# Fundamental Concepts of Hospital Medicare Cost Reports: How and Why?

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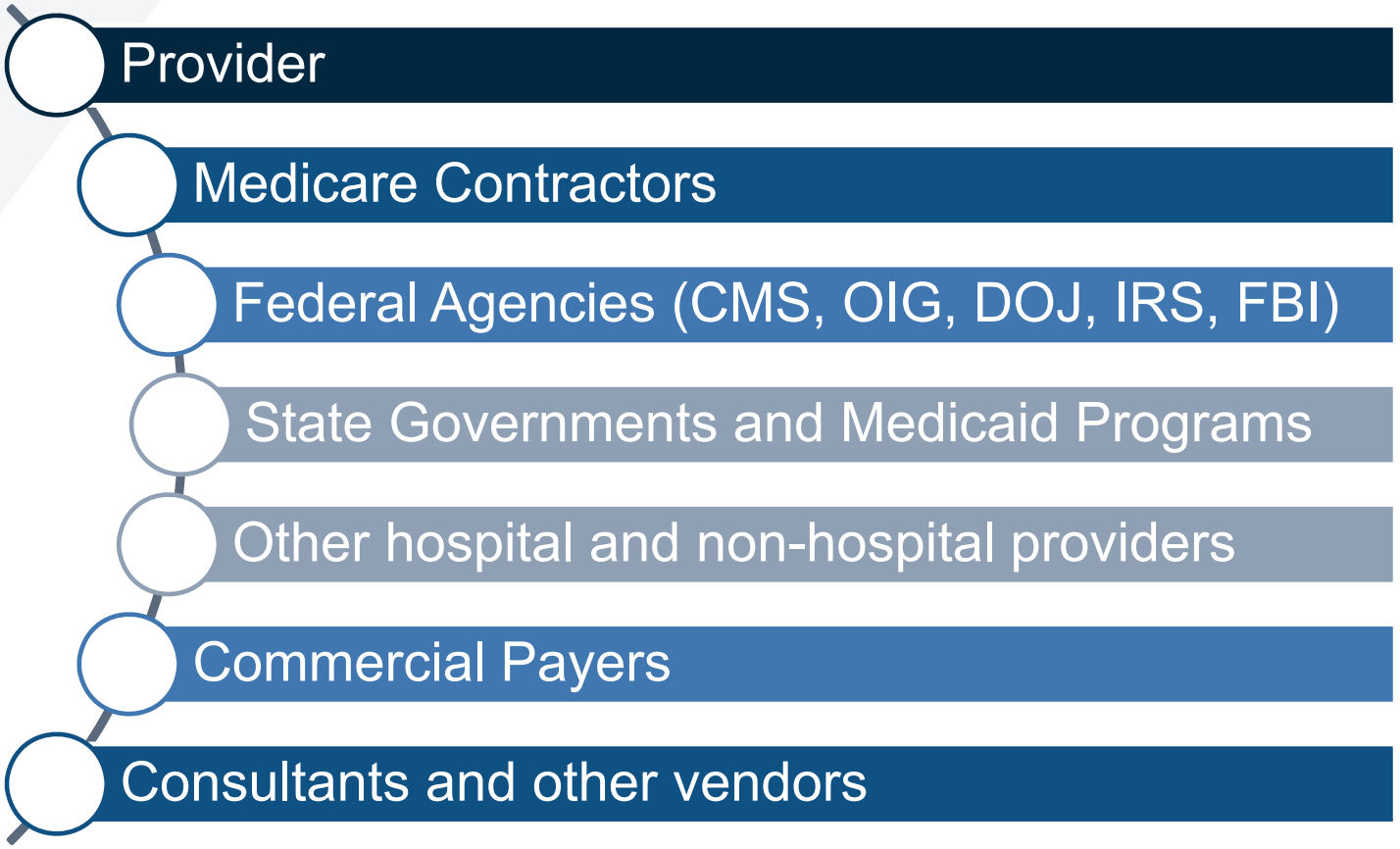
# Why file a Medicare Cost Report?

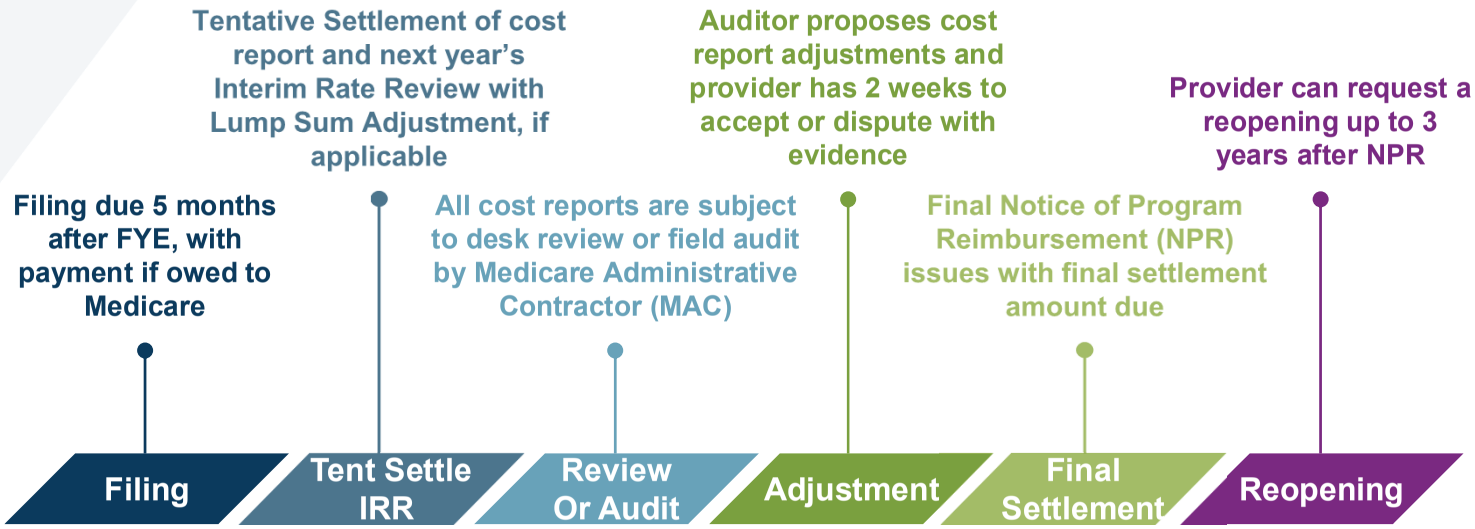
- Required in order to participate in Medicare and Medicaid programs
- To determine settlement amounts due to/from Medicare
- Used to establish payment rates
  - Future payment rates under Prospective Payment Systems (PPS)
  - Interim payment rates for cost-based reimbursement systems
- Various exception requests and determinations
- May have impact on Medicaid payments
  - varies by state

# Who Uses Medicare Cost Reports?

Filed and Settled Medicare Cost Reports are publically available under the Freedom of Information Act



# What happens after filing a Cost Report?




**Providers can file amended cost reports before the initial NPR is issued, with exceptions related to wage index and DSH*

