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CPAs & BUSINESS ADVISORS

ADVENTURES IN MEDICARE COST REPORTING

September 2023

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PRESENTERS

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GOALS FOR SESSIONS

Theory on each cost report section

- Why the information is important?
- What does the information mean?
- How does it affect the reimbursement of the hospital?

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GOALS FOR SESSIONS

Strategies on each cost report section

- Best Practices
- Thinking outside the "box"

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- Every transaction/decision within your facility has an impact on the cost report and your Medicare reimbursement (more pronounced for CAHs):
  - Staffing
  - Purchase of building/equipment
  - Leasing
  - Practitioner contracts
  - New Services/Exiting of Services

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COST REPORT OVERVIEW

- Used to determine provider settlements for services.
- Used by outside entities to evaluate hospitals (state agencies, commercial insurers, peers/competitors).
- Due five months after fiscal year end.
- Subject to annual audits by MAC:
  - Desk reviews, field or remote audits.
- MAC issues a Notice of Program Reimbursement (NPR) after review/audit is complete.
- Hospitals have 180 days from date of NPR to appeal to PRRB:
  - Three years for reopening of a cost report to correct errors and omissions.

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COST REPORT OVERVIEW

This is your Notice of Amount of Program Reimbursement (NPR) for the cost reporting period 01/01/2019 through 12/31/2019 and is issued in accordance with 42 CFR 405.1803.

This cost report has been settled. Enclosed as part of this notice is the Amended Cost Report (if applicable), Audit Adjustment Report, and Report of Audit.

If you disagree with our determination, you have a right to request a hearing in accordance with 42 CFR 405.1801 - 405.1889. You may also want to refer to CMS Pub. 15-1, Chapter 29. The hearing request must be filed within 180 days following receipt of this NPR. Please keep in mind that routine issues may be resolved without going through the appeals process by providing clarification or additional documentation to us. However, if a formal appeal is necessary, an acceptable request must be in writing, be signed by a duly authorized representative of the provider and should:

(1) identify the disputed issues by specific audit adjustments with which you disagree,
(2) identify the amount of Program reimbursement in controversy for each issue and provide a calculation of each amount,
(3) give specific reasons why you feel the adjustments are inappropriate,
(4) be accompanied by evidentiary materials necessary to support your position, and
(5) include a copy of the filed cost report, NPR, and audit adjustment report.

A Provider Reimbursement Review Board (PRRB) Hearing may be requested if the Amount of Program Reimbursement in controversy is at least $10,000. A group of providers may request a PRRB Hearing where

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COST REPORT OVERVIEW

Cost reimbursement explained

Formula	Principle
Hospital Costs	Allowable Costs Related to Patient Care
÷ Hospital Units of Service	Consistent Charge Structure for all Payors
= Cost Per Unit	Cost to Charge Ratio / Per Diem
x Medicare Units of Service	Medical Necessity
= Medicare Costs / Reimbursement	

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COST REPORT OVERVIEW

Cost reimbursement further defined

	Room & Board	Ancillary	Cost Report Worksheet
	Direct Costs	Direct	A
+	Overhead Costs	Overhead Costs	B
=	Total Department Costs	Total Department Costs	
÷	Total Patient Days	Revenues	C & D-1
=	Per Diem Costs	Cost to Charge Ratio	
X	Medicare Days	Medicare Revenue	D-1, D-3 & D, V
=	Medicare Costs	Medicare Costs	D-1, D-3 & D, V
-	Deductibles/Coinsurance	Deductibles/Coinsurance	E Series
=	Net Due From Medicare	Net Due From Medicare	E Series

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COST REPORT OVERVIEW

Cost reimbursement – example 1

		Routine	Ancillary
	Hospital Costs	$1,000,000	$2,000,000
÷	Hospital Units of Service	2,000	5,000,000
=	Cost Per Diem/Charge	$500.00	40.00%
X	Medicare Units of Service	1,400	2,000,000
=	Medicare Costs/Reimbursement	$700,000	$800,000
	Total Medicare Reimbursement		$1,500,000

Assumptions: Medicare Utilization = 70%: Inpatient

Medicare Utilization = 40%: All Ancillary Services

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COST REPORT OVERVIEW

Cost reimbursement – example 2

		Routine	Ancillary
	Hospital Costs	$1,000,000	$2,000,000
÷	Hospital Units of Service	1,600	4,000,000
=	Cost Per Diem/Charge	$625.00	50.00%
x	Medicare Units of Service	1,120	1,600,000
=	Medicare Costs/Reimbursement	$700,000	$800,000
	Total Medicare Reimbursement		$1,500,000

Assumptions: Patient Volumes Decrease by 20% Including Medicare

Comment: Medicare Utilization Stays the Same. (1,120/1,600 = 70%)

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COST REPORT OVERVIEW

- Commonly used source data in a cost report
- General ledger
- Labor distribution and payroll reports
- Revenue usage report by department and financial class
- Patient census data
- Overhead allocation statistics
- Provider Statistical & Reimbursement Report (PS&R)

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COST REPORT OVERVIEW

- Basic data preparation hints.
- Reconcile data from general ledger to supporting documents:
  - Other revenue detail.
  - Department wages and related hours.
  - Census statistics to revenue usage report.
  - Review revenue code crosswalk for Medicare revenue codes used by general ledger departments.
  - Matching of expenses, revenue and Medicare revenue by cost report line.
- Coding of expenses on general ledger.

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SUBMISSION OF COST REPORT

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UPLOAD OF COST REPORT TO CMS PORTAL

Electronically signed cost report (PI file) uploaded to CMS portal. Be diligent in following instructions in uploading to CMS portal.

MUST HAVE MEDICARE BAD DEBT LISTING

If including Medicare bad debts, must have listing and included as a separate document at time of cost report submission or cost report could be rejected.

CLAIMING HOME OFFICE COSTS

Home Office cost report must be included in the filing of your cost report or your cost report could be rejected.

RECOMMEND SENDING SUPPORTING WORKPAPERS

Not a requirement for cost report submission, but recommended for ease of cost report acceptance and if only doing a desk review.

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IPPS SUBMISSION REQUIREMENTS

Formal submission requirements effective 10/1/22

PATIENT LOG OF DSH MEDICAID ELIGIBLE DAYS (EX. 3A)

If claiming DSH reimbursement, must complete new exhibit (25 columns of data inputs)

PATIENT LOG OF CHARITY CARE REPORTED ON S-10 (EX. 3B)

Charity care log used for audit of S-10 (21 columns of data inputs)

PATIENT LOG OF BAD DEBT REPORTED ON S-10 (EX. 3C)

Bad debt log used for audit of S-10 (17 columns of data inputs)

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WORKSHEET SERIES

Worksheet S series
- Statistical and other information

Worksheet A series
- Expenses

Worksheet B series
- Overhead allocations

Worksheet C series
- Facility revenues

Worksheet D series
- Medicare revenues
- Calculation of Medicare cost

Worksheet E series
- Calculation of cost settlement

Worksheet G series
- Balance Sheet and Statement of Revenue and Expenses

Worksheet M series
- Rural Health Clinic (mini-cost report)

Other Topics
- Clinic Types, RHC vs ER compensation, Specialty Clinics

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WORKSHEET S

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WORKSHEET S-2, I & II

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WORKSHEET S-2

- Any changes in "sub-providers" must inform cost report preparer.
- If not listing all appropriate "sub-providers" could have cost report rejected.
- Ensure proper payment types by provider:
  - "P" is for prospective payment.
  - "O" is for other, usually cost-based.

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ALL-INCLUSIVE (A.K.A. METHOD II PAYMENT)

- Ability for a CAH to bill Medicare only for outpatient professional services on a UB-04 claim (typically billed on CMS 1500, Method I) and receive an additional 15% on what Medicare pays under the fee schedule. Patient responsible for coinsurance
- Services usually are ER, outpatient surgical, observation visits, provider-based clinic visits, again professional services only (practitioner billing).

	Rural Providers	
105.00	Does this hospital qualify as a critical access hospital (CAH)?	Y
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y

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- CRNA pass through = cost-based reimbursement for Medicare.
- CRNA non-pass through = fee schedule reimbursement for Medicare.
- 42 CFR 412.113(c):
  - Effective December 2, 2010, the hospital or CAH is either located in a rural area as defined at §412.62(f) and is not deemed to be located in an urban area under the provisions of §412.64(b)(3) or the hospital or CAH has reclassified as rural under the provisions at §412.103.
  - The hospital or CAH may employ or contract with more than one anesthetist; however, the total number of hours of service furnished by the anesthetists may not exceed 2,080 hours per year.
  - volume of surgical procedures requiring anesthesia service did not exceed 500 procedures; or, effective October 1, 2002, did not exceed 800 procedures.
  - For purposes of this section, a *surgical procedure requiring anesthesia services* means a surgical procedure in which the anesthesia is administered and monitored by a qualified nonphysician anesthetist, a physician other than the primary surgeon, or an intern or resident.

