiple spells of illnesses (multiple visits, multiple episodes, and/or multiple discharges and admissions) within a cost reporting period must be counted only once in the unduplicated census count.

4901.51 Part I - Visits and Census Data.

Columns 1 and 2.--Enter data pertaining to title XVIII-Medicare beneficiaries only. Enter in column 1 all Medicare visits rendered during the entire cost reporting period. See CMS Pub. 100-02, chapter 7, §70.2, for visit count determination. For each line, enter in column 2 the patient census count applicable to the Medicare visits reported in column 1.

Columns 3 and 4.--Enter data pertaining to title XIX-Medicaid patients only. Enter in column 3 all Medicaid visits rendered during the entire cost reporting period. For each line, enter in column 4 the patient census count applicable to the Medicaid visits reported in column 3.

Columns 5 and 6.--Enter data pertaining to Medicare Managed Care, Medicaid Managed Care, and all other patients. Do not include data reported in columns 1 through 4. Enter in column 5 all visits from patients not covered by Medicare (reported in column 1) or Medicaid (reported in column 3). For each line, enter in column 6 the patient census count applicable to all other patient visits reported in column 5.

Columns 7 and 8.--Enter total agency visits and patient census count. Enter in column 7, all visits rendered for all patients during the cost reporting period for each discipline. For each line, enter in column 8, the patient census count for all patients during the cost reporting period. The sum of columns 1, 3, and 5 must equal column 7. The sum of columns 2, 4, and 6 may not equal column 8. For example, if a patient receives both Medicare covered services (columns 1 and 2) and Medicare non-covered services (columns 5 and 6), he or she is counted once in column 2 (for covered services), once in column 6 (for non-covered services), and once in column 8, total.

Lines 1 through 9.--These lines identify the type of home health service rendered to patients. The entries reflect the number of visits furnished and the number of patients receiving a particular type of service.

Line 10.--This line may not be used for columns 1 through 4. Enter in columns 5 and 7 the total of all other visits provided by the SNF-based HHA. Enter in columns 6 and 8 the patient census count applicable to visits furnished by the SNF-based HHA.

Line 11.--Enter the sum of lines 1 through 9 for each of columns 1 and 3. Enter the sum of lines 1 through 10 for each of columns 5 and 7.

Line 12.--Enter the number of hours applicable to home health aide services.

Line 13.--Enter the unduplicated count of all patients receiving home visits or other care provided by employees of the SNF-based HHA or under contractual arrangement in the appropriate column for the entire cost reporting period. Count each individual only once. However, because a patient may be covered under more than one health insurance program, the total census count may not equal the sum of the title XVIII and all other patient census counts. For purposes of calculating the unduplicated census count, if a beneficiary has received health care by more than one HHA, you must prorate the unduplicated census count based on the ratio of visits provided by this SNF-based HHA to the total visits furnished to the beneficiary by all HHAs so as to not exceed a total of one. For example, if an HHA furnishes 100 visits to an individual beneficiary in Maryland during the cost reporting period and the same individual received a total of 400 visits (the other 300 visits were furnished in Florida during the cost reporting period), the reporting HHA would count the beneficiary as a .25 (100 divided by 400) in the unduplicated census count for Medicare beneficiaries for the cost reporting period. Round the result to two decimal places, e.g., .2543 is rounded to .25. A SNF-based HHA must query the beneficiary to determine if he or she has received health care from another HHA during the year, i.e., Maryland versus Florida for beneficiaries with seasonal residence.

4901.52 Part II - Employment Data FTEs.

Line 1.--Enter the total number of hours in a normal workweek (i.e. 40 hours per week or 35 hours per week).

Line 2 through 20.--Provide statistical data related to the human resources of the SNF-based HHA. The human resources statistics are required for each of the job categories specified on lines 2 through 19. Enter any additional categories needed on line 20 and its subscripts.

Report in column 1 the FTE employees on the SNF-based HHA's payroll. These are staff for which an IRS Form W-2 is issued.

Report in column 2 the FTE contracted and consultant staff of the SNF-based HHA.

Compute staff FTEs for column 1 as follows: Add all hours for which employees were paid and divide by 2080 hours. Round to two decimal places, e.g., .04447 is rounded to .04. Compute contract FTEs for column 2 as follows: add all hours for which contracted and consultant staff worked and divide by 2080 hours.

If employees are paid for unused vacation, unused sick leave, etc., exclude these paid hours from the numerator in the calculations.

4901.53 Part III - CBSA Data.

Line 1.--Enter the total number of CBSAs where Medicare covered services were provided during this cost reporting period. CBSA codes are five-character numeric codes that identify the geographic area at which Medicare covered services are furnished. Obtain these codes from your contractor.

Line 2.--List all CBSA codes where Medicare covered home health services were provided during the cost reporting period. Line 2 contains the first code. Enter one CBSA code on each line. If additional lines are needed, subscript line 2 beginning with lines 2.01, 2.02 etcetera, as necessary, entering one CBSA code on each subscripted line. Obtain these codes from your contractor.

4901.54 Part IV - PPS Activity Data.

The statistics required on this worksheet pertain to home health services reimbursed under the HHA PPS in accordance with §1895 of the Act. Depending on the services provided by the SNF-based HHA the data to be maintained for each period of care payment category for each covered discipline include aggregate program visits, corresponding aggregate program charges, total visits, total charges, total episodes/period and total outlier periods, and total non-routine medical supply charges.

All data reported in Part IV must be associated only with episodes/periods of care that end during the cost reporting period for payment purposes. Similarly, when an episode/period of care begins in one cost reporting period and ends in the subsequent cost reporting period, all data required in Part IV of this worksheet associated with that episode/period will appear in the cost reporting period on the PS&R in which the episode/period of care ended.

HHA Visits.--See the second paragraph of §4901.50 for the definition of an HHA visit.

Period of Care. Home health services under a plan of care are paid based on a 30-day period of care (beginning on or after January 1, 2020) as required by section 1895(b)(2)(B) of the Act, as amended by section 51001(a)(1) of the Bipartisan Budget Act (BBA) of 2018. A beneficiary can be covered for an unlimited number of non-overlapping periods of care. For periods of care beginning on or after January 1, 2020, the duration of a period must end by the 30th day from the start of care.

Periods of care may be shorter than 30 days. For example, a period may end earlier than the 30th day in the case of a transfer to another HHA, or a discharge and readmission to the same HHA, and payment is pro-rated for these shortened periods, in which more home care is delivered in the same period. In such cases, payment will be pro-rated.

Low Utilization Payment Adjustments (LUPA). If an HHA provides fewer than the threshold of visits specified for the period's home health resources group (HHRG), they will be paid a standardized per visit payment. Such payment adjustments are called LUPAs.

Partial Period Payment (PEP). A partial period payment adjustment occurs when a patient has been discharged and readmitted to home care within the same 30-day period of care; or when a patient transfers to another HHA during a 30-day period of care.

Use lines 1 through 12 to identify the number of visits and the corresponding visit charges for each discipline for each episode/period payment category. Lines 13 and 15 identify the total number of visits and the total corresponding charges, respectively, for each period payment category. Line 16 identifies the total number of periods completed for each period payment category. Line 17 identifies the total number of outlier periods completed for each period payment category. Outlier periods do not apply to: 1) Full Periods without Outliers, and 2) LUPA Periods. Line 18 identifies the total non-routine medical supply charges incurred for each period payment category. The statistics and data required on this worksheet are obtained from the PS&R report.

Columns 1 through 4.--Enter in the appropriate columns 1 through 4, lines 1 through 12, the number of aggregate program visits furnished in each period of care payment category for each covered discipline and the corresponding aggregate program visit charges imposed for each covered discipline for each period of care payment category. The visit counts and corresponding charge data are mutually exclusive for all period of care payment categories.

Line 13.--Enter in columns 1 through 4 for each period of care payment category, respectively, the sum total of visits from lines 1, 3, 5, 7, 9, and 11.

Line 14.--Enter in columns 1 through 4 for each period of care payment category, respectively, the sum total of other charges for all other unspecified services reimbursed under HHA PPS.

Line 15.--Enter in columns 1 through 4 for each period of care payment category, respectively, the sum total of charges for services from lines 2, 4, 6, 8, 10, 12, and 14.

NOTE for lines 16 and 17: The standard periods entered on line 16 and outlier periods entered on line 17 are mutually exclusive.

Line 16.--Enter in columns 1, 3, and 4, for each period of care payment category identified, respectively, the total number of standard periods of care rendered and concluded in the SNF-based HHA's cost reporting period.

Line 17.--Enter in columns 2 and 4 for each period of care payment category identified, respectively, the total number of outlier periods of care rendered and concluded in the SNF-based HHA's cost reporting period. Outlier periods do not apply to columns 1 and 3 (Full Periods without Outliers and LUPA Periods, respectively).

Line 18.--Enter in columns 1 through 4 for each period of care payment category, respectively, the total non-routine medical supply charges for services rendered and concluded in the SNF-based HHA's cost reporting period.

Column 5.--For each of lines 1 through 18, enter the sum of the amounts from columns 1 through 4.

4901.60 WORKSHEET S-5 - SNF-BASED HOSPICE STATISTICAL DATA

In accordance with 42 CFR 418.310, hospices participating in the Medicare program are required to submit information for health care services rendered to Medicare beneficiaries. The regulation at 42 CFR 413.20 requires cost reports from providers on an annual basis. The data submitted on the cost report supports management of federal programs. The statistics required on this worksheet pertain to a SNF-based hospice. Complete a separate worksheet for each SNF-based hospice.

4901.61 Part I - Enrollment Days.

For the purposes of the Medicare and Medicaid hospice programs, a patient electing hospice can receive only one of the following four types of care per day:

Hospice Continuous Home Care (HCHC) Day.--An HCHC day is a day on which the hospice patient is not in an inpatient facility, and receives continuous care during a period of crisis in order to maintain the individual at home. A day consists of a minimum of 8 hours and a maximum of 24 hours of predominantly nursing care. For each day a beneficiary received 8 or more hours of predominantly nursing care, count the day as one HCHC day. Note: Do not count days by dividing the total hours by 24.

Hospice Routine Home Care (HRHC) Day.--An HRHC day is a day on which the hospice patient is at home and not receiving HCHC.

Hospice Inpatient Respite Care (HIRC) Day.--An HIRC day is a day on which the hospice patient receives care in an approved inpatient facility, to provide respite for the individual's family or other persons caring for the individual at home.

Hospice General Inpatient Care (HGIP) Day.--An HGIP day is a day on which the hospice patient receives care in a Medicare certified hospice facility, hospital or SNF for pain control or acute or chronic symptom management which cannot be managed in other settings.

Lines 1 through 4.--Enter the enrollment days applicable to each level of care (LOC) in columns 1 through 3. Include dually eligible (Medicare/Medicaid) beneficiaries in column 1. Enrollment days are unduplicated days of care received by a hospice patient. Report a day for each day a hospice patient received one of four levels of care -- HCHC, HRHC, HIRC, or HGIP. When a patient was transferred from one LOC to another, count the day of transfer as one day of care at the LOC billed. Report an HIRC day on line 3 only when the hospice provided or arranged to provide the inpatient respite care. For each of lines 1 through 4, enter in column 4 the sum of columns 1 through 3.

Line 5.--For each of columns 1 through 4, enter the sum of lines 1 through 4.

4901.62 Part II - Contracted Services.

This section collects unduplicated day's data for inpatient services at a contracted facility. The days reported are a subset of the days reported in Part I.

Lines 1 and 2.--Enter the contracted inpatient service enrollment days applicable to each LOC in columns 1 through 3. Include dually eligible (Medicare/Medicaid) beneficiaries in column 1. Enrollment days are unduplicated days of care received by a hospice patient. Report a day for each day a hospice patient received HIRC or HGIP care at a contracted facility. When a patient was transferred from one LOC to another, count the day of transfer as one day of care at the LOC billed. For each line enter the total unduplicated days by LOC (sum of columns 1 through 3) in column 4.

Line 3.--For each of columns 1 through 4, enter the sum of lines 1 and 2.

4902 A SERIES

On the A series of worksheets, the SNF reports the costs incurred related to the provision of patient care, and the adjustments and reclassifications necessary to determine allowable SNF costs, and if applicable, its SNF-based HHA and/or SNF-based hospice. The A series consists of the following worksheets:

- Worksheet A - Reclassification and Adjustment of Trial Balance of Expenses
- Worksheet A-6 - Reclassifications
- Worksheet A-7 - Reconciliation of Capital Cost Centers
- Worksheet A-8 - Adjustments to Expenses
- Worksheet A-8-1 - Statement of Costs of Services from Related Organizations and HO/CO Costs
- Worksheet A-8-2 - Provider-Based Physician Adjustments

4902.10 WORKSHEET A - RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

In accordance with 42 CFR 413.20, the methods of determining costs payable under title XVIII involve making use of data available from the institution's basic accounts, as usually maintained, to arrive at equitable and proper payment for services. Worksheet A provides for recording the trial balance of expense accounts from your accounting books and records. It also provides for the necessary reclassification and adjustments to certain accounts. The cost centers on this worksheet are listed in a manner that facilitates the transfer of the various cost center data to the cost finding worksheets (e.g., on Worksheets A, B, C, and D, the line numbers are consistent, and the total line is set at number 100).

Do not include on this worksheet items not claimed in the cost report but you wish to claim and contest because they conflict with the regulations, manuals, or instructions. Enter the protested amounts on the appropriate settlement worksheet (Worksheet E, Part A, line 17; Worksheet E, Part B, line 20; Worksheet H-4, Part II, line 39).

If the cost elements of a cost center are separately maintained on your books, you must maintain a reconciliation of the costs per the accounting books and records to those 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 you need to use additional or different cost center descriptions, you may do so by adding (subscripting) additional lines to the cost report. When 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 description. Identify the added line as a numeric (only) subscript of the immediately preceding line. That is, 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 on Worksheets B; B-1; and H-2, Parts I and II.

Submit the working trial balance of the institution 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 used as a basic summary for financial statements.

Cost center coding is a methodology for standardizing the meaning of cost center labels used by providers on the Medicare cost report. Form CMS-2540-24 provides for preprinted cost center labels 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. In addition, there are additional cost centers with general meaning provided in various sections of Worksheet A. These additional nonstandard cost centers must contain a description if used, and will hereafter be referred to as nonstandard cost center labels that provide for situations where no match in meaning to the standard cost centers can be found. Refer to Worksheet A, lines 18, 47, 64, 74, 81, and 94.

The cost center 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 their electronic file provide standardized meaning for data analysis. You are required to compare any added or changed label to the descriptions offered on the standard or nonstandard cost center tables. A description of cost center coding and the table of cost center codes are in §4990, Table 5.

Columns 1, 2, and 4.--The expenses listed in these columns must be reported in accordance with your accounting books and records and/or trial balance. List on the appropriate lines in columns 1, 2 and 4, the total expenses incurred during the cost reporting period. Detail the expenses between labor costs in column 1, *contract labor costs in column 2 and all other costs in column 4*. The sum of columns 1 and 2 must equal column 3.

Column 1 - Salaries & Wages.--For each cost center, enter the direct salaries and wages, including salary amounts for paid vacation, holiday, sick, other PTO, severance, and bonus pay for employees that receive an IRS Form W-2.

Column 2 - Contract Labor Costs.--For each cost center, enter the contract labor cost incurred for employees that receive an IRS Form 1099. Include both contract labor salaries and wages and wage-related costs for services contracted by the SNF.

Column 3 - Labor Subtotal.--For each cost center, enter the sum of columns 1 and 2.

Column 4 - Other Costs.--For each cost center, enter all non-labor costs incurred, including non-labor costs associated with contract labor. Non-labor costs include equipment, supplies, travel expenses, and other miscellaneous or overhead items.

Column 5 - Subtotal.--For each cost center, enter the sum of columns *3 and 4*.

Column 6 - Reclassifications.--For each cost center, enter the sum of reclassifications associated with each cost center reported on Worksheet A-6, columns 4, 5, 8, and 9, which are needed to effect proper cost allocation. The net total of the entries in this column must equal zero on line 100.

Column 7 - Reclassified Trial Balance.--For each cost center, enter the sum of the amount entered in column 5 and the amount entered in column 6 (increase or decrease). The total on line 100, must equal the total of column 5, line 100.

Column 8 - Adjustments.--For each cost center, enter the sum of adjustments to expenses associated with each cost center and reported on Worksheet A-8, column 2. The net total of the entries in column 9, must equal Worksheet A-8, column 2, line 100.

Column 9 - Expenses for Cost Allocation.--For each cost center, enter the sum of the amount reported in column 7 and the amount reported in column 8 (increases or decreases). Transfer the amounts reported in this column to the appropriate lines on Worksheet B, Part I, column 0.

NOTE: All professional staff reported on the cost report must be licensed, certified, or registered in accordance with State laws (see 42 CFR 483.70(f)). The infection preventionist must meet the requirements set forth in 42 CFR 483.80(b) and the Assessment Coordinator is required under 42 CFR 483.20(h) to be an RN.

The SNF must maintain the records necessary to determine the split in salary (and employee-related fringe benefits) between two or more cost centers, where applicable, and must adequately substantiate the method used to split the salary and employee wage-related costs. These records must be available for audit by your contractor.

Line Descriptions

The trial balance of expenses is broken down into general service cost centers, inpatient routine nursing cost centers, ancillary service cost centers, outpatient service cost services, outpatient reimbursable cost centers, cost reimbursed cost centers, and nonreimbursable cost centers to facilitate the transfer of costs to the various worksheets. The line numbers on Worksheet A are used on subsequent worksheets, for example, the category of ancillary service costs centers appears on the Worksheet C, using the same line numbers as on Worksheet A.

NOTE: The category titles do not have line numbers. Only cost centers, data items, and totals have line numbers.

GENERAL SERVICE COST CENTERS

These cost centers include expenses incurred in operating the institution or institutional complex 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 in the SNF or SNF healthcare complex.

Lines 1 and 2 Capital Related - Buildings & Fixtures (CRC-B&F) and Capital Related - Movable Equipment (CRC-ME).--These cost centers include depreciation, leases, and rentals for the use of facilities and/or equipment, including electronic health records systems, interest incurred in acquiring land and depreciable assets used for patient care, insurance on depreciable assets used for patient care, taxes on land or depreciable assets used for patient care, and software and hardware updates attributable to electronic health records systems. Do not include in these cost centers, costs incurred for the repair or maintenance of equipment or facilities, amounts included in rentals or lease payments for repair and/or maintenance agreements, 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 insurance or any other form of insurance to provide protection other than the replacement of depreciable assets, or taxes other than those assessed on the basis of some valuation of land or depreciable assets used for patient care. However, if no amount of the lease payment is identified in the lease agreement for maintenance, you are not required to carve out a portion of the lease payment to represent the maintenance portion. Thus, the entire lease payment is considered a capital-related cost subject to the provisions of 42 CFR 413.130(b). Appliances and equipment that are defined as durable medical equipment (DME) that meet the requirements set forth in §2203.2, must be reported on line 44.

Many providers incur costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control. The regulation at 42 CFR 413.17 and CMS Pub. 15-1, Chapter 10, require that the allowable cost of the provider include the costs for these items at the cost to the supplying organization (unless the exception provided in 42 CFR 413.17(d) and CMS Pub. 15-1, §1010, is applicable).

If you include on the cost report costs incurred by a related organization, the nature of the costs (i.e., capital-related or operating costs) does not change. Treat capital-related costs incurred by a related organization as your capital-related costs.

However, if the price in the open market for comparable services, facilities, or supplies is lower than the cost to the supplying related organization, your allowable cost may not exceed the market price. Unless the services, facilities, or supplies are otherwise considered capital-related cost, no part of the market price is considered capital-related cost. Also, if the exception in 42 CFR 413.17(d) and CMS Pub. 15-1, §1010, applies, no part of the cost to you of the services, facilities, or supplies is considered capital-related cost unless the services, facilities, or supplies are otherwise considered capital-related.

If the supplying organization is not related to you within the meaning of 42 CFR 413.17, no part of the charge to you may be considered a capital-related cost (unless the services, facilities, or supplies are capital-related in nature) unless:

- The capital-related equipment is leased or rented by you;
- The capital-related equipment is located on your premises or is located offsite and is on real estate owned, leased, or rented by you; and
- The capital-related portion of the charge is separately specified in the charge to you.

Under certain circumstances, costs associated with minor equipment may be considered capital-related costs. CMS Pub. 15-1, §106, discusses methods for writing off the cost of minor equipment. Three methods are presented in that section. Amounts treated as expenses under method (a) are not capital-related costs because they are treated as operating expenses. Amounts included in expenses under method (b) are capital-related costs because such amounts represent the amortization of the cost of tangible assets over a projected useful life. Amounts determined under method (c) are capital-related costs because method (c) is a method of depreciation.

Line 3 - Employee Benefits Department.--This cost center only includes the cost incurred for employees in the employee benefits department and/or human resources department charged with finding, screening, recruiting, and training job applicants, as well as administering benefits.

Line 4 - Administrative and General.--This cost center includes the costs incurred for the Administrator, Grievance Official, and Compliance Officer and designated staff person for the resident or family group, required under 42 CFR 483.70(d) and/or 483.410(a), 483.10(j)(4)(ii), 483.85(d)(2), 483.10((f)(5)(iii) and other administrative staff, including legal and accounting services must be included in this cost center. Facility administrative services that are required by the Requirements are included in line 4, as are those administrative costs not already included in other general service cost centers. If this line is componentized into more than one cost center, eliminate line 4. Componentized A&G lines must begin with subscripted line 4.01 and continue in sequential and consecutive order except where otherwise specified.

Line 5 - Plant Operation, Maintenance and Repairs.--This cost center includes the costs incurred for maintenance and service of utility systems such as heat, light, water, air conditioning and air treatment, and maintenance of the facility and grounds, such as the costs of routine painting, plumbing, mowing and snow removal required by 42 CFR 483.10(i), 483.73, 483.90, and/or 483.470.

Line 6 - Laundry and Linen Service.--This cost center includes the costs incurred to provide laundry and linen services required by 42 CFR 483.10(i)(3) and 483.80(e), whether performed in-house or by outside contractors.

Line 7 - Housekeeping.--This cost center includes the costs incurred to provide routine housekeeping activities such as mopping, vacuuming, cleaning restrooms, lobbies, waiting areas and otherwise maintaining patient and non-patient areas required by 42 CFR 483.10(i)((2).

Line 8 - Dietary.--This cost center includes the costs incurred in complying with the requirements for food and nutrition services in SNFs/NFs required by 42 CFR 483.60 and/or dietetic services in ICF/IID's required by 42 CFR 483.480, including the cost of a qualified dietitian or clinically qualified nutrition professional and/or a director of food and nutrition services as defined at 42 CFR 483.60(a) and/or 483.480(a); the costs for paid feeding assistants who meet the requirements specified in 42 CFR 483.60(h); and, the cost for special dietary supplements used for tube feeding or oral feeding, such as elemental high nitrogen diet, even if written as a prescription item by a physician, because these supplements have been classified by the Food and Drug Administration as a food rather than a drug in accordance with §2203.1 the PRM, CMS Pub. 15-1.

Line 9 - Nursing Administration--This cost center includes the costs incurred to provide nursing administration. The amounts reported must include the direct salaries, wages, and salary amounts for paid vacation, holiday, sick, PTO, severance, and bonus pay and corresponding wage-related costs incurred in this cost center for the director of nursing required by 42 CFR 483.35(b)(2); a portion of direct salaries, wages, and salary amounts for paid vacation, holiday, sick, PTO, severance, and bonus pay and corresponding wage-related costs, plus any costs related for contract labor and HO/CO costs, for the designated Charge Nurses required at 42 CFR 483.35(a)(2), the infection preventionist required at 42 CFR 483.80(b), and the registered nurse coordinator required at 42 CFR 483.20(h).

The salary cost of direct nursing services, including the salary cost of nurses who render direct services in more than one patient care area, are directly assigned to the various patient care cost centers in which the services were rendered. Direct nursing services include gross salaries and wages of head nurses, registered nurses, licensed practical and vocational nurses, aides, orderlies, and ward clerks. However, if your accounting system fails to specifically identify all direct nursing services to the applicable patient care cost centers, then the salary cost of all direct nursing service is also included in this cost center.

Line 10 - Central Services & Supply--This cost center includes the cost incurred for routine supplies used in the normal course of caring for patients, such as gloves, masks, swabs, or glycerin sticks and the costs of routine personal hygiene items and services as required to meet the needs of residents. Costs incurred by SNF/NFs to provide central services and supply, including the costs of routine personal hygiene items and services as required by 42 CFR 483.10(f)(11)(i)(E), and/or by ICF/IIDs as part of a medical plan developed by the physician at 42 CFR 483.460(a)(2), must be reported here. Medical supplies that can be traced to individual patients must be included on line 40, except for the cost of medical supplies in administering preventative (not therapeutic) influenza, pneumococcal, hepatitis B and COVID-19 vaccines paid under Medicare Part B, as these costs are reported on line 60.