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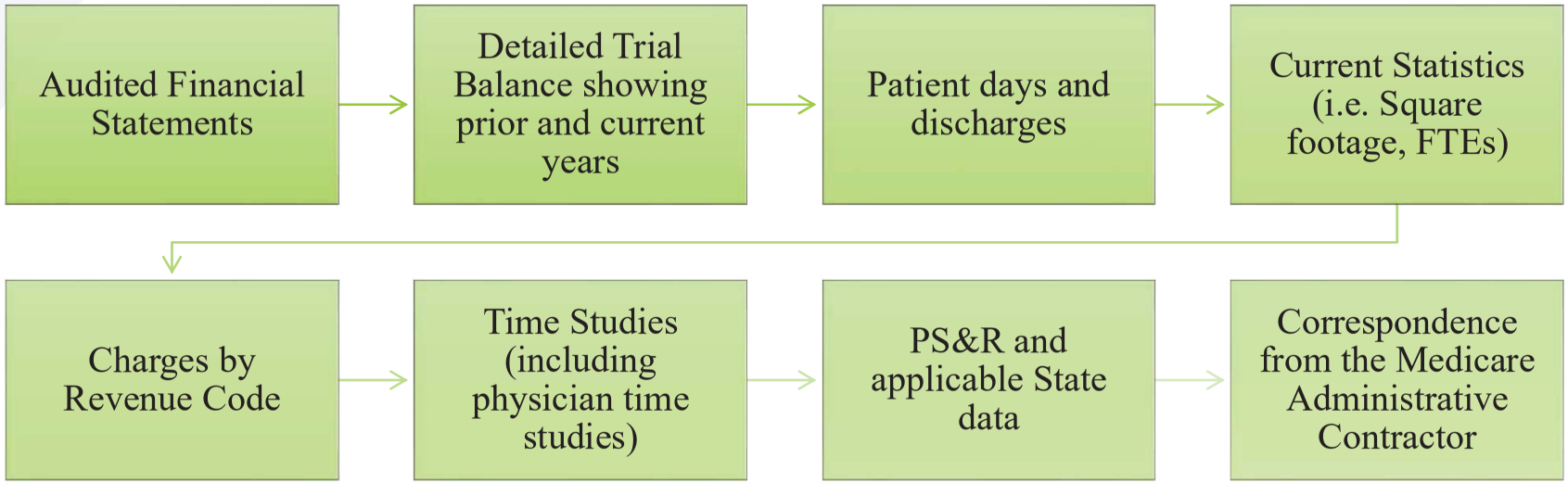
# All Cost Reports Are Reviewed by the MAC

- All filed Medicare cost reports are subject to review by the Medicare Administrative Contractor
- May be a desk review or field audit
- Maintain all documentation used in its preparation
- Organize your documentation so that when records are requested, or the audit team arrives, they are readily available
- Prepare your cost report with confidence that it will withstand audit scrutiny

# Before You Start

- Review prior year's filed Medicare cost report
- Review most recent audit adjustment report
- Updated Cost Report Software
- Gather necessary documents and reports:



# Cost Report Worksheets

| Series | Description |
|---|---|
| S Series | Certification, Informational, Statistical Data, Wage Index, Uncompensated Care |
| A Series | Expenses |
| B Series | Cost Allocation - Statistical Bases |
| C Series | Computation of ratios of Costs to Charges |
| D Series | Cost Apportionments to Program |
| E Series | Calculation of Reimbursement Settlements |
| G Series | Financial Statements |
| H Series | Home Health & Hospice |
| I Series | Renal Dialysis |
| L Series | Capital Payment (PPS Hospitals) |
| M Series | RHC/FQHC Reimbursement |

# Worksheet S Series

| | |
|---|---|
| Worksheet S | Certification & Settlement |
| Worksheet S-2 Part I<br>Worksheet S-2 Part II | Identification Data<br>Reimbursement Questionnaire |
| Worksheet S-3 Part I | Statistical Data |
| Worksheet S-3 Parts II, III<br>Worksheet S-3 Part IV<br>Worksheet S-3 Part V | Wage Index Information (PPS Hospitals Only)<br>Hospital Wage Related Costs<br>Contract Labor and Benefit Costs (PPS Hospitals Only) |
| Worksheet S-4 | Home Health Agency Statistical Data |
| Worksheet S-5 | Renal Dialysis Statistical Data |
| Worksheet S-6 | CORF Statistical Data & FTEs |
| Worksheet S-7 | PPS SNF Statistical Data |
| Worksheet S-8 | RHC/FQHC Statistical Data |
| Worksheet S-9 | Hospice Identification Data |
| Worksheet S-10 | Uncompensated and Indigent Care Data |

# S-2, Part I: Identification Data

Read carefully and answer every question!

- Determines how reimbursement will be calculated for Medicare (Title XVIII) and Medicaid (Title XIX)
- Triggers which worksheets must be completed, examples:
  - Line 105 – Critical Access Hospital → E-3 Part V
  - Line 109 – Therapy services from outside providers → A-8-3
  - Line 140 – Related organizations → A-8-1
  - Line 144 – Hospital-based physicians → A-8-2
- Don't forget to update these inputs:
  - Line 24 – Medicaid days for DSH
  - Line 118.01 – Malpractice premiums and paid losses
  - Lines 167-171 – Meaningful user status

# S-2, Part II: Reimbursement Questionnaire

Formerly CMS Form 339

- Must be completed by all hospitals
- Designed to answer questions about key reimbursement concepts and to gather supporting information
- Lines 1 - 21 are required for all hospitals
  - Provider Organization and Operation
  - Financial Data and Reports
  - Approved Education Activities
  - Bad Debts
  - Bed Compliment
  - PS&R Data

# S-2, Part II: Reimbursement Questionnaire

Formerly CMS Form 339

- Lines 22 - 40 are required for cost reimbursed hospitals only
  - Capital Related Cost
  - Interest Expense
  - Purchased Services
  - Provider Based Physicians
  - Home Office Costs
- Lines 41 – 43 are optional to include the cost report preparer contact information

# S-3, Part I: Statistical Data

- Beds at the end of the cost report period
- Available bed days adjusted for:
  - Any changes in available beds during the year
  - Leap year
  - Temporary expansion beds for COVID-19 from 3/1/2020 thru the end of the PHE (look out for new Line 34 coming soon)
- CAH hours from Hospital's Health Information System
  - Review to ensure compliance with 96 Hour rule
- Days and Discharges by Unit and sub-providers
  - Title XVIII (PS&R data) and XIX days and discharges (S-2 for DSH days)
  - Swing Bed SNF = PS&R Title XVIII days, Swing Bed NF = All other Swing Bed days
  - HMO days
- Observation hours converted to days

# S-3, Parts II-V: Wage Index Information


- Wage index calculation for PPS hospitals
  - Part IV Wage Related Costs is required for CAH facilities with IPPS providers
- Used to set future period PPS rates
- Things to remember…
  - Incorporate any prior period audit adjustments
  - Review your Average Hourly Wages compared to last year
  - Hours from payroll detail - incorporate reclassifications and adjustments
  - Physicians – administrative (Part A) allocation must be supported by time studies
  - Home Office – report salaries, hours, fringes & contract labor
  - Related Parties – report salaries, hours, fringes & contract labor
  - Contract Labor – include direct patient care & executive, administrative, dietary and housekeeping, physician administrative services

# S-10: Uncompensated Care & Indigent Care

- Computes indigent care programs shortfall and cost of uncompensated care
  - Uses Hospital cost to charge ratio (CCR)
- Drives reimbursement
  - Uncompensated care payment (PPS with DSH)
- Read the Instructions!
- Medicaid Shortfall
  - Net Medicaid reimbursement
  - Exclude physician and other professional services
  - Medicaid cost = Medicaid charges x CCR

# S-10: Uncompensated Care

## Definition of Uncompensated Care

- Charity care and uninsured discounts
- Non-Medicare bad debt
- Unreimbursed Medicare bad debt
- Includes all non-professional providers under hospital agreement
- Excludes physicians and professional services
- Excludes Medicaid and Indigent Care program shortfalls