108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N

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CRNA PASS-THROUGH

Need to apply 30 days prior to end of calendar year (i.e.- December 1).

Obtain pass through approval exemption letters from MAC for each calendar year for cost report preparation.

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- Did the facility bill revenue utilizing the following revenue codes:
  - Revenue code 275 - Pacemaker
  - Revenue code 276 – Intraocular Lens (IOLs)
  - Revenue code 278 – Other Implants
  - Revenue code 624 – Investigational Devices
- If so, need to have separate line on worksheet A, line 72, Implants Charged to Patients.
- Why? – Medicare rule regarding charge compression.
- Recommend facility separate out implant expense to separate general ledger account(s).

121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y

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IMPLANTABLES

- Charge Compression – lower markup on higher cost items vs. higher markup on lower cost items.
- ***Supply cost $20, charge may be $100 CCR = .200***
- ***Implant cost $900, charge may be $1,800 CCR = .500***
- While required for compliance purposes, this breakout could possibly generate additional reimbursement dollars.

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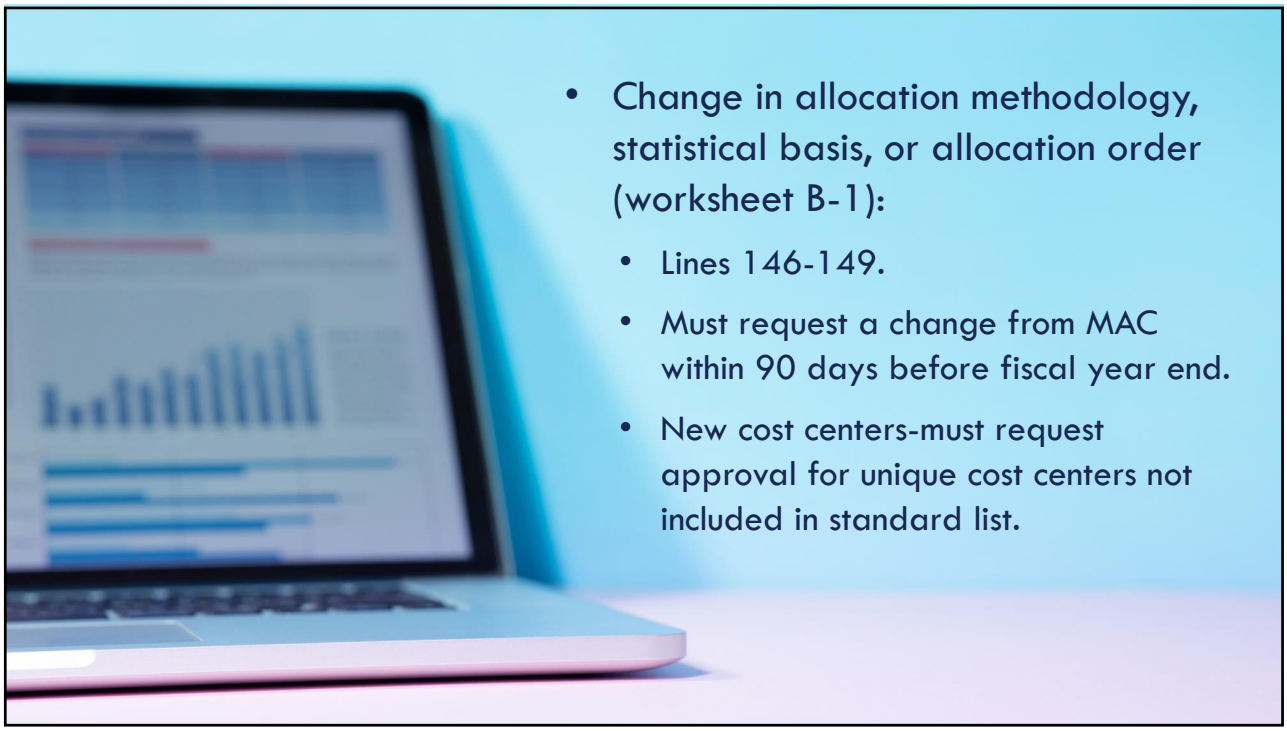

- Change in allocation methodology, statistical basis, or allocation order (worksheet B-1):
  - Lines 146-149.
  - Must request a change from MAC within 90 days before fiscal year end.
  - New cost centers-must request approval for unique cost centers not included in standard list.

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Important to be meaningful user/promoting interoperability otherwise payments are reduced:

- CAH – Inpatient cost reduced to 100% (C/R periods beginning in FFY 2017 and thereafter).
- PPS – Federal base rate increase 0.725% over prior year instead of 3.8% (FY 2023 factors). MU federal rate of $6,376; Non-MU federal rate $6,187

Example - Reimbursement Impact of not meeting Promoting Interoperability

	Meeting PI	Not Meeting PI
Inpatient Medicare Cost	$ 1,253,150	$ 1,253,150
With Additional 1%	$ 1,265,682	$ 1,253,150
Loss on Reimbursement		$ 12,532

Reminder: Keep copies of successful attestations for each period and provide to cost report preparer.

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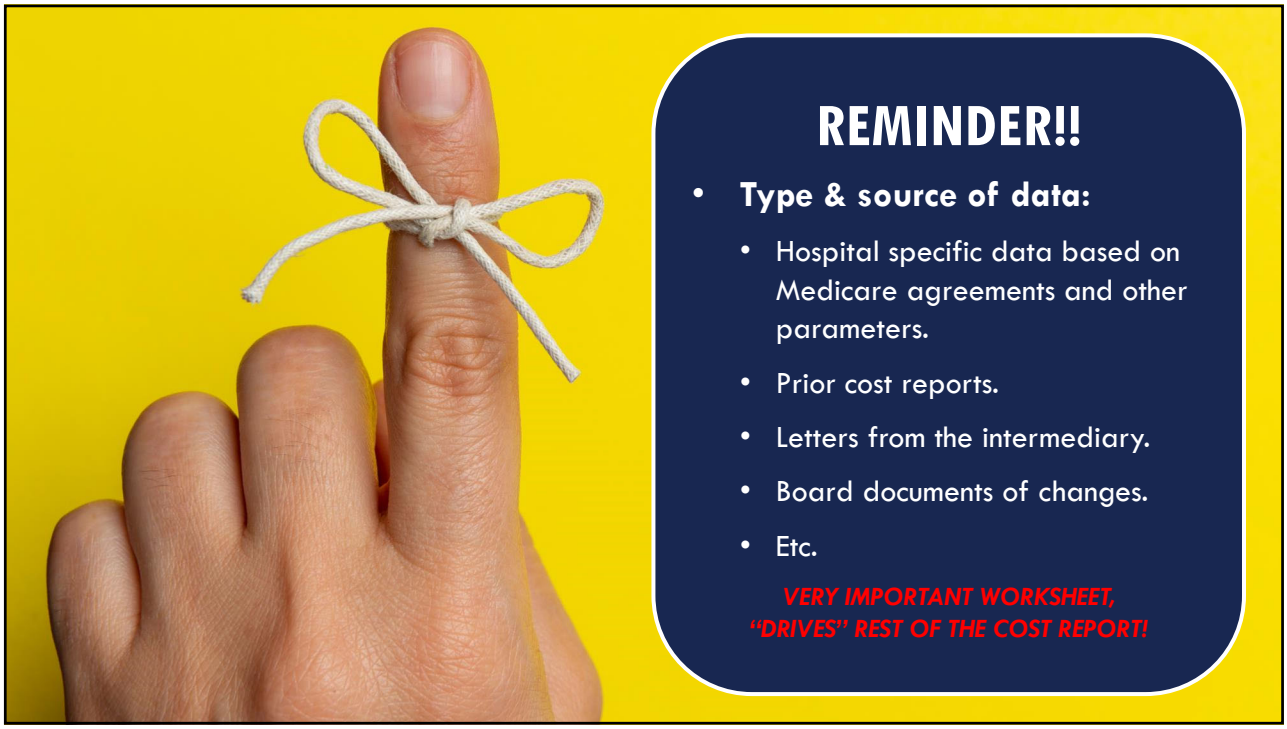
REMINDER!!
Type & source of data:
Hospital specific data based on Medicare agreements and other parameters.
Prior cost reports.
Letters from the intermediary.
Board documents of changes.
Etc.
VERY IMPORTANT WORKSHEET, "DRIVES" REST OF THE COST REPORT!