Line 11 - Pharmacy--This cost center includes only the costs incurred for routine drugs (both prescription and over the counter), pharmacy supplies, pharmacy personnel, including the services of a pharmacist that are required at 42 CFR 483.45 for SNF/NFs and/or at 42 CFR 483.460(i)(j)(k)(l)(m) for ICF/IIDs, and pharmacy services. SNF/NFs must not charge a resident for specialized cleansing agents when indicated to treat special skin problems or to fight infection, nor over the counter drugs in accordance with 42 CFR 483.10(f)(11). Drugs and pharmacy supplies that can be traced to individual patients must be included on lines 41 and 42, Drugs Charged to Patients and IV Solutions; and line 40, Medical Supplies Charged to Patients.

Line 12 - Medical Records--This cost center includes the direct cost incurred for the medical records department where patient records are maintained in accordance with 42 CFR 483.70(i) for SNF/NFs and 42 CFR 483.410(c) for ICF/IIDs. The general library and the medical library are not included in this cost center but are included in the A&G cost center. None of the costs associated with electronic health records are included in this cost center.

Line 13 - Medical Social Services--This cost center includes the costs incurred to provide medically related social services in SNFs, NFs and ICF/IID's, including the costs incurred for the qualified social worker required by 42 CFR 483.70(p), in SNFs with more than 120 beds. Such services include, but are not limited to: (a) assessment of the social and emotional factors related to the patient's illness, his need for care, his response to treatment, and his adjustment to care in the facility; (b) appropriate action to obtain case work services to assist in resolving problems in these areas; (c) assessment of the relationship of the patient's medical and nursing requirements to their home situation, their financing resources, and the community resources available to them in making the decision regarding discharge in accordance with the requirements at 42 CFR 483.21(c) for SNF/NFs and 42 CFR 483.440(b) for ICF/IID's.

Line 14 - Activities Program.--This cost center includes the costs incurred for an ongoing program of activities in a SNF and/or NF designed to meet the interests and the physical, mental, and psychosocial well-being of each resident, including the costs of a qualified therapeutic recreation specialist, activities professional, qualified occupational therapist or qualified OT assistant required by 42 CFR 483.24(c).

Line 15 - QA & Performance Improvement Program.--This cost center includes the cost incurred to operate a Quality Assurance and Performance Improvement (QAPI) program described in 42 CFR 483.75 and the SNF Quality Reporting Program (QRP) required by Section 1899B of the Act; the cost incurred for the medical director required by 42 CFR 483.70(h), and allowable costs incurred for provider-based physicians determined on Worksheet A-8-2.

Line 16 - Training and In-Service Education.--This cost center includes the cost incurred for the Nurse Aid Training and Competency Evaluation Program (NATCEP) required by 42 CFR 483.35(d)(1)(ii)(A), and the training costs set forth at 42 CFR 483.73(d)(1) and 42 CFR 483.95 in SNF/NFs and at 42 CFR 483.430(b)(4) and (e), 42 CFR 483.460(c)(5), 42 CFR 483.460(e)(3) and 42 CFR 483.475(d) for ICF/IIDs.

Line 17 - Patient Transportation Part A.--This cost center includes the cost incurred for patient transportation covered under Part A that is the responsibility of the SNF. Ambulance services covered under Part B are not included in this cost center. Ambulance services covered under Part B are reported on line 71. This cost center is not applicable to NFs or ICF/IID's.

Line 18.--Use this line to report expenses for other general service costs incurred not previously identified on lines 1 through 17. Provide a line description that reflects the general service cost(s) reported on this line and its subscripts. Do not label this line other general service cost. See Table 5 in §4990 for the proper cost center code for this line.

Lines 19 through 24.--Reserved for future use.

INPATIENT ROUTINE NURSING COST CENTERS

Line 25 - Skilled Nursing Care.--This cost center accumulates the direct salaries, wages, and salary amounts for paid vacation, holiday, sick, PTO, severance and bonus pay for RNs, LPNs and CNAs, and all other direct care staff the fringe benefits corresponding to paid salaries and wages for employees and contract labor and HO/CO costs incurred to meet the nursing services requirements set forth in 42 CFR 483.35 for skilled nursing care and related services for residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons covered under 42 CFR 409 Subpart D for SNFs and 42 CFR 440.40 for NFs. Other residents must receive the same type of care as would be covered by Medicare/Medicaid as set forth in 42 CFR 409 Subpart D for SNFs those costs to be reported here. This cost center does not include the cost for feeding assistants allowed by 42 CFR 483.60(h). The cost for feeding assistants must be included in the dietary cost center.

Line 26 - Nursing Care.--This cost center accumulates the direct salaries, wages, and salary amounts for paid vacation, holiday, sick, PTO, severance and bonus pay for RNs, LPNs and CNAs and all other direct care staff, the fringe benefits corresponding to paid salaries and wages for employees and contract labor and HO/CO costs incurred to meet the nursing service requirements set forth in 42 CFR 483.35 for patients who on a regular basis, receive health-related care and services who because of their mental or physical condition require care and services (above the level of room and board) which can only be made available to them through institutional facilities covered under 42 CFR 440.155 for NFs. Other residents must receive the same type of care as would be covered by Medicaid under 42 CFR 440.155 for those costs to be reported here. This cost center does not include the cost for feeding assistants allowed by 42 CFR 483.60(h). The cost for feeding assistants must be included in the dietary cost center.

Line 27 - ICF/IID.--This cost center accumulates the direct salaries, wages, and salary amounts for paid vacation, holiday, sick, PTO, severance, and bonus pay, corresponding fringe benefits and contract labor and HO/CO costs incurred to meet the facility staffing requirements set forth at 42 CFR 483.430 and 42 CFR 483.460. Other residents must receive the same type of care as would be covered by Medicaid under 42 CFR 440.150 for those costs to be reported here.

Lines 28 through 29.--Reserved for future use.

ANCILLARY SERVICE COST CENTERS

Ancillary services are items and services (other than the types classified as routine services in CMS Pub. 15-1, chapter 22, §2203.1) that may be considered ancillary in a SNF if charges for them meet the requirements in §2203 for recognition of ancillary services and such items and services are identifiable items and services tailored to an individual patient's specific medical needs, are furnished at the direction of a physician, are not generally furnished to most patients, and are either not reusable or represent a cost for each preparation.

Line 30 - Radiology Diagnostic.--This cost center only includes the cost incurred for the technical component of radiology diagnostic tests.

Lines 31 - Radiology - Therapeutic/Chemotherapy.--This cost center includes the costs incurred for chemotherapy administration, be it provided by injection, orally or through IV, and radiation therapy provided in a non-hospital setting included in the SNF PPS payment.

Line 32 - Laboratory.--This cost center includes the costs incurred for clinical diagnostic laboratory tests and diagnostic non-laboratory tests, including materials and the services of technicians. The cost of tests performed as part of a preventive and screening service are not included in this cost center. Instead, that cost is reported on line 60.

Line 33 - Intravenous Therapy.--This cost center includes the cost incurred for administering intravenous infusions of fluids, drugs, or blood products.

Line 34 - Respiratory Therapy.--This cost center includes the cost incurred for providing RT services defined as those services that are prescribed by a physician for the assessment, diagnostic evaluation, treatment, management, and monitoring of patients with deficiencies and abnormalities of cardiopulmonary function. Routine administration of oxygen is not an ancillary service.

Line 35 - Physical Therapy.--This cost center includes the costs incurred related to the provision of skilled rehabilitation services by a qualified PT who meets the requirements in 42 CFR Part 484, concurrent with the management of a patient's care plan; the costs incurred related to the provision of skilled rehabilitation services by a qualified PTA who meets the requirements in 42 CFR Part 484, who works under the supervision of a qualified PT, concurrent with the management of a patient's care plan; the costs incurred for those set-up services provided by a therapy aide to the qualified PT under their direct supervision; and the costs incurred for a PT therapy student, participating in field experience, under the supervision of the qualified PT.

Line 36 - Occupational Therapy.--This cost center includes the costs incurred related to medically prescribed treatment concerned with improving or restoring function which has been impaired by illness or injury or, where function has been permanently lost or reduced by illness or injury, to improve the individual's ability to perform those tasks required for independent functioning by a qualified OT who meets the requirements in 42 CFR Part 484, concurrent with the management of a patient's care plan; the costs incurred related to an OTA who meets the requirements set forth in 42 CFR Part 484, who works under the supervision of an qualified OT, concurrent with the management of a patient's care plan; the costs incurred for those set-up services provided by a therapy aide to the qualified OT under their direct supervision; and the costs incurred for an OT student, participating in field experience, under the supervision of the qualified OT.

Line 37 - Speech-Language Pathology.--This cost center includes the costs incurred for those services necessary for the diagnosis and treatment of speech and language disorders which result in communication disabilities and for the diagnosis and treatment of swallowing disorders (dysphagia), regardless of the presence of a communication disability by a qualified SLP who meets the requirements set forth in 42 CFR 484.115, concurrent with the management of a patient's care plan; and, the costs incurred for those set-up services provided by a therapy aide to the qualified SLP under their direct supervision; and the costs incurred for a SLP student, participating in field experience, under the supervision of the qualified SLP.

Line 38 - Audiology.--This cost center includes the cost incurred for hearing and balance assessment services furnished by a qualified audiologist.

Line 39 - Electrocardiology.--This cost center includes the cost incurred in recording the electrical activity of the heart over a period of time using electrodes placed on the skin.

Line 40 - Medical Supplies Charged to Patients.--This cost center includes the cost incurred for medical supplies that are tailored to an individual patient's specific medical needs, are furnished at the direction of a physician, and are either not reusable or represent a cost for each preparation.

Line 41 – Drugs: Drugs Charged to Patients.--This cost center includes the cost incurred for drugs that are tailored to an individual patient's specific medical needs, are furnished at the direction of a physician, and are either not reusable or represent a cost for each preparation. Do not include IV solutions or preventative pneumococcal, influenza, hepatitis B, or COVID-19 vaccines in this cost center. These costs are reported on lines 42 and 80, respectively.

Line 42 - Drugs: IV Solutions.--This cost center includes the costs incurred for iv solutions such as colloid and crystalloid solutions. Blood products are not included in this cost center and must be reported on line 45.

Line 43 - Dental Care.--The cost center includes the costs incurred for dental care required under 42 CFR 483.55, to the extent that such services are covered under a State Plan for Medicaid.

Line 44 - Appliances and Equipment.--This cost center includes the costs incurred for orthotics, prosthetics, complex medical equipment and level 2 and level 3 support surfaces, that are ordinarily furnished by the SNF for the care and treatment of the beneficiary solely during the inpatient stay that meet the requirements in §2203.1.

Line 45 - Blood and Blood Products.--The cost center includes the cost incurred for un-replaced blood (after satisfaction of the 3 pint blood deductible) beginning with the first pint or unit.

Line 46 - Blood Transfusion/Processing/Storage.--This cost center includes the costs associated with blood transfusions and processing and storage of blood and blood components.

Line 47.--Use this line to report expenses for other ancillary services incurred not previously identified on lines 30 through 46. Provide a line description that reflects the other ancillary service cost(s) reported on this line and its subscripts. Do not label this line other ancillary services. See Table 5 in §4990 for the proper cost center code for this line.

Lines 48 through 59.--Reserved for future use.

OUTPATIENT SERVICE COST CENTERS

Covered Part B services rendered to beneficiaries who are not inpatients of a SNF are considered SNF outpatient services.

Line 60 - Screening and Preventative Services.--This cost center includes the cost of medical supplies and labs, that can be traced to individual patients, used in administering preventative (not therapeutic) influenza, pneumococcal, hepatitis B and COVID-19 vaccines paid under Medicare Part B. This cost center does not include the cost incurred for preventative (not therapeutic) pneumococcal, influenza, hepatitis B, and COVID-19 vaccines reported on line 80.

Line 61 - Outpatient Laboratory.--This cost center only includes costs incurred by a Medicare approved laboratory with its own CLIA number or CLIA certificate of waiver that is owned and operated by the SNF for laboratory services provided to residents whose benefit days are exhausted, or who are not entitled to have payment made for services under Part A, as well as those residents who are no longer inpatients of the SNF (i.e. outpatients).

Line 62 - Portable X-Ray Services.--This cost center only includes costs incurred by a radiological department that meets the same standards required of furnishing such services under the program or the standards to provide portable x-ray services that is owned and operated by the SNF for portable x-ray services provided to residents whose benefit days are exhausted, or who are not entitled to have payment made for services under Part A, as well as those residents who are no longer inpatients of the SNF (i.e., outpatients).

Line 63 - Outpatient Durable Medical Equipment.--This cost center includes costs incurred for DME provided to outpatients where the SNF qualifies as a supplier, is enrolled with the National Supplier Clearinghouse, and bills the DME Medicare administrative contractor.

Line 64.--Use this line to report expenses for other outpatient services incurred not previously identified on lines 60 through 63. Provide a line description that reflects the other outpatient service cost(s) reported on this line and its subscripts. Do not label this line other outpatient services. See Table 5 in §4990 for the proper cost center code for this line.

Lines 65 through 69.--Reserved for future use.

OUTPATIENT REIMBURSABLE COST CENTERS

Line 70 - Home Health Agency.-- This line accumulates costs that are specific to an HHA that is owned and operated by the SNF (SNF-based).

Line 71 - Ambulance.--Enter on this line the ambulance cost where the ambulance is owned and operated by the SNF and paid under Part B. Part A patient transportation provided via an ambulance is reported on line 17.

Line 72 - Hospice.--This line accumulates costs that are specific to a hospice that is owned and operated by the SNF (SNF-based).

Line 73.--This cost center accumulates the direct costs for SNF-based outpatient rehabilitation providers (CORFs, OPTs, OOTs or OSPs). If you have multiple components, subscript this line accordingly. Use lines 73.00-73.09 for CORFs, 73.10-73.19 for OPTs, 73.20-73.29 for OOTs and 73.30-73.39 for OSPs.

Line 74.--Use this line to report expenses for other reimbursable costs incurred not previously identified on lines 70 through 73. Provide a line description that reflects the other reimbursable cost(s) reported on this line and its subscripts. Do not label this line other reimbursable costs. See Table 5 in §4990 for the proper cost center code for this line.

Lines 75 through 79.--Reserved for future use.

COST REIMBURSED SERVICES

Line 80 - Preventative Vaccines.--This cost center includes only the cost incurred for preventative (not therapeutic) pneumococcal, influenza, hepatitis B, and COVID-19 vaccines and monoclonal antibody products for treatment of COVID-19. Medical supplies attributable to preventative pneumococcal, influenza, hepatitis B and COVID-19 vaccines and monoclonal antibody products for treatment of COVID-19 and their administration are reported on line 60.

Line 81.--Use this line to report expenses for other cost reimbursed services incurred not previously identified on line 80. Provide a line description that reflects the other cost reimbursed service cost(s) reported on this line and its subscripts. Do not label this line other cost reimbursed services. See Table 5 in §4990 for the proper cost center code for this line.

Lines 82 through 88.--Reserved for future use.

Line 89 - Subtotals.--Enter the subtotals for each column, lines 1 through 88, on this line.

NONREIMBURSABLE COST CENTERS

Use these lines to record 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, add a subscript consisting of a numeric subscript code to one or more of these lines. The subscripted lines must be appropriately labeled to indicate the purpose for which they are being used. However, if the expense (direct and all applicable overhead) attributable to any non-allowable cost area is so insignificant as not to warrant establishment of a nonreimbursable cost center and the sum total of all such expenses is so insignificant as not to warrant the establishment of a composite nonreimbursable cost center, adjust these expenses on Worksheet A-8. (See CMS Pub. 15-1, chapter 23, §2328)

Line 90 - Gift, Flower, Coffee Shops & Canteen.--Enter the costs associated with transactions between the SNF and/or NF and/or ICF/IID and non-residents for gifts, flower, coffee shop and canteen services.

Line 91 - Nonpaid Workers.--Enter the cost of nonpaid workers described in CMS Pub. 15-1, chapter 7.

Line 92 - Physician Private Offices.--This cost center includes the cost incurred by the provider for services related to physician's private offices including depreciation costs for the space occupied, movable equipment used by physicians' offices, administrative services, medical records, housekeeping, maintenance and repair, operation of plant, drugs, medical supplies and nursing services.

Line 93.--Use this line to report expenses for other nonreimbursable cost incurred not previously identified on lines 90 through 92. Provide a line description that reflects the other nonreimbursable cost(s) reported on this line and its subscripts. Do not label this line other nonreimbursable cost. See Table 5 in §4990 for the proper cost center code for this line.

Lines 94 through 99.--Reserved for future use.

Line 100 - Total.--Enter the total for each column, 1 through 10.

4902.70 WORKSHEET A-6 - RECLASSIFICATIONS

This worksheet provides for the reclassification of certain costs to effect proper cost allocation under cost finding. For each reclassification adjustment, assign an alpha character in column 1 to identify each reclassification entry, e.g., A, B, C. All reclassification entries must have a corresponding Worksheet A line number reference in columns 3 and 7. In column 10, indicate the column of Worksheet A-7 affected by the reclassification, where applicable. If more than one column on Worksheet A-7 is impacted by one reclassification, report each entry as a separate line to properly report each column affected on Worksheet A-7.

Submit with the cost report copies of any work papers used to compute the reclassifications effected on this worksheet.

Identify any reclassifications made as salary and non-salary costs in the appropriate column. However, when transferring to Worksheet A, column 6, transfer the sum of the two columns.

NOTE: Salary amounts paid to an employee in addition to direct salaries or wages (such as paid vacation, holiday, sick, other paid-time-off (PTO), severance, and bonus pay) must be reported on Worksheet A, column 1, of the same cost center as the employees' direct salaries and wages. For example, if the indirect salaries (such as paid vacation, holiday, sick, other paid-time-off (PTO), severance, and bonus pay) are reported on Worksheet A, column 4, of the cost center where the related direct salary and wages are reported, a reclassification entry must be made to reclassify them to a salary amount, for the cost center(s) in which the related direct salaries and wages are reported.

If there is any reclassification to general service cost centers for compensation of provider-based physicians, make the appropriate adjustment for RCE limitation on Worksheet A-8-2.

Examples of reclassifications that may be needed are:

1. Capital-related costs that are not included in one of the capital-related cost centers on Worksheet A, column 5. Examples include insurance on buildings and fixtures and movable equipment, rent on buildings and fixtures and movable equipment, interest on funds borrowed to purchase buildings and fixtures and movable equipment, personal property taxes, and real property taxes. Interest on funds borrowed for operating expenses is not included in capital related costs. It must be allocated with administrative and general expenses.
2. Wage-related costs (e.g., personnel department, employee health service, hospitalization insurance, workmen's compensation, employee group insurance, social security taxes, unemployment taxes, annuity premiums, past service benefits and pensions) included in the administrative and general cost center.
3. Insurance expense included in the administrative and general cost center and applicable to buildings and fixtures and/or movable equipment.
4. Interest expense included on Worksheet A, column 5, applicable to funds borrowed for administrative and general purposes (e.g., operating expenses) or for the purchase of buildings and fixtures or movable equipment.

5. Rent expenses included in the administrative and general cost center and applicable to the rental of buildings and fixtures and to movable equipment from other than related organizations. (See the instructions for Worksheet A-8-1 for treatment of rental expenses for related organizations.)
6. Any taxes (real property taxes and/or personal property taxes) included in the administrative and general cost center and applicable to buildings and fixtures and/or movable equipment.
7. Any dietary cost included in the dietary cost center and applicable to any other cost center.
8. Any direct expense included in the central service and supply cost center and directly applicable to other cost centers, e.g., IV therapy, Respiratory Therapy.
9. Any direct expenses included in the laboratory cost center and directly applicable to other cost centers, e.g., electrocardiology.
10. Any direct expenses included in the radiology diagnostic or radiology therapeutic/chemotherapy cost centers directly applicable to other cost centers, e.g., electrocardiology.
11. When you purchase services (e.g., PT) under arrangements for Medicare beneficiaries but do not purchase such services under arrangements for non-Medicare patients, your books reflect only the cost of the Medicare services. However, if you do not use the grossing up technique for purposes of allocating your overhead and if you incur related direct costs applicable to all patients, Medicare and non-Medicare (e.g., therapy aides who assist a qualified physical therapist by providing support and/or administrative services related to PT), such related costs are reclassified on Worksheet A-6 from the ancillary service cost center and are allocated as part of administrative and general expense.

However, when you purchase therapy services that include performing administrative functions such as completion of medical records, training, etc. as discussed in CMS Pub. 15-1, §1412.5, the bundled charge for therapies provided under arrangements includes the provision of these services. Therefore, for cost reporting purposes, these related services are NOT reclassified to A&G.

12. Rental expense on movable equipment that was charged directly to the appropriate cost center or cost centers must be reclassified on this worksheet to the capital-related movable equipment cost center unless the provider has identified and charged all depreciation on movable equipment to the appropriate cost centers.

4902.80 WORKSHEET A-7 - RECONCILIATION OF CAPITAL COST CENTERS

This worksheet enables the Medicare program to analyze the changes that occurred in your capital asset balances during the current cost reporting period.

4902.81 Part I - Analysis of Changes in Capital Asset Balances.

The analysis of changes in capital asset balances during the cost reporting period must be completed by all SNFs and SNF healthcare complexes. Do not reduce the amount entered by any accumulated depreciation reserves.

Columns 1 and 6.--Enter the balance recorded in your book of accounts at the beginning of your cost reporting period (column 1) and at the end of your cost reporting period (column 6). You must submit a reconciliation demonstrating that the amount reported on Part I, column 6, line 9, agrees with your fixed assets on Worksheet G, plus any directly allocated assets from the HO/CO or related organization, less any assets not allocated through the cost finding method on Worksheet B. Include fully depreciated assets still used for patient care.

Columns 2 through 4.--Enter the cost of capital assets acquired by purchase (including assets transferred from another provider, noncertified healthcare unit, or non-healthcare unit) in column 2 and the fair market value at date acquired of donated assets in column 3. Enter the sum of columns 2 and 3 in column 4.

Column 5.--Enter the cost or other approved basis of all capital assets sold, traded, or transferred to another provider, a non-certified healthcare unit, or non-healthcare unit or retired or disposed of in any other manner during your cost reporting period.

Column 6.--Enter the sum of columns 1 and 4 minus column 5.

Column 7.--Enter the initial acquisition cost of fully depreciated assets for each category. An asset that is fully depreciated and continues to be used in the facility must be recorded in this column. There will be no depreciation expense recorded after the asset is fully depreciated.

4902.82 Part II - Reconciliation of Capital Cost Centers (Summary of Capital).

The purpose of this worksheet is to segregate and specifically identify the depreciation and capital-related costs that are directly assigned to Worksheet A, column 9, lines 1 and 2.

Columns 1 through 7.--Enter in columns 1 through 7, the depreciation and other capital-related costs. For each line enter the sum of columns 1 through 6 in column 7. Column 7, lines 1 and 2, must equal the sum of the amounts reported on Worksheet A, column 9, lines 1 and 2.

4902.90 WORKSHEET A-8 - ADJUSTMENTS TO EXPENSES

In accordance with 42 CFR 413.9(c)(3), if your operating costs include amounts not related to patient care (specifically not reimbursable under the program) or amounts 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 adjustment in support of those items listed on Worksheet A, column 8. The adjustments that are required under the Medicare principles of reimbursement are made based on cost or amount received (revenue) only if the cost (including direct cost and all applicable overhead) cannot be determined. If the total direct and indirect cost can be determined, enter the cost. Submit with the cost report a copy of any work papers used to compute a cost adjustment. Once an adjustment to an expense is made based on cost, you cannot change the basis to revenue in any future cost reporting periods. Enter the following symbols in column 1 to indicate the basis for the adjustment: "A" for cost and "B" for amount received. For each adjustment, enter in column 4, the Worksheet A line number where the expense is reported. Line descriptions indicate the more common activities that affect allowable costs or that result in costs incurred for reasons other than patient care and, thus, require adjustment.

The types of adjustments entered on this worksheet are (1) those needed to adjust expenses to reflect actual expenses incurred; (2) those items which constitute recovery of expenses through sales, charges, fees, grants, gifts; (3) those items needed to adjust expenses in accordance with the Medicare principles of reimbursement; and (4) those items that are provided for separately in the cost apportionment process.

If an adjustment to an expense affects more than one cost center, record the adjustment to each cost center on a separate line on Worksheet A-8.

Lines 1 - Investment Income on Restricted Funds.--Enter the investment income to be applied against interest expense. (See CMS Pub. 15-1, chapter 2.)

Line 2 - Trade, Quantity, Time, and Other Discounts on Purchases.--Enter all discounts of expenses as reductions of the costs of whatever was purchased. (See 42 CFR 413.98 and CMS Pub. 15-1, chapter 8.)

Line 3 - Rebates and Refunds of Expenses.--Enter all rebates/refunds of previous expense payments as they are reductions of the costs to which they relate. (See 42 CFR 413.98 and CMS Pub. 15-1, chapter 8.)

Line 4 - Rental of Provider Space by Suppliers.--Enter amounts paid by a supplier for the use of space or equipment in the SNF. (See CMS Pub. 15-1, chapter 8.)