# S-10: Uncompensated Care

## Charity Care Charges and Payments

- Line 20 – Charity Care Charges
  - Write-offs in cost report period, regardless of service date
  - Exclude courtesy discounts and charity related to professional fees (physicians and non-physician providers)
  - Column 1 – Uninsured Patients
    - Uninsured or coverage under plan without a contractual relationship with provider
    - Charges patient is not responsible for paying
  - Column 2 – Insured Patients
    - Deductible and coinsurance amount
- Line 22 – Charity Care Payments
  - Patient payment for patients included on Line 20

# S-10: Uncompensated Care

Total Bad Debts – Line 26

- Total facility bad debts, net of recoveries
- Write-offs in cost report period
- Include gross Medicare bad debts from settlement pages
- Include patient responsibility only
- Exclude amounts due from insurers
- Exclude physician and professional services
- Do not duplicate charity care amounts

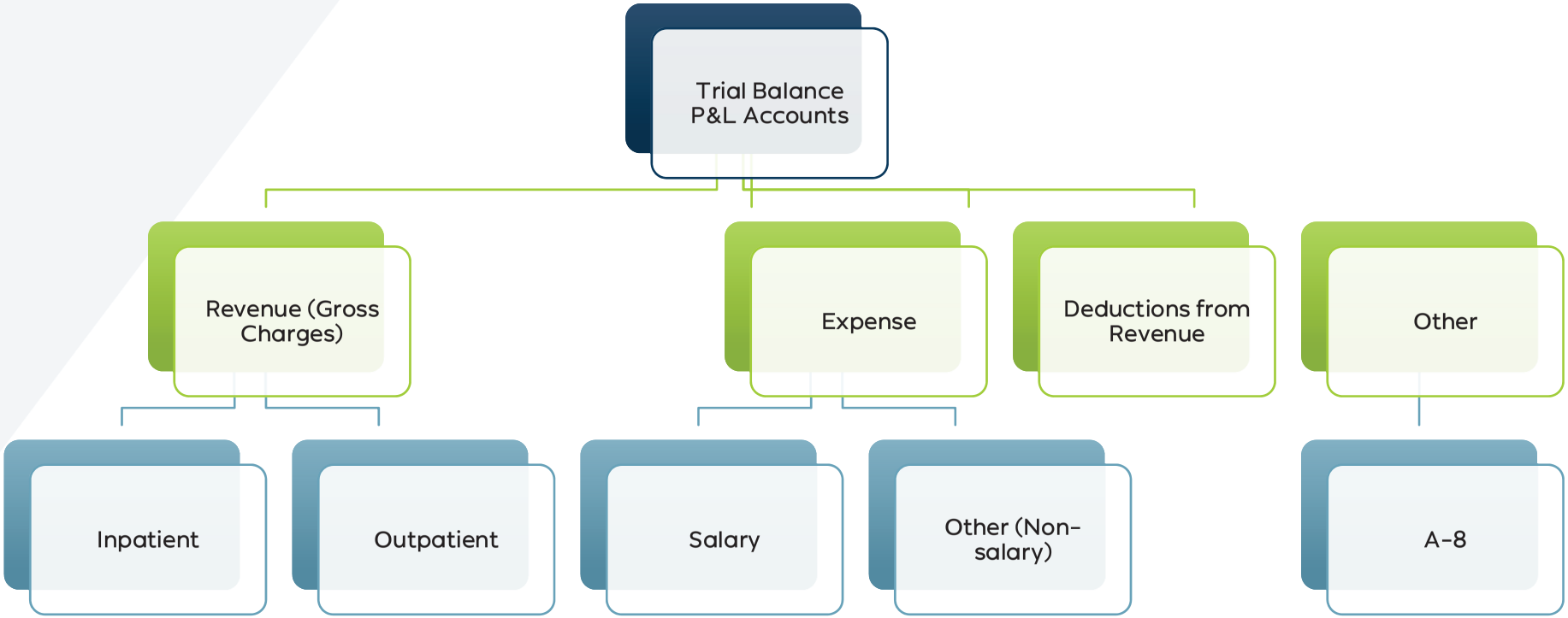
# Worksheet A Series: Expenses

| Worksheet | Description |
|---|---|
| A | Trial Balance |
| A-6 | Reclassifications |
| A-7 | Capital Assets & Capital-Related Costs |
| A-8 | Adjustments |
| A-8-1 | Related Organizations |
| A-8-2 | Hospital Based Physicians |
| A-8-3 | Contracted Therapy Services-CAHs |

- Assign direct expenses to Medicare cost centers
- Reclassify costs for appropriate matching with charges or assign cost to overhead or non-reimbursable cost centers
- Adjust costs to remove amounts not deemed allowable by Medicare
- Calculates Net Expenses for Allocation

# Worksheet A Series: Mapping the Trial Balance

Create a mapping file to assign Trial Balance accounts to cost report worksheets, lines, and columns

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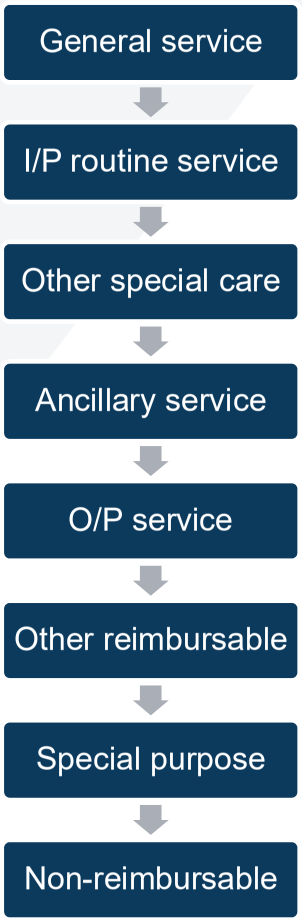
# Worksheet A Series: Mapping the Trial Balance

Important to maintain consistent cost center mapping throughout the cost report!




- Establish or update a crosswalk of hospital departments to Medicare cost centers ("Lines")
  - General Service (Capital, Benefits, Admin, Plant Ops, Housekeeping, Dietary, Nursing Admin, Central Services, HIM, Social Services, etc.)
  - Inpatient Routine Costs (Med/Surg, OB, ICU, Nursery, IPF, IRF)
  - Ancillary Services (OR, Radiology, Lab, Therapy, Supplies, Drugs, etc.)
  - Outpatient Services (Clinics, ED)
  - Special Purpose (Interest)
  - Non-Reimbursable Cost Centers (Private Phys Practice, gift shop, etc.)
- Select the Medicare cost center that:
  - Best aligns the department's costs and charges with Medicare charges by revenue code (revenue codes are limited)
  - Results in the most appropriate allocation of general services cost (overhead) and facilitates the application of Medicare's principles of reimbursement

# Worksheet A: Expenses from Trial Balance

Complete using the Mapped Trial Balance file

- Assign all expense accounts to Worksheet A lines and columns
  - Column 1 = Salaries,  Column 2 = Other (all non-salary, including contracted labor)
- Reconcile Worksheet A Total Expenses to Audit Financial Statements (filing requirement)
- Review expenses by Medicare cost center line
  - Are mappings consistent with the prior year or most recent Medicare audit or review? If changes are necessary, be sure to follow the mapping change all the way through the cost report (reclassifications, adjustments, stats, charges)
  - Did you invest in new construction or renovation that warrants subscripting of capital cost center(s)?
  - Are overhead costs assigned to non-overhead cost centers? If so, either correct in mapping of expense accounts or reclassify in Worksheet A-6
  - Are all expenses related to patient chargeable supplies, implants, and drugs assigned to Lines 71, 72, or 73?  Are supply costs NOT charged to patients assigned to the appropriate department's cost center?
  - Remember: It's important to matching costs with Medicare charges

# Worksheet A-6: Reclassification of Expenses

Purpose: matching costs with charges or assigning to overhead or non-reimbursable cost centers