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WORKSHEET S-2 PART II
Provider organization & operation
Financial data and reports
Approved educational activities
Bad debts
Bed complement
PS&R report data
Capital related cost
Interest expense
Purchased services
Provider based physicians
Home office costs

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IMPORTANCE OF ANSWERING S-2, PART II CORRECTLY

Interest Expense – answered "No" on additional debt borrowed:

- Refinanced existing debt with new debt.
- Could be significant impacts on reimbursement.
- Loss/Gain on refinancing and how to handle.
- Was additional amounts borrowed – purpose? Is it allowable?

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IMPORTANCE OF ANSWERING S-2, PART II CORRECTLY

- Bad debt – answered "Yes" to seeking reimbursement:
  - Exhibit 2A finalized and will be required for reporting periods after 10/1/22.
  - 25 columns for data points

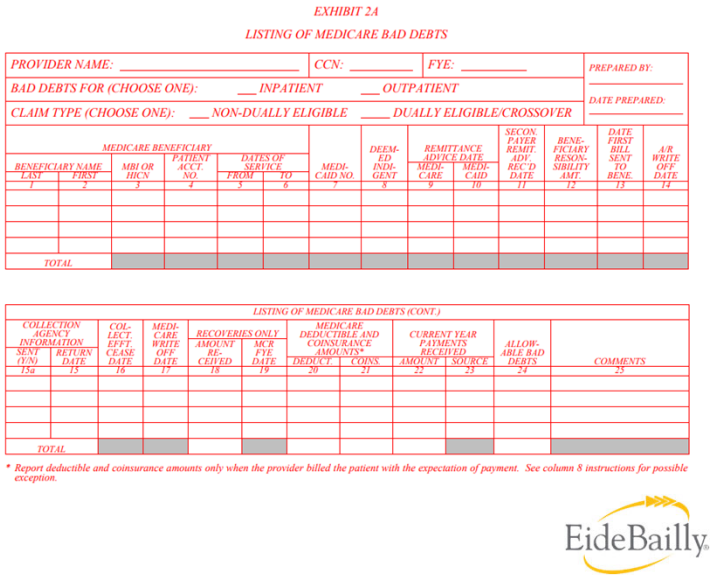

EXHIBIT 2A

LISTING OF MEDICARE BAD DEBTS

PROVIDER NAME: _____ CCN: _____ FYE: _____ PREPARED BY: _____

BAD DEBTS FOR (CHOOSE ONE): ___ INPATIENT ___ OUTPATIENT DATE PREPARED: _____

CLAIM TYPE (CHOOSE ONE): ___ NON-DUALLY ELIGIBLE ____ DUALLY ELIGIBLE/CROSSOVER

MEDICARE BENEFICIARY													
BENEFICIARY NAME		MBI OR HICN	PATIENT ACCT. NO.	DATES OF SERVICE		MEDI-CAID NO.	DEEM-ED INDI-GENT	REMITTANCE ADVICE DATE		SECON. PAYER REMIT. ADV. REC'D DATE	BENE-FICIARY RESON-SIBILITY AMT.	DATE FIRST BILL SENT TO BENE.	A/R WRITE OFF DATE
LAST	FIRST			FROM	TO			MEDI-CARE	MEDI-CAID				
1	2	3	4	5	6	7	8	9	10	11	12	13	14
TOTAL													

LISTING OF MEDICARE BAD DEBTS (CONT.)

COLLECTION AGENCY INFORMATION		COL-LECT. EFFT. CEASE DATE	MEDI-CARE WRITE OFF DATE	RECOVERIES ONLY		MEDICARE DEDUCTIBLE AND COINSURANCE AMOUNTS*		CURRENT YEAR PAYMENTS RECEIVED		ALLOW-ABLE BAD DEBTS	COMMENTS
SENT (Y/N)	RETURN DATE			AMOUNT RE-CEIVED	MCR FYE DATE	DEDUCT.	COINS.	AMOUNT	SOURCE		
15a	15	16	17	18	19	20	21	22	23	24	25
TOTAL											

* Report deductible and coinsurance amounts only when the provider billed the patient with the expectation of payment. See column 8 instructions for possible exception.

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WORKSHEET S-3 PART I

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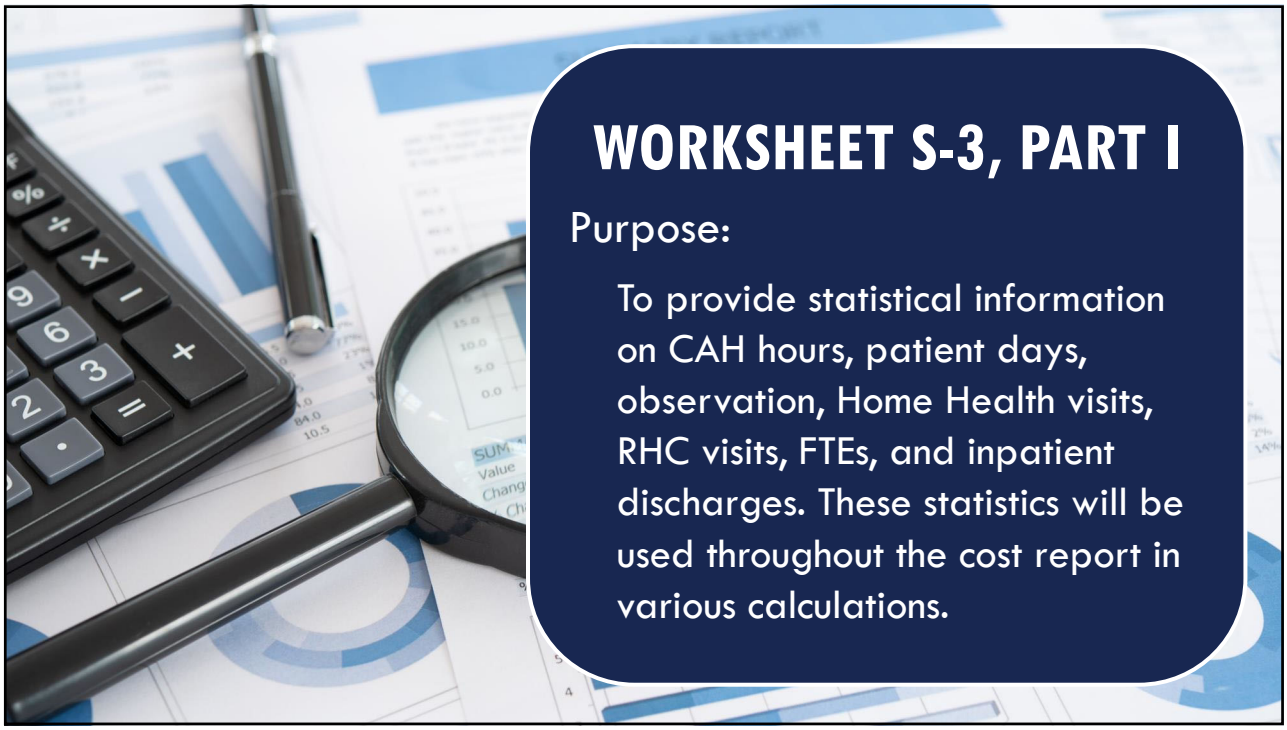

WORKSHEET S-3, PART I

Purpose:

To provide statistical information on CAH hours, patient days, observation, Home Health visits, RHC visits, FTEs, and inpatient discharges. These statistics will be used throughout the cost report in various calculations.

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Source of Data

- Provider's statistical reports.
- Provider's wage and hour reports.
- Revenue and usage report.
- PS&R data.
- Internal spreadsheets.

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CAH HOURS

- Required to allow CMS to monitor compliance with CAH conditions of participation (Average length of stay of less than 96 hours).
- Should include all inpatient & ICU acute hours for all payors.
- Hours are calculated from admission to discharge – many providers have software solution to automate the collection of this information.
- Not appropriate to report based on 24 hours per inpatient day. CMS is looking for exact for their calculations.
  - Edits in cost report software.
- Breakout between Adults and Peds and ICU, etc. if days are also broken out on cost report.

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IMPACT OF ACCURATE PATIENT DAYS

Impact of inaccurate days:

- Overstatement of days = under payment.
- Understatement of days = over payment.

Errors come from:

- Misstated days – tie to usage report?
- Test patient days included in count.
- Hospice, Labor and Delivery days, etc.