Line 5 - Telephone Services.--Patient telephones, located in the patient's room, that are furnished solely for the personal comfort of the patient are not includable in allowable costs. Make an adjustment on this line or establish a nonreimbursable cost center. (See CMS Pub. 15-1, chapter 21, §2106.1)

Line 6 - Television and Radio Services.--Patient television and radio services, located in the patient's room, that are furnished solely for the personal comfort of the patient are not includable in allowable costs. Make an adjustment on this line or establish a nonreimbursable cost center. (See CMS Pub. 15-1, chapter 21, §2106.1)

Line 7 - Parking Lot.--Offset parking lot revenue in accordance with CMS Pub. 15-1, chapter 21, §2107.

Line 8 - Remuneration Applicable to Provider-Based Physician Adjustment.--Enter the adjustment amount from Worksheet A-8-2, column 17. (See CMS Pub. 15-1, §§2108 - 2108.11.)

Line 9 - Sale of scrap, waste, etc.--Enter the income from these items to adjust the applicable expense. (See CMS Pub. 15-1, chapter 23, §2328.)

Line 10 - Related Organization and Home Office Costs.--Transfer the amount from Worksheet A-8-1, Part I, line 100, column 7. Note that Worksheet A-8-1 provides the detail of the various cost centers on Worksheet A that must be adjusted.

Line 11 - Laundry and Linen Service.--An adjustment is required for non-allowable patient personal laundry if this cost is not included in the nonreimbursable cost center titled Items and Services Charged to Resident's Funds.

Line 12 - Revenue - Employee Meals.--Enter the amount received from the sale of meals to employees. This income offsets the dietary expense.

Line 13 - Cost of Meals - Guests.--Enter the cost of meals provided for non-employees. This amount offsets the allowable dietary costs.

Line 14 - Sale of Medical Supplies to Other than Patients.--Enter the amount received from the sale of medical supplies to other than patients to be offset against the central service and supplies cost center.

Line 15 - Sale of Drugs to Other than Patients.--Enter the amount received from the sale of drugs to other than patients to be offset against the pharmacy cost center.

Line 16 - Revenue - Copying Costs of Medical Records and Abstracts.--Revenue from reasonable, cost-based fees including the cost of labor, supplies and postage as set forth in 42 CFR 483.10(g). This amount offsets the allowable administrative and general costs.

Line 17 - Vending Machines.--Remove the direct cost plus applicable overhead of operating vending machines from allowable cost. If cost cannot be calculated, then income received may be used.

Line 18 - Income from Imposition of Interest, Finance or Penalty Charges.--Enter the cash received from imposition of interest, finance, or penalty charges on overdue receivables. This income must offset the allowable administrative and general costs. (See CMS Pub. 15-1, chapter 21, §2110.2.)

Line 19 - Interest Expense on Medicare Overpayments and Borrowing to Repay Medicare Overpayments.--Enter the interest expense imposed by the contractor on Medicare overpayments to you. Also, enter the interest expense on borrowing made to repay Medicare overpayments to you. (See CMS Pub. 15-1, chapter 2.)

Lines 20 and 21 - Depreciation Buildings and Fixtures/Movable Equipment.--When depreciation expense computed in accordance with the Medicare principles of reimbursement differs from depreciation expenses per your books, enter the difference on line 20 and/or line 21. (See CMS Pub. 15-1, chapter 1.)

Line 22 - Short Term Inpatient Hospice Care.--Enter the amount received from a hospice that has contracted with the SNF to provide short term inpatient care for pain control, symptom management, or respite services for a patient who has elected the hospice benefit.

Line 23 - Hospice Non-Core Contracted Services.--Enter the amount received from a hospice with which the SNF has a contract to provide non-core hospice services.

Line 24.--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.

NOTE: An example of an adjustment entered on these lines is the grossing up of costs in accordance with the provisions of CMS Pub. 15-1, chapter 23, §2314, and is explained below.

If you furnish ancillary services to Medicare beneficiaries under arrangements with others but simply arrange for such services for non-Medicare patients and do not pay the non-Medicare portion of such services, your books reflect only the costs of the program's portion. Therefore, allocation of indirect costs to a cost center that includes only the cost of the program portion results in excessive assignment of indirect costs to the program. Since services were also arranged for the non-Medicare patients, allocate part of the overhead costs to those groups.

In the foregoing situation, no indirect costs may be allocated to the cost center unless the contractor determines that you are able to gross up both the costs and the charges for services to non-Medicare patients so that both costs and charges for services to non-Medicare patients are recorded as if you had provided such services directly.

Line 100.--For column 2, enter the sum of lines 1 through 99. Transfer the amounts in column 2 to Worksheet A, column 8.

4902.100 WORKSHEET A-8-1 - RELATED ORGANIZATIONS AND HOME OFFICE COSTS

In accordance with 42 CFR 413.17, costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control are includable in the allowable cost of the provider at the cost to the related organization. However, such cost must not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere. (See 42 CFR 413.17(d) for exceptions) This worksheet computes needed adjustments to costs applicable to services, facilities, and supplies furnished to the SNF by organizations related to the provider. 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.)

Complete this worksheet if you answered yes to question 16 or 23, on Worksheet S-2. Do not complete Worksheet A-8-1 if Worksheet A does not include cost that resulted from transactions with related organizations or a HO/CO.

4902.101 Part I - Costs Incurred and Adjustments Required as a Result of Transactions with Related Organizations or Claimed Home Office Costs.

Cost applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control, i. e., a HO/CO or other related party, are includable in the allowable cost of the provider at the cost to the related organization. However, such cost must not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere.

Column 1.--Enter the Worksheet A line number from your books and/or records associated with the acquisition of services, facilities, and/or supplies from related organizations or HO/CO.

Column 2.--The Worksheet A cost center description is automatically completed based on the line number entered in column 1.

Column 3.--Enter the specific expense category from your books and/or records associated with the acquisition of services, facilities, and/or supplies from related organizations or HO/CO.

Column 4.--Enter the Part II line number related to the expense reported in column 3. For example, Genesis Home Office leases the SNF's physical plant from Genesis Property Management, a related organization. The home office reports the lease expense on line 1, column 3 and identifies Genesis Property Management as a related organization in Part II, line 1. On Part I, line 1, column 4, the home office enters 1, the line number from Part II, to identify the interrelationship.

Column 5.--Enter the allowable cost from the books and/or records of the related organization which includes only the actual cost incurred by the related organization for services, facilities, and/or supplies and excludes any markup, profit or amounts that otherwise exceed the acquisition cost of such items.

Column 6.-- Enter the amount included on Worksheet A for services, facilities, and/or supplies acquired from related organizations.

Column 7.--Enter the result of column 5 minus column 6.

4902.102 Part II - Interrelationship Between Related Organizations and/or Home Office.

Use this part to show the interrelationship of the provider to organizations furnishing services, facilities, or supplies to the provider. The requested data relative to all individuals, partnerships, corporations, or other organizations having either a related interest to the provider, a common ownership of the provider, or control over the provider as defined in CMS Pub. 15-1, chapter 10, must be shown in columns 1 through 7, as appropriate.

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

Column 1.--Enter the appropriate symbol that describes the interrelationship of the provider to the related organization.

Column 2.--If the symbols A, D, E, F, or G are 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 indicated in column 4 has a financial interest in the provider, enter the percent of ownership in the provider.

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

Column 5.--If the organization in column 4 is a HO/CO, enter the Medicare Home Office # used when completing the SNF's home office cost statement.

Column 6.--If the individual indicated in column 2 or the provider has a financial interest in the related organization, enter the percent of ownership in such organization.

Column 7.--Enter the type of business in which the related organization engages (e.g., medical drugs and/or supplies, laundry and linen service).

4902.110 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 costs only those costs which you incur for physician services that benefit the general patient population. 42 CFR 415.70 imposes limits on the amount of physician compensation that may be recognized as a reasonable provider cost.

Worksheet A-8-2 provides for the computation of the allowable provider-based physician cost you incurred. The regulation at 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 includable in allowable cost on the cost report. This worksheet provides for application 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 that are included in the SNF PPS rate. These limits apply only to physicians who direct a provider department in which the physician's expertise is required or who furnish other services, such as participating in quality control activities.

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

Column Descriptions

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

Column 2.--When RCE limits are applied on an individual basis to each physician, list each physician using an individual identifier that protects the identity or any protected health information (PHI) associated with the physician (e.g., Dr. A, Dr. B). The identity of the physician must be made available to your contractor upon request. Where the physicians are all included in the same cost center reported in column 1, the physicians must be reported on successive lines.

When the RCE limits are applied on an aggregate basis to a physician specialty, identify the physician specialty associated with the cost center identified in column 1. Each specialty must be separately reported. Where there are multiple specialties all included in the same cost center reported in column 1, each specialty must be reported on successive lines.

Columns 3 through 17.--When the aggregate method is used enter the data for each of these columns in the aggregate for each specialty included in the cost center reported in column 1. When the individual method is used, enter the data for each column on the individual physician identifier lines for each cost center reported in column 1.

Column 3--Total remuneration is total physician compensation including monetary payments, wage-related costs, 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 are furnished to a physician in return for the physician's services subject to the limitations set forth in 42 CFR 411, Subpart J. (see 42 CFR 415.60(a).) Report the total paid salaries and wages for each physician identified, or for each specialty if reporting in the aggregate, including overtime, vacation, holiday, sick, lunch, and other paid-time-off, severance, and bonuses.

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 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, which is 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, to 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 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. (See CMS Pub. 15-1, §2182)

Columns 7 and 8--Enter for each line of data the physician's hours which are allocated to professional services and 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 in columns 7 and 8.

The hours entered are the actual hours for which the physician is compensated by you for furnishing services of a general benefit to your patients. If the physician is paid for unused vacation, unused sick leave, etc., exclude the hours so paid from the hours entered. Time records or other documentation that supports this allocation must be available for verification by your contractor upon request. (See CMS Pub. 15-1, §2182.3E.)

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.

Column 9--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 8 to 2080 hours.

Column 10--Enter for each line of data five percent of the amounts entered in column 9.

Column 11.-- The computed RCE limit in column 9 may be adjusted upward up to five percent to take into consideration the actual costs of membership for physicians in professional societies and continuing education paid by you subject to the limitations set forth in 42 CFR 411, Subpart J. Enter for each line of data the actual amounts of these expenses paid by you.

Column 12.--Enter for each line of data the result of multiplying the amount in column 5 by the amount in column 11 and dividing that amount by the amount in column 3.

Column 13.--The computed RCE limit in column 9 may also be adjusted upward to reflect the actual malpractice expense incurred by you for the physician's (or a group of physicians) services to your patients. Enter for each line of data the actual amounts of these malpractice expenses paid.

Column 14.--Enter for each line of data the result of multiplying the amount in column 5 by the amount in column 13 and dividing the result by the amount in column 3.

Column 15.--Enter for each line of data the sum of the amounts in columns 9 and 14 plus the lesser of the amounts in columns 10 or 12.

Column 16.--Compute the RCE disallowance for each cost center by subtracting the RCE limit in column 15 from your component remuneration in column 5. If the result is a negative amount, enter zero.

Column 17.--The adjustment for each cost center entered represents the provider-based physician elimination from costs entered on Worksheet A-8, column 2, line 8 and on Worksheet A, column 8 to each cost center affected. Compute the amount by deducting, for each cost center, the lesser of the amounts recorded in column 5 (provider component remuneration) or column 15 (adjusted RCE limit) from the total remuneration recorded in column 3.

Total Line 100.--Total the amounts in columns 3 through 5, and 7 through 17.

4903 B SERIES

On the B series of worksheets consists of the following:

- Worksheet B - Part I - Allocation of General Service Costs
- Worksheet B-1 - Cost Allocations - Statistical Bases
- Worksheet B - Part II - Allocation of Capital Related Cost
- Worksheet B-2 - Post Step-Down Adjustments

4903.10 WORKSHEET B - PART I - ALLOCATION OF GENERAL SERVICE COSTS AND WORKSHEET B-1 - COST ALLOCATIONS - STATISTICAL BASES

In accordance with 42 CFR 413.24(a), 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 the cash basis of accounting. Cost data based on such basis of accounting are acceptable subject to appropriate treatment of capital expenditures. 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. The various cost finding methods recognized are outlined in 42 CFR 413.24. Worksheets B, Part I, and B-1 have been designed to accommodate the step-down method of cost finding.

A change in order of allocation and/or allocation statistics is appropriate for the current cost reporting period if received by the contractor, in writing, within 90 days prior to the end of the cost reporting period. The contractor has 60 days to render a decision or the change is automatically accepted. The change must be shown to more accurately allocate the overhead cost, or if the change is as accurate, should be changed due to simplification of maintaining the statistics. The provider must include with the request all supporting documentation and a thorough explanation of why the alternative approach should be used. If a change in statistics is requested, the provider must maintain both sets of statistics until an approval is made. If the request is denied, the provider must use the previously approved methodology. (See CMS Pub. 15-1, chapter 23, §2313.)

Worksheet B, Part I, provides for the allocation of the expenses of each general service cost center to those cost centers that receive the services. The cost centers serviced by the general service cost centers include all cost centers within the provider i.e., other general service cost centers, ancillary service cost centers, inpatient routine service cost centers, outpatient service cost centers, other reimbursable cost centers, cost reimbursed services, and nonreimbursable cost centers. The total direct expenses are obtained from Worksheet A, column 9.

Worksheet B-1 provides for the proration of the statistical data needed to equitably allocate the expenses of the general service cost centers on Worksheet B, Part I. To facilitate the allocation process, the general format of Worksheets B, Part I and B-1, is identical. Each general service cost center has the same line number as its respective column number across the top and is consistent with the cost centers and line numbers found on Worksheet A. The statistical basis shown at the top of each column on Worksheet B-1 is the recommended basis of allocation of the cost center indicated.

NOTE: General service columns 1 through 21 and subscripts thereof must be consistent on Worksheets B, Parts I and II; and H-2, Part I.

Most cost centers are allocated on different statistical bases. However, for those cost centers for which the basis is the same (e.g., square feet), the total statistical base over which the costs are allocated differs because of the prior elimination of cost centers that have been closed.

The general service cost centers are ordered sequentially such that the cost centers that render the most services to and receive the least services from other cost centers are listed first. When closing the general service cost centers, first close the cost centers that render the most services to and receive the least services from other cost centers. The cost centers are listed in this sequence from left to right on the worksheets. However, your circumstances may be such that a more accurate result is obtained by allocating to certain cost centers in a sequence different from that followed on these worksheets.

If the amount of any cost center on Worksheet A, column 9, has a credit balance, this must be shown as a credit balance on Worksheet B, Part I, column 0. Allocate the costs from the applicable overhead cost centers in the normal manner to such cost center showing a credit balance. After receiving costs from the applicable overhead cost centers, if a general service cost center has a credit balance at the point it is to be allocated, such general service cost center must not be allocated. Rather, enter the credit balance in parentheses on line 99 as well as on the first line of the column and on line 100. This enables line 100, column 21, to cross foot to line 100, columns 0 and 3A. After receiving costs from the applicable overhead cost centers, if a revenue producing cost center has a credit balance on Worksheet B, Part I, column 21, do not carry forward such credit balance to Worksheet C.

On Worksheet B-1, enter on the first line in the column of the cost center being allocated the total statistical base (including accumulated cost for allocating administrative and general expenses) over which the expenses are to be allocated (e.g., for column 1, CRC - B&F, enter on line 1 the total square feet of the building on which depreciation was taken). For all cost centers to which the capital-related cost is allocated, enter that portion of the total statistical base applicable to each. The sum of the statistical base applied to each cost center receiving the services rendered must equal the total base entered on the first line. Use accumulated cost for allocating A&G expenses.

Do 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 your records; or
- the contractor determines that you are able to (and do) gross up the costs and charges for services to non-Medicare patients so that both cost and charges are recorded as if you had furnished such services directly to all patients. (See CMS Pub. 15-1, chapter 23, §2314.)

Enter on Worksheet B-1, line 102, the total expenses of the cost center to be allocated. Obtain this amount from Worksheet B, Part I, from the same column and line number used to enter the statistical base on Worksheet B-1 (in the case of CRC - B&F, this amount is on Worksheet B, Part I, line 1, column 1).

Divide the amount entered on Worksheet B-1, line 102, by the total statistics entered in the same column on the first line. Enter the resulting unit cost multiplier on Worksheet B-1, line 103. Round the unit cost multiplier to six decimal places.

Multiply the unit cost multiplier by that portion of the total statistics applicable to each cost center receiving the services rendered. Enter the result of each computation on Worksheet B, Part I, in the corresponding column and line. (See §4900.10 for rounding standards.)

After the unit cost multiplier has been applied to all the cost centers receiving the services rendered, the total cost (line 100) of all of the cost centers receiving the allocation on Worksheet B, Part I, must equal the amount entered on the first line. The preceding procedures must be performed for each general service cost center. Each cost center must be completed on both Worksheets B, Part I, and B-1 before proceeding to the next cost center.

If a general service cost center has a credit balance at the point it is allocated on Worksheet B, Part I, do not allocate general service cost center. However, the statistic must be displayed departmentally. Do not calculate the unit cost multipliers on Worksheet B-1, lines 103 or 105.

Use Worksheet B-1, lines 104 and 105, in conjunction with the allocation of capital-related cost on Worksheet B, Part II. Complete Worksheet B-1, line 104, for all columns after completing Worksheets B, Part I, and B-1 and determining the amount of direct and indirect capital-related cost on Worksheet B, Part II. Worksheet B-1, line 105, for all columns is the unit cost multiplier used in allocating the direct and indirect capital-related cost on Worksheet B, Part II. Compute the unit cost multiplier after the amounts to be entered on line 104 have been determined by dividing the capital-related cost recorded on line 104 by the total statistics entered in the same column on the first line. Round the unit cost multiplier to six decimal places. (See instructions for Worksheet B, Part II, for the complete methodology and exceptions.)

After the costs of the general service cost center have been allocated on Worksheet B, Part I, enter in Worksheet B, Part I, column 19 the sum of the costs in Worksheet B, Part I, columns 3A through 18 for lines 25 through 93.

When an adjustment is required to expenses after cost allocation, show the amount applicable to each cost center in Worksheet B, Part I, column 20. A corresponding adjustment to Worksheet B, Part II, may be applicable for capital-related cost adjustments. Submit a supporting worksheet showing the computation of the adjustment in addition to completing Worksheet B-2.

Some examples of adjustments which may be required to expenses after cost allocation are (1) the allocation of available costs between the certified portion and the noncertified portion of a distinct part provider where there is a substantial difference in occupancy rates and (2) costs attributable to unoccupied beds of a SNF with a restrictive admission policy. (See CMS Pub. 15-1, chapter 23, §§2342 - 2344.3.)

After the adjustments have been entered on Worksheet B, Part I, column 20, adjust the amounts in Worksheet B, Part I, column 19, by the amounts in Worksheet B, Part I, column 20, and extend the new balances to Worksheet B, Part I, column 21, for each line. The total costs entered in Worksheet B, Part I, line 100, column 21, must equal the total costs entered in Worksheet B, Part I, line 100, column 0.

Transfer the totals in lines 30 through 47, column 21, and lines 64, 71, 80, and 81, column 21, from the Worksheet B, Part I, to the corresponding line on Worksheet C, column 1.

Transfer the totals in column 21:

From Worksheet B, Part I, Column 21	To Worksheet D-1, Line 5
Line 25, SNF	For SNF
Line 26, NF	For NF
Line 27, ICF/IID	For ICF/IID

The nonreimbursable cost center totals, lines 90 through 93, are not transferred.

Column Descriptions

Column 1.--Depreciation on buildings and fixtures and expenses pertaining to buildings and fixtures such as insurance, interest, rent, and real estate taxes are combined in this cost center to facilitate cost allocation.

Column 2.--Providers that do not directly assign the depreciation on movable equipment and expenses pertaining to movable equipment such as insurance, interest, and rent as part of their normal accounting systems must accumulate the expenses in this cost center.

Column 4.--Allocate the administrative and general expenses on the basis of accumulated costs. Therefore, the amount entered on Worksheet B-1, line 4, column 4, is the difference between the amount on Worksheet B, Part I, column 3A, and the amount entered on 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.

4903.20 WORKSHEET B - PART II - ALLOCATION OF CAPITAL RELATED COSTS

This worksheet provides for the determination of direct and indirect capital-related costs allocated to inpatient general routine and ancillary services, as well as to other cost centers. It also provides CMS with data on capital-related costs for program purposes.

Use this worksheet in conjunction with Worksheets B, Part I, and B-1. The format and allocation process employed are identical to that used on Worksheets B, Part I, and B-1.

Column 0.--If capital-related costs have been directly assigned to specific cost centers on Worksheet A, column 4, enter those amounts directly assigned from your records. If you include costs incurred by a related organization in your cost report, the portion of these costs that are capital-related costs are considered directly assigned capital-related costs of the applicable cost center. For example, a provider that is part of a chain organization includes some costs incurred by the HO/CO of the chain organization in its administrative and general cost center. The amount so included representing capital-related cost is included in this column.

Columns 1 and 2.--Transfer the amounts from Worksheet B, Part I, lines 3 through 93, column 1, to column 1. Transfer the amounts from Worksheet B, Part I, lines 3 through 93, column 2, to column 2.

Column 2A.--Enter the sum of columns 0 through 2 on each line.

On Worksheet B-1, line 104, for each cost center (column), enter the capital-related costs to be allocated from line 100 on the Worksheet B, Part II. Calculate the unit cost multiplier for each column by dividing the amount on Worksheet B-1, line 104, by the statistic reported on the first line of the same column. Enter the unit cost multiplier on Worksheet B-1, line 105, and round to six decimal places, e.g., round 0.102589241 to 0.102589.

The allocation process on Worksheet B, Part II, is identical to that used on Worksheets B, Part I, and B-1. For each column, multiply the unit cost multiplier by the portion of the total statistic applicable to each cost center. Enter the result of each computation on Worksheet B, Part II, in the corresponding column and line.

After applying the unit cost multiplier to each cost center in the column, the total cost on Worksheet B, Part II, line 100 (the sum of all the cost centers receiving the allocation), must equal the amount being allocated on the first line of the column. Perform these allocation steps for each general service cost center. Complete each cost center on Worksheets B-1 and B, Part II, before proceeding to the next cost center.

4903.30 WORKSHEET B-2 - POST STEP-DOWN ADJUSTMENTS

This worksheet provides an explanation of the post step down adjustments reported on Worksheet B, Parts I and II, column 20.

Column 1.--Enter a brief description of the post step down adjustment.

Column 2.--The post step down adjustment may be made on Worksheet B, Parts I and II. Enter the worksheet part to which the post step down adjustment applies.

Column 3.--Enter the Worksheet B line number to which the adjustment applies.

Column 4.--Enter the amount of the adjustment. Transfer the amounts to the applicable lines on Worksheet B, Parts I or II, column 20.

4904 C SERIES

On the C series of worksheets, the SNF computes the cost to charge ratio for ancillary services, outpatient services, and cost-reimbursed services, including where applicable, for a SNF-based HHA or hospice. This ratio is used on the Worksheet D to determine Medicare's portion of the costs incurred by the SNF for ancillary, outpatient, and cost-reimbursed services. The series consists of the following worksheets:

- Worksheet C - Ratio of Cost to Charges for Ancillary and Outpatient Cost Centers
- Worksheet C-6 - Reclassifications of Charges

4904.10 WORKSHEET C - RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTERS

This worksheet computes the ratio of cost to charges for ancillary services, outpatient services, and cost reimbursed services. All charges entered on this worksheet must comply with CMS Pub. 15-1, chapter 22, §§2202.4 and 2203. Use this ratio on Worksheet D to determine the program share of ancillary service costs in accordance with 42 CFR 413.53.

Column 1.--For each cost center, enter the amount from the corresponding line of Worksheet B, Part I, column 21, excluding any negative amounts (credit balances); however, report the charges applicable to cost centers with a credit balance in column 2 of the applicable line on Worksheet C.

Column 2.--For each cost center, enter the total gross patient charges as reported in your trial balance. Include all charges, regardless of how they are paid (FFS or managed care), as well as charges for charity care. Do not reclassify charges directly on Worksheet C to match charges and expenses; reclassify charges on Worksheet C-6, to match charges and expenses.

Column 3.--For each cost center, enter the sum of reclassifications associated with each cost center reported on Worksheet C-6, columns 5 and 8, that are needed to effect proper cost allocation. The net total of the entries in this column must equal zero on line 100.

Column 4.--For each cost center, enter the sum of the amount entered in column 2 and the amount entered in column 3 (increase or decrease). The total on line 100 must equal the total of column 2, line 100.

Column 5.--Calculate the cost to charge ratio for each cost center by dividing column 1 by column 4 and enter the result in column 5. Do not calculate the cost to charge ratio for lines 25 through 27.

Line 100.--Enter the sum of lines 25 through 27, 30 through 47, plus lines 64, 71, 80, and 81.

4904.70 WORKSHEET C-6 - RECLASSIFICATIONS OF CHARGES

This worksheet provides for the reclassification of certain charges from the cost center as reported in the provider's trial balance to the cost center containing the matching expenses for reporting on Worksheet C. For each reclassification adjustment, provide a brief explanation of the reclassification in column 1 and assign an alpha character in column 2 to identify each reclassification entry, e.g., A, B, C. Report the Worksheet C line numbers in columns 4 and 7 and the corresponding cost center name in columns 3 and 6. Submit copies of any work papers used to compute the reclassifications on this worksheet. Transfer the sum of columns 5 and 8, for each cost center reported in columns 4 and 7, to Worksheet C, column 3 accordingly.