## General Service Costs (Overhead):

- Capital related costs to Lines 1-3
  - Depreciation allocated to clinics or other departments
  - Subscripting Line 1 for more accurate costing (for example a new building or renovation, physician practices, or RHCs)
  - Property insurance
- Interest expense from Line 133 to Admin and Capital
- Physician cost for administrative roles (CMO, Director stipends)
- Provider benefits and malpractice insurance cost
  - Reclassify to the cost center where the provider's wages are reported
    - *Tip: Use actual benefits rather than a hospital-wide benefit %*
- Cafeteria costs from Dietary (Line 10) to Cafeteria (Line 11)
  - Use count of meals service as allocation basis
  - Option to do this via A-6 Reclass or via B-1 Cost Allocation Statistic

# Worksheet A-6: Reclassification of Expenses, continued

Purpose: matching costs with charges or assigning to overhead or non-reimbursable cost centers

## Matching costs with charges:

- Birthing Center cost allocated between OB (Line 30), Nursery (Line 43), and Labor & Delivery (Line 52)
- Imaging costs allocated between Radiology (Line 54), MRI (Line 58), and CT Scan (Line 57)
- Clinic ancillary service costs should go to ancillary service cost center(s)
  - Common examples: Radiology to Line 54 and lab services to Line 60
- Cost of chargeable supplies and implantable devices to Lines 71 and 72
- Carefully review departmental charges by UB revenue code for Worksheet C and PS&R to ensure that related costs are reported in the same cost center

# Worksheet A-6: Reclassification of Expenses, continued

Purpose: matching costs with charges or assigning to overhead or non-reimbursable cost centers

## Non-reimbursable cost centers:

- Determine if non-reimbursable costs need to be reclassified to their own cost center in Worksheet A-6 or simply adjusted out in Worksheet A-8
  - Reclassify if general service costs (overhead) should be applied
  - Adjust if direct and any overhead costs attributable are not significant
- Conduct a full review of Marketing and Development Expenses
  - Important to know the regulations for what is considered allowable and what is non-allowable
  - Is a media publication an announcement for the benefit of patients or is it intended to increase business and attract new patients?
- Childcare costs allocated among employee benefits (Line 4) and community (non-reimbursable cost center)

# Worksheet A-8: Adjustments

- Adjustments are necessary to exclude:
  - Costs unrelated to providing patient care
  - Costs not deemed reasonable or necessary
  - Costs reimbursed by other sources of income
  - Costs reimbursed under Part B (Physician Fee Schedule)
  - Other adjustments necessary under the Medicare principles of reimbursement
- Adjustments are entered on the basis of cost (code A) or amount received (code B).
- Capital costs adjustments are assigned a Worksheet A-7 Reference (9-14) that indicates the type of capital cost
- Generally entered as negative amount, but some adjustments may increase cost. They should be well documented
- Non-reimbursable cost centers on Lines 19x.xx are not typically adjusted

# Worksheet A-8: Adjustments – Investment Income

Interest expense must be reduced by certain investment income

- Limit the interest income adjustment to no more than total allowable interest expense
- Allocate the adjustment ratably to allowable interest by cost center (Admin and Capital cost centers)
- Investment income from the following sources does not require offset:
  - Grants, gifts, and endowments, whether restricted or unrestricted
  - Funded depreciation account
  - Qualified pension or deferred compensation funds
  - Non-allowable borrowing (separately adjusted)
  - Other exclusion

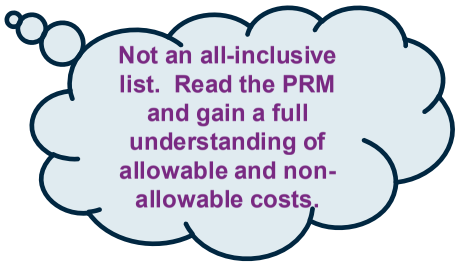
# Worksheet A-8: Adjustments – Other Revenue

Other operating or non-operating income required to offset cost

- Carefully review all other operating and non-operating income accounts to determine if they should offset cost. Document reasons for not offsetting
  - Do not offset income related to grants, non-reimbursable cost center, contribution revenue
  - Be careful not to have income adjustments that are greater than the costs you are offsetting
- Common revenue required to offset cost:
    - Trade discounts, refunds, rebates
    - Cafeteria meals revenue
    - Vending machine income
    - Rental revenue
    - Medical records sales
    - Sale of supplies or drugs to non-patients
    - Other miscellaneous revenue

# Worksheet A-8: Unallowable Costs & Other Adjustments

Costs unrelated to patient care or deemed not allowable for reimbursement




- Patient convenience or luxury items
- Lobbying costs included in Hospital Association dues, legal fees
- Penalties, fines, and/or interest on Medicare overpayments
- Cost of unnecessary borrowing - deemed to be in excess of financial need or unrelated to patient care
- Unallowable advertising intended to increase business and attract new patients
- Defined benefit pension expenses must be adjusted to actual contributions, subject to limitation
- 340(b) retail drug program costs

# Worksheet A-8: Adjustments – Professional Costs

Professional costs are excluded from the cost report as they are reimbursed under Medicare Part B

- Part B billing costs – paid on Fee Schedule
  - Don't forget to include benefit cost of employed billing staff
  - If hospital and phys practice billing are all done by the same staff, allocate based on gross charges
- Non-Physician Providers (NPPs) – CRNAs, PAs, NPs, etc.
  - Salaries, non-statutory benefits, malpractice, CME, dues, contracted NPPs
  - Benefits adjusted should not include FICA, workers' comp, unemployment
  - Note: NPPs adjusted in Wkst A-8, Physicians adjusted in Wkst A-8-2

# Worksheet A-8-2: Provider Based Physicians Adjustment

- Reports allowable provider-based physician (PBP) costs and adjusts Part B physician costs on Worksheet A-8
  - Excludes Professional component – services provided directly to patients (reimbursed under Part B, Physician Fee Schedule)
  - Allows Provider component (Part A) – administrative support services such as directorships, supervision, availability/on-call, quality management, committee assignments, etc.
  - Subject to limitation based on reasonable compensation equivalents (RCE) established for various specialties (CAH's exempt)
- Total Remuneration includes salaries, certain benefits, CME, dues, licensure, malpractice, contracted physicians
  - Benefits – do not include statutory benefits (FICA, unemployment, workers' comp)
  - Obtain actual benefit costs for each physician rather than using hospital wide percentage
- Hours must be reported for employed and contracted physician time to compute the RCE adjustment

# Worksheet A-8-2: Provider Based Physicians Adjustment

- All PBP cost/time is considered Professional Part B time unless adequately documented as Provider Part A time
- Time study requirements:
  - One full work week per month of the year
  - Must use alternating weeks, not consecutive weeks (example: Week 1 in Month 1, Week 3 in Month 2, Week 2 in Month 3, etc.)
  - Must be signed by the physician or physician's chief
  - Complete Exhibit 1: Allocation of PBP Time for each physician or group of physicians in the same specialty
  - Ensure that Exhibit 1 agrees to the % of Part A time used to derive Provider component remuneration and hours on Wrkst A-8-2
- CAH's Emergency Department physician availability time
  - Time that ED physicians are not providing patient care services, but are on-call or available for patient care
  - Time study, ED log, Real-time location system (RTLS) to track availability

# Worksheets A-8-1 and A-8-3

- A-8-1 Related party costs are includable as allowable costs at the cost to the related party
  - Home Office Cost Statement - allocation by cost center
  - Other related party costs – adjusted to actual allowable cost
    - Common examples: Intercompany Rent, Shared Services
- A-8-3 Limitation on Therapy Services provided by an outside supplier to CAHs
  - PT, OT, Speech Therapy, and Respiratory Therapy
  - Accumulate invoice level details for cost, hours worked, travel time, mileage, # of days onsite, etc.
  - Uses Average Hourly Salary Equivalency Amount (AHSEA)
    - CMS Pub. 15-1, Chapter 14, §1412.5, Exhibit C-1 per State
    - Monthly inflation factor from Exhibit C-3 (as of beginning of period)
  - Additional allowance for travel, overtime, supplies, and equipment