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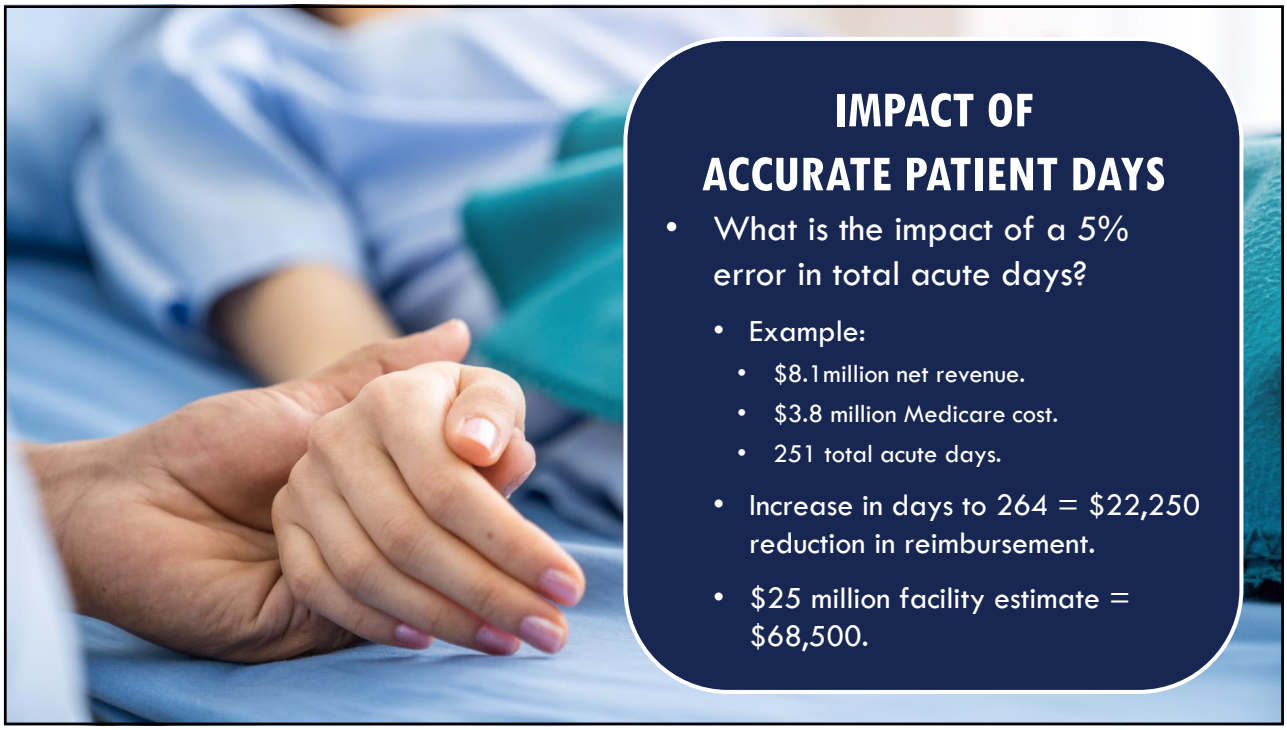

IMPACT OF ACCURATE PATIENT DAYS

- What is the impact of a 5% error in total acute days?
  - Example:
    - $8.1 million net revenue.
    - $3.8 million Medicare cost.
    - 251 total acute days.
  - Increase in days to 264 = $22,250 reduction in reimbursement.
  - $25 million facility estimate = $68,500.

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PATIENT DAYS

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Are you accurately tracking patient days for cost reporting purposes?

1. Acute Days
2. Swingbed SNF Days
3. Swingbed NF Days
4. Nursery Days
5. Observation Hours/Days
6. Labor/Delivery Days

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PATIENT DAYS

$$\frac{\text{IP Routine (Adult/Peds) Direct \& Indirect (Allocated) Costs}}{\text{Adult \& Peds Days + Swingbed SNF Days + Observation Days Equivalent}} = \text{Routine Cost per Day}$$

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SWINGBED DAYS

- Swingbed SNF – Medicare and Medicare Advantage days only.
- Swingbed NF:
  - All other payers swingbed days.
  - Carved out at average statewide Medicaid rate.

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SWINGBED DAYS – ISSUE

Significant variance between Medicare PSR and reported internal Medicare swingbed days.

Were they really Medicare days and reported on Swingbed SNF line?

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SWINGBED DAYS – ISSUE (EXAMPLE)

Total Acute Days = 945

Medicare Acute Days (PSR) = 500

Swingbed SNF Days Reported by Hospital = 710

Swingbed NF Days Reported by Hospital = 155

Medicare Swingbed Days PSR = 665

Observation Days = 145

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SWINGBED DAYS – ISSUE (EXAMPLE)

45 Swingbed days were determined not to be Medicare days.

Revised Swingbed SNF Days = 665

Revised Swingbed NF Days = 200

Medicare Swingbed Days per PSR = 665

Impact on Overall Reimbursement for those 45 Swingbed days

$61,150 Increase!

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SWINGBED DAYS – ISSUE

Are there outstanding days in accounts receivable at time of PSR for period before end of fiscal year?

Original admit entered as Medicare, but subsequently changed payer source. Were Medicare days exhausted?

Changed payer source part way through stay, but system still listed as Medicare.

Split billing patient at the end of the fiscal year.

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Med/Surg Days:

- Separately identify Medicare Advantage and Medicaid HMO days:
  - Medicare Advantage should be found on a separate PS&R.
  - Providers are required to submit "shadow" claims to Medicare for Medicare Advantage patients.
- Inpatient Psych.
- Inpatient Rehab.

Specialty care & sub provider days:

- Not included in Med/Surg days if costs are separately identified:
  - ICU, CCU, IPF.

Nursery days:

- Required (even if the baby is cared for in mother's room).

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Hospice Days:

- Hospice days for patients occupying general inpatient routine beds under contractual agreement.

Observation hours/days:

- Separate breakdown for Medicaid and total.
- Do not include hours for observation done outside the Adults and Peds area.
- B-2 could be required if observation is performed in separately reported specialty care areas (see above).

CAH visits – Outpatient visits:

- Guidance on definition of visit lacking.
- No impact on reimbursement…

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LABOR/DELIVERY DAYS

- Maternity patient is in labor/delivery ancillary area and is an inpatient at time (midnight) of census taking.
- Maternity patient is in LDP room and is an inpatient at time of census taking but has yet to deliver.
- Costs of labor/delivery should be shown in separate ancillary cost center, not inpatient cost center (Med/Surg) on cost report.
- Need to identify hours/days of time for labor/delivery:
  - Most often done of time mom comes through birth of baby.
  - If mom was initially admitted as an inpatient then need to identify the time in previous point.
  - If mom was admitted after the birth of the baby, then wouldn't need to remove the days.

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LABOR/DELIVERY DAYS
• Impact of reporting these days correctly.
• 945 total inpatient days.
• Identified 25 patient days/hours of time admitted patient was actually in labor/delivery.
• Increase of approximately $35,500 in Medicare reimbursement.

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• Discharges – Acute only
• Skilled Nursing home days
• Other Long Term Care days
• Home Health visits
• Hospice days
• RHC/FQHC visits
• Ambulance trips
• Employee discount days
• FTEs

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OTHER S SERIES WORKSHEETS

- S-3 pt. II-V hospital wage index
  - IPPS only, calculate AHW that is factor in the labor component of DRG payment
  - High focus by IPPS versus other worksheets that are more impactful to CAHs
- S-8 RHC information (consolidated RHCs, productivity standard exemption)
- S-9 Hospice information
- S-10 Uncompensated care
  - Required for all hospitals (CAH and IPPS)
  - Component of uncompensated care payment add on (IPPS)
  - No significant reimbursement impact to CAHs, low risk of inaccurate inputs

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WORKSHEET A PART I

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LAYOUT OF COST CENTERS HAVE HIERARCHY

- General Service
- Inpatient Routine Service
- Ancillary Service
- Outpatient Services
- Other Reimbursable
- Special Purpose
- Non-Reimbursable

Worksheet A total expenses must tie to financial statement total expenses or have reconciliation!!!

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WHAT IS A COST CENTER?

2302.8 Cost Center.--An organizational unit, generally a department or its subunit, having a common functional purpose for which direct and indirect costs are accumulated, allocated and apportioned. In addition, those natural expense classifications (e.g., depreciation) and nonallowable cost centers (e.g., research) specifically required by the instructions to be shown on the cost report fall under this definition. See §§2302.9 and 2302.10 for the proper classification of a cost center as general service or special service. See also §§2202.6, 2202.7, 2202.8, and 2203ff, for the proper classification of costs as either general routine, special care, or ancillary. (See also §§2302.4 and 2313.2.)

2302.9 General Service Cost Centers.--Those organizational units which are operated for the benefit of the institution as a whole. Each of these may render services to other general service areas as well as to special or patient care departments. Examples of these are: housekeeping, laundry, dietary, operation of plant and maintenance of plant. Costs incurred for these cost centers are allocated to other cost centers on the basis of services rendered.