4905. D SERIES

On the D series of worksheets, the SNF apportions the cost applicable to inpatient and outpatient services reimbursable under the program. The series consists of the following worksheets:

- Worksheet D - Apportionment of Ancillary and Outpatient Costs
- Worksheet D-1 - Computation of Inpatient Routine Service Costs

4905.10 WORKSHEET D - APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS

This worksheet apportions costs applicable to inpatient, outpatient, and preventive vaccine services reimbursable under titles V, XVIII, and XIX for SNFs, NFs, and ICF/IIDs in accordance with 42 CFR 413.53(b). Complete a separate worksheet for each component. Identify the healthcare program and provider component by checking the appropriate boxes at the top of the worksheet.

Column 1.--For lines 30 through 47, 65, 71, 80, and 81, transfer the cost to charge ratio from the corresponding line on Worksheet C, column 5.

Column 2.--Enter, from the PS&R or provider records, the inpatient charges for lines 30 through 47, 65, 71, 80, and 81. For Medicare purposes these charges are paid under SNF PPS and are NOT subject to cost reimbursement. Do not include any charges identified as MSP/LLC. Submit a reconciliation of variances if the charges entered on each line differ from the source (e.g., to show the elimination of any professional component charges).

Column 3.--Enter from the PS&R or provider records, the inpatient Part B and outpatient charges for lines 30 through 47, 65, 71, 80, and 81. For Medicare purposes these services are paid under OPSS and are NOT subject to cost reimbursement.

Column 4.--Enter from the PS&R or provider records the preventive vaccine charges for line 80, that are subject to cost reimbursement and not subject to deductible and coinsurance. Do not include preventive vaccine charges in columns 2 or 3.

Column 5.--For each line 30 through 47, 65, 71, 80, and 81, enter the result of multiplying the charges in column 2, by the ratio in column 1.

Column 6.--For each line 30 through 47, 65, 71, 80, and 81, enter the result of multiplying the charges in column 3, by the ratio in column 1.

Column 7.--For line 80, enter the result of multiplying the charges in column 4 by the ratio in column 1.

Line 100.--For each of columns 2 through 7, enter the sum of lines 30 through 47, 65, 71, 80, and 81, as applicable.

4905.20 WORKSHEET D-1 - COMPUTATION OF INPATIENT ROUTINE SERVICE COSTS

This worksheet provides for the computation of inpatient routine service cost in accordance with 42 CFR 413.53 (determination of cost of services to beneficiaries) and 42 CFR 413.30 (limitations on reimbursable costs). This worksheet applies to all Title V, Title XVIII, and Title XIX inpatient routine costs.

As applicable, complete a separate worksheet for each provider component (SNF, NF, ICF/IID) and healthcare program. Indicate the healthcare program and provider component on the worksheet by selecting the appropriate program and component at the top of the worksheet.

Line Descriptions

Line 1.--Enter the total inpatient days, including private room days for the provider component and healthcare program for which the worksheet is completed:

<u>Description</u>	<u>Total Inpatient Days from:</u>
SNF	Worksheet S-3, Part I, line 1, column 7
NF	Worksheet S-3, Part I, line 2, column 7
ICF/IID	Worksheet S-3, Part I, line 3, column 7

EXCEPTION: When the SNF is located in a state that licenses the provider as a SNF regardless of the level of care given for titles V and XIX patients, enter the days from Worksheet S-3, column 7, sum of lines 1 and 2.

Line 2.--Enter the total private room days (from provider records).

Line 3.--Enter the inpatient days, including private room days for the healthcare program and provider component for which the worksheet is completed:

<u>Description</u>	<u>Inpatient Days by Program from:</u>
SNF	Title V - Worksheet S-3, Part I, line 1, column 3; Title XVIII - Worksheet S-3, Part I, line 1, column 4; Title XIX - Worksheet S-3, Part I, line 1, column 5
NF	Title V - Worksheet S-3, Part I, line 2, column 3; Title XIX - Worksheet S-3, Part I, line 2, column 5
ICF/IID Care	Title V - Worksheet S-3, Part I, line 3, column 3; Title XIX - Worksheet S-3, Part I, line 3, column 5

EXCEPTION: When the SNF is located in a state that certifies the provider as a SNF regardless of the level of care given for titles V and XIX patients, enter the program inpatient days for title V from Worksheet S-3, lines 1 and 2, column 3; and for title XIX from Worksheet S-3, lines 1 and 2, column 5.

Line 4.--Enter the total medically necessary private room days applicable to each healthcare program and provider component.

Line 5.--Enter the total general inpatient routine service cost from Worksheet B, Part I, column 21, line 25 for the SNF, line 26 for the NF, or line 27 for the IID/ICF.

EXCEPTION: When the SNF is located in a state that licenses the provider as a SNF regardless of the level of care given for titles V and XIX patients enter the general inpatient routine service costs from lines 26 and 27.

Line 6.--Enter the total charges for general inpatient routine services for SNF, NF or IID/ICF, as applicable from provider records. These charges should agree with the amounts on Worksheet G-2, column 7, lines 1, 2, or 3. See exception after line 5 above.

Line 7.--Calculate the general inpatient routine cost/charge ratio (rounded to six decimal places, e.g., round 0.102589241 to 0.102589) by dividing the total inpatient general routine service costs on line 5 by the total inpatient general routine service charges on line 6.

Line 8.--Enter the private room charges from provider records.

Line 9.--Calculate the average per diem charge (rounded to two decimal places) for private room accommodations by dividing the total charges for private room accommodations on line 8 by the total number of days of care furnished in private room accommodations on line 2.

Line 10.--Enter the semi-private room charges from provider records.

Line 11.--Calculate the average per diem charge (rounded to two decimal places) for semi-private accommodations by dividing the total charges for semi-private room accommodations on line 10 by the total number of days of care furnished in semi-private room accommodations (line 1 minus line 2).

Line 12.--Subtract the average per diem charge for all semi-private accommodations on line 11 from the average per diem charge for all private room accommodations on line 9 to determine the average per diem private room charge differential. If a negative amount results from this computation, enter zero.

Line 13.--Multiply the average per diem private room charge differential on line 12 by the inpatient general routine cost/charge ratio on line 7 to determine the average per diem private room cost differential (rounded to two decimal places).

Line 14.--Multiply the average per diem private room cost differential on line 13 by the private room accommodation days on line 2 to determine the total private room accommodation cost differential adjustment.

Line 15.--Subtract the private room cost differential adjustment on line 14 from the general inpatient routine service cost on line 5 to determine the adjusted general inpatient routine service cost net of private room accommodation cost differential adjustment.

Line 16.--Calculate the adjusted general inpatient routine service cost per diem by dividing the amount on line 15 by inpatient days (including private room days) on line 1.

Line 17.--Calculate the routine service cost by multiplying the program inpatient days (including the private room days) on line 3 by the adjusted general inpatient routine service cost per diem on line 16.

Line 18.--Calculate the medically necessary private room cost applicable to the program by multiplying medically necessary private room days on line 4 by the average per diem private room cost differential amount on line 13.

Line 19.--Enter the total program general inpatient routine service cost, sum of lines 17 and 18.

Line 20.--Transfer the capital-related cost allocated to the general inpatient service cost center from Worksheet B, Part II, column 21, for the SNF line 25; for the NF line 26; or for the ICF/IID line 27.

Line 21.--Calculate the per diem capital-related cost by dividing line 20 by total inpatient days on line 1.

Line 22.--Calculate the program capital-related cost by multiplying line 21 by line 3.

Line 23.--Calculate the inpatient routine service cost by subtracting the amount on line 22 from the amount on line 19.

Line 24.--Obtain the aggregate charges to beneficiaries for excess costs from provider records.

Line 25.--Calculate the total program routine service costs for comparison to the cost limitation by subtracting the amount on line 24 from the amount on line 23.

Line 26.--**This line is not applicable for title XVIII, but may be used for title V or XIX.** Enter the per diem limitation for routine service cost applicable to the respective title, if applicable.

Line 27.--**This line is not applicable for title XVIII, but may be used for title V or XIX.** Calculate the inpatient routine service cost limitation by multiplying the number of inpatient days on line 3 by the per diem limitation for inpatient routine service cost on line 26.

Line 28.--**This line is not applicable for title XVIII, but may be used for title V or XIX.** Calculate the amount of reimbursable inpatient routine service cost by adding line 22 to the lesser of lines 25 or 27.

4906 E SERIES

On the E series of worksheets, the SNF calculates its reimbursement settlement. The series consists of the following worksheets:

- Worksheet E, Part A - Calculation of Reimbursement Settlement - Medicare Part A
- Worksheet E, Part B - Calculation of Reimbursement Settlement - Medicare Part B
- Worksheet E-1 - Analysis of Payments to Providers for Services Rendered to Medicare Beneficiaries
- Worksheet E-2 - Calculation of Reimbursement Settlement - Other

4906.10 WORKSHEET E PART A - CALCULATION OF REIMBURSEMENT SETTLEMENT - MEDICARE PART A

Use this part to calculate the reimbursement settlement under SNF PPS for program services.

Line 1.--Enter the inpatient SNF prospective payment amount from the PS&R.

Line 2.--Enter Medicare allowable bad debts for deductibles and coinsurance (from your records), excluding deductibles and coinsurance for physicians' professional services and net of bad debt recoveries.

Line 3.--Enter Medicare allowable bad debts for indigent dual-eligible beneficiaries as defined at 42 CFR 413.89(e)(iii). This amount must also be included in the amount reported on line 2.

Line 4.--Calculate reimbursable bad debts as the amount on line 2 multiplied by 65 percent.

Line 5.--Enter the sum of lines 1 and 4.

Line 6.--Enter primary payers amounts from the PS&R. Primary payor amounts occur when the Medicare program's liability is secondary to that of the primary payer. The following list identifies some common situations where Medicare may make payment secondary to a primary payer:

- Worker's compensation insurance,
- No-fault insurance and liability insurance,
- Working Aged and Employer Group Health Plan (GHP),
- Disability and Employer GHP, and the
- 30-month coordination period for End Stage Renal Disease covered by a GHP or COBRA plan.

For more information on who pays and how much under the Medicare secondary payer provisions, see 42 CFR Part 411, Subpart B.

Line 7.--Enter the Part A coinsurance billed to Medicare beneficiaries for services paid under the SNF PPS. Obtain this amount from the PS&R.

Line 8.--This line is used for other adjustments needed to effectuate proper reimbursement for PPS payments or payments outside of PPS. Enter decreases to costs as a negative. Provide a description for each other adjustment in column zero, as needed.

Line 9.--Enter all demonstration payment adjustment amounts before sequestration. Obtain this amount from the PS&R.

Line 10.--Calculate the sequestration adjustment for non-claims based amounts as [(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 six decimal places), rounded to four decimal places) times the sum of lines 4 and 8]. Do not apply the sequestration calculation when gross reimbursement (sum of lines 4 and 8) is less than zero.

Line 11.--Enter the sequestration adjustment amount from the PS&R (claims based amounts) rounded to four decimal places.

Line 12.--Enter all demonstration payment adjustment amounts after sequestration. Obtain this amount from the PS&R.

Line 13.--Enter the sum of the amount on line 5 minus lines 6, 7, 9 through 12, plus line 8.

Line 14.--Enter interim payments from Worksheet E-1, line 4, column 2. Include on this line amounts received from SNF PPS (for inpatient routine services) as well as amounts received for cost reimbursed ancillary services provided under Part A.

Line 15.--Enter the Part A tentative adjustments from Worksheet E-1, line 5.99, column 2.

Line 16.--Enter the sum of the amount on line 13, minus lines 14 and 15. Enter a negative amount in parenthesis (). Transfer this amount to Worksheet S, Part III, line 1, column 3.

Line 17.--If the SNF seeks payment that it believes may not be allowable or may not comport with Medicare policy, enter the protested amounts on this line. Estimate the reimbursement effect of the non-allowable items by applying a reasonable methodology that closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See 42 CFR 413.24(j)(2)). Submit with the cost report a schedule showing the details and computations for amount reported on this line.

4906.20 WORKSHEET E PART B - CALCULATION OF REIMBURSEMENT SETTLEMENT - MEDICARE PART B

Use this part to calculate reimbursement settlement for title XVIII for SNF Part B services.

Line 1.--Enter the cost of Part B ancillary and outpatient services furnished to Medicare beneficiaries from Worksheet D, line 100, column 6.

Line 2.--Enter the cost of preventive vaccines such as pneumococcal, influenza, hepatitis B, and COVID-19 vaccines from Worksheet D, line 80, column 7.

Line 3.--Enter the sum of the amounts on lines 1 and 2.

Line 4.--Enter the charges applicable to the ancillary and outpatient services from Worksheet D, line 100, column 3.

Line 5.--If Worksheet S-2, line 41, column 2, is Y, the provider is exempt from the application of lower of cost or charges, enter the total reasonable costs from line 3. If Worksheet S-2, line 41, column 2, is N, enter the lesser of line 3 or 4.

Line 6.--Enter Medicare allowable bad debts for deductibles and coinsurance (from your records), excluding deductibles and coinsurance for physicians' professional services and net of bad debt recoveries.

Line 7.--Enter Medicare allowable bad debts for indigent dually-eligible beneficiaries as defined at 42 CFR 413.89(e)(iii). This amount must also be included in the amount included on line 6.

Line 8.--Calculate reimbursable bad debts as the amount on line 6 multiplied by 65 percent.

Line 9.--Enter the sum of line 5 plus line 8.

Line 10.--Enter primary payer amounts from the PS&R. Primary payor amounts occur when the Medicare program's liability is secondary to that of the primary payer. The following list identifies some common situations where Medicare may make payment secondary to a primary payer:

- Worker's compensation insurance,
- No-fault insurance and liability insurance,
- Working Aged and Employer Group Health Plan (GHP),
- Disability and Employer GHP, and the
- 30-month coordination period for End Stage Renal Disease covered by a GHP or COBRA plan.

For more information on who pays and how much is paid under the Medicare secondary payer provisions, see 42 CFR Part 411, Subpart B.

Line 11.--Enter the Part B deductible and coinsurance billed to Medicare beneficiaries for services reported on lines 1 and 2, and paid on a cost basis. Do not include coinsurance billed to program patients for physicians' professional services.

Line 12.-- This line is used for "other adjustments" needed to effectuate proper reimbursement for cost based payments. Enter decreases to costs as a negative. Provide a description for each "other adjustment" in column zero, as needed.

Line 13.--Enter all demonstration payment adjustment amounts before sequestration from the PS&R.

Line 14.--Calculate the sequestration adjustment as [(2 percent times (total days in the cost reporting period that occurs during the sequestration period divided by total days in the entire cost reporting period, rounded to six decimal places), rounded to four decimal places) times the sum of lines 9, 12, and 13]. Do not apply the sequestration calculation when gross reimbursement (sum of lines 9, 12, and 13) is less than zero.

Line 15.--Enter all demonstration payment adjustment amounts after sequestration. Obtain this amount from the PS&R.

Line 16.--Enter the sum of the amount on line 9 minus 10, 11, 13, 14, and 15, plus line 12.

Line 17.--Enter interim payments from Worksheet E-1, line 4, column 4.

Line 18.--Enter the Part B tentative adjustments from Worksheet E-1, line 5.99, column 4.

Line 19.--Enter the sum of the amount on line 16 minus lines 17 and 18. Enter a negative amount in parenthesis (). Transfer this amount to Worksheet S, Part III, line 1, column 4.

Line 20.--If the SNF seeks payment that it believes may not be allowable or may not comport with Medicare policy, enter the protested amounts on this line. Estimate the reimbursement effect of the non-allowable items by applying a reasonable methodology that closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See 42 CFR 413.24(j)(2)). Submit with the cost report a schedule showing the details and computations for the amount reported on this line.

4906.30 WORKSHEET E-1 - ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED TO MEDICARE BENEFICIARIES

On Worksheet E-1, report Medicare interim payments received from the contractor. Do not report interim payments for title V or XIX.

The column headings designate two categories of payments:

Columns 1 and 2 - Part A
Columns 3 and 4 - Part B

Complete lines 1 through 4. Your contractor completes lines 5 through 9. Report only the Medicare interim payments received for the Medicare services reported in this cost report. Do not reduce any interim payments by recoveries as result of medical review adjustments where recoveries were based on a sample percentage applied to the universe of claims reviewed and the PS&R was not adjusted.

Line Descriptions

Line 1.--Enter the total Medicare interim payments paid to you. The amount entered must reflect the sum of all interim payments paid on individual bills (net of adjustment bills) for services rendered in the cost reporting period. Include amounts withheld from your interim payments due to an offset against overpayments to you, applicable to prior cost reporting periods. Do not include (1) any retroactive lump sum adjustment amounts based on a subsequent revision of the interim rate, (2) tentative or net settlement amounts, or (3) interim payments payable. If you are reimbursed under the periodic interim payment (PIP) method of reimbursement, enter the PIP received for this cost reporting period.

Line 2.--Enter the total Medicare interim payments payable on individual bills (amount due for services rendered in the cost reporting period but not paid as of the end of the cost reporting period).

Line 3.--List separately the date and amount for each retroactive lump sum adjustment based on revision of the interim rate for the cost reporting period.

Line 4.--Enter the sum of lines 1, 2, and 3.99. Transfer the Part A amount from column 2 to Worksheet E, Part A, line 14, and the Part B amount from column 4 to Worksheet E, Part B, line 17.

Lines 5 through 8 are for contractor use only. Do not complete the remainder of Worksheet E-1 unless Worksheet S, Part I, line 5, is 2, 3, or 4.

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 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, enter the amount and date on which the determination was made and the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.

Line 7.--In columns 2 and 4, enter the sum of lines 4, 5.99, and 6.01 or 6.02. The amount in column 2 must equal Worksheet E, Part A, line 13. The amount in column 4 must equal Worksheet E, Part B, line 16.

Line 8.--Enter the contractor name, contractor number, and the NPR date in columns 1, 2, and 3, respectively.

4906.40 WORKSHEET E-2 - CALCULATION OF REIMBURSEMENT SETTLEMENT - OTHER

Worksheet E-2 calculates the reimbursement settlement for titles V and XIX services furnished by SNFs, NFs, and ICF/IIDs. The SNF completes separate worksheets for each component for titles V and XIX, as needed, by selecting the applicable program and component at the top of Worksheet E-2.

Line Descriptions

Line 1.--Transfer the healthcare program (title V or XIX as selected in the worksheet header) cost of ancillary services furnished to inpatients from the healthcare program Worksheet D, line 100, column 5.

Line 2.--Transfer the healthcare program cost of outpatient services from the healthcare program Worksheet D, line 100, sum of columns 6 and 7.

Line 3.--Transfer the healthcare program inpatient operating costs from the healthcare program Worksheet D-1, line 28.

Line 4.--Enter the sum of lines 1, 2, and 3.

Line 5.--Enter the applicable charge differential between semi-private and less than semi-private accommodations. The amount of the differential is the difference between the customary charge for semi-private accommodations and the customary charge for the less than semi-private accommodations furnished for all program patient days when the accommodations provided were not medically necessary.

Line 6.--Enter the amount on line 4 minus the amount on line 5.

Line 7.--Enter the amounts paid or payable to the healthcare program by worker's compensation and other primary payers where program liability is secondary to that of the primary payer. The following list identifies some common situations where Medicare may make payment secondary to a primary payer:

- Worker's compensation insurance,
- No-fault insurance and liability insurance,
- Working Aged and Employer Group Health Plan (GHP),
- Disability and Employer Group Health Plan, and the
- 30-month coordination period for End Stage Renal Disease Covered by a GHP or COBRA plan.

For more information on who pays and how much is paid under the Medicare secondary payer provisions, see 42 CFR Part 411, Subpart B.

Line 8.--Enter the amount on line 6 minus the amount on line 7.

Lines 9 through 13.--These lines provide for the accumulation of charges that relate to the reasonable cost on line 8. Do not include on these lines the portion of charges applicable to the excess costs of luxury items or services (see CMS Pub. 15-1, chapter 21, §2104.3).

Line 9.--Enter the healthcare program total charges for inpatient ancillary services from the healthcare program Worksheet D, line 100, sum of column 2.

Line 10.--Enter the healthcare program total charges for outpatient services from the healthcare program Worksheet D, line 100, sum of columns 3 and 4.

Line 11.--Enter the healthcare program inpatient routine service charges from your records for the applicable component. Include covered late charges that have been billed to the healthcare program where the patient's medical condition is the cause of the extended stay. Also include the charges for semi-private accommodations of inpatients paid by workmen's compensation and other primary payers. Adjust these charges on line 11 in determining final settlement.

Line 12.--If the amount entered on line 11 has not been adjusted to take into consideration the differential between semi-private room charges and charges for less than semi-private accommodations, enter the amount from line 5.

Line 13.--Enter the sum of lines 9, 10, and 11, minus line 12.

Lines 14 through 17.--These lines provide for the reduction of program charges when the provider does not actually impose such charges in the case of most patients liable for payment for services on a charge basis or fails to make reasonable efforts to collect such charges from those patients. Providers that do impose these charges and make reasonable efforts to collect the charges from patients liable for payment for services on a charge basis are not required to complete lines 14, 15, and 16, but instead enter on line 17 the amount from line 13. (See 42 CFR 413.13(b).) In no instance may the customary charges on line 17 exceed the actual charge on line 13.

Computation of Reimbursement Settlement

Line 18.--Enter the lesser of reasonable cost (line 8 before the application of the primary payer amount) or customary charges (line 17), minus the primary payer amount on line 7.

Line 19.--Enter the cost sharing billed to the healthcare program beneficiaries.

Line 20.--Enter the result of line 18 minus line 19.

Line 21.--Enter healthcare program allowable bad debts for deductibles and coinsurance (from your records), excluding deductibles and coinsurance for physicians' professional services and net of bad debt recoveries.

Line 22.--Enter the sum of line 20 plus line 21.

Line 23.--This line is used for "other adjustments" needed to effectuate proper reimbursement for cost based payments. Enter decreases to costs as a negative. Provide a description for each "other adjustment" in column zero, as needed.

Line 24.--Enter the sum of the amounts on line 22, plus line 23.

Line 25.--Enter the healthcare program interim payment from your records.

Line 26.--Enter the sum of the amount on line 24, minus line 25. Enter a negative amount in parenthesis (). Transfer the amount on this line as follows:

- For SNF, title V, transfer to Worksheet S, Part III, line 1, column 2.
- For SNF, title XIX, transfer to Worksheet S, Part III, line 1, column 5.
- For NF, title V, transfer to Worksheet S, Part III, line 2, column 2.
- For NF, title XIX, transfer to Worksheet S, Part III, line 2, column 5.
- For ICF/IID, title V, transfer to Worksheet S, Part III, line 3, column 2.
- For ICF/IID, title XIX, transfer to Worksheet S, Part III, line 3, column 5.

4908 G SERIES

On the G series of worksheets, the SNF reports its balance sheet based on information contained in its accounting records and reports consistent with its financial statement. The series consists of the following worksheets:

- Worksheet G - Balance Sheet
- Worksheet G-2 - Statement of Patient Revenues and Operating Expenses
- Worksheet G-3 - Statement of Revenues and Expenses

4908.10 WORKSHEET G - BALANCE SHEET

Prepare this worksheet from your accounting records and reports consistent with the SNF financial statements. Cost reports received with incomplete G-series worksheets are returned for completion. If the lines on the Worksheet G are not sufficient, use lines 5 (Other receivables), 9 (Other current assets), 41 (Other current liabilities), and 47 (Other long term liabilities), as appropriate, to report the sum of account balances and adjustments. Maintain supporting documentation or subscript the appropriate lines.

Line 1 - Cash on hand and in banks.--Enter the amount of cash on deposit in banks and immediately available for use in financing activities, amounts on hand for minor disbursements and amounts invested in savings accounts and certificates of deposit. Typical accounts would be cash, general checking accounts, payroll checking accounts, other checking accounts, impress cash funds, saving accounts, certificates of deposit, treasury bills and treasury notes and other cash accounts.

Line 2 - Temporary investments.--Enter the amount of current securities evidenced by certificates of ownership or indebtedness. Typical accounts would be marketable securities and other current investments.

Line 3 - Notes receivable.--Enter the amount of current unpaid amounts evidenced by certificates of indebtedness.

Line 4 - Accounts receivable.--Enter the amount of unpaid inpatient and outpatient billings. Include direct billings to patients for deductibles, co-insurance and other patient chargeable items not included in line 6.

Line 5 - Other receivables.--Enter the amount of any other receivable that is not included on lines 3 or 4.

Line 6 - Less: allowance for uncollectable notes and accounts.--These are valuation (or contra-asset) accounts whose credit balances represent the estimated amount of uncollectible receivables from patients and third-party payers. Enter this amount as a positive.

Line 7 - Inventory.--Enter the costs of unused supplies. Perpetual inventory records may be maintained and adjusted periodically to reflect a physical count. The extent of inventory control and detailed record keeping will depend upon the size and organizational complexity of the institution. The inventories may be valued by any generally accepted method, but the method must be consistently applied from year to year.