# Worksheet B Series: Allocation of General Service Costs

| Column | Descriptions |
|---|---|
| Worksheet B Part 1 | Cost Allocation General Service Costs |
| Worksheet B Part II | Allocation of Capital-Related Costs |
| Worksheet B-1 | Cost Allocation-Statistical Bases |
| Worksheet B-2 | Post Step-down Adjustments |

# Worksheet B, Part I: Cost Allocation – General Service Costs

No input required. Displays the calculated allocation of General Service Costs, "stepped down" based on statistics entered in Worksheet B-1

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 20-1303 Period From: 1/1/2020 To: 12/31/2020 Worksheet B, Part I

| | Cost Center Description | Net Expenses for Cost Allocation (from Wkst A col. 7) | CAPITAL RELATED COSTS | | | | | ADMINISTRATIVE & GENERAL | OPERATION OF PLANT | OPERATION OF PLANT-MOB | LAUNDRY & LINEN SERVICE | HOUSEKEEPING | DIETARY | CAFETERIA | NURSING ADMINISTRATION | PHARMACY | MEDICAL RECORDS & LIBRARY | SOCIAL SERVICE | Subtotal | Intern & Res | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 0 | NEW BLDG & FIXT 1 | MOB 1.01 | NEW MVBLE EQUIP 2 | EMPLOYEE BENEFITS DEPARTMENT 4 | Subtotal 4A | 5 | 7 | 7.01 | 8 | 9 | 10 | 11 | 13 | 15 | 16 | 17 | 24 | 25 | 26 |
| | GENERAL SERVICE COST CENTERS | | | | | | | | | | | | | | | | | | | | |
| 1 | 100 NEW CAP REL COSTS-BLDG & FIXT | 240,729 | 240,729 | | | | | | | | | | | | | | | | | | |
| 1 | 101 CAP REL COSTS-MOB | 33,006 | 0 | 33,006 | | | | | | | | | | | | | | | | | |
| 2 | 200 NEW CAP REL COSTS-MVBLE EQUIP | 159,323 | | | 159,323 | | | | | | | | | | | | | | | | |
| 4 | 400 EMPLOYEE BENEFITS DEPARTMENT | 1,341,078 | 1,551 | 0 | 0 | 1,342,629 | | | | | | | | | | | | | | | |
| 5 | 500 ADMINISTRATIVE & GENERAL | 2,615,591 | 13,814 | 0 | 26,013 | 244,078 | 2,899,496 | 2,899,496 | | | | | | | | | | | | | |
| 7 | 700 OPERATION OF PLANT | 791,431 | 22,561 | 0 | 2,179 | 46,939 | 863,110 | 201,808 | 1,064,918 | | | | | | | | | | | | |
| 7 | 701 OPERATION OF PLANT-MOB | 6,284 | 0 | 0 | 0 | 0 | 6,284 | 1,469 | 0 | 7,753 | | | | | | | | | | | |
| 8 | 800 LAUNDRY & LINEN SERVICE | 38,609 | 2,267 | 0 | 0 | 5,060 | 45,936 | 10,741 | 11,902 | 0 | 68,579 | | | | | | | | | | |
| 9 | 900 HOUSEKEEPING | 184,369 | 1,781 | 0 | 265 | 30,407 | 216,822 | 50,696 | 9,351 | 0 | 19,758 | 296,627 | | | | | | | | | |
| 10 | 1000 DIETARY | 179,889 | 9,980 | 0 | 1,364 | 30,405 | 221,638 | 51,822 | 52,407 | 0 | 1,294 | 14,714 | 341,875 | | | | | | | | |
| 11 | 1100 CAFETERIA | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | | | | |
| 13 | 1300 NURSING ADMINISTRATION | 17,414 | 0 | 0 | 0 | 3,392 | 20,806 | 4,865 | 0 | 0 | 0 | 0 | 0 | 0 | 25,671 | | | | | | |
| 15 | 1500 PHARMACY | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | | |
| 16 | 1600 MEDICAL RECORDS & LIBRARY | 210,860 | 4,403 | 0 | 0 | 32,704 | 247,967 | 57,978 | 23,118 | 0 | 0 | 5,189 | 0 | 0 | 0 | 0 | 334,252 | | | | |
| 17 | 1700 SOCIAL SERVICE | 131,984 | 820 | 0 | 0 | 20,212 | 153,016 | 35,777 | 4,306 | 0 | 0 | 1,207 | 0 | 0 | 0 | 0 | 0 | 194,306 | | | |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | | | | | | | | | | | | | | | |
| 30 | 3000 ADULTS & PEDIATRICS | 1,453,418 | 50,999 | 0 | 18,905 | 243,774 | 1,767,096 | 413,174 | 267,793 | 0 | 21,253 | 74,862 | 341,875 | 0 | 13,810 | 0 | 20,659 | 175,712 | 3,096,234 | 0 | 3,096,234 |
| | ANCILLARY SERVICE COST CENTERS | | | | | | | | | | | | | | | | | | | | |
| 50 | 5000 OPERATING ROOM | 479,461 | 45,494 | 0 | 65,461 | 67,973 | 658,389 | 153,941 | 238,888 | 0 | 5,988 | 66,967 | 0 | 0 | 3,791 | 0 | 34,227 | 0 | 1,162,191 | 0 | 1,162,191 |
| 53 | 5300 ANESTHESIOLOGY | 369,821 | 0 | 0 | 0 | 0 | 369,821 | 86,470 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 456,291 | 0 | 456,291 |
| 54 | 5400 RADIOLOGY-DIAGNOSTIC | 806,520 | 12,095 | 0 | 15,247 | 51,468 | 885,330 | 207,003 | 63,513 | 0 | 2,936 | 17,805 | 0 | 0 | 0 | 0 | 25,593 | 0 | 1,202,180 | 0 | 1,202,180 |
| 57 | 5700 CT SCAN | 158,227 | 2,444 | 0 | 0 | 30,623 | 191,294 | 44,727 | 12,834 | 0 | 62 | 3,598 | 0 | 0 | 0 | 0 | 0 | 0 | 252,515 | 0 | 252,515 |
| 58 | 5800 MAGNETIC RESONANCE IMAGING (MRI) | 204,597 | 0 | 0 | 0 | 0 | 204,597 | 47,838 | 0 | 0 | 788 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 253,223 | 0 | 253,223 |
| 60 | 6000 LABORATORY | 1,140,067 | 8,293 | 0 | 6,257 | 101,286 | 1,255,903 | 293,649 | 43,549 | 0 | 0 | 11,993 | 0 | 0 | 0 | 0 | 38,544 | 0 | 1,643,638 | 0 | 1,643,638 |
| 63 | 6300 BLOOD STORING, PROCESSING, & TRANS. | 31,807 | 0 | 0 | 0 | 0 | 31,807 | 7,437 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 39,244 | 0 | 39,244 |
| 65 | 6500 RESPIRATORY THERAPY | 38,116 | 3,139 | 0 | 2,042 | 4,493 | 47,790 | 11,174 | 16,482 | 0 | 0 | 3,421 | 0 | 0 | 0 | 0 | 7,092 | 0 | 85,959 | 0 | 85,959 |
| 66 | 6600 PHYSICAL THERAPY | 655,220 | 35,153 | 0 | 5,202 | 132,442 | 828,017 | 193,603 | 184,589 | 0 | 4,145 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1,210,354 | 0 | 1,210,354 |
| 71 | 7100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 352,275 | 7,479 | 0 | 0 | 26,161 | 385,915 | 90,233 | 39,271 | 0 | 0 | 10,939 | 0 | 0 | 0 | 0 | 0 | 0 | 526,358 | 0 | 526,358 |
| 72 | 7200 IMPL. DEV. CHARGED TO PATIENT | 26,132 | 0 | 0 | 0 | 0 | 26,132 | 6,110 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 32,242 | 0 | 32,242 |
| 73 | 7300 DRUGS CHARGED TO PATIENTS | 765,319 | 4,773 | 0 | 475 | 8,731 | 779,298 | 182,212 | 25,065 | 0 | 0 | 7,026 | 0 | 0 | 0 | 0 | 0 | 0 | 993,601 | 0 | 993,601 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | | | | | | | | | | | | | | | |
| 88 | 8800 RURAL HEALTH CLINIC | 525,141 | 0 | 11,996 | 1,482 | 87,733 | 626,352 | 146,450 | 0 | 2,818 | 0 | 21,279 | 0 | 0 | 0 | 0 | 0 | 0 | 796,899 | 0 | 796,899 |