2302.10 Special Service Cost Centers.--Commonly referred to as Ancillary Cost Centers. Such centers usually provide direct identifiable services to individual patients, and include departments such as the operating room, radiology, laboratory, etc.

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CONSISTENCY IS KEY

2304. Adequacy of Cost Information

Cost information as developed by the provider must be current, accurate, and in sufficient detail to support payments made for services rendered to beneficiaries. This includes all ledgers, books, records and original evidences of cost (purchase requisitions, purchase orders, vouchers, requisitions for materials, inventories, labor time cards, payrolls, bases for apportioning costs, etc.), which pertain to the determination of reasonable cost, capable of being audited.

Financial and statistical records should be maintained in a consistent manner from one period to another. However, a proper regard for consistency need not preclude a desirable change in accounting procedures, provided that full disclosure of significant change is made to the intermediary.

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- Worksheet begins process of matching expenses to revenues:
  - In order to do this properly, need to understand what the department/cost center is for, where is the revenue, if any?
  - Provide cost report preparer with explanations regarding what each new department represents. Purpose, patients served, who is providing the service, where.
  - Almost every new account, unless small balance and part of existing department should be understood.
  - There are often significant issues in this area:
    - Preparers not understanding the nature of revenues and expenses.
    - Providers not understanding all the changes that have occurred in their facility.

Considerations for new cost centers (strategy opportunity):

- Ability to properly segregate revenues and expenses.
- Impact on reimbursement.
- Required?

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CODING OF EXPENSES

- Imperative to code expenses properly on general ledger to ensure proper reimbursement.
- Each department has its own Medicare percentage that is cost reimbursed creating this importance.
- Largest expense for most hospitals is labor, very important to ensure wages are in correct departments for the revenue being generated:
  - EKGs
  - Labor/Delivery/Nursery/OB
  - Emergency Room
- Recommend all labor be coded to correct department on general ledger rather than doing reclassifications on cost report.

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CODING OF EXPENSES – EXAMPLE

- Med/Surg Medicare utilization = 65%
- Emergency Room Medicare utilization = 32%
- Facility utilizes "floating" nurses between departments. Imperative to capture accurate costs for these separate departments.
- Each $100,000 of expense results in a change of $33,000 in Medicare reimbursement under this scenario.

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GENERAL SERVICE COST CENTERS

Need to understand overhead costs here also!

What is the cost and who are they providing services too?
Will "drive" proper cost center set-up on
Worksheet A for allocations on Worksheet B series.

Building Capital – One or more cost centers,
do we have correct cost in cost centers.

Are there any directly assigned capital costs?

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Equipment Capital

- Any directly assigned equipment to revenue producing departments?
- In order to directly assign, depreciation on movable equipment needs to be broken out by cost center where the equipment is physically located or used.
- MAC approval required for direct assignment.

Employee Benefits

- Directly assigning benefits versus allocating them?
- In order to directly assign them, need to be broken out by cost center on general ledger. Can't be allocated to cost centers through internal calculations.

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- Provide an understanding of where all practitioner expenses have been coded on general ledger and on worksheet A. HIGHLY RECOMMEND SEPARATE ACCOUNTS
- High probability cost centers for practitioner expenses:
  - Admin & General
  - Adults and Peds
  - Operating Room
  - Radiology
  - Sleep Study
  - Emergency Room
  - Provider-based Clinics

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WORKSHEET A

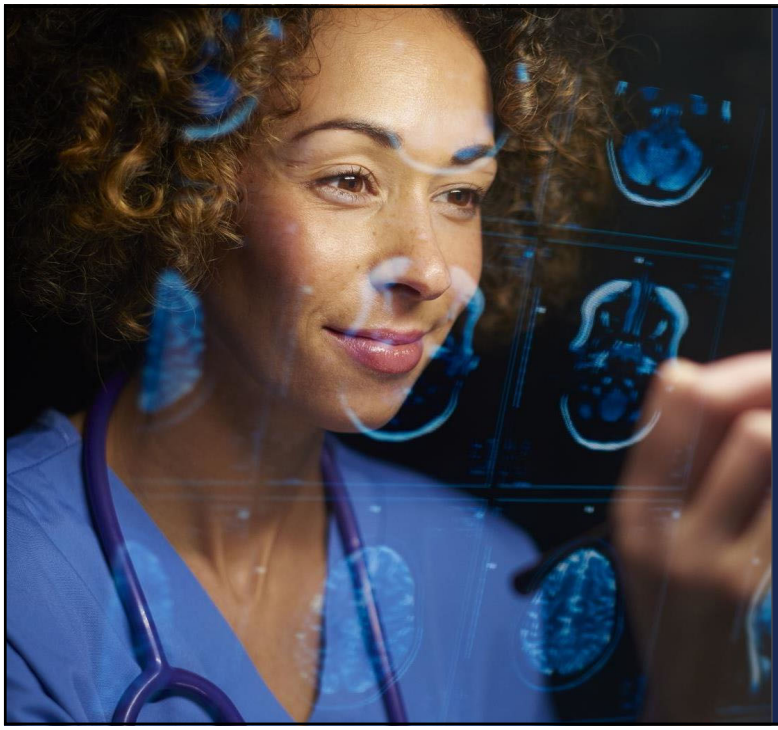
Where are chargeable supplies and drugs coded?

- Multiple departments or single department.
- Where is revenue?
  - Major area of concern on many new EHR implementations.
- How can we best properly match expense and revenue and also Medicare revenue?
- Recommendation chargeable supply expense should be separated in general ledger from non-chargeable supply expense.
- As noted previously Implant expense would also be separate expense account(s).

Historically small departments may have been combined with larger departments

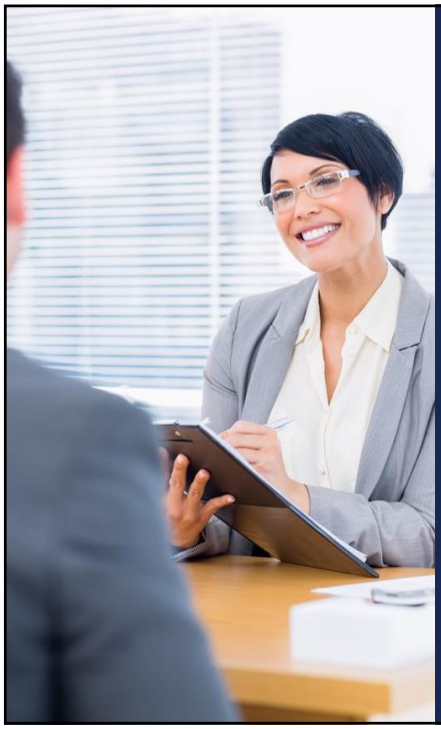
- Cardiac Rehab
- Cardiology
- EKG
- Occupation
- Speech Therapy

65



- **Should Imaging be one cost center or multiple cost centers?**
  - CT Scans
  - MRI
  - Nuclear Medicine
  - Ultrasound
- **May gain reimbursement, but is it correct?**
- **Radiology – Imaging, one cost center or multiple?**
  - If multiple, do we have salaries in each of the cost centers? How do we handle the department director salaries?
  - Is revenue separated appropriately for matching?

66



- **Combine all provider-based clinics in to one cost center or have separate cost centers?**
  - Reimbursement impact?
  - 340B recognition.
  - Should other ancillary costs within provider-based clinics be shown within the clinic?
    - Lab
    - Radiology
    - Chargeable supplies
    - Chargeable pharmacy
- **Reimbursable vs. Non-reimbursable cost centers:**
  - Non-reimbursable cost centers are those departments for which costs are incurred for non-hospital patients.
  - If NRCC cost (direct and indirect) will be immaterial, then would recommend an A-8 offset instead.
  - Assisted Living
  - Freestanding Clinics

67

PHYSICIAN PRIVATE OFFICES – WHAT ABOUT SURGEON COSTS, RADIOLOGIST COSTS, OTHERS?

Line 192 -- Establish a nonreimbursable cost center to accumulate the cost incurred by you for services related to the physicians' private practice. Such costs include depreciation costs for the space occupied, movable equipment used by the physicians' offices, administrative services, medical records, housekeeping, maintenance and repairs, operation of plant, drugs, medical supplies, and nursing services. Do not include costs applicable to services rendered to hospital patients by hospital-based physicians since such costs may be included in hospital costs.

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WORKSHEET A-6

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WORKSHEET A-6

Purpose:

- To provide for the reclassification of expenses from one cost center to another, establish proper matching of revenue & expense. Goal would be to minimize these.

Common reclasses:

- Interest expense;
- Depreciation;
- ER vs RHC compensation;
- Salary;
- Administrative and General costs in individual cost centers.