Line 8 - Prepaid expenses.--Enter the costs incurred that are properly chargeable to a future accounting period.

Line 9 - Other current assets.--Enter the amount of current assets not included in other asset categories (lines 1 through 8).

Line 10 - Due from other funds.--Enter amounts due from other funds as reported on line 41. Do not include any amounts from line 41

Line 11 - Total current assets.--Enter the sum of lines 1 through 10, minus line 6.

Line 12 - Land.--Enter the cost of land used in operations. Include the cost of off-site sewer and water lines, public utility, charges for servicing the land, governmental assessments for street paving and sewers, costs of permanent roadways and of grading of a non-depreciable nature. Unlike building and equipment, land does not deteriorate with use or with the passage of time; therefore, no depreciation is accumulated. The cost of land includes (1) the cash purchase price, (2) closing costs such as title and attorney's fees, (3) real estate broker's commission, and (4) accrued property taxes and other liens on the land assumed by the purchaser.

Land 13 - Land improvements.--Enter the cost of structural additions made to land, such as driveways, parking lots, sidewalks; as well as the cost of shrubbery, fences and walls, landscaping, on-site sewer and water lines, and underground sprinklers. The cost of land improvements includes all expenditures necessary to make the improvements ready for their intended use.

Line 15 - Buildings.--Enter the cost of all buildings and subsequent additions used in operations, including purchase price, closing costs, (attorney fees, title insurance, etc.), and real estate broker commission. Include all architectural, consulting and legal fees related to the acquisition or construction of buildings, and interest paid for construction financing.

Line 17 - Leasehold improvements.--Enter the cost for the improvement of a leasehold used in operations are included on this line.

Line 19 - Fixed equipment.--Include the cost of building equipment that has the following general characteristics:

- Affixed to the building, not subject to transfer or removal.
- A life of more than one year, but less than that of the building to which it is affixed.
- Used in SNF or SNF healthcare complex operations.

Fixed equipment includes such items as boilers, generators, engines, pumps, and refrigeration machinery, wiring, electrical fixtures, plumbing, elevators, heating systems, air conditioning systems, etc.

Line 21 - Automobiles and trucks.--Enter the cost of automobiles and trucks used in SNF or SNF healthcare complex operations.

Line 23 - Major movable equipment.--Costs of equipment included on this line has the following general characteristics:

- Ability to be moved, as distinguished from fixed equipment (but not automobiles or trucks).
- A more or less fixed location in the building.
- A unit cost large enough to justify the expense incident to control by means of an equipment ledger and greater than or equal to \$5,000.
- Sufficient individuality and size to make control feasible by means of identification tags.
- A minimum life of usually three years or more.
- Used in SNF or SNF healthcare complex operations.

Line 25 - Minor equipment-depreciable.--Costs of equipment included on this line has the following general characteristics:

- Ability to be moved, as distinguished from fixed equipment.
- A more or less fixed location in the building
- A unit cost large enough to justify the expense incident to control by means of an equipment ledger but less than \$5,000.
- Sufficient individuality and size to make control feasible by means of identification tags.
- A minimum life of usually three years or more.
- Used in SNF or SNF healthcare complex operations.

Line 26 - Minor equipment-non-depreciable.--Costs of equipment included on this line has the following general characteristics:

- Location generally not fixed; subject to requisition or use by various departments of the SNF or SNF healthcare complex.
- Relatively small size.
- Subject to storeroom control.
- Fairly large number in use.
- Generally a useful life of usually three years or less.
- Used in SNF or SNF healthcare complex operations.

Minor equipment includes items such as, but not limited to wastebaskets, bedpans, syringes, catheters, basins, glassware, silverware, pots and pans, sheets, blankets, ladders, and surgical instruments.

Lines 14, 16, 18, 20, 22, and 24 - Less accumulated depreciation.--These balances, respectively, include the depreciation accumulated on the related assets used in operations. Enter these amounts as a positive.

Line 27 - Other fixed assets.--Enter the amount of any fixed asset not included in lines 12 through 26.

Line 28 - Total fixed assets.--Enter the sum of lines 12 through 27, minus lines 14, 16, 18, 20, 22, and 24.

Line 29 - Investments.--This field contains the cost of investments purchased with SNF or SNF healthcare complex funds and the fair market value (at date of donation) of securities donated to the SNF or SNF healthcare complex.

Line 30 - Deposits on leases.--Report the amount of deposits on leases, including security deposits.

Line 31 - Due from owners/officers.--Enter the amount loaned to the SNF or the SNF healthcare complex by owners and/or officers.

Line 32 - Other assets.--Enter the amount of assets not reported on line 9 (other current assets) or any other line 1 through 31, including intangible assets such as goodwill, unamortized loan costs and other organization costs.

Line 33 - Total other assets.--Enter the sum of lines 29 through 32.

Line 34 - Total assets.--Enter the sum of lines 11, 28, and 33. For each column, line 34 must equal line 60.

Line 35 - Accounts payable.--Enter the amounts due trade creditors and others for supplies and services purchased.

Line 36 - Salaries, wages and fees payable.--Enter the amount of the actual or estimated liabilities of the SNF or SNF healthcare complex for salaries and wages/fees payable.

Line 37 - Payroll taxes payable.--Enter the amount of the actual or estimated liabilities of the SNF or SNF healthcare complex for amounts payable for payroll taxes withheld from salaries and wages, payroll taxes to be paid by the SNF or SNF healthcare complex and other payroll deductions, such as medical insurance premiums.

Line 38 - Notes and loans payable (short-term).--Enter the amount of current amounts owing as evidenced by certificates of indebtedness coming due in the 12 months following the end of the cost reporting period.

Line 39 - Deferred income.--Enter the amount of deferred income to be received or accrued applicable to services to be rendered within the 12 months following the end of the cost reporting period. These amounts also reflect the effects of any timing differences between book and tax or third party reimbursement accounting. (Report deferred income applicable to accounting periods extending beyond the 12 months following the end of the cost reporting period as other current liabilities.)

Line 40 - Accelerated payments.--Enter the amount of accelerated payments not yet due to be repaid to the contractor.

Line 41 - Due to Other Funds.--Enter the amounts due to other funds as reported on line 10. Do not include any amounts from line 10 on line 41. The amount on line 41, must equal the amount on line 10.

Line 42 - Other current liabilities.--Enter the amount of the current liabilities not reported on lines 35 through 41.

Line 43 - Total current liabilities.--Enter the sum of lines 35 through 42.

Line 44 - Mortgage payable.--Enter the amount of the long-term financing obligations used to purchase real estate/property.

Line 45 - Notes payable.--Enter the amount of the liabilities of the SNF or SNF healthcare complex to vendors, banks and others, evidenced by promissory notes due and payable beyond the 12 months following the end of the cost reporting period.

Line 46 - Unsecured loans.--Enter the amount of loans not loaned on the basis of collateral.

Line 47 - Loans from owners.--Enter the amount of any loans from the owners of the SNF or the SNF healthcare complex.

Line 48 - Other long-term liabilities.--Enter the amount of the long-term liabilities not reported on lines 44 through 47.

Line 49 - Total long-term liabilities.--Enter the sum of lines 44 through 48.

Line 50 - Total liabilities.--Enter the sum of lines 43 and 49.

Line 51 - Fund balance.--Enter the end of period fund balance.

Line 52 - Total liabilities and fund balance.--Enter the sum of lines 50 and 51.

4908.30 WORKSHEET G-2 - STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

This worksheet requires the reporting of total patient revenues and operating expenses for the entire SNF healthcare complex. If cost report total revenues and total expenses differ from those on your filed financial statements, submit a reconciliation report with your cost report submission.

Prepare this worksheet from your accounting books and records.

4908.31 Part I - Patient Revenues.

Enter total patient revenues, reduced by adjustments and rebates, by payer source and provider payment and delivery system (i.e., FFS and/or managed care) associated with the appropriate cost centers on lines 1 through 3, and lines 5 through 9 for the SNF or SNF healthcare complex.

Column Definitions

Inpatient Services.--This definition applies to columns 1, 2, 3, and 7. The patient must demonstrate signs and/or symptoms severe enough to warrant the need for medical care and must receive services of such intensity that they can be furnished safely and effectively only upon admission to a SNF with a doctor's order.

Outpatient Services.--This definition applies to columns 4, 5, 6 and 7. The patient receives medical care under a doctor's order that does not require admission to a SNF or the beneficiary has exhausted their Medicare Part A coverage.

Medicare FFS.--Include Medicare FFS payments based upon reasonable cost principles for covered services made directly to the provider by the program.

Medicare HMO.--Include Medicare managed care payments based upon capitated arrangements for covered services made by a plan to the provider for each person covered by Medicare advantage.

Medicaid.--Include Medicaid FFS payments based upon reasonable cost principles for covered services made directly to the provider by Medicaid.

Medicaid HMO.--Include Medicaid managed care payments based upon capitated arrangements for covered services made by a plan to the provider for each person covered by a Medicaid HMO.

Other.--Include all other third party payer payment amounts for covered services paid by a commercial insurer or private paying individual.

Line 1 - Skilled Nursing Facility.--For each column 1 through 10, enter the SNF revenue from your accounting books and/or records. In column 11, enter the sum of columns 1 through 10.

Line 2 - Nursing Facility.--For each column 1 through 10, enter the NF revenue from your accounting books and/or records. In column 11, enter the sum of columns 1 through 10.

Line 3 - ICF/IID.--For each column 1 through 10, enter the ICF/IID revenue from your accounting books and/or records. In column 11, enter the sum of columns 1 through 10.

Line 4 - Total General Inpatient Care.--For each column 1 through 10, enter the sum of lines 1 through 3. In column 11, enter the sum of columns 1 through 10.

Line 5 - Ancillary Services.--For each column 1 through 10, enter the revenue from inpatient ancillary services and outpatient ancillary services from your accounting books and/or records. In column 11, enter the sum of columns 1 through 10.

Line 6 - Home Health Agency.--For each column 1 through 10, enter SNF-based HHA revenue from your accounting books and/or records. If the complex includes more than one SNF-based HHA, include the revenues for all SNF-based HHAs on this line. In column 11, enter the sum of columns 1 through 10.

Line 7 - Ambulance.--For each column 1 through 10, enter from your accounting books and/or records the revenue for the ambulance service cost reported on Worksheet A, line 71. In column 11, enter the sum of columns 1 through 10.

Line 8 - Hospice.--For each column 1 through 10, enter from your accounting books and/or records, the revenue generated from hospice services rendered. In column 11, enter the sum of columns 1 through 10.

Line 9 - All other revenues.--For each column 1 through 10, enter from your accounting books and/or records, the revenue not reported on lines 1 through 8. In column 11, enter the sum of columns 1 through 10.

Line 10 - Total Patient Revenues.--For each column, enter the sum of lines 4 through 9.

4908.32 Part II - Operating Expenses.

Enter the expenses incurred that arise during the ordinary course of operating the SNF or SNF healthcare complex.

Line 11 - Operating Expenses.--Transfer the amount from Worksheet A, line 100, column 9.

Line 12 - Add (Specify).--Identify additional operating expenses not included on line 11. Subscript each addition.

Line 13 - Total Additions.--Enter the sum of line 12 and its subscripts.

Line 14 - Deduct (specify).--Identify deductions from operating expenses not included in line 11. Subscript each addition.

Line 15 - Total Deductions.--Enter the sum of line 14 and its subscripts.

Line 16 - Total Operating Expenses.--Enter the sum of line 11 plus line 13 minus line 15.

4908.40 WORKSHEET G-3 - STATEMENT OF REVENUES AND EXPENSES

This worksheet requires the reporting of total revenues for the entire SNF and total operating expenses for the entire SNF. If cost report total revenues and total expenses differ from those on your filed financial statement, submit a reconciliation report with the cost report submission.

Line 1.--Total Patient Revenue--Transfer from Worksheet G-2, Part I, line 10, column 11.

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,
Policy Discounts,
Administrative Adjustments, and
Other Deductions from Revenue

Line 3.--Net Patient Revenues--Subtract line 2 from line 1.

Line 4.--Less: Total Operating Expenses--Transfer from Worksheet G-2, Part II, line 16.

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

Lines 6 through 23.--Enter on the appropriate lines 6 through 23 all other revenue not reported on line 1. Obtain these amounts from your accounting books and/or records.

Line 24.--Other Miscellaneous Revenue (Specify)--Enter all other revenue not reported on lines 6 through 23. Obtain this from your accounting books and/or records. Subscript this line as necessary.

Line 25.--PHE Funding--Enter the aggregate revenue received for PHE funding.

Line 26. Total Other Income--Enter the sum of lines 6 through 25.

Line 27.--Total Income--Enter the sum of lines 5 plus line 26.

Line 28.--Other Expenses (Specify)--Enter all other expenses not reported on lines 6 through 26.

Line 31.--Total Other Expenses--Enter the sum of lines 28 through 30, including subscripts.

Line 32.--Net Income (or Loss) for the Period--Enter the result of line 27 minus line 31.

4909 H SERIES

On the H series of worksheets, the SNF reports the cost incurred by its SNF-based HHA to provide patient related services to Medicare beneficiaries, including an allocation of general service costs from the SNF, in order to calculate the SNF-based HHA reimbursement settlement. Complete separate H series worksheets for each SNF-based HHA. The series consists of the following worksheets:

- Worksheet H - Analysis of SNF-Based HHA Costs
- Worksheet H-1 - Part I - Allocation of SNF-Based HHA General Service Costs
- Worksheet H-1 - Part II - Allocation of SNF-Based HHA General Service Costs - Statistical Basis
- Worksheet H-2, Part I - Allocation of SNF General Service Costs to SNF-Based HHA
- Worksheet H-2, Part I - Allocation of SNF General Service Costs to SNF-Based HHA - Statistical Basis
- Worksheet H-3 - Apportionment of SNF-Based HHA Patient Service Costs
- Worksheet H-4 - Calculation of SNF-Based HHA Reimbursement Settlement
- Worksheet H-5 - Analysis of Payments to SNF-Based HHA for Services Rendered to Program Beneficiaries

4909.10 WORKSHEET H - ANALYSIS OF SNF-BASED HHA COSTS

This worksheet provides for the recording of direct SNF-based HHA costs such as salaries, fringe benefits, transportation, and contracted/purchased services, as well as other costs from your accounting books and records to arrive at the identifiable agency cost. This data is required by 42 CFR 413.20. This worksheet also provides for the necessary reclassifications and adjustments to certain accounts prior to the cost finding calculations. Include on Worksheet H, all expenses incurred for only those visits completed in the current cost reporting period, when the episode of care overlaps the cost report year end. On Worksheet H, in the appropriate cost centers, enter the total expenses for Salaries (column 1), Employee Benefits (column 2), Transportation (column 3), Contracted/Purchased Services (column 4), and Other Costs (column 5). Obtain these direct costs from your accounting books and records. Not all of the cost centers listed may apply to all agencies.

The SNF-based HHA must maintain the records necessary to determine the split in salary (and employee-related fringe benefits) between two or more cost centers, and must adequately substantiate the method used to split the salary and employee-related fringe benefits. These records must be available for audit by your contractor. Your contractor can accept or reject the method used to determine the split in salary. Any deviation or change in methodology to determine splits in salary and employee fringe benefits must be requested in writing and approved by your contractor before any change is effectuated. Where approval of a method has been requested in writing and this approval has been received (prior to the beginning of the cost reporting period), the approved method remains in effect for the requested period, and all subsequent periods, until you request in writing to change to another method, or until your contractor determines that the method is no longer valid due to changes in your operations.

Column 1.--Enter all salaries and wages (a salary is the gross amount paid to the employee before taxes and other items are withheld, including deferred compensation, overtime, incentive pay, and bonuses (see CMS Pub. 15-1, chapter 21)) for the SNF-based HHA in this column for the actual work performed within the specific area or cost center. For example, if the administrator spends 100 percent of his/her time in the SNF-based HHA and performs skilled nursing care which accounts for 25 percent of that person's time, then 75 percent of the administrator's salary is entered on line 6 (Administrative and General) and 25 percent of the administrator's salary is entered on line 16 (Skilled Nursing Care - RN). Enter the sum of lines 1 through 49 on line 100.

Column 2.--Enter all payroll-related employee fringe benefits for the SNF-based HHA in the appropriate cost center in this column. See CMS Pub. 15-1, chapter 21, §§2144-2145, for a definition of fringe benefits. Enter amounts using the same basis as that used for reporting salaries and wages in column 1. For example, 75 percent of the administrator's payroll-related fringe benefits is entered on line 6 (Administrative and General) and 25 percent of the administrator's payroll-related fringe benefits is entered on line 16 (Skilled Nursing Care - RN). Enter the sum of lines 1 through 49 on line 100.

Report payroll-related employee fringe benefits in the cost center where the applicable employee's compensation is reported. This assignment is performed on an actual basis or upon the following basis:

- FICA based on actual expense by cost center;
- Pension and retirement and health insurance (non-union) based on gross salaries of participating individuals by cost centers;
- Union health and welfare based on gross salaries of participating union members by cost center; or
- All other payroll-related fringe benefits based on gross salaries by cost center.

Include non-payroll-related employee fringe benefits in line 6, the Administrative and General cost center. Costs for such items as personal education, recreation activities, and day care are included in line 6.

Column 3.--If the transportation costs, i.e., owning or renting vehicles, public transportation expenses, or payments to employees for driving their private vehicles can be directly assigned to a particular cost center, enter those costs in the appropriate cost center. If these costs are not identifiable to a particular cost center, enter them on line 4 (Transportation). Enter the sum of lines 1 through 49 on line 100.

Column 4.--Enter the contracted and purchased services amounts in the appropriate cost center in this column. If a contracted/purchased service covers more than one cost center, then include the amount applicable to each cost center on each affected cost center line. Enter the sum of lines 1 through 49 on line 100.

Column 5.--From your books and records, enter on the applicable lines all other identifiable costs not reported in columns 1 through 4. Enter the sum of lines 1 through 49 on line 100.

Column 6.--For each line, enter the sum of columns 1 through 5. Enter the sum of lines 1 through 49 on line 100.

Column 7.--For each line 1 through 49, enter reclassifications needed to effect proper cost allocation among the cost center expenses in column 6. Enter reductions as negative amounts. The total of all entries, line 100, must equal zero. This column need not be completed by all agencies, but is completed only to the extent reclassifications are needed and appropriate in the particular circumstance.

Column 8.--For each line 1 through 49, adjust the amounts entered in column 6 by the amounts entered in column 7 (increase or decrease) and report the net expenses in column 8. The total of column 8 must equal the total of column 6 on line 100.

Column 9.--For each line 1 through 49, enter any adjustments to the expenses listed in column 8 needed to effect proper cost allocation under the Medicare principles of reimbursement (see 42 CFR 413ff), including any adjustments to expenses included on Worksheet A-8, column 2. Enter reduction as negative amounts. Enter the sum of lines 1 through 49 on line 100.

Column 10.--For each line, enter the sum of columns 8 and 9 (increase or decrease) and report the net balances in column 10. Enter the sum of lines 1 through 49 on line 100. Transfer the amounts on lines 1 through 49 to the corresponding lines on Worksheet H-1, Part I, column 0.

Line DescriptionsGeneral Service Cost Centers

Lines 1 and 2 - Capital Related - Buildings and Fixtures and Capital Related - Movable Equipment.--Capital related buildings and fixtures and capital related moveable equipment costs include depreciation, leases and rentals for the use of buildings and/or equipment, interest incurred in acquiring land or 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.

Line 3 - Plant Operations & Maintenance.--Enter the direct expenses incurred in the operation and maintenance of the physical plant and equipment, maintaining general cleanliness and sanitation of the physical plant, and protecting employees, visitors, and SNF-based HHA property.

Line 4 - Transportation.--Enter all of the cost of transportation except those costs previously directly assigned in column 3. This cost is allocated during the cost finding process.

Line 5 - Telecommunication Technology.--Enter allowable administrative costs related to the use of telecommunication technology (other than audio-only telephone calls) in the provision of home health care as described in 42 CFR 409.46(e). This can include: remote patient monitoring defined as the collection of physiologic data (for example, ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient or caregiver or both to the SNF-based HHA, teletypewriter (TTY) technology, and two-way audio-video telecommunication technology that allows for real-time interaction between the patient and clinician. If remote telecommunication technologies are used by the SNF-based HHA, the costs of the equipment, set-up, and service related to these systems are allowable only as administrative costs. Visits to a beneficiary's home for the sole purpose of supplying, connecting, or training the patient on the equipment, without the provision of a skilled service are not separately billable.

Line 6 - Administrative & General.--Enter all A&G costs, including services that are allowable as administrative costs as described in 42 CFR 409.46 (a) through (d). A&G costs are general service costs that benefit the entire SNF-based HHA that are not included on lines 1 through 5. Examples include fiscal services, legal services, accounting, data processing, taxes, and malpractice costs. If the option to componentize A&G costs into more than one cost center is elected, eliminate line 6. Componentized A&G lines must begin with subscripted line 6.01 and continue in sequential order (e.g., 6.01 A&G shared costs). See §4909.20 for additional information on componentized A&G costs.

Line 7 - Nursing Administration.--Enter the cost of overall management and direction of the nursing services. Do not include the cost of direct nursing services including nursing supervisor services assigned on lines 16 through 30, and lines 39 through 49.

Line 8.-- Use this line to identify expenses for other general service costs not identified on lines 1 through 7. Provide a description for the amount reported on this line. If more than one other general service is offered, subscript this line as necessary.

Lines 9 through 15.--Reserved for future use.

HHA Reimbursable Services

Line 16 - Skilled Nursing Care - RN.--This cost center includes skilled nursing care which is a service that must be provided by, or under the supervision, of a registered nurse for the purpose of assessing a beneficiary's health needs, determining if the SNF-based HHA can meet those health needs, and formulating a plan of care for the beneficiary.

Line 17 - Skilled Nursing Care - LPN.--This cost center includes the costs of nursing care furnished by licensed practical nurses. Do not include costs for home health aide services on this line; report the costs for home health aide services on line 24.

Line 18 - PT - Physical Therapist.--This cost center includes the direct costs of physical therapy services provided by a qualified physical therapist, as prescribed by a physician. The physical therapist provides evaluation, treatment planning, instruction, and consultation. These services meet the individual's medical needs, promote recovery, and ensure medical safety for the purpose of rehabilitation.

Line 19 - PT - Physical Therapy Assistant.--This cost center includes the costs of the performed under the direct supervision of a qualified physical therapist as prescribed by a physician. These services are planned, delegated and supervised by the qualified physical therapist. The physical therapy assistant also provides support to the physical therapist as they assist in preparing clinical notes and progress reports, and participates in educating the patient and family, and in-service programs.

Line 20 - OT - Occupational Therapist.--This cost center includes the cost of occupational therapy services provided by a qualified occupational therapist, as prescribed by a physician. This includes: (1) teaching of compensatory techniques to permit an individual with a physical impairment or limitation to engage in daily activities; (2) evaluation of an individual's level of independent functioning; (3) selection and teaching of task-oriented therapeutic activities to restore sensory-integrative function; and (4) assessment of an individual's vocational potential, except when the assessment is related solely to vocational rehabilitation.

Line 21 - OT - Occupational Therapy Assistant.--This cost center includes the costs of occupational therapy assistant services provided under the direct supervision of a qualified occupational therapist, as prescribed by a physician. These services are planned, delegated, and supervised by the occupational therapist. The occupational therapy assistant also provides support to the occupational therapist as they assist in preparing clinical notes and progress reports, and participate in educating the patient and family.

Line 22 - Speech Language Pathologist.--This cost center includes the costs of physician-prescribed services provided by or under the direction of a qualified speech-language pathologist to those with functionally impaired communications skills. This includes the evaluation and management of any existing disorders of the communication process centering on the reception and production of speech and language related to organic and/or nonorganic factors. Speech-language pathology 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 23 - Medical Social Services.--Enter the cost of medical social services. These services include: (1) assessment of the social and emotional factors related to the individual's illness, need for care, response to treatment, and adjustment to care furnished by the agency; (2) casework services to assist in resolving social or emotional problems that may have an adverse effect on the beneficiary's ability to respond to treatment; and (3) assessment of the relationship of the individual's medical and nursing requirements to his or her home situation, financial resources, and the community resources available upon discharge from the agency's care.

Line 24 - Home Health Aide.--Enter the cost of home health aide services. The primary function of a home health aide is the personal care of a patient. The services of a home health aide are given under the supervision of a registered professional nurse and, if appropriate, a qualified physical, speech, or occupational therapist. The assignment of a home health aide to a case must be made in accordance with a written plan of treatment established by a physician that indicates the patient's need for personal care services. The specific personal care services to be provided by the home health aide must be determined by a registered professional nurse and not by the home health aide. Include the cost of CNAs that meet the criteria for an aide in this cost center.

Line 25 - Medical Supplies Charged to Patients.--The cost of medical supplies reported in this cost center are those costs which are directly identifiable supplies furnished to individual patients and for which a separate charge is made. These supplies are specified in the patient's plan of treatment and furnished under the specific direction of the patient's physician.