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# Worksheet B-1: Cost Allocation Statistics

Purpose: Statistical basis used for allocating General Service costs to various cost centers

- Standard Order and Medicare-approved Statistics
  - Approval for changes may be requested through the MAC at least 90 days prior the close of your fiscal year
  - Must demonstrate that change is more accurate, easier to maintain
- Must be current, accurate, and capable of being audited
  - Remember to maintain consistent cost center mapping for departmental statistics, including reclassifications and adjustments from Wrkst A Series
  - Review and update statistics every year
- Include department heads on your stat collection team and provide them with the tools and formats you require
  - Get everyone on board at the beginning of the year and collect stats monthly or quarterly to ensure they are being properly documented
  - Remember that the most accurate stats are those collected at point of occurrence rather than trying to recreate at the end of the year

# Worksheet B-1: Cost Allocation Statistics, continued

- Square Feet – Building & fixed equipment, Maintenance, Plant Operations, and Housekeeping*
  - Plant Operations should maintain a log of square footage changes including effective date of room movement, room closure/vacancy, additions from renovation or new construction, etc.
  - Be sure to weigh changes in square footage for mid-year space changes, and don't forget to adjust the weighted square footage of prior year changes
  - Exclude any non-owned square footage
  - Consider fragmentation to separately allocate the cost of new building additions or renovations, or physician practice sites
  - Square footage statistics used to allocate maintenance, plant operations, and housekeeping* can be different than square footage for depreciation
    - Include rented areas if they are maintained by hospital facilities staff
  - Review square footage – question the accuracy of cost centers that have FTEs or equipment, but no square feet

* Housekeeping – MAC may require time study unless square feet has been approved.

# Worksheet B-1: Cost Allocation Statistics, continued

- Major Movable equipment – Dollar value of Depreciation
  - Obtain a fixed asset detail by department that reconciles to the trial balance
  - Map departments to Medicare cost centers consistent with mapping of Worksheet A and adjust for A-6 reclassifications and A-8 adjustments
- Employee Benefits – Gross Salaries
  - Begin with Salaries in Worksheet A, Column 1, and adjust for A-6 reclassifications and A-8 adjustments
  - Exclude all physician and non-physician provider salaries – their benefits should have already been reclassified to cost centers in Worksheet A-6
  - Exclude any departments where actual benefits are directly assigned
- Admin & general – accumulated cost
  - Analyze the financial impact of fragmented A&G cost centers – can result in more accurate costing and less cost allocation to non-reimbursable cost centers
    - Common examples: PFS allocated on gross charges, Patient Access allocated on outpatient admissions, IT costs allocated by number of computers serviced

# Worksheet B-1: Cost Allocation Statistics, continued

- Laundry – pounds of laundry
  - If outsourcing laundry, make sure your invoices include pounds and not pieces. Alternatively, estimate pounds from pieces or request a change a statistical allocation method
- Dietary – Meals served
  - Review patient meals – are they more than 3 meals a day?
- Cafeteria – FTEs
  - Adjust FTE counts for A-6 reclassifications
  - Be sure to exclude FTEs for staff that are not located on campus or those who for other reasons do not utilize the cafeteria
- Nursing Admin – Nursing Hours or FTEs
  - Only include staff being managed by Nursing Administration. If you have a nursing home or physician practices managed by a separate admin team, they should be excluded
  - Incorporate any A-6 reclassifications

# Worksheet B-1: Cost Allocation Statistics, continued

- Central Supply – Costed Requisitions
  - Use internal records for cost of supplies requisitioned from material management by ordering department
  - If using trial balance supplies expense, exclude departments that do their own ordering (ie. lab, pharmacy, etc.)
- Pharmacy – Costed Requisitions or %
  - Most commonly all allocated to Line 73 where all chargeable drugs are reported
- Medical Records – Time Study or Gross Revenue
  - Report observation on Line 30 instead of Line 92
  - If using Gross Revenue, exclude any cost centers that HIM does not provide services to (ie. does clinic have their own coding staff?)
- Social Service – Time Study or Patient Days

# Worksheet C Series: Ratio of Costs to Charges

Computation of Ratio of Costs to Charges (RCC) for inpatient and outpatient ancillary services

| Column | Description |
|---|---|
| Column 1 | Hospital costs by revenue producing cost center flow from Worksheet B Part I Column 27 lines 30 through 91. Cost center line numbers correspond to those on Worksheet B. Observation bed costs on line 92 flow from Worksheet D-1 line 89 |
| Column 2 | Flow of therapy adjustments from Worksheet A-8 |
| Column 4 | Flow of RCE disallowances from Worksheet A-8-2, column 17 (PPS hospitals) |
| Column 5 | Total costs by cost center (PPS hospitals and sub providers) |
| Column 6 | Total Inpatient Gross Charges |
| Column 7 | Total Outpatient Gross Charges |
| Column 8 | Total Inpatient and Outpatient Gross Charges |
| Column 9-11 | Cost/PPS RCCs are calculated |

# Worksheet C, Part 1: Ratio of Costs to Charges

Input inpatient and outpatient charges, excluding professional fees

- Start with your Mapped Trial Balance
  - Revenue departments should be mapped consistently with Wrkst A expenses and align with reporting of Medicare charges
  - Assign gross revenue accounts to Worksheet C columns
    - Column 6 = inpatient charges  Column 7 = outpatient charges
- Obtain a detailed revenue report that breaks down charges by:
  - Patient status (ie. inpatient, outpatient, physician clinic, etc.)
  - UB revenue code – categorizes type of service billed and helps identify professional fees that need to be excluded
  - Department where charges were posted in the Trial Balance
    - Reconcile to the Trial Balance

# Worksheet C, Part 1: Ratio of Costs to Charges, continued

- Establish or update a crosswalk of UB revenue codes to Medicare cost centers
  - Also used with Medicare charges from PS&R to maintain consistent mapping
  - Medicare has a standard revenue code crosswalk – better to tailor it to hospital
  - Person responsible for assigning UB Revenue Codes in the Chargemaster should be in tune with the cost center structure in the Cost Report
    - Common challenges for CDM manager: Minor Procedure, Treatment Room, Clinics, Other Diagnostic Service, Other Therapeutic Services
- Review cost center assignment for UB revenue code vs Department
  - Identify reclassifications necessary to align Costs with Charges and Medicare Charges. Common reclassifications:
    - Chargeable Supplies and Implants, Drugs Sold
    - Observation charges to Line 92
    - Laboratory charges, EKG technical charges
    - Ancillary charges within clinics (Radiology, Lab)

# Worksheet C, Part 1: Ratio of Costs to Charges, continued

- Remove all professional fees reimbursed under Part B Fee Schedule
  - Physicians and non-physician providers (CRNA, NP, PA, etc.)
  - UB Revenue codes 960-989 are professional fees
  - If all professional fees are not eliminated, reimbursement will be impaired
- Provider-based Clinics (Revenue Code 510)
  - Facility/Technical portion of clinic charges are only billed to Medicare
  - Need to impute Facility/Technical portion of charges billed to all payors to compute an accurate Ratio of Cost to Charge

# Worksheet C, Part 1: Ratio of Costs to Charges, continued

Review calculated Ratios of Cost to Charge, including comparison to prior year

## RCC Greater than 1.0

- Means costs are greater than charges
- Review costs in Wkst A Series
  - Consistent mapping of department with Medicare cost center?
  - Missing adjustment for professional cost?
- Review overhead allocations in Wkst B, Part I
  - Does overhead assigned to that cost center make sense?
- Is it a low-volume and/or high-cost cost service?