70

Estimating reclass amounts, is this OK?

	Hours/Birth	from stat sheet/usage report # of Days/Births	Hours	Average Salary	Salary Allocation	FICA Portion
Nursery	6	141	846	17.84	$ 15,093	$ 1,155
Labor/Delivery	13	68	884	17.84	$ 15,771	$ 1,206

How were hours per birth arrived at? (Time study)

71

WORKSHEET A-6

Preference would be to have salaries moved within general ledger rather than reclass.

Actual time spent would be best. (Timesheets!)

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• Reclass expenses from non-reimbursables or other cost centers to overhead so as not to double allocate costs.
• Capital
• Admin & General
• Maintenance
• Housekeeping
• Medical Records
• Primarily salary amounts, but can be "other" amounts also.
• Most often additional overhead amounts found in major service lines.
• Clinics
• Nursing Home
• Assisted Living
• Home Health

73


WHY IS THIS DONE?
• Allocate indirect costs to major service lines to reflect better departmental financial statements throughout the year.
• However, makes it more difficult for accurate cost reporting as need to eliminate these internal allocations.

74

Overhead reclass, RHC or PB clinic is more than likely less Medicare utilized department than others so by reclassifying overhead cost back up improves reimbursement.

N	Reclass Business Office salaries benefits from RHC	5.03	192,833	68,784	88	192,833	68,784

75

WORKSHEET A-7

76

WORKSHEET A-7

Purpose

- Analyze the changes that occurred in the capital assets during the current period.
- Allocates property insurance and other expenses between building and equipment.

Type & source of data

- Depreciation schedules, including detail, and summary information.
- List of asset additions and deletions.
- Property insurance.

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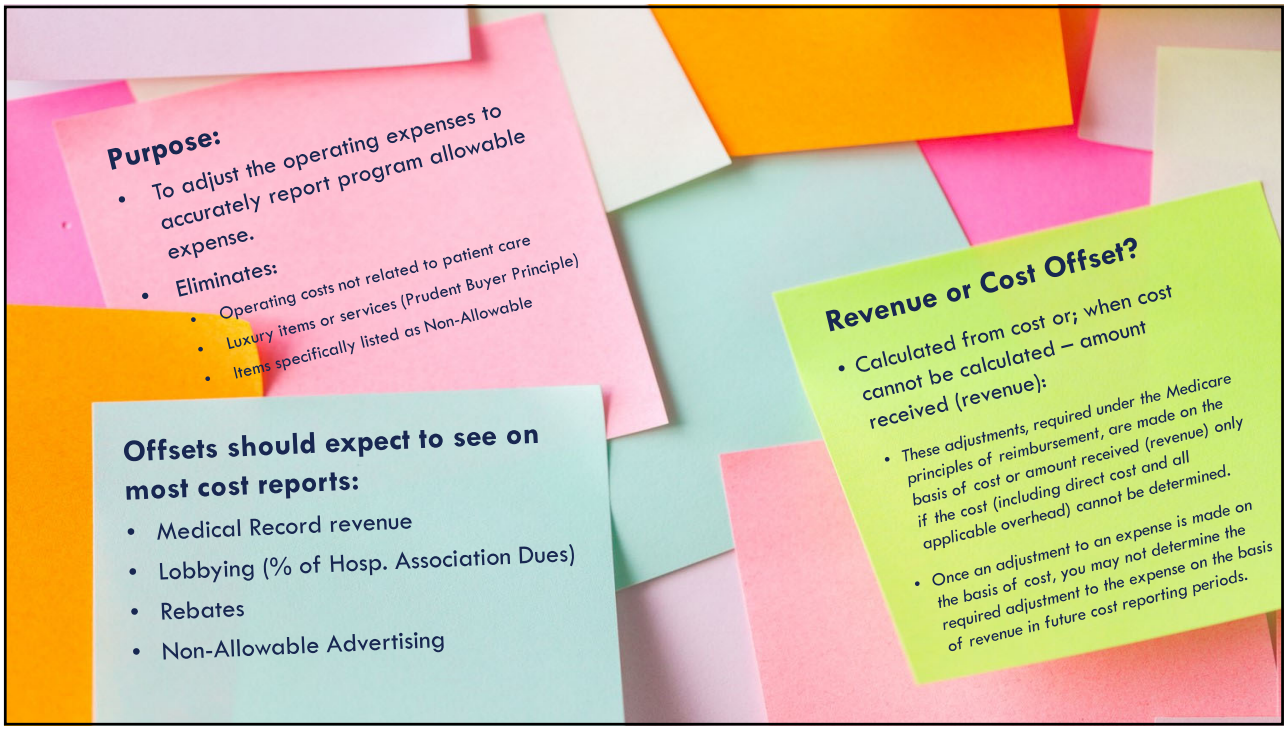
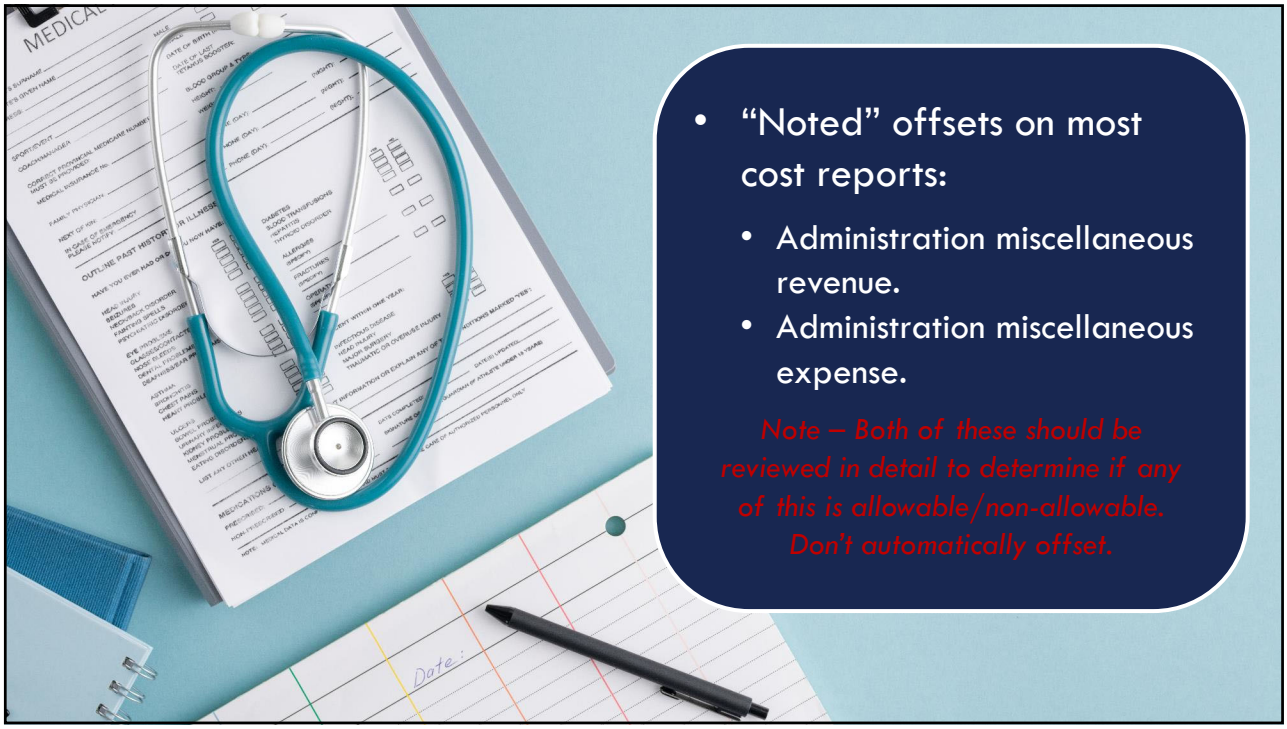
WORKSHEET A-8

78


Purpose:
To adjust the operating expenses to accurately report program allowable expense.
Eliminates:
Operating costs not related to patient care
Luxury items or services (Prudent Buyer Principle)
Items specifically listed as Non-Allowable
Offsets should expect to see on most cost reports:
Medical Record revenue
Lobbying (% of Hosp. Association Dues)
Rebates
Non-Allowable Advertising
Revenue or Cost Offset?
Calculated from cost or; when cost cannot be calculated – amount received (revenue):
These adjustments, required under the Medicare principles of reimbursement, are made on the basis of cost or amount received (revenue) only if the cost (including direct cost and all applicable overhead) cannot be determined.
Once an adjustment to an expense is made on the basis of cost, you may not determine the required adjustment to the expense on the basis of revenue in future cost reporting periods.