Medical supplies that are not reported on this line are those minor medical and surgical supplies that would not be specifically identified in the plan of treatment or for which a separate charge is not made. These supplies (e.g., cotton balls, alcohol prep) are items that are frequently furnished to patients in small quantities (even though in certain situations, these items may be used in greater quantity), and are reported in the A&G cost center.

Line 26 - Drugs Charged to Patients.--Enter only the cost incurred for preventative pneumococcal, influenza, hepatitis B, and COVID-19 vaccines and monoclonal antibody products for treatment of COVID-19, and osteoporosis drugs. Do not include the cost of administering vaccines and drugs on this line.

Line 27 - Cost of Administering Vaccines.--Enter only the cost of administering preventative pneumococcal, influenza, hepatitis B, COVID-19 vaccines, and osteoporosis drugs. The cost of administering these vaccines is reimbursable only under Part B if administered in the course of an otherwise covered home health visit. Accordingly, the cost and charges for the vaccine and its administration must be excluded from the cost and charges of the visit.

A visit by an SNF-based HHA nurse for the sole purpose of administering a vaccine is not covered as an HHA visit under the home health benefit, even though the patient may be an eligible home health beneficiary receiving services under a home health plan of treatment. Section 1862(a)(1)(B) of the Act excludes Medicare coverage of vaccines and their administration other than the Part B coverage contained in §1861 of the Act.

Submit a schedule detailing the methodology employed to develop the cost of administering these vaccines. The cost of travel is not permissible as a cost of administering vaccines, nor is the travel cost includable in the A&G cost center. The travel cost is nonreimbursable.

The cost of administering pneumococcal, influenza, and hepatitis B vaccines and COVID-19 vaccines and monoclonal antibody products for treatment of COVID-19, is reimbursed under the outpatient prospective payment system (OPPS). The cost of administering osteoporosis drugs is reimbursed under the home health benefit.

Line 28 - Durable Medical Equipment/Oxygen.--Enter the direct expenses incurred in renting or selling durable medical equipment (DME) items to the patient for the purpose of carrying out the plan of treatment. Also, include all the direct expenses incurred in requisitioning and issuing DME to patients.

Line 29 - Disposable Devices.--Enter the cost of disposable devices, i.e., negative pressure wound therapy (NPWT) devices.

Line 30.--Use this line and subscripts of this line to identify expenses for other reimbursable services not identified on lines 16 through 29. Provide a description for each amount reported on this line and its subscripts.

Lines 31 through 38.--Reserved for future use.

HHA Non-Reimbursable Services

Line 39 - Home Dialysis Aide Services.--Enter the cost of home dialysis aide services furnished in connection with a home dialysis program.

Line 40 - Respiratory Therapy.--For RT services enter the cost incurred for the assessment, diagnostic evaluation, treatment, management, and monitoring of patients with deficiencies or abnormalities of cardiopulmonary function.

Line 41 - Private Duty Nursing.--Enter the costs of private duty nurses, who may be licensed as RNs, LPNs, or CNAs that provide private duty care working one-on-one with individual beneficiaries.

Line 42 - Clinic.--Enter the nonreimbursable clinic costs. A clinic is a facility that is primarily focused on the care of outpatients.

Line 43 - Health Promotion Activities.--Enter the costs of health promotion and disease prevention programs focused on keeping people healthy.

Line 44 - Day Care Program.--Adult day care programs provide frail seniors and persons with Alzheimer's with supervision and care in a structured setting during daytime hours allowing their primary caregivers to work or take a break from their caregiving responsibilities. Medicare does not cover adult day care programs.

Line 45 - Home Delivered Meals Program.--Home health coverage does not include home delivered meals or personal care as part of its coverage. Enter the costs of the HHA's home delivered meals program on this line.

Line 46 - Homemaker Service.--Services such as shopping, cleaning, laundry, etc. are considered homemaker services and they are not reimbursed by Medicare. Enter the costs of homemaker services on this line.

Line 47 - Advertising.--Enter the costs associated with nonallowable community education, business development, marketing and advertising. (See CMS Pub. 15-1, chapter 21, §2136)

Line 48 - Fundraising.--Enter the costs associated with nonallowable fundraising. (See CMS Pub. 15-1, chapter 21, §2136)

Line 49.--Use this line and subscripts of this line to identify expenses for other nonreimbursable services not identified on lines 39 through 48. Provide a description for each amount reported on this line and its subscripts.

Lines 50 through 98.--Reserved for future use.

Line 100.--Enter the total of lines 1 through 49.

4909.20 WORKSHEET H-1 - PART I - ALLOCATION OF SNF-BASED HHA GENERAL SERVICE COSTS AND PART II - ALLOCATION OF SNF-BASED HHA GENERAL SERVICE COSTS - STATISTICAL BASIS

Worksheet H-1, Part I provides for the allocation of the expenses of each SNF-based HHA general service cost center to those cost centers that receive the services. The cost centers serviced by the general service cost centers include all cost centers within the SNF-based HHA, i.e., general service cost centers, HHA reimbursable cost centers, and HHA nonreimbursable cost centers. The net expenses for allocation are from Worksheet H, column 10. To facilitate transferring amounts from Worksheet H to Worksheet H-1, Part I, the same cost centers with corresponding line numbers (lines 1 through 49) are listed on both worksheets.

Worksheet H-1, Part II provides for the proration of the statistical data needed to equitably allocate the expenses of the SNF-based HHA general service cost centers on Worksheet H-1, Part I. If there is a difference between the total accumulated costs reported on the Part II statistics and the total accumulated costs calculated on Part I, use the reconciliation column on Part II for reporting any adjustments. See §4903.10 for the appropriate usage of the reconciliation columns. For componentized A&G cost centers, the accumulated cost center line number must match the reconciliation column number.

To facilitate the allocation process, the general format of Parts I and II are identical. The cost centers and line numbers are consistent with Worksheet H. The column and line numbers for each general, reimbursable, and nonreimbursable cost center are identical on the two parts of the worksheet.

The statistical bases shown at the top of each column on Worksheet H-1, Part II, are the recommended bases of allocation for the cost centers indicated. If a different basis of allocation is used, the agency must indicate the basis of allocation actually used at the top of the column.

Most cost centers are allocated on different statistical bases. However, for those cost centers where the basis is the same (e.g., square feet), the total statistical base over which the costs are to be allocated will differ because of the prior elimination of cost centers that have been closed.

Close the general service cost centers in accordance with 42 CFR 413.24(d)(1) which states, in part, that the cost of nonrevenue-producing cost centers serving the greatest number of other centers, while receiving benefits from the least number of centers, is apportioned first. This is further clarified in CMS Pub. 15-1, chapter 23, §2306.1, which also clarifies the order of allocation for step-down purposes. Consequently, first close those cost centers that render the most services to and receive the least services from other cost centers. The cost centers are listed in this sequence from left to right on the worksheet. However, the circumstances of an agency may be such that a more accurate result is obtained by allocating to certain cost centers in a sequence different from that followed on these worksheets.

The SNF-based HHA may elect to change the order of allocation and/or allocation statistics, as appropriate, for the current cost reporting period if a request is received by the contractor, in writing, within 90 days prior to the end of the cost reporting period. The contractor has 60 days to decide or the change is automatically accepted. The change must be shown to more accurately allocate the overhead cost or demonstrate simplification in maintaining the changed statistics. The SNF-based HHA must include with the request all supporting documentation and a thorough explanation of why the alternative approach should be used. If a change in statistics is requested, the SNF-based HHA must maintain both sets of statistics until an approval is made. If the request is denied, the HHA must use the previously approved methodology. (See CMS Pub. 15-1, chapter 23, §2313)

If the amount of any cost center on Worksheet H, column 10, has a negative balance, show this amount as a credit balance on Worksheet H-1, Part I, column 0. Allocate the costs from the applicable overhead cost centers in the normal manner to the cost center showing a negative balance. After receiving costs from the applicable overhead cost centers, if a general service cost center has a negative balance at the point it is allocated; do not allocate the general service cost center. Rather, enter the negative balance on line 99, the first line of the column and on line 100. This enables line 100, column 9, to cross foot to line 100, columns 0 and 5A. If a cost center has a credit balance on Worksheet H-1, Part I, column 9, do not carry forward a credit balance to any worksheet.

On Worksheet H-1, Part II, enter on the first line in the column of the cost center being allocated, the total statistical base over which the expenses are allocated (e.g., in column 1, capital-related - buildings and fixtures, enter on line 1 the total square feet of the building on which depreciation was taken). For all cost centers to which capital-related cost is allocated, enter the portion of the total statistical base applicable to each. The sum of the statistical base applied to each cost center receiving the services must equal the total base entered on the first line. Use accumulated cost for allocating A&G expenses.

Enter on Worksheet H-1, Part II, line 101, the total costs of the general service cost center to be allocated. Obtain this amount from Worksheet H-1, Part I, from the same column and line number used to enter the cost center total statistic on Worksheet H-1, Part II. For example, capital related - buildings and fixtures, total cost is recorded on Worksheet H-1, Part I, line 1, column 1 and the capital related - buildings and fixtures cost center total statistic is entered on Worksheet H-1, Part II, line 1, column 1.

Calculate on Worksheet H-1, Part II, line 102 the unit cost multiplier. This is derived by dividing the cost to be allocated from Worksheet H-1, Part II, line 101, by the total statistic entered in the same column on the first line. Round the unit cost multiplier to six decimal places.

Calculate on Worksheet H-1, Part I, in the corresponding column and line, the result of the unit cost multiplier (Worksheet H-1, Part II, Line 102) multiplied by the portion of the total statistic applicable to each cost center receiving the services rendered.

After the unit cost multiplier has been applied to all the cost centers receiving costs, the total expenses on Worksheet H-1, Part I, line 100, must equal the expense amount entered on the first line of the cost center being allocated.

The preceding procedures must be performed for each general service cost center. Each cost center must be completed on both Part I and Part II before proceeding to the next cost center.

After all the general service cost centers (lines 1-8) have been allocated to the HHA Reimbursable Services and HHA Non-Reimbursable Services cost centers on Worksheet H-1, Part I, enter the totals as follows: 1.) Enter in column 9, for lines 16 through 49, and line 99, the sum of the net expenses for cost allocation (from column 0) and the allocated expenses from the general service cost centers (from columns 1 through 8), and 2.) Enter in column 9, line 100, the sum of column 9 lines 16 through 49, and line 99. The total expenses entered on line 100, column 9, must equal the total expenses entered on line 100, column 0.

Column Descriptions for the Worksheet H-1, Part I

Column 1 - Capital Related - Buildings and Fixtures.--Depreciation on buildings and fixtures and expenses pertaining to buildings and fixtures such as insurance, interest, rent, and real estate taxes are combined in this cost center to facilitate cost allocation. Allocate all expenses to the cost centers based on square footage of the occupied area.

Column 2 - Capital Related Costs Movable Equipment.--Allocate all expenses (e.g., interest, personal property tax) for movable equipment to the appropriate cost centers on the basis of dollar value or if approved, the alternative basis of square feet. A SNF-based HHA must request the use of the alternative method in accordance with CMS Pub. 15-1, chapter 23, §2313.

Column 3 - Plant Operation & Maintenance.--Allocate all expenses for the physical plant operation and maintenance to the appropriate cost centers based on square feet.

Column 4 - Transportation.--The costs of vehicles owned or rented by the SNF-based HHA and all other transportation costs that were not directly assigned to another cost center on Worksheet H, column 3, are included in this cost center. Allocate this expense to the cost centers to which it applies based on miles applicable to each cost center.

This basis of allocation is not mandatory and a SNF-based HHA may use weighted trips rather than actual miles as a basis of allocation for transportation costs that are not directly assigned. However, a SNF-based HHA must request the use of the alternative method in accordance with CMS Pub. 15-1, chapter 23, §2313. The SNF-based HHA must maintain adequate records to substantiate the use of this allocation.

Worksheet H-1, Part I, column 4A - Subtotal.--For each line 16 through 24, enter the sum of columns 0 through 4.

Column 5 - Telecommunication Technology.--Allocate all expenses for telecommunication technology to the appropriate cost centers based on accumulated costs. These expenses will only be allocated to the HHA Reimbursable Services cost centers reported in lines 16 through 24. Transfer the amounts from Worksheet H-1, Part I, column 4A, lines 16 through 24 to Worksheet H-1, Part II, column 5, lines 16 through 24, as the accumulated cost statistic.

Worksheet H-1, Part II, column 5A - Reconciliation.--Enter on line 5A the costs attributable to the difference between the total accumulated cost reported on Worksheet H-1, Part I, column 4A, line 100, and the accumulated costs reported on Worksheet H-1, Part II, column 5, line 5. If only a portion of the costs from a cost center are to receive an allocation, use the reconciliation column to reduce the allocation statistic by that amount to ensure proper allocation.

Worksheet H-1, Part I, column 5A - Subtotal.--For lines 16 through 24, enter the sum of columns 4A and 5. For lines 6, 7, 8, and 25 through 49, enter the sum of columns 0 through 4.

Worksheet H-1, Part I, column 6 - Administrative & General.--The A&G expenses are allocated based on accumulated costs after reclassifications and adjustments. Therefore, on Worksheet H-1, Part II, column 6, lines 7 through 49, enter the amounts from Worksheet H-1, Part I, column 5A.

A negative cost center balance in the statistics for allocating A&G expenses causes an improper distribution of this overhead cost center. Negative balances are excluded from the allocation statistics when A&G expenses are allocated based on accumulated cost.

When contract service costs include A&G costs, the contracted services must be excluded from the total cost statistic on Worksheet H-1, Part II, column 6. For purposes of determining the basis of allocation, use Worksheet H-1, Part II, column 6A, to adjust the allocation statistic on Worksheet H-1, Part II, column 6. This procedure may be followed when the SNF-based HHA contracts for services to be performed for the SNF-based HHA and the contract identifies the A&G costs applicable to the purchased services.

An HHA may establish multiple A&G cost centers (referred to as componentized or fragmented) by using one of two possible methodologies. The rationale for allocating the shared A&G service cost center first is that shared A&G cost centers service all other cost centers, while 100 percent of HHA A&G reimbursable and 100 percent of HHA A&G nonreimbursable only service their respective cost centers. That is consistent with 42 CFR 413.24(d)(1), which states, in part, that “the cost of nonrevenue-producing cost centers serving the greatest number of other centers, while receiving benefits from the least number of centers, is apportioned first.” Under the first methodology (also referred to as option 1), the HHA must classify all A&G costs as either A&G shared costs, A&G reimbursable costs, or A&G nonreimbursable costs. That is, 100 percent of the componentized A&G costs relate exclusively to either the HHA reimbursable or HHA nonreimbursable cost centers. The remaining costs are classified as A&G shared costs. The componentized A&G costs are allocated through cost finding to their respective cost centers in aggregate.

First, allocate A&G shared costs to all applicable cost centers, including to the A&G reimbursable and A&G nonreimbursable cost centers based on accumulated costs. Then allocate HHA A&G reimbursable costs to all applicable HHA reimbursable cost centers (not including special purpose cost centers) based on accumulated costs and allocate HHA A&G nonreimbursable costs to all applicable HHA nonreimbursable cost centers based on accumulated costs. Only A&G shared costs will be allocated to the special purpose cost centers. The following three A&G cost center categories will be created: (1) A&G shared costs, (2) 100 percent HHA reimbursable costs, and (3) 100 percent HHA nonreimbursable costs, in this order only. Do not allocate A&G reimbursable costs to the A&G nonreimbursable cost center. Calculate the accumulated cost statistics as follows:

A&G Cost Center	Sum of WS H-1, Part I	Transfer to WS H-1, Part II
A&G Shared Costs	Col. 5A, lines 6.02 through 49	Col. 6.01, lines 6.02 through 49
A&G Reimb. Costs	Col. 5A plus 6.01, lines 16 through 30	Col. 6.02, lines 16 through 30
A&G Nonreimb. Costs	Col. 5A plus 6.01, lines 39 through 49	Col. 6.03, lines 39 through 49

Under the second methodology (also referred to as option 2), unique A&G cost centers may be created (see CMS Pub. 15-1, chapter 23, §2313.1) to further refine the allocation process. The statistical basis used to allocate fragmented A&G costs must represent, as accurately as possible, the consumption or usage of A&G services by the benefiting cost centers. An HHA wishing to use an alternative allocation methodology (i.e., a change in allocation basis or the sequence of cost center allocation) must do so in accordance with CMS Pub. 15-1, chapter 23, §2313. The fragmentation of A&G costs may constitute a direct assignment of A&G costs and, as such, must follow the policy established under CMS Pub. 15-1, chapter 23, §2307.

Worksheet H-1, Part II, column 6A- Reconciliation.--Enter on line 6 the subtotal from Worksheet H-1, Part I, column 5A, line 6, as a negative amount. Enter any amounts reported on Worksheet H-1, Part I, column 5A, for (1) any service provided under arrangements to program patients that is not grossed up and (2) negative balances. Enter a negative one (-1) in the accumulated cost column to identify the cost center that should be excluded from receiving any A&G costs. If some of the costs from that cost center are to receive A&G costs then enter in the reconciliation column the amount not to receive A&G costs to assure that only those costs to receive overhead receive the proper allocation. Including these costs in the statistics for allocating administrative and general expenses causes an improper distribution of overhead.

For fragmented or componentized 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 6 (A&G), the reconciliation column designation must be 6A.

Worksheet H-1, Part II, column 6.--The administrative and general expenses are allocated based on accumulated costs. Therefore, the amount entered on Worksheet H-1, Part II, column 6, line 6, is the difference between the amounts entered on Worksheet H-1, Part I, column 5A, line 100 and Worksheet H-1, Part II, column 6A, line 6. 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.

Column 7, Nursing Administration.--Allocate all expenses for nursing administration to the appropriate cost centers based on direct nursing hours. Enter the direct nursing hours on Worksheet H-1, Part II, column 7.

Column 8 - Other General Service.--Allocate all expenses for other general service costs not identified in columns 1 through 7 using a statistical basis that will equitably allocate costs.

Transfer the amounts on Worksheet H-1, Part I, column 9, to Worksheet H-2, Part I, column 0, as follows:

<u>From Worksheet H-1</u> <u>Part I, Column 9</u>	<u>To Worksheet H-2,</u> <u>Part I, Column 0</u>
Line 16	Line 2
17	3
18	4
19	5
20	6
21	7
22	8
23	9
24	10
25	11
26	12
27	13
28	14
29	15
30	16
39	17
40	18
41	19
42	20
43	21
44	22
45	23
46	24
47	25
48	26
49	27

4909.30 WORKSHEET H-2 - PART I - ALLOCATION OF SNF GENERAL SERVICE COSTS TO THE SNF-BASED HHA AND PART II - ALLOCATION OF GENERAL SERVICE COSTS TO THE SNF-BASED HHA - STATISTICAL BASIS

Use this worksheet only if you operate a Medicare certified SNF-based HHA as part of your complex. To facilitate the allocation process, the general format of Worksheet H-2, Parts I and II, is identical.

Worksheet H-2, Part I, provides for the allocation of the expenses of each general service cost center of the SNF to those cost centers that receive the services. Worksheet H-2, Part II, provides for the proration of the statistical data needed to equitably allocate the expenses of the general service cost centers on Worksheet H-2, Part I.

Obtain the total direct expenses reported on Worksheet H-2, Part I, column 0, line 100 from Worksheet A, line 70, column 9. Obtain the cost center allocation for the amount reported on line 100 from Worksheet H-1, Part I, lines 16 through 49, column 9 and report in column 0, accordingly.

Obtain the SNF general service costs allocated to the SNF-based HHA from Worksheet B, Part I, line 70, columns 1 through 18, and 20. For each column on Worksheet B, Part I, line 70, enter in the corresponding column on Worksheet H-2, Part II, line 101, the total costs to be allocated to the SNF-based HHA cost centers receiving services. For each column on Worksheet B-1, line 70, enter in allocation statistic to the corresponding column on Worksheet H-2, Part II, line 100.

Complete the instruction for Worksheet H-2, Part II, lines 1 through 27.

Line 100.--Enter the unit cost multiplier (column 21, line 1, divided by the sum of column 21, line 100 minus column 21, line 1, rounded to 6 decimal places). Multiply each amount in column 21, lines 2 through 27, by the unit cost multiplier, and enter the result on the corresponding line of column 22.

On Worksheet H-2, Part I, column 19, for each line enter the total of columns 3A through 18. In column 20, enter any post-stepdown adjustments. In column 21, enter the sum of columns 19 and 20. The total cost on Worksheet H-2, Part I, column 21, line 100 must agree to the total SNF allocated cost from Worksheet B Part I, column 21, line 70.

On Worksheet H-2, Part I, column 23, enter on lines 2 through 27 the sum of columns 21 and 22. The total in column 23, line 100 equals the total in column 21, line 100.

The statistical basis at the top of each column on Worksheet H-2, Part II, is the recommended basis of allocation and must correspond to the statistical basis reported on Worksheet B, Part I.

An HHA may request a change in the order of allocation if the request meets the conditions set forth in CMS Pub. 15-1, chapter 23, §2313. Likewise, new SNF owners after a change of ownership may request a change in the order of allocation if the request meets the conditions set forth in CMS Pub. 15-1, chapter 23, §2313.

Lines 1 through 27.--On Worksheet H-2, Part II, for each column where the total allocation statistic on line 100 contains an amount, enter on lines 1 through 27 that portion of the total statistical applicable to each cost center. For each column 1 through 18, the sum of the amounts on lines 1 through 27 must equal the amount on line 100.

Line 101.--Enter the total SNF general service cost allocated to the SNF-based HHA. For each column on Worksheet B, Part I, line 70, enter in the corresponding column on Worksheet H-2, Part II, line 101, the total costs to be allocated to the SNF-based HHA cost centers receiving services.

Line 102.--Calculate the unit cost multiplier by dividing the cost entered on line 101 by the total statistic entered in the same column on line 100. Round the unit cost multiplier to six decimal places.

To complete Worksheet H-2, Part I, for each column multiply the unit cost multiplier by the statistics applicable to each cost center receiving the service. Enter the result of each computation on Worksheet H-2, Part I, in the corresponding column and line.

After the unit cost multiplier has been applied to all the cost centers receiving the services, the total cost on Worksheet H-2, Part I, line 100, must equal the total cost on Worksheet H-2, Part II, line 101.

4909.40 WORKSHEET H-3 - APPORTIONMENT OF SNF-BASED HHA PATIENT SERVICE COSTS

This worksheet provides for the apportionment of SNF-based HHA patient service costs to titles V, XVIII, and XIX.

Most services rendered by a SNF-based HHA are covered under the home health prospective payment system at §1833(a)(2)(A) of the Act. The SNF-based HHA may also render preventive vaccines and osteoporosis drugs that are paid under the lesser of reasonable cost or the customary charges (LCC) for services rendered to beneficiaries or they may be paid under OPPS for other medical services or disposable devices. Reimbursement for services reimbursed under reasonable cost are subject to LCC, and as such, reimbursement cannot exceed 80 percent of the reasonable cost of these services.

4909.41 Part I - Apportionment of Cost to SNF-Based HHA for Services Furnished by Shared SNF Departments.

Use this part only when the SNF healthcare complex maintains a separate department for any of the cost centers listed on this part of the worksheet, and these departments provide services to patients of the SNF-based HHA. Subscript lines 1 through 5, as applicable, if subscripted on Worksheet C.

Column 1.--Lines 1 through 5, enter in column 1 the cost to charge ratio from Worksheet C, column 5, lines as indicated.

Column 2.--Where SNF departments provide services to the SNF-based HHA, enter on the appropriate lines the charges applicable to the SNF-based HHA.

Column 3.--Multiply the amounts in column 2 by the ratios in column 1, and enter the result in column 3. Transfer the amounts in column 3 to Worksheet H-3, Parts II and III, as follows:

	From Col.3	to	<u>Worksheet H-3</u>	
	<u>Line</u>		<u>Part</u>	<u>Line</u>
Physical Therapy	1		II	3
Occupational Therapy	2		II	5
Speech Language Pathologist	3		II	7
Medical Supplies Charge to Patients	4		III	1
Drugs Charged to Patients	5		III	2

4909.42 Part II - SNF-Based HHA Cost Per Visit and Program Cost Computation.

This part provides for the computation of the total cost and reasonable program cost by discipline based on program patient care visits as required by 42 CFR 413.53.

Column Descriptions

Column 1.--For each line 1 through 9, transfer the cost from Worksheet H-2, Part I, column 23, lines as indicated. Enter on line 10, the sum of lines 1 through 9.

Column 2.--For lines 3, 5, and 7, enter the amounts from H-3, Part I, lines 1 through 3 accordingly. Enter on line 10, the sum of lines 3, 5, and 7.

Column 3.--For each line 1 through 9, enter the sum of columns 1 and 2. Enter on line 10, the sum of lines 1 through 9.

Column 4.--For each line 1 through 9, transfer the visits from the corresponding line on Worksheet S-4, Part I, column 7. Enter on line 10, the sum of lines 1 through 9.

Column 5.--For each line, compute the average cost per visit by dividing the cost in column 3 by the number of visits in column 4.