## RCC Close to 0

- Means charges greatly exceed cost
- Review cost structure of the service
  - Ensure that all necessary reclassifications are made to properly match costs with charges
- Review charges by revenue code
  - Missing a reclassification of charges?
  - Missing an adjustment to remove professional fees from Wrkst C?
- Is it a high-volume and/or low-cost cost service?

# Worksheet C, Part 1: Ratio of Costs to Charges, continued

Review calculated Ratios of Cost to Charge, including comparison to prior year

- Be able to explain significant changes from year to year
  - Increased/decreased volume
    - new service, winding down a service
    - provider turnover impacting referrals/orders
  - Increased/decreased cost
    - Staff recruitment, turnover
    - Investment in technology and equipment
    - Cost containment efforts
    - Home office cost allocation changes
  - If you can't explain a significant trend, go back and review alignment of costs, stats, charges, and Medicare charges

# Worksheet D Series

| Worksheet | Description |
|---|---|
| Worksheet D Parts I-IV | Apportionment of Inpatient Routine and Ancillary Service Capital Costs and Other Pass Through Costs (PPS hospitals and PPS components) |
| Worksheet D Part V | Apportionment of Medical and Other Health Service Costs and Vaccine Cost Apportionment |
| Worksheet D-1 | Computation of Inpatient Operating Costs |
| Worksheet D-2 | Apportionment of Costs of Services rendered by I&Rs |
| Worksheet D-3 | Inpatient Ancillary Cost Apportionment |
| Worksheet D-4 | Computation of Organ Acquisition Costs and Charges |
| Worksheet D-5 | Apportionment of cost for Services of Teaching Physicians/RCE Computation for PPS Hospitals |

# Worksheet D Parts I–IV

- Parts I through IV provide for the computation of inpatient hospital routine, inpatient and outpatient ancillary service capital costs and other pass through costs (PPS hospitals and PPS components), rehabilitation and psychiatric facilities-free standing, and hospital-based sub-providers. A separate copy of this worksheet must be completed for the hospital, each sub provider and hospital based SNF.
- Costs flow from the Worksheet D Series worksheets (capital-related, non-physician anesthetists, and approved medical education costs) to the E Series worksheets, as applicable.
- CAHs without PPS components do not complete Parts I through IV.

# Worksheet D Parts I–IV, continued

- Worksheet D Part I: Apportionment of Inpatient Routine Service Capital costs
  - This worksheet computes the amount of capital related costs applicable to Program hospital inpatient routine service costs. For PPS hospitals the hospital component is subject to PPS as capital is reimbursed at 100% of the federal rate.
  - Only one worksheet is completed for the Program. No input is entered on this worksheet.
- Worksheet D Part IV: Apportionment of Inpatient Ancillary Service Other Pass-through Costs
  - This worksheet computes the amount of pass through costs other than capital (i.e. medical education and allied health) applicable to hospital inpatient and outpatient ancillary services for the Program

# Worksheet D Part V

- Apportionment of Medical, Other Health Services, and Vaccine Cost
  - This worksheet provides for the apportionment of cost applicable to hospital outpatient services and inpatient ancillary services reimbursable under Part B of the Program. Outpatient services for PPS hospitals are subject to prospective payment – APCs. A separate worksheet for each hospital component is completed.
  - Program charges are obtained through provider records or reports generated by the web-based Redesigned PS&R System. All providers should be registered and have online access to the summary PS&R reports containing aggregate Program charges on a FY basis.
- Enter Medicare Charges from the PS&R
  - Note at this point expenses on Worksheet A and B Part I, Revenue from Worksheet C and PS&R revenue on the Worksheet D series should parallel one another
  - Special care to:
    - Observation
    - Ancillaries performed in clinics
    - EKG
    - Revenue code 510 - clinics

# D-3: Inpatient Ancillary Service Cost Apportionment

- This worksheet provides for the apportionment of cost applicable to hospital inpatient ancillary services reimbursable under the Program, payable under Part A. A separate Worksheet D-3 is completed for each SNF, sub-provider as well as swing bed
- Program charges for each ancillary cost center are obtained through provider records or reports generated by the web-based Redesigned PS&R System. All providers should be registered and have on-line access to the summary PS&R reports containing aggregate Program charges on a FY basis
  - Col 1—RCCs flow from Worksheet C
  - Col 2—Enter Program inpatient charges by line (PS&R)
  - Col 3—Apportionment of inpatient ancillary costs

# PS&R Crosswalk

- Crosswalk should map the revenue reported on PS&R to same line where facility revenue is reported which should mirror where expenses are reported.
- What department performs EKGs in your facility? If Lab, map to line 60. If respiratory therapy, map to line 65.
- Proper treatment of Rev Code 510 - Clinic

# Preparation of Worksheets D Part V & D-3

- Incorporate any mapping changes into current cost report
- Incorporate corrections to collection of data
- Look at Revenue Codes – how you map revenue codes may determine how you need to map revenues and expenses or reclassifications that might be required
- Reconcile PS&R charges to Worksheets
- Map revenue codes to cost centers in the same manner as you mapped charges
- Review the reasonableness of clinic charges to the physician practices

# Worksheet D-1

- **Part I** All Provider Components (including swing bed adjustment)
- **Part II** Hospital and Sub-providers only
- **Part III** Provides for the apportionment of inpatient operating costs for SNFs
- **Part IV** Provides for the computation of observation bed costs

| | |
|---|---|
| **Lines 87-89** | Total non-distinct observation unit bed costs are determined by multiplying total observation bed days by the routine per diem. The result flows to Worksheet C line 62 Column 1 |
| **Lines 90-93** | Routine pass through costs and capital-related costs associated with non-distinct observation beds are calculated for PPS providers |

# Worksheet E Series

Pulls the information from other worksheets to calculate the settlement for each component

| Worksheet | Description |
|---|---|
| E Part A | PPS Inpatient Hospital Settlement |
| E Part B | Medical and Other Health Services |
| E-1 | Analysis of Payments |
| E-2 | Swing Beds |
| E-3 Part II | Inpatient Psych Facility Settlement |
| E-3 Part III<br>E-3 Part V | Inpatient Rehab Facility Settlement<br>CAH Inpatient Settlement |
| E-4 | GME, ESRD |

# E, Part A: PPS Inpatient Hospital Reimbursement Settlement

- Calculates the settlement for inpatient hospital services paid under PPS
- Line 1.02—Other than outlier DRG payments (PS&R)
- Line 2—Outlier payments (PS&R data)
- Line 3—Managed Care Simulated Payments
- Line 4—Bed days available divided by number of days in the cost report period
- Lines 5-22—Indirect Medical Education Adjustment
- Lines 23-29—Indirect Medical Education Adjustment for the Add-on