79


"Noted" offsets on most cost reports:
Administration miscellaneous revenue.
Administration miscellaneous expense.
Note – Both of these should be reviewed in detail to determine if any of this is allowable/non-allowable. Don't automatically offset.

80

All "Other Revenue" accounts should be reviewed to determine if any of the revenue should be offset.

- Grant revenue - allowable
- Incentive payments from other payers – allowable
- Outreach revenue (cost) – not allowable
- Rent income – not allowable

Hospice – offset amount received under contract from hospice in use of general inpatient routine beds.

81

82

- Interest Expense – allowable versus nonallowable
- Interest Income Offsets
- Funded Depreciation
- Excess Borrowing

83

- Necessary –
  To be considered necessary, the interest must be:
  - Incurred on a loan that is made to satisfy a financial need,
  - **For a purpose related to patient care**, and
  - **Incurred on a loan that is reduced by investment income.**
  - If a borrowing or a portion of a borrowing is considered unnecessary, the interest expense on the borrowing, or the unnecessary portion of the borrowing, is not an allowable cost.
  - **The repayment of the funds borrowed is applied first to the allowable portion of the loan.**
  - The allowable interest for a year is determined by multiplying the total interest for the year by the ratio of the allowable share of the loan to the total amount of the loan outstanding. The ratio is based on the loan balance (allowable and total) at the beginning of the cost report year.

Possibility of "curing" the unnecessary borrowing portion by:

- Purchasing patient care related capital assets:
  - Untainted funded depreciation dollars used first.
- Using funded depreciation dollars to repay borrowing.

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OFFSET BY INVESTMENT INCOME

- Investment income for offset is the aggregate net amount realized (not unrealized) from all investments of patient care funds in nonpatient care related activities and may include interest, dividends, operating profits and losses, and gains and losses on sale or disposition of investments.
- Excluded from the definition of investment income is the investment income from:
  - Grants, gifts, and endowments, whether restricted or unrestricted,
  - Funded depreciation,
  - Qualified pension funds,
  - Deferred compensation funds.

- **The investment income is only offset against allowable interest expense.**
- **Any investment income (subject to offset) in excess of allowable interest expense is not used to offset other expenses.**

If the aggregate net amount realized from all investments of patient care related funds is a loss, the loss is not allowable. The net loss is not added to interest expense and it is not an allowable expense.

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CRNA

- If don't have pass-through exemption, must offset CRNA costs on A-8. (line 19 or line 53):
  - Salaries
  - Benefits (don't include: FICA, work comp, unemploy)
  - Purchased CRNA costs
  - Training
- Remember – exemption is calendar year, so may have exemption for part of fiscal year, only offset costs for calendar year don't have exemption.
- CRNA professional revenue should be offset for same period on worksheet C.
- Whether have CRNA exemption or not, professional revenue is billed under revenue code 964.
- If by chance lose exemption, ensure no revenue for revenue code 964 on PSR type 850 for that calendar year.
- If no exemption and billing Method II for CAH, revenue should show up on PSR type 855.
- Jurisdictional issues to consider:
  - CRNA on-call offset.
  - CRNA reasonable compensation limitations by MAC.

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DIETARY REVENUE

- Consists of following purchased meals:
  - Employee meals (Cafeteria)
  - Guest Meals
  - Meals on Wheels
  - Jail Meals
  - Apartment Meals
  - Assisted Living Meals
- Offset revenue or cost allocated through B-1?
- Revenue does not usually cover the total cost (direct and indirect) of the meal.
- Average meal revenue - $4 to $7.
- Average meal cost - $10 to $20.

87

	Revenue	
Total meals provided for Meals on Wheels		5,000
Revenue per meal	$	6.00
Dietary revenue offset for Meals on Wheels	$	30,000
Medicare Utilization of dietary department		50%
Net impact on Medicare Reimbursement	$	15,000

	Cost - Stepdown	
Total meals provided for Meals on Wheels		5,000
Total cost per meal - Direct & Indirect	$	14.00
Total costs allocated for Meals on Wheels	$	70,000
Medicare Utilization of dietary department		50%
Net impact on Medicare Reimbursement	$	35,000
Difference in Medicare Reimbursement	$	(20,000)

88

NON-RHC COSTS

- Relate to compensation of practitioners for time they spend performing services outside of the rural health clinic and not part of the all-inclusive rate.
- Section 40.1 of Benefit Policy Manual for RHC:
  - *RHC and FQHC visits may not take place in:*
  - *an inpatient or outpatient department of a hospital, including a CAH, or*
  - *a facility which has specific requirements that preclude RHC or FQHC visits (e.g., a Medicare comprehensive outpatient rehabilitation facility, a hospice facility, etc.).*
- Non-RHC time/services includes the following:
  - Inpatient visits (acute only)
  - Outpatient visits:
    - Observation
    - Outpatient surgical
    - Emergency Room
  - Telehealth Visits
  - Services to external entities:
    - Medical Directors
    - Etc.
- Paid under the Medicare physician fee schedule for these services, not the RHC AIR.

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SECTION 40.1 OF BENEFIT POLICY MANUAL FOR RHC

RHC or FQHC visits may take place in:

- the RHC or FQHC,
- the patient's residence (including an assisted living facility),
- a Medicare-covered Part A SNF (see Pub. 100-04, Medicare Claims Processing Manual, chapter 6, section 20.1.1), or
- the scene of an accident.

Note – Medicare-covered Part A SNF includes Medicare swingbed.

90

NON-RHC COSTS

Provider Time Study Summary

	RHC	RHC	RHC	RHC	RHC	RHC	RHC	NRHC	NRHC	NRHC					
	Clinic hours	Clinic hours	SB hours	Nursing Home hours	Clinic mtgs hours	XIX er/ip/op hours	Other mtgs hours	OP/Proc hours	ER hours	IP hours	Worked Hours Total	ER On Call hours	Hours Worked while on Call	ER On Call Stand by	Total Hours
7/17/16 to 7/23/16	24.5			6.5	1		2.5		8.5	2.5	45.5	48	18.5	29.5	75
8/14/2016 to 8/20/16	31								5	8	44	24	19	5	49
9/4/16 to 9/10/16	29.75								12	6.5	48.25	48	26.5	21.5	69.75
10/2/16 to 10/8/16	16			8					11.5	5	40.5	48	24.5	23.5	64
11/13/16 to 11/19/16	29		2.25						2	4	37.25	48	19.25	28.75	66
12/18/16 to 12/24/16	26.5						1.5		6	1	35	24	17	7	42
1/22/17 to 1/28/17	30			7					3	6	46	26	16	10	56
2/5/17 to 2/11/17	27.25		0.5						5.5	7.5	41.75	46	22	24	64.75
3/12/17 to 3/18/17	24		2						3	2.5	31.5	23.5	16	7.5	39
4/9/17 to 4/15/17	28.5		0.5						4	4.75	37.75	26	16	10	47.75
5/7/17 to 5/13/17	38								2.5	1	41.5	53	15	38	79.5
6/18/17 to 6/24/17	35						1		1	0	37	15	2	13	50
	339.5	0	5.25	21.5	1	0	5	0	64	48.75				217.75	702.75
	48%	0%	1%	3%	0%	0%	1%	0%	9%	7%				31%	100%

SALARIES	ER	RHC	IP/OP	Total
Practitioner 1	45,075.78	54,020.78	876.96	99,973.52
Practitioner 2	82,581.20	73,104.67	6,092.06	161,777.92
Practitioner 3	-	-	-	-
Practitioner 4	12,115.22	5,617.67	3,519.51	21,252.40
Practitioner 5	17,039.03	38,538.62	-	55,637.65
Practitioner 6	41,902.19	55,361.45	7,250.16	104,513.80
Practitioner 7	7,345.58	11,780.64	554.38	19,680.60
Practitioner 8	47,768.58	37,857.41	4,549.39	90,175.38
	253,827.57	276,341.25	22,842.45	553,011.27
	253,827.57	276,341.25	22,842.45	553,011.27
			A-8	-

Recommend capture information via time study instead of visits. However, sometimes difficult to get time study.

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340b Program – Impact on Cost Report

Two Programs

- Reduction in pharmacy expense for drugs dispensed for outpatients in the hospital setting.
- Contract pharmacy.

340b Contract Pharmacy

Ways to address 340b Contract Pharmacy on cost report:

- Offset expenses related to contract pharmacy.
- Offset revenue associated with contract pharmacy.
- Include direct expenses related to contract pharmacy as a non-reimbursable cost center.