Column 6.--For each line 1 through 9, enter the title XVIII Program visits by practitioner from your records or PS&R data. For titles V and XIX, enter the healthcare program visits by practitioner from your records. The total visits on line 10, column 6, must equal the total visits on Worksheet S-4, Part IV, line 13, column 5, for title XVIII. Enter on line 10, the sum of lines 1 through 9. The visits in this column represent services that are part of a home health plan, and thus not subject to deductibles and coinsurance.

Column 7.--For each line, calculate Program cost by multiplying the visits in column 6 by the average cost per visit amount in column 5. Enter on line 10, the sum of lines 1 through 9.

4909.43 Part III - Medical Supplies, Drugs, and Disposable Devices Cost Computation.

This worksheet part calculates the program cost for services covered by the program and furnished by a SNF-based HHA but not included in the cost per visit for apportionment purposes. Neither an average cost per visit nor HHA PPS apply to these items. To determine the program cost for these services, this worksheet part develops and applies the ratio of total-cost-to-total-charges to program charges.

Column 1.--Transfer the total SNF-based HHA costs to lines 1 through 4 from Worksheet H-2, Part I, column 23, lines 11, 12, 13, and 15.

Column 2.--Transfer the SNF-based HHA shared ancillary costs to lines 1 and 2 from Worksheet H-3, Part I, column 3, lines 4 and 5.

Columns 3 through 5.--For each line in column 3, enter the sum of columns 1 and 2. For each line in column 4, enter the total charges from SNF-based HHA records. For each line in column 5, calculate the ratio of total cost to total charges by dividing column 3 by column 4, rounded to six decimal places.

Columns 6 through 8.--Enter Program charges from the PS&R or provider records.

Line 1.--Enter medical supplies charges not subject to deductibles and coinsurance in column 7 and charges subject to deductibles and coinsurance in column 8. These charges are captured for statistical purposes only; line 1 has no reimbursement impact as all medical supplies are covered under the HHA PPS.

Line 2.--Enter in column 7 the charges for preventative pneumococcal, influenza, hepatitis B, and COVID-19 vaccines. These vaccines are not subject to deductibles and coinsurance. Enter in column 8 the charges for covered osteoporosis drugs. Osteoporosis drugs are cost reimbursed and are subject to deductibles and coinsurance. Do not include the charges for administering vaccines or drugs.

Line 3.--Enter in column 6 the charges for administering pneumococcal, influenza, hepatitis B, and COVID-19 vaccines from the HHA records or the PS&R. These amounts are paid under OPSS.

Line 4.--Enter in column 6 the charges for covered disposable devices from your records or the PS&R. Medicare makes a separate payment amount for a disposable negative pressure wound therapy (NPWT) device for a patient under a home health plan of care. Payment is equal to the amount of the payment that would otherwise be made under the Outpatient Prospective Payment System (OPSS). Disposable devices are subject to deductibles and coinsurance.

Columns 9 through 11.--Calculate the program cost of services. To determine the costs for each column, multiply the charges reported in columns 6 through 8 by the ratio in column 5.

Line 1.--For informational purposes, calculate in column 10, the program cost not subject to deductibles and coinsurance, by multiplying the charges in column 7 by the ratio in column 5. Calculate in column 11, the program cost subject to deductible and coinsurance, by multiplying the charges in column 8 by the ratio in column 5.

Line 2.--Calculate the costs for preventive pneumococcal, influenza, hepatitis B, and COVID-19 vaccines not subject to deductibles and coinsurance in column 10, by multiplying the charges in column 7 by the ratio in column 5. Calculate the costs for osteoporosis drugs subject to deductible and coinsurance in column 11, by multiplying the charges in column 8 by the ratio in column 5.

Line 3.--To determine the cost of vaccine administration for costs devices reimbursed under OPSS in column 9, multiply the charges in column 6 by the ratio in column 5. Informational only.

Line 4.--To determine the cost of disposable devices reimbursed under OPSS in column 9, multiply the charges in column 6 by the ratio in column 5. Informational only.

4909.50 WORKSHEET H-4 - CALCULATION OF SNF-BASED HHA REIMBURSEMENT SETTLEMENT

This worksheet provides for the reimbursement calculation of title V; title XVIII, Parts A and B; and title XIX. This computation is required by 42 CFR 413.9, 42 CFR 413.13, and 42 CFR 413.30.

4909.51 Part I - Computation of the Lesser of Reasonable Cost or Customary Charges.

Preventive vaccines and osteoporosis drugs for SNF-based HHAs are paid the lesser of the reasonable cost of services furnished to beneficiaries or the customary charges for the same services. This part provides for the computation of the lesser of reasonable cost as defined in 42 CFR 413.13(b) or customary charges as defined in the 42 CFR 413.13(a).

Line Descriptions

Line 1.--Transfer the costs from Worksheet H-3, Part III as follows:

From		Worksheet H-4
Worksheet H-3		Part I
Part III	to	Part I
line 2, col. 10		line 1, col. 1
line 2, col. 11		line 1, col. 2

Line 2.--Transfer the charges from Worksheet H-3, Part III, line 2 as follows:

From		Worksheet H-4
Worksheet H-3		Part I
Part III	to	Part I
line 2, col. 7		line 2, col. 1
line 2, col. 8		line 2, col. 2

Line 3.--Enter in each column the excess of total charges, line 2 over the total reasonable cost, line 1. In situations when, in any column, the total charges on line 2 are less than the total cost on line 1 of the applicable column, enter zero on line 3.

Line 4.--Enter in each column the excess of total reasonable cost, line 1 over total charges, line 2. In situations when, in any column, the total cost on line 1 is less than the total charges on line 2 of the applicable column, enter zero on line 4.

Line 5.--For each column, calculate the reasonable costs of line 1 minus line 4.

4909.52 Part II - Computation of SNF-Based HHA Reimbursement Settlement.

Lines 1 through 4.--Under HHA PPS, enter the payment amounts associated with periods of care completed in the current cost reporting period. Payments for periods of care that overlap cost reporting periods must be recorded in the cost reporting period in which the period was completed. Enter on lines 1 through 4, as applicable, the PPS payment amount for each period of care payment category. Obtain these amounts from your records or PS&R.

Lines 5 and 6.--Enter on lines 5 and 6, as applicable, the appropriate PPS outlier reimbursement amount for each period of care payment category as indicated on the worksheet. Obtain these amounts from your records or PS&R.

Lines 7 through 9.--Enter on lines 7 through 9 the gross payments for prosthetics and orthotics, DME, and oxygen, associated with home health PPS services. Obtain these amounts from your records or PS&R.

Line 10.--Enter on line 10, as applicable, OPSS payments for services rendered. This includes OPSS payments for the administration of pneumococcal, influenza, hepatitis B, and COVID-19 vaccines, and disposable devices such as NPWT devices.

Line 11.--Enter the sum of line 5, columns 1 and 2, and lines 1 through 10. These are the total reimbursable costs.

Line 12.--Enter the deductibles billed to program patients from your records or the PS&R.

Line 13.--Enter the coinsurance billed to program patients from your records or the PS&R.

Line 14.--Enter the amounts paid or payable by the primary payer from your records or the PS&R.

Line 15.--Enter the result of line 11 minus the sum of lines 12 through 14.

Line 16.--Enter Medicare allowable bad debts, reduced by bad debt recoveries. If recoveries exceed the current year's bad debts, lines 16 and 17 will be negative.

Line 17.--Calculate reimbursable bad debts, multiply the amount (including negative amounts) on line 16 by 65 percent.

Line 18.--Enter the allowable bad debts for indigent dual eligible individuals as defined at 42 CFR 413.89(e)(2)(iii). This amount is also included on line 16.

Line 19.--Enter the sum of line 15 and line 17.

Line 20.--Enter all demonstration payment adjustment amounts before sequestration. Obtain this amount from the PS&R.

Line 21.--Enter the result of line 19 minus line 20

Line 22.--Enter the claims based sequestration adjustment amount from the PS&R.

Line 23.--Calculate the sequestration adjustment for non-claims based amounts as [(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 six decimal places), rounded to four decimal places)) times the sum of (line 5, columns 1 and 2, plus line 17)]. If the sum of line 5, columns 1 and 2, plus line 17, is less than zero, do not calculate the sequestration adjustment.

Line 24.--Enter all demonstration payment adjustment amounts after sequestration. Obtain this amount from the PS&R.

Line 25.--Enter the amount of other adjustments from the PS&R.

Line 26.--Enter the result of line 21 minus the sum of lines 22 through 25.

Line 27.--Enter the total interim payments from Worksheet H-5, column 2, line 4.

Line 28.--Contractor use only. Enter the total tentative settlement payments from Worksheet H-5, column 2, line 5.99.

Line 29.--Enter the result of line 26 minus lines 27 and 28. This represents the amount due to or from the SNF-based HHA. Transfer to Worksheet S, Part III, line 4, as applicable.

Line 30.--If the SNF-based HHA seeks payment that it believes may not be allowable or may not comport with Medicare policy, enter the protested amounts on this line. Estimate the reimbursement effect of the non-allowable items by applying a reasonable methodology that closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See 42 CFR 413.24(j)(2)). Submit with the cost report a schedule showing the details and computations for amount reported on this line.

4909.60 WORKSHEET H-5 - ANALYSIS OF PAYMENTS TO SNF-BASED HHA FOR SERVICES RENDERED TO MEDICARE BENEFICIARIES

The HHA completes lines 1 through 4. (See 42 CFR 413.64.) Enter Medicare interim payments only; do not complete this worksheet for titles V and XIX.

The contractor completes lines 5 through 8. All amounts reported on this worksheet must be for services rendered during the cost reporting period for costs included in this cost report.

NOTE: DO NOT reduce any interim payments by recoveries because of medical review adjustments where the recoveries were based on a sample percent applied to the universe of claims reviewed and the PS&R was not adjusted.

Line Descriptions

Line 1.--Enter the total Medicare interim payments paid to the HHA for all covered services. Additionally, enter the total Medicare interim payments paid to the HHA for covered osteoporosis drugs paid under OPPTS, and vaccines such as pneumococcal, influenza, hepatitis, and COVID-19 vaccines paid on a cost reimbursement basis. Enter the sum of all interim payments paid on individual bills (net of adjustment bills) for services rendered in this cost reporting period, including amounts that may have been withheld from HHA interim payments due to an offset against overpayments applicable to prior cost reporting periods. Do not include any retroactive lump sum adjustment amounts based on a subsequent revision of the interim rate; tentative or net settlement amounts; or interim payments payable. If the HHA is reimbursed under the PIP method of reimbursement, enter the PIP payments received for this cost reporting period. Do not include payments received for services reimbursed on a fee schedule basis.

Line 2.-- Enter the total Medicare interim payments payable on individual bills (amount due for HHA services rendered in the cost reporting period but not paid as of the end of the cost reporting period).

Line 3.--In column 1, enter the date each retroactive lump sum adjustment was paid and, in column 2, enter the corresponding retroactive lump sum adjustment amount. Payments made to the HHA from the Program are reported on lines 3.01 through 3.05 (may be subscripted through line 3.49). Payments paid by the HHA to the program are reported on lines 3.50 through 3.54 (may be subscripted through line 3.98). Report these payments as positive amounts. Enter on line 3.99, column 2, the total net retroactive lump sum payments calculated as the sum of lines 3.01 through 3.49 less the sum of lines 3.50 through 3.98.

NOTE FOR LINE 3: When an amount is due from the SNF-based HHA to the program, show the amount and date on which the SNF-based HHA agrees to the amount of repayment even though total repayment is not accomplished until a later date.

Line 4.--In column 2, enter the total amount of the interim payments (sum of lines 1, 2, and 3.99). Transfer this total to Worksheet H-4, Part II, line 27.

DO NOT COMPLETE THE REMAINDER OF WORKSHEET H-5. LINES 5 THROUGH 7 ARE FOR CONTRACTOR USE ONLY. (EXCEPTION: IF WORKSHEET S, PART I, LINE 3, IS GREATER THAN ZERO (AMENDED COST REPORT), THE SNF-BASED HHA MAY COMPLETE LINES 5 THROUGH 7.)

Line 5.--Report all settlement payments after the cost report is received. In column 1, enter the date of each tentative settlement payment, and, in column 2, enter the corresponding tentative settlement payment amount. Report payments made to the SNF-based HHA from the Program on lines 5.01 through 5.05 (may be subscripted through line 5.49). Report payments paid by the HHA to the program on lines 5.50 through 5.54 (may be subscripted through line 5.98). Report these payments as positive amounts. On line 5.99, enter the total net tentative settlement payments calculated as the sum of lines 5.01 through 5.49 minus the sum of lines 5.50 through 5.98.

For each cost report reopening, report all settlement payments prior to the current reopening settlement on line 5.

NOTE FOR LINES 5 and 6: When an amount is due from the SNF-based HHA to the program, show the amount and date on which the SNF-based HHA agrees to the amount of repayment even though total repayment is not accomplished until a later date.

Line 6.--Enter the net settlement amount from Worksheet H-4, Part II, line 29, and the date of the payment. If Worksheet H-4, Part II, line 29, is a positive amount, i.e., amount due the provider, report the amount on line 6.01, column 2, and, in column 1, enter the date of the NPR. If Worksheet H-4, Part II, line 29, is a negative amount, i.e., amount due the program, report the amount on line 6.02, column 2, and, in column 1, enter the date on which the provider agrees to the amount of repayment even though the total repayment is not accomplished until a later date.

Line 7.--In column 2, enter the sum of the amounts from column 2, lines 4, 5.99, and 6.01 or 6.02. Line 7, column 2, must equal Worksheet H-4, Part II, line 26.

Line 8.--Enter the contractor name, contractor number, and NPR date in columns 1, 2 and 3, respectively.

4912 K SERIES

On the K series of worksheets, the SNF reports the cost incurred by its SNF-based Hospice to provide patient related services to Medicare beneficiaries, including an allocation of general service costs from the SNF. The series consists of the following worksheets:

- Worksheet K - Analysis of SNF-Based Hospice Costs
- Worksheet K-1 - Analysis of SNF-Based Hospice Continuous Home Care
- Worksheet K-2 - Analysis of SNF-Based Hospice Routine Home Care
- Worksheet K-3 - Analysis of SNF-Based Hospice Inpatient Respite Care
- Worksheet K-4 - Analysis of SNF-Based Hospice General Inpatient Care
- Worksheet K-5 - Determination of SNF-Based Hospice Total Expenses for Allocation
- Worksheet K-6 - Cost Allocation - SNF-Based Hospice General Service Costs
- Worksheet K-7 - Apportionment of SNF-Based Hospice Shared Service Costs by Level of Care
- Worksheet K-8 - Calculation of SNF-Based Hospice Per Diem Cost

4912.10 WORKSHEET K - ANALYSIS OF SNF-BASED HOSPICE COSTS

This worksheet is used to record the trial balance of expense accounts from the SNF-based hospice accounting books and records. It also provides for reclassifications 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 SNF-based hospice using these forms. Complete only those lines that are applicable.

The SNF-based hospice must maintain the records necessary to determine the split in salary (and employee-related fringe benefits) between two or more cost centers and must adequately substantiate the method used to split the salary and employee-related fringe benefits. These records must be available for audit by your contractor. Your contractor can accept or reject the method used to determine the split in salary. Any deviation or change in methodology to determine splits in salary and employee fringe benefits must be requested in writing and approved by your contractor before any change is effectuated. Where approval of a method has been requested in writing and this approval has been received (prior to the beginning of the cost reporting period), the approved method remains in effect for the requested period and all subsequent periods until you request in writing to change to another method or until your contractor determines that the method is no longer valid due to changes in your operations.

Column Descriptions

For columns 1, 2, 4, and 6, report direct patient care service costs (lines 25 through 47) by LOC on Worksheets K-1, K-2, K-3, and K-4. For each cost center on Worksheet K, enter the sum of the amounts from Worksheets K-1, K-2, K-3, and K-4, for salaries, other costs, reclassifications, and adjustments, in columns 1, 2, 4, and 6, respectively.

Column 1.--Enter salaries from the provider's accounting books and records. Salaries for the direct patient care service cost centers (lines 25 through 47) must equal the sum of amounts reported on the corresponding lines in column 1 of Worksheets K-1, K-2, K-3, and K-4. The total salaries for line 100, column 1, must equal the salaries reported on Worksheet A, line 72, column 1.

Column 2.--Enter all costs other than salaries from the provider's accounting books and records. Other costs for the direct patient care service cost centers (lines 25 through 47) must equal the sum of amounts reported on the corresponding lines in column 2 of Worksheets K-1, K-2, K-3, and K-4. The total other costs for line 100, column 2, must equal the other costs reported on Worksheet A, line 72, sum of columns 2 *and* 4.

Column 3.--For each cost center, enter the total of column 1 plus column 2.

Column 4.--Enter any reclassifications among cost center expenses in column 3 needed to effect proper cost allocation. This column need not be completed by all providers but is completed only to the extent reclassifications are needed or reported on Worksheet A, line 72, column 6. Show reductions to expenses as negative amounts.

If reclassifications are needed for direct patient care service cost centers (lines 25 through 47), enter the reclassification amounts on the appropriate Worksheets K-1, K-2, K-3, and K-4, column 4, for each LOC.

Reclassifications for the direct patient care service cost centers (lines 25 through 47) must equal the sum of amounts reported on the corresponding lines in column 4 of Worksheets K-1, K-2, K-3, and K-4. The total reclassifications for line 100, column 4, must equal the reclassifications reported on Worksheet A, line 72, column 6.

Column 5.--For each cost center, enter the total of the amount in column 3 plus or minus the amount in column 4.

Column 6.--In accordance with 42 CFR 413.9(c)(3), enter on the appropriate lines the amounts of any adjustments to expenses required under Medicare principles of reimbursement. (See §4016.) This column need not be completed by all SNF-based hospices but is completed only to the extent adjustments are needed or reported on Worksheet A, line 72, column 8. Show reductions to expenses as negative amounts.

If adjustments are needed for direct patient care service cost centers (lines 25 through 47), enter the adjustment amounts on the appropriate Worksheets K-1, K-2, K-3, and K-4, column 6, for each level of care.

Adjustments for the direct patient care service cost centers (lines 25 through 47) must equal the sum of amounts reported on the corresponding lines in column 6 of Worksheets K-1, K-2, K-3, and K-4. The total adjustments for line 100, column 6, must equal the adjustments reported on Worksheet A, line 72, column 8.

Column 7--For each cost center, enter the total of the amount in column 5 plus or minus the amount in column 6. Transfer the amounts in column 7 for cost centers 1 through 16, and 60 through 71, to Worksheet K-5, as follows:

<u>From Worksheet K, Column 7, Line Number and Cost Center Description</u>	<u>To Worksheet K-5, Column 1:</u>
1 Cap Related Costs-Building & Fixtures	line 1
2 Cap Related Costs-Movable Equipment	line 2
3 Employee Benefits	line 3
4 Administrative & General	line 4
5 Plant Operation & Maintenance	line 5
6 Laundry & Linen	line 6
7 Housekeeping	line 7
8 Dietary	line 8
9 Nursing Administration	line 9
10 Routine Medical Supplies	line 10
11 Medical Records	line 11
12 Staff Transportation	line 12
13 Volunteer Service Coordination	line 13
14 Pharmacy	line 14
15 Physician Administrative Services	line 15
16 Other General Service	line 16
60 Bereavement Program	line 60
61 Volunteer Program	line 61
62 Fundraising	line 62
63 Hospice/Palliative Medicine Fellows	line 63
64 Palliative Care Program	line 64
65 Other Physician Services	line 65
66 Residential Care	line 66
67 Advertising	line 67
68 Telehealth/Telemonitoring	line 68
69 Thrift Store	line 69
70 Nursing Facility Room and Board	line 70
71 Other Nonreimbursable	line 71

Line Descriptions

The Worksheet K cost centers are segregated into general service, direct patient care service, and nonreimbursable cost centers to facilitate the transfer of costs to the various worksheets. The general service cost centers appear on Worksheet K-5, and Worksheet K-6, Parts I and II, using the same line numbers as Worksheet K. The direct patient care service cost centers appear on Worksheets K-1, K-2, K-3, and K-4, using the same line numbers as Worksheet K.

GENERAL SERVICE COST CENTERS

General service cost centers (lines 1 through 17) include expenses incurred in operating the program as a whole that are not directly associated with furnishing patient care such as, mortgage, rent, plant operations, administrative salaries, utilities, telephone, and computer hardware and software costs. Except where descriptions are provided below, see §4902 for descriptions of general service cost centers.

Lines 1 and 2 - Capital Related-Building & Fixtures and Capital Related-Movable Equipment.--Enter in column 2, the capital-related costs for buildings and fixtures and the capital-related costs for movable equipment on lines 1 and 2, respectively.

Line 3 - Employee Benefits Department.--Enter in columns 1 and 2, the salary and other costs of the employee benefits department and wage related costs paid (see CMS Pub. 15-1, chapter 21, §2144, and CMS Pub. 15-1, chapter 23, §2307).

Line 4 - Administrative & General.--Enter in columns 1 and 2, the salary and other costs of A&G.

If the option to subscript A&G costs into more than one cost center is elected (in accordance with CMS Pub. 15-1, chapter 23, §2313), eliminate line 4. Begin numbering the subscripted A&G cost centers with line 4.01 and continue in sequential order.

Line 5 - Plant Operation & Maintenance.--This cost center includes the costs incurred for plant operations and maintenance and repair services for utility systems such as heat, light, water, air conditioning and air treatment, and maintenance of the facility and grounds, such as the costs of routine painting, plumbing, mowing and snow removal.

Line 6 - Laundry & Linen Service.--Enter in columns 1 and 2, the cost of routine laundry and linen services.

Line 7 - Housekeeping.--Enter in columns 1 and 2, the cost of routine housekeeping activities.

Line 8 - Dietary.--Enter in columns 1 and 2, the cost of preparing meals for patients. Do not include the cost of dietary counseling in this cost center; report dietary counseling on line 35.

Line 9 - Nursing Administration.--Enter in columns 1 and 2, the cost of overall management and direction of the nursing services. Do not include the cost of direct nursing services reported on lines 27 through 29. The salary cost of direct nursing services, including the salary cost of nurses who render direct service in more than one patient care area, is directly assigned to the various patient care cost centers in which the services were rendered.

Line 10 - Routine Medical Supplies.--Enter in columns 1 and 2, the cost of supplies used in the normal course of caring for patients, such as gloves, masks, swabs, or glycerin sticks, that generally are not traceable to individual patients. Do not include the costs of non-routine medical supplies that can be traced to individual patients; report non-routine medical supplies on line 42.

Line 11 - Medical Records.--Enter in columns 1 and 2, the cost of the medical records department where patient medical records are maintained. The general library and the medical library are not included in this cost center but are included in the A&G cost center.

Line 12 - Staff Transportation.--Enter in columns 1 and 2, the cost of owning or renting vehicles, public transportation expenses, parking, tolls, or payments to employees for driving their private vehicles to see patients or for other hospice business. Staff transportation costs do not include patient transportation costs; report patient transportation costs on line 39.

Line 13 - Volunteer Service Coordination.--Enter in columns 1 and 2, the cost of the overall coordination of volunteer services, including recruitment and training costs.

Line 14 - Pharmacy.--Enter in columns 1 and 2, the costs of drugs (both prescription and over-the-counter), pharmacy supplies, pharmacy personnel, and pharmacy services. Do not report the cost of palliative chemotherapy drugs on this line; report the cost of palliative chemotherapy on line 45.

Line 15 - Physician Administrative Services.--Enter in columns 1 and 2, the costs for physicians' administrative and general supervisory activities that are included in the hospice payment rates. These activities include participating in the establishment, review and updating of plans of care, supervising care and services, conducting required face-to-face encounters for recertification, and establishing governing policies. These activities are generally performed by the physician serving as the medical director and the physician member of the interdisciplinary group. Nurse practitioners may not serve as or replace the medical director or physician member of the interdisciplinary group.

Line 17 - Patient/Residential Care Services.--Do not use this line on this worksheet. This cost center is used on Worksheet K-6 to accumulate in-facility costs (not separately identified as HIRC, HGIP, or residential care services that are not part of a separate and distinct residential care unit, e.g., depreciation related to in-facility areas that provide HIRC, HGIP or residential care). The amounts allocated to this cost center on Worksheet K-6 are allocated to HIRC, HGIP and residential care services that are not part of a separate and distinct residential care unit, based on in-facility days. This cost center does not include any costs related to contracted inpatient services.

When a residential care unit is separate and distinct and only used for resident care services (such as hospice home care, i.e., routine or continuous, provided in a residential unit), report costs directly on line 66.

Lines 18 through 24.--Reserved for future use.

DIRECT PATIENT CARE SERVICE COST CENTERS

Direct patient care service costs (lines 25 through 46) are reported by LOC on Worksheets K-1, K-2, K-3, and K-4. For each cost center on Worksheet K, enter the sum of the amounts from Worksheets K-1, K-2, K-3, and K-4 for salaries, other costs, reclassifications, and adjustments in columns 1, 2, 4, and 6, respectively.