# Worksheet E Part A (PPS Hospitals)

- Lines 30-34—Disproportionate Share Adjustment
- Lines 35-36—Uncompensated Care Adjustment
- All PPS hospitals are eligible to receive DSH payments if the total of SSI and Medicaid day ratios exceed 15%
- SSI Ratios
- Allowable disproportionate share percentage
- Lines 40-47—Additional payment for high percentage of ESRD beneficiary discharges
- Line 48-49—Special Payment Provisions for SCHs and MDHs (calculations performed off the cost report)
- Line 50—Inpatient Program Capital Costs (flow from Worksheet L)
- Lines 52-59—GME and other pass through costs (flow amounts from various Worksheets)

# Worksheet E Part A (PPS Hospitals)

- Line 60—Primary Payer Amounts (PS&R)
- Line 62-63—Deductibles and Coinsurance (PS&R)
- Line 64—Allowable Medicare Bad Debts (Appendix C)
- Line 65—Adjusted Reimbursable Bad Debts (Line 64 multiplied by 65%)
- Line 66—Allowable bad debts for dual eligible beneficiaries
- Lines 70.96-70.98—Low Volume Payments
- Line 71.01—Sequestration Adjustment (MCR calculation)
- Line 72—Payments (flow from Worksheet E-1)
- Line 74—Balance Due Provider/Program
- Line 75—Protested Amounts (Appendix D)

# Review of Worksheet E Part A

- DSH
  - Use the most current SSI %
  - Count all the appropriate and applicable Medicaid days – categories are now identified on W/S S-2 Part I (Line 24)
  - Recalculate the allowable DSH % based on information used in the cost report
- SCH/MDH Hospitals
  - Obtain the appropriate Hospital Specific Rate(s)
  - Calculate the aggregate Hospital Specific amounts based on the DRG Weight
  - Use the Hospital Specific amounts for the appropriate fiscal period

# E, Part B: Medical & Other Services Reimbursement Settlement

Calculates the reimbursement settlement for hospitals, sub providers and SNFs. A separate copy of Worksheet E Part B is used for each hospital based facility.

| Line | Description |
|---|---|
| Line 1 | Program Medical and Other Services (flow from Worksheet D Part V); Cost-based reimbursement |
| Line 2 | Medical and other services reimbursed under OPPS |
| Lines 3 - 4 | PPS Payments including Outlier payments |
| Line 5 | Hospital Specific Payment to Cost Ratio (supplied by the MAC) |
| Line 8 | Computation of TOPs payment if applicable (PPS Hospitals only) |
| Line 9 | PPS Hospital Pass-through costs (flow from Worksheet D, Part IV) |
| Line 10 | Organ acquisitions |
| Line 11 | Total Cost |

# E, Part B: Medical & Other Services Reimbursement Settlement

| Line | Description |
|---|---|
| Lines 12 – 24 | Computation of lesser of costs or charges |
| Lines 25 – 26 | Deductibles and Coinsurance (PS&R) |
| Lines 28 – 29 | Direct GME and ESRD direct medical education costs (from E-4) |
| Line 31 | Primary Payer Payments (PS&R) |
| Lines 34 - 36 | Allowable Medicare Bad Debts (Appendix C) |
| Line 40.01 | Sequestration Adjustment (MCR calculation) |
| Line 41 | Interim Payments (flow from Worksheet E-1) |
| Line 43 | Balance Due Provider/Program |
| Line 44 | Protested Amounts (Appendix D) |

# Medicare Bad Debts

- Toughest documentation to recreate so have your patient accounts team on board prospectively
- Medicare Beneficiaries qualify for Charity Care; maintain files with completed applications, determination letters, and timely renewal applications
- All Medicare Bad Debts claimed should be supported by packet of information including copies of detail bills and EOBs

# Protest Amounts

- Calculate and disclose reimbursement impact of self disallowed items
- Attach a workpaper to show the justification and reasonable methodology used to calculate the protested amount

# Worksheet E-1 Part I

- Payments should include not only payments per PS&R but also any lump sum adjustments received throughout the course of the year
- Dates must correspond to dates on settlement or lump sum notices
- Ensure to properly classify hospital payments as Part A or Part B
- Each provider is reported on a separate E-1
- Analysis of Payments To Providers For Services Rendered
  - Worksheet E-1 reports Program payments to providers for service. A separate Worksheet E-1 must be completed for each hospital component (sub-provider, SNF, Swing bed SNF) Columns 1 and 2 are used to report Part A payments and Columns 3 & 4 are used to report Part B payments.
  - Lines 1-4 should be completed by the hospital. The MAC will complete the rest of the Worksheet. Therefore, Line 1 should include all interim payments made to the hospital as well as TOPs payments. Lump Sums to the hospital are reported on line 3.0 and payments made back to the Program are reported on line 3.5.

# Worksheet E-1 Part II

- Calculation of Reimbursement Settlement for HIT
  - Calculates settlement of HIT amounts due to the provider based on actual utilization and cost for CAHs
  - Uses info from W/S C charges S-3 Part I (statistics) and S-10 (uncompensated care)
  - This worksheet captures relevant data for IPPS and CAHs that are eligible for health information technology (HIT) payments. HIT interim payments are paid based on a prior cost reporting period; certain lines are limited to contractor use only
  - Final settlement will be outside of the cost report process

# Worksheet E-2: Reimbursement Settlement – Swing Beds

- Worksheet E-2 provides for the reimbursement calculation for Program swing bed costs for PPS hospitals and CAHs.
- PPS hospital swing beds are paid on the basis of SNF PPS.
- CAH swing beds are paid 101% of reasonable costs.
- This worksheet also provides for the Part B computation of the lesser of 80 percent of reasonable cost after deductibles or reasonable cost minus deductibles and billed coinsurance amounts.

# Worksheet E-3: Calculation of Reimbursement Settlement

| Part | Description |
|---|---|
| Part I | Calculation of Medicare Reimbursement Settlement under TEFRA |
| Part II | Calculation of Reimbursement Settlement for Medicare Part A Services-IPF PPS |
| Part III | Calculation of Reimbursement Settlement for Medicare Part A Services-IRP PPS |
| Part IV | Calculation of Reimbursement Settlement for LTCH PPS |
| Part V | Medicare Part A Services-Cost Reimbursement (CAHs) |
| Part VI | Title V or Title XIX services or Title XVIII SNF PPS Only |
| Part VII | Title V and XIX SNF Reimbursement |

# E-3, Part V: Medicare Part A Cost Reimbursements (CAHs)

- Line 1—Program costs for inpatient services
- Line 20—Deductibles
- Line 23—Coinsurance
- Line 25—Allowable bad debts
- Line 26—Adjusted reimbursable bad debts
- Line 30.01—Sequestration (MCR Calculation)
- Lines 31—Interim Payments (flow from Worksheet E-1)
- Line 33—Balance due Provider/Program
- Line 34—Protested Amounts (Appendix D)

# Review of Worksheet E Series

- Medicare Bad Debts:
  - Bad Debt listing needs to meet the requirements of Exhibit 2 of Worksheet S-2 Part II
  - Were bad debts sent to and returned from a collection agency?
- Worksheet E-1:
  - Review all MAC correspondence for the year to ensure all lump sum settlements have been included
  - Include bad debt pass-through payments
  - Include Low Volume Adjustment payments
  - Include TOPs payments
- Settlement Data:
  - Reconcile deductibles, coinsurance, MSP amounts from the PS&R to the appropriate Worksheet
  - This is particularly important if you uploaded the PS&R using the cost report software
- Review your settlements based on estimates made for year end
  - Reconcile the differences
  - Rate & volume variances

# Questions?


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