340b Contract Pharmacy

Non-Reimbursable Cost Center:

- Costs of purchased pharmaceuticals.
- Should include any pharmacist direct costs.
- Can overstate allocations of indirect expenses.
  - Recommend strategizing on allocation of costs:
    - Information technology
    - Business Office

340b Contract Pharmacy

If offsetting direct expenses:

- Does it include any pharmacist time monitoring program.
- Any A&G expenses for paying invoices, etc.
- Risk of MAC establishing as a non-reimbursable cost center:
  - What is that dollar amount?

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340B CONTRACT PHARMACY HANDLING

	Non-Reimbursable Cost Center		Fragmented A&G		Additional direct & indirect offset
Direct drug cost and pharmacy time	$ 700,000	Direct drug cost and pharmacy time	$ 700,000	Direct drug cost and pharmacy time	$ 700,000
Allocated A&G costs - one cost center	$ 170,000	Allocated A&G costs - multiple cost centers	$ 100,000	A&G offset of direct costs - Time spent	$ 50,000
Medicare Utilization of A&G department	35%	Medicare Utilization of A&G department	35%	Medicare Utilization of A&G department	35%
Net decrease on Medicare Reimbursement	$ (59,500)	Net decrease on Medicare Reimbursement	$ (35,000)	Net decrease on Medicare Reimbursement	$ (17,500)
		Impact	$ 24,500	Impact	$ 42,000

93

- Adjustment to Non-Reimbursable areas

NOT ALLOWED

- Adjustments are typically reductions to expense – however there may be instances of increases:
  - Expenses from a prior year which needed to be amortized in subsequent years yet expense in financial statement when incurred.

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WORKSHEET A-8-1

95

WORKSHEET A-8-1

Purpose (Related Organizations)

- To provide computation of adjustments needed to account for costs applicable to services, facilities, and supplies furnished by organizations related to the hospital or associated with the home office.

Type & source of data

- Financial statements and expense lead schedules from related organization or home office.

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1000. Principle

12-82 COST to RELATED ORGANIZATIONS 1004.1

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. The purpose of this principle is two-fold: (1) to avoid the payment of a profit factor to the provider through the related organization (whether related by common ownership or control), and (2) to avoid payment of artificially inflated costs which may be generated from less than arm's-length bargaining. (Cross-refer to section 2150ff.)

1002. Definitions

1002.1 Related to the provider means that the provider to a significant extent is associated or affiliated with, or has control of, or is controlled by, the organization furnishing the services, facilities, or supplies.

1002.2 Common ownership exists when an individual or individuals possess significant ownership or equity in the provider and the institution or organization serving the provider.

1002.3 Control exists where an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution.

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WORKSHEET A-8-1

Removes cost on worksheet A and adds in "true" cost to worksheet A.

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5
	1.00	2.00	3.00	4.00	5.00
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	4.01	BILLING & COLLECTIONS	ADDITIONAL ALLOCATED COSTS	131,972	3,940
2.00	5.00	ADMINISTRATIVE & GENERAL	ADDITIONAL ALLOCATED COSTS	1,051,252	450,000
3.00	16.00	MEDICAL RECORDS & LIBRARY	ADDITIONAL ALLOCATED COSTS	8,410	0
3.01	44.00	SKILLED NURSING FACILITY	ADDITIONAL ALLOCATED COSTS	29,212	2,212
3.02	73.00	DRUGS CHARGED TO PATIENTS	ADDITIONAL ALLOCATED COSTS	39,535	45,482
3.03	91.00	EMERGENCY	ADDITIONAL ALLOCATED COSTS	41,122	47,970
4.00	0.00			0	0
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			1,301,503	549,604

	Net Adjustments (col. 4 minus col. 5)*
	6.00
	A. COSTS INCURR HOME OFFICE COS
1.00	128,032
2.00	601,252
3.00	8,410
3.01	27,000
3.02	-5,947
3.03	-6,848
4.00	0
5.00	751,899

Home office allocated cost

Amount paid to home office

Additional expenses included on worksheet A

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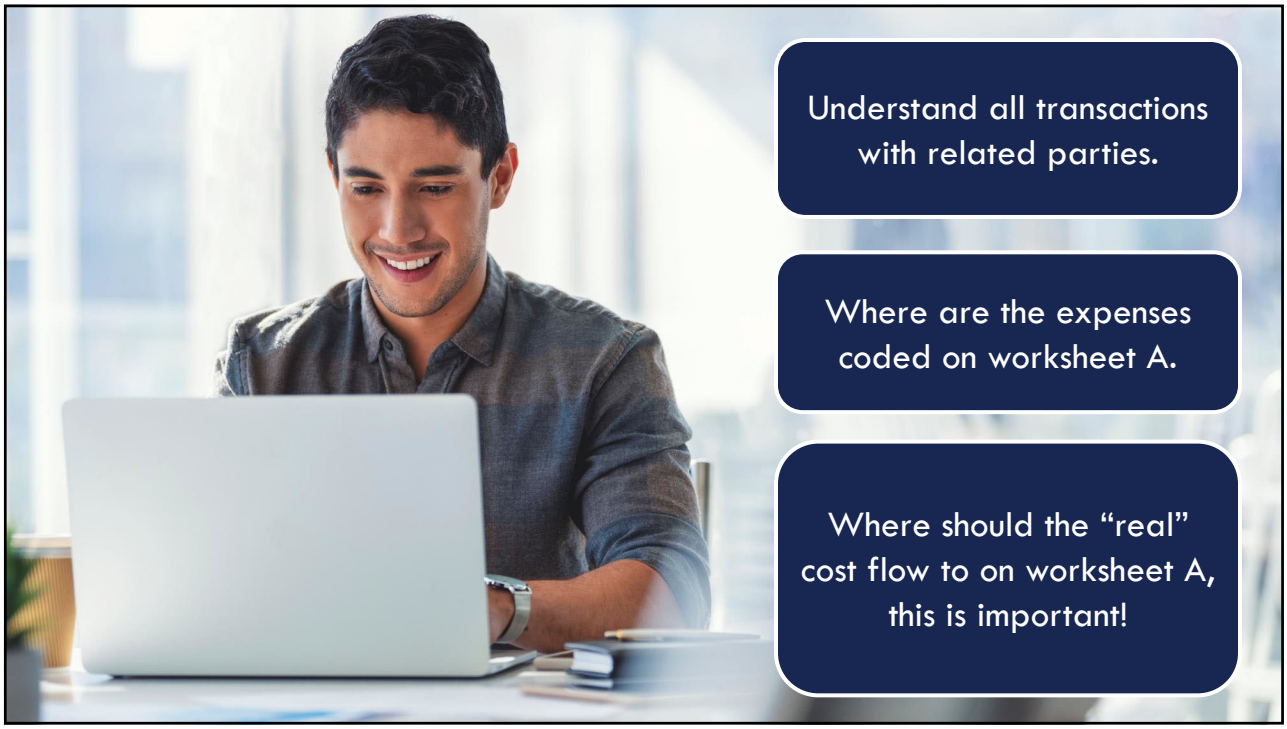

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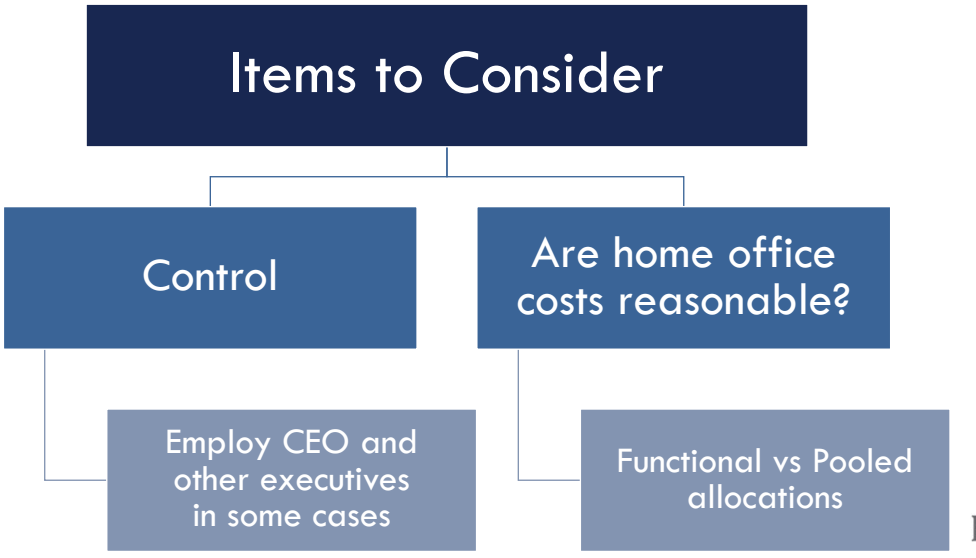
RECENT CHALLENGES – RELATED PARTY



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WORKSHEET A-8-2

101

WORKSHEET A-8-2

Purpose