Line 25 - Inpatient Care - Contracted.--This cost center includes the contractual costs paid to another inpatient facility for use by the hospice for hospice inpatient care (HIRC or HGIP) in accordance with 42 CFR 418.108I. This cost center does not include the cost of any direct patient care services or nonreimbursable services provided by hospice staff in the contracted setting. Costs of any services provided by hospice staff in the contracted setting are included in the appropriate direct patient care service or nonreimbursable cost center. Costs in this cost center are excluded from the allocation of A&G costs.

Line 26 - Physician Services.--This cost center includes the costs incurred by the hospice for physicians, or nurse practitioners providing physician services, for direct patient care services and general supervisory services, participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care, and establishment of governing policies by the physician member of the interdisciplinary group. (See 42 CFR 418.304.) Reclassify the cost for the portion of time physicians, or nurse practitioners spent on general supervisory services or other hospice administrative activities to Physician Administrative Services (line 15). This cost center must not include costs associated with palliative care or other nonreimbursable physician services. Nonreimbursable physician services must be reported in the appropriate nonreimbursable cost center.

Line 27 - Nurse Practitioner (NP).--This cost center includes the costs of nursing care provided by NPs. Do not include costs for NPs providing physician services on this line; report the costs for nurse practitioners providing physician services on line 26.

Line 28 - Registered Nurse(RN).--This cost center includes the costs of nursing care provided by RNs other than nurse practitioners.

Line 29 - Licensed Practical Nurse (LPN).--This cost center includes the costs of nursing care provided by an LPN. Do not include costs for I services on this line; report the costs for I services on line 37.

Line 30 - Physical Therapy (PT).--This cost center includes the costs of physical or corrective treatment of bodily or mental conditions by the use of physical, chemical, and other properties of heat, light, water, electricity, sound massage, and therapeutic exercise by or under the direction of a physical therapist that meets the requirements set forth in 42 CFR 418.114, as prescribed by a physician. PT 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 31 - Occupational Therapy (OT).--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 provided by or under the direction of an occupational therapist that meets the requirements set forth in 42 CFR 418.114, as prescribed by a physician. OT 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 32 - Speech/Language Pathology (SLP).--This cost center includes the costs of physician-prescribed services provided by or under the direction of a speech/language pathologist who meets the requirements set forth in 42 CFR 418.114, to those with functionally impaired communications skills. This includes the evaluation and management of any existing disorders of the communication process centering entirely, or in part, on the reception and production of speech and language related to organic and/or nonorganic factors. SLP 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 33 - Medical Social Services.--This cost center includes the cost of medical social services defined in CMS Pub. 100-02, chapter 9, §40.1.2, including the costs of a social worker who meets the requirements set forth in 42 CFR 418.114. Reclassify costs for nonreimbursable activities included in this cost center to the appropriate nonreimbursable cost center.

Line 34 - Spiritual Counseling.--This cost center includes the cost of spiritual counseling services. Reclassify costs for nonreimbursable activities included in this cost center to the appropriate nonreimbursable cost center.

Line 35 - Dietary Counseling.--This cost center includes the costs of dietary counseling services.

Line 36 - Counseling - Other.--This cost center includes the cost of counseling services not identified as spiritual, dietary or bereavement counseling. Reclassify costs for nonreimbursable activities included in this cost center to the appropriate nonreimbursable cost center.

Line 37 - Hospice Aide & Homemaker Services.--This cost center includes the costs of:

- Hospice aide services such as personal care services and household services to maintain a safe and sanitary environment in areas of the home used by the patient; and,
- Homemaker services such as assistance in the maintenance of a safe and healthy environment and services to enable the individual to carry out the plan of care.

Include the cost of CNAs and homemakers that meet the criteria for a hospice aide and homemaker, as set forth at 42 CFR 418.114 in this cost center.

Line 38 - Durable Medical Equipment/Oxygen.--This cost center includes the costs of DME and oxygen, as defined in 42 CFR 410.38 and 42 CFR 418.202(f), furnished to individual HRHC or HCHC patients. Report DME costs by the LOC the patient was receiving at the time the DME/oxygen was delivered. If the LOC of a patient changed after delivery of the DME/Oxygen, the SNF-based hospice may report the costs proportionally between HRHC and HCHC based on patient days.

Line 39 - Patient Transportation.--This cost center includes the costs of ambulance transports of hospice patients, related to the terminal prognosis and occurring after the effective date of the hospice election, that are the responsibility of the SNF-based hospice. (See CMS Pub. 100-02, chapter 9, §40.1.9.) When a patient is transferred to a new LOC, report the transportation cost to that LOC. For example, a patient in a HGIP LOC is transferred to HRHC LOC and transported to their home; the transportation cost associated with this transfer must be included in the HRHC LOC.

Line 40 - Imaging Services.--This cost center includes the costs of imaging services.

Line 41 - Labs & Diagnostics.--This cost center includes the costs of laboratory and diagnostic tests.

Line 42 - Medical Supplies - Non-routine.--This cost center includes the costs of medical supplies furnished to individual patients for which a separate charge would be applicable. These supplies are specified in the patient's plan of treatment and furnished under the specific direction of the patient's physician. Do not include the cost of routine medical supplies used in the normal course of caring for patients, (such as gloves, masks, swabs, or glycerin sticks) on this line; report routine medical supplies on line 10. When a provider does not track the use of non-routine medical supplies by LOC, the provider may report the costs proportionally between LOCs based on patient days.

Line 43 - Drugs Charged to Patients.--This cost center includes the costs of drugs furnished to individual patients for which a separate charge would be applicable. These drugs are specified in the patient's plan of treatment and furnished under the specific direction of the patient's physician. When a provider does not track the use of drugs by LOC, the provider must report the costs on line 14.

Line 44 - Outpatient Services.--This cost center includes the costs of outpatient services not captured elsewhere. This cost can include the cost of an emergency room department visit when related to the terminal condition.

Lines 45 and 46 - Palliative Radiation Therapy and Palliative Chemotherapy.--These cost centers include costs of radiation, chemotherapy and other modalities used for palliative purposes based on the patient's condition and the hospice's caregiving philosophy.

Line 47 - Other Direct Patient Care Services.--Use this line to identify expenses for other direct patient care service costs not identified on lines 25 through 46.

Lines 48 through 49.--Reserved for future use.

Lines 50 through 53.--Reserved for use on Worksheet K-6, Parts I and II.

Lines 54 through 59.--Reserved for future use.

NONREIMBURSABLE COST CENTERS

Nonreimbursable cost centers (lines 60 through 71) 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 60 - Bereavement Program.--Enter in columns 1 and 2, the salary and other costs of bereavement services, defined as emotional, psychosocial, and spiritual support and services provided before and after the death of the patient to assist with grief, loss, and adjustment (42 CFR 418.3). Bereavement counseling is a required hospice service, but it is not reimbursable (see §1814(I)(1)(A) of the Act).

Line 61 - Volunteer Program.--Enter in columns 1 and 2, the salary and other costs of volunteer programs. (See CMS Pub. 15-1, chapter 7.)

Line 62 - Fundraising.--Enter in columns 1 and 2, the salary and other costs of fundraising. (See CMS Pub. 15-1, chapter 21, §2136.)

Line 63 - Hospice/Palliative Medicine Fellows.--Enter in columns 1 and 2, the salary and other costs of hospice and palliative medicine fellows.

Line 64 - Palliative Care Program.--Enter in columns 1 and 2, the salary and other costs of palliative care provided to non-hospice patients. This includes physician services.

Line 65 - Other Physician Services.--Enter in columns 1 and 2, the salary and other costs of other physician services that are provided outside of a palliative care program to non-hospice patients.

Line 66 - Residential Care.--Enter in columns 1 and 2, the salary and other costs of residential care for patients living in the hospice facility, but who are not receiving inpatient hospice services. Patients living in the hospice facility are considered residents, when the hospice facility is their home. These patients are liable for their room and board charges; however, the outpatient hospice care services provided must be recorded in the direct patient care cost centers on the appropriate HRHC and/or HCHC LOC worksheet.

Line 67 - Advertising.--Enter in columns 1 and 2, the salary and other costs of non-allowable community education, business development, marketing and advertising (see CMS Pub. 15-1, chapter 21, §2136).

Line 68 - Telehealth/Telemonitoring.--Enter in columns 1 and 2, the salary and other costs of telehealth/telemonitoring services. These costs are nonreimbursable since a hospice is not an approved originating site (see 42 CFR 410.78(b)(3)).

Line 69 - Thrift Store.--Enter in columns 1 and 2, the salary and other costs of thrift stores.

Line 70 - Nursing Facility Room and Board.--Enter the costs incurred by a SNF-based hospice for dually eligible beneficiaries residing in a NF when room and board is paid by the State to the SNF-based hospice. The full amount paid to the NF by the SNF-based hospice must be included on this line and offset by the State payment via an adjustment on Worksheet A-8. The residual cost is the net cost incurred.

For example, a dually eligible beneficiary residing in a NF and has elected the Medicare hospice benefit. The NF charges \$100 per day for room and board. The State pays the SNF-based hospice \$95 for the NF room and board. The SNF-based hospice has a written agreement with the NF that requires full room and board payment of \$100 per day. The SNF-based hospice receives \$95 per day, but pays the NF \$100 per day, thereby incurring a net cost of \$5 per day.

Line 71.--Use this line to identify expenses for other nonreimbursable costs not identified on lines 60 through 70.

Lines 72 through 99.--Reserved for future use.

4912.20 WORKSHEETS K-1 through K-4 - ANALYSIS OF SNF-BASED HOSPICE COSTS BY LEVEL OF CARE

- Worksheet K-1 - Analysis of SNF-Based Hospice Continuous Home Care
- Worksheet K-2 - Analysis of SNF-Based Hospice Routine Home Care
- Worksheet K-3 - Analysis of SNF-Based Hospice Inpatient Respite Care
- Worksheet K-4 - Analysis of SNF-Based Hospice General Inpatient Care

Worksheets K-1, K-2, K-3, and K-4, provide for recording the direct patient care costs by LOC, including reclassifications and adjustments. The general format of these worksheets is identical to Worksheet K in order to facilitate the transfer of direct patient care costs to Worksheet K. For each cost center, the sums of the amounts reported in columns 1, 2, 4, and 6 of these worksheets are transferred to the corresponding columns on Worksheet K.

Column 1--For each LOC worksheet, enter salaries from the provider's accounting books and records.

Column 2--For each LOC worksheet, enter all costs other than salaries from the provider's accounting books and records.

Column 3--For each cost center, add the amounts in columns 1 and 2 and enter the total in column 3.

Column 4--For each LOC worksheet, enter any reclassification of direct patient care service costs needed to effect proper cost allocation. For each line, the sum of the reclassification entries on Worksheets K-1, K-2, K-3, and K-4, column 4, must equal the amount on the corresponding line on Worksheet K, column 4.

Column 5--For each cost center, enter the total of the amount in column 3 plus or minus the amount in column 4.

Column 6--For each LOC worksheet, enter any adjustments for direct patient care service costs (lines 25 through 46) required under Medicare principles of reimbursement. Show reductions to expenses as negative amounts. For each line, the sum of the adjustment entries on Worksheets K-1, K-2, K-3, and K-4, column 6, must equal the amount on the corresponding line of Worksheet K, column 6.

Column 7--For each cost center, enter the total of the amount in column 5 plus or minus the amount in column 6. For each LOC worksheet, transfer the amount on line 100 to the corresponding LOC line on Worksheet K-5, column 1, as follows:

<u>From line 100 of:</u>	<u>To Worksheet K-5,</u> <u>column 1,</u>
Worksheet K-1	line 50
Worksheet K-2	line 51
Worksheet K-3	line 52
Worksheet K-4	line 53

4912.60 WORKSHEET K-5 - DETERMINATION OF SNF-BASED HOSPICE TOTAL EXPENSES FOR ALLOCATION

Worksheet K-5 determines total expenses of each general service cost center for proper allocation of general service costs to each LOC and to nonreimbursable cost centers. This worksheet combines the direct general service costs reported on Worksheet K, lines 1 through 16, with the overhead allocation of the SNF general service costs reported on Worksheet B, Part I, line 72, columns 1 through 18.

Column Descriptions

Column 1.--For each general service and nonreimbursable cost center, transfer the amount from the corresponding cost center on Worksheet K, column 7. For each LOC line, transfer amounts as follows:

<u>Line:</u>	<u>From column 7, line 100 of:</u>
50	Worksheet K-1
51	Worksheet K-2
52	Worksheet K-3
53	Worksheet K-4

The total on line 100, column 1, must equal the amount on Worksheet A, line 72, column 9.

Column 2.--For each general service cost center, transfer the amount from the corresponding column on Worksheet B, Part I, line 72, as follows:

<u>Line:</u>	<u>From Worksheet B, Part I, line 72, column**:</u>	<u>Line:</u>	<u>From Worksheet B, Part I, line 72, column**:</u>
1	1	10	10
2	2	11	12
3	3	12	N/A
4	4, 15, and 16*	13	N/A
5	5*	14	11
6	6	15	N/A
7	7	16	18
8	8	17	13, 14, and 17
9	9		

*NOTE: If Worksheet K-6, Part II, line 6, column 6, is zero (no in-facility days), then transfer the amounts from Worksheet B, Part I, line 72, columns 4, 5, 15, and 16, to line 4, column 2, of this worksheet; and enter zero on line 5, column 2, of this worksheet.

**If a general service cost center on Worksheet B, Part I, is subscripted, add the amounts on the standard cost center line and its corresponding subscripted lines, and transfer the sum total to column 2 of the applicable line on this worksheet.

Column 3.--For each line, enter the sum of columns 1 and 2. The total on line 100, column 3, must equal the amount on Worksheet B, Part I, line 72, column 21. Transfer the amount from each cost center to the corresponding line on Worksheet K-6, Part I, column 0.

4912.70 WORKSHEET K-6 - PART I - COST ALLOCATION OF SNF-BASED HOSPICE GENERAL SERVICE COSTS AND PART II - COST ALLOCATION OF SNF-BASED HOSPICE GENERAL SERVICE COSTS - 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.

Worksheet K-6, Parts I and II, facilitate the step-down method of cost finding. This method recognizes that the general service costs of the SNF-based hospice are utilized by other general service cost centers, LOC cost centers, and nonreimbursable cost centers. Worksheet K-6, Part I, provides for the equitable allocation of general service costs based on statistical data reported on Worksheet K-6, Part II. To facilitate the allocation process, the general format of Worksheet K-6, Part I, is identical to that of Worksheet K-6, Part II (i.e., the column and line numbers for each general service cost center are identical on the two worksheets). The direct patient care service cost centers (lines 25 through 47 of Worksheet K) are reported by LOC on Worksheet K-6, Parts I and II, lines 50 through 53. The line numbers for nonreimbursable cost centers are identical on Worksheet K and Worksheet K-6, Parts I and II.

When certain general service costs are related to in-facility days and are not separately identifiable by LOC or service, Worksheet K-6, Parts I and II, provide for the accumulation of these costs on line 17, Patient/Residential Care Services. The amounts accumulated in this cost center are allocated based on the in-facility days for HIRC, HGIP, and residential care services that are not part of a separate and distinct residential care unit. This cost center does not include any costs related to contracted inpatient services.

The statistical basis shown at the top of each column on Worksheet K-6, Part II, 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. A SNF-based hospice can elect to change the order of allocation and/or allocation statistics, as appropriate, for the current cost reporting period if a request is submitted in accordance with CMS Pub. 15-1, chapter 23, §2313.

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 SNF-based hospice must request approval in accordance with CMS Pub. 15-1, chapter 23, §2313.

If the amount of any cost center on Worksheet K-5, column 3, has a negative balance, this amount must be reported as a negative balance on Worksheet K-6, Part I, column 0. Allocate the costs from the overhead cost centers to applicable cost centers, including those with a negative balance. After receiving costs from the overhead cost centers, if a general service cost center has a negative balance at the point it is to be allocated, such general service cost center must not be allocated. Close a general service cost center with a negative balance by entering the negative balance in parentheses on line 99, the first line of the column and on line 100 and do not allocate. This enables Worksheet K-6, Part I, line 100, column 18, to cross foot to Worksheet K-6, Part I, line 100, column 0. After receiving costs from overhead cost centers, LOC cost centers with negative balances on Worksheet K-6, Part I, column 18, are not transferred to Worksheet K-8.

On Worksheet K-6, Part II, enter on the first available line of each column, the total statistics applicable to the cost center being allocated (e.g., in column 1, Capital Related-Building & Fixtures enter on line 1 the total square feet of the building on which depreciation was taken). Use accumulated cost for allocating A&G expenses.

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 SNF-based hospice's books/records; or
- The contractor determines that the SNF-based hospice 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 SNF-based hospice had furnished such services directly to all patients. (See CMS Pub. 15-1, chapter 23, §2314.)

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.

For each column on Worksheet K-6, Part II, line 101, enter the total expenses of the cost center to be allocated. Obtain the total expenses from the first line of the corresponding column on Worksheet K-6, Part I, which includes the direct expenses from Worksheet K-6, Part I, column 0, plus the allocated costs from previously closed cost centers. Divide the amount entered on Worksheet K-6, Part II, line 101, by the total statistical base entered in the same column on the first line. Enter the resulting unit cost multiplier (rounded to six decimal places) on line 102.

For each column on Worksheet K-6, Part II, multiply the unit cost multiplier on line 102 by the portion of the total statistical base applicable to each cost center receiving services and enter the result in the corresponding column and line on Worksheet K-6, Part I. For each column on Worksheet K-6, Part I, the sum of the costs allocated (line 100) must equal the total cost on the first line.

After the costs of the general service cost centers have been allocated on Worksheet K-6, Part I, enter on each line of column 18, the sum of the costs in columns 3A through column 17, for lines 50 through 71. The total costs entered on Worksheet K-6 Part I, line 100, column 18, must equal the total costs entered on line 100, column 0.

Column Descriptions

Column 0.--For each line, enter the total direct costs from the corresponding line on Worksheet K-5, column 3.

Column 3A.--For each line, enter the sum of columns 0 through 3. The sum for each line is the accumulated cost and, unless an adjustment is required, is the Worksheet K-6, Part II, column 4, statistic for allocating A&G costs.

If an adjustment to the accumulated cost statistic on Worksheet K-6, Part II, column 4, is required to properly allocate A&G costs, enter the adjustment amount on Worksheet K-6, Part II, column 4A, for the applicable line. For example, when the SNF-based hospice contracts for HIRC or HGIP services and the contractual costs include A&G costs, the contractual costs reported on Worksheet K-3, line 25, column 7, or Worksheet K-4, line 25, column 7, may be used to reduce the accumulated cost statistic in column 4A on Worksheet K-6, Part II, line 52 and line 53, respectively.

For each line, the accumulated cost statistic on Worksheet K-6, Part II, column 4, is the difference between the amount on Worksheet K-6, Part I, column 3A, and the adjustment amount on Worksheet K-6, Part II, column 4A. Accumulated cost for A&G is not included in the total statistic for the A&G cost center; therefore, transfer the amount on Worksheet K-6, Part I, line 4, column 3A, to Worksheet K-6, Part II, line 4, column 4A.

The total accumulated cost statistic for Worksheet K-6, Part II, line 4, column 4, is the difference between the total on Worksheet K-6, Part I, line 100, column 3A, and the amounts in Worksheet K-6, Part II, column 4A.

A negative cost center balance in the statistics for allocating A&G expenses causes an improper distribution of this overhead cost center. Negative balances are excluded from the allocation statistics when A&G expenses are allocated based on accumulated cost.

Column 18.--Transfer the amounts on lines 50 through 53 as follows:

<u>From Worksheet K-6, Part I, column 18:</u>	<u>To Worksheet K-8, column 3:</u>
line 50	line 1
line 51	line 6
line 52	line 11
line 53	line 16

4912.80 WORKSHEET K-7 - APPORTIONMENT OF SNF-BASED HOSPICE SHARED SERVICE COSTS BY LEVEL OF CARE

This worksheet calculates the cost of ancillary services provided by SNF ancillary departments to SNF-based hospice patients.

Column Description

Column 1.--For each cost center, enter in column 1, the cost-to-charge ratio from Worksheet C, column 3, line as indicated in column 0.

Columns 2 through 5.--For each cost center, enter the charges, from the provider records, for ancillary services provided by SNF ancillary departments to SNF-based hospice patients. Enter the charges by LOC in the appropriate LOC column.

Line 8, column 1.--To calculate the cost to charge ratio to be applied to drugs charged to patients, add the costs on Worksheet C, column 1, lines 41 and 42, to establish department level costs and then add the charges found in column 2, lines 41 and 42, to establish department level charges. Divide the total departmental cost by the total departmental charges and enter the result in column 1.

Line 10, columns 2 through 5.--Combine the charges for palliative radiation therapy and chemotherapy, from the SNF based-hospice's records, to ensure that all radiology-therapeutic charges are subject to the radiology therapeutic/chemotherapy CCR from Worksheet C, line 31, column 3.

Columns 6 through 9.--For each line within each column, calculate cost of ancillary services provided by SNF ancillary departments to SNF-based hospice patients as follows:

<u>Column:</u>	<u>Calculation:</u>
6	col. 1 multiplied by col. 2
7	col. 1 multiplied by col. 3
8	col. 1 multiplied by col. 4
9	col. 1 multiplied by col. 5

For each column 6 through 9, enter the sum of lines 1 through 13 on line 20.

4912.90 WORKSHEET K-8 - CALCULATION OF SNF-BASED HOSPICE PER DIEM COST

Worksheet K-8 calculates the average cost per diem by LOC and in total.

Line 1.--Enter in column 3 the total HCHC cost from Worksheet K-6, Part I, line 50, column 18, plus Worksheet K-7, line 20, column 6.

Line 2.--Enter in column 3 the total HCHC days from Worksheet S-5, Part I, line 1, column 4.

Line 3.--Enter in column 3 the average HCHC cost per diem by dividing line 1, column 3, by line 2, column 3.

Line 4.--Enter in column 1 the title XVIII - Medicare HCHC days from Worksheet S-5, Part I, line 1, column 1. Enter in column 2 the title XIX - Medicaid HCHC days from Worksheet S-5, Part I, line 1, column 2.

Line 5.--Enter in column 1 the title XVIII - Medicare program cost calculated by multiplying line 3, column 3, by line 4, column 1. Enter in column 2 the title XIX - Medicaid program cost calculated by multiplying line 3, column 3, by line 4, column 2.

Line 6.--Enter in column 3 the total HRHC cost from Worksheet K-6, Part I, line 51, column 18, plus Worksheet K-7, line 20, column 7.

Line 7.--Enter in column 3 the total HRHC days from Worksheet S-5, Part I, line 2, column 4.

Line 8.--Enter in column 3 the average HRHC cost per diem by dividing line 6, column 3, by line 7, column 3.

Line 9.--Enter in column 1 the title XVIII - Medicare HRHC days from Worksheet S-5, Part I, line 2, column 1. Enter in column 2 the title XIX - Medicaid HRHC days from Worksheet S-5, Part I, line 2, column 2.

Line 10.--Enter in column 1 the title XVIII - Medicare program cost calculated by multiplying line 8, column 3, by line 9, column 1. Enter in column 2 the title XIX - Medicaid program cost calculated by multiplying line 8, column 3, by line 9, column 2.

Line 11.--Enter in column 3 the total HIRC cost from Worksheet K-6, Part I, line 52, column 18, plus Worksheet K-7, line 20, column 8.

Line 12.--Enter in column 3 the total HIRC days from Worksheet S-5, Part I, line 3, column 4.

Line 13.--Enter in column 3 the average HIRC cost per diem by dividing line 11, column 3, by line 12, column 3.

Line 14.--Enter in column 1 the title XVIII - Medicare HIRC days from Worksheet S-5, Part I, line 3, column 1. Enter in column 2 the title XIX - Medicaid HIRC days from Worksheet S-5, Part I, line 3, column 2.

Line 15.--Enter in column 1 the title XVIII - Medicare program cost calculated by multiplying line 13, column 3, by line 14, column 1. Enter in column 2 the title XIX - Medicaid program cost calculated by multiplying line 13, column 3, by line 14, column 2.

Line 16.--Enter in column 3 the total HGIP cost from Worksheet K-6, Part I, line 53, column 18, plus Worksheet K-7, line 20, column 9.

Line 17.--Enter in column 3 the total HGIP days from Worksheet S-5, Part I, line 4, column 4.

Line 18.--Enter in column 3 the average HGIP cost per diem by dividing line 16, column 3, by line 17, column 3.

Line 19.--Enter in column 1, the title XVIII - Medicare HGIP days from Worksheet S-5, Part I, line 4, column 1. Enter in column 2, the title XIX - Medicaid HGIP days from Worksheet S-5, Part I, line 4, column 2.

Line 20.--Enter in column 1 the title XVIII - Medicare program cost calculated by multiplying line 18, column 3, by line 19, column 1. Enter in column 2 the title XIX - Medicaid program cost calculated by multiplying line 18, column 3, by line 19, column 2.

Line 21.--Enter in column 3 the sum of lines 1, 6, 11, and 16.

Line 22.--Enter in column 3 total days from Worksheet S-5, Part I, line 5, column 4.

Line 23.--Enter the average cost per diem by dividing line 21, column 3, by line 22, column 3.

Form CMS-2540-24 Worksheets

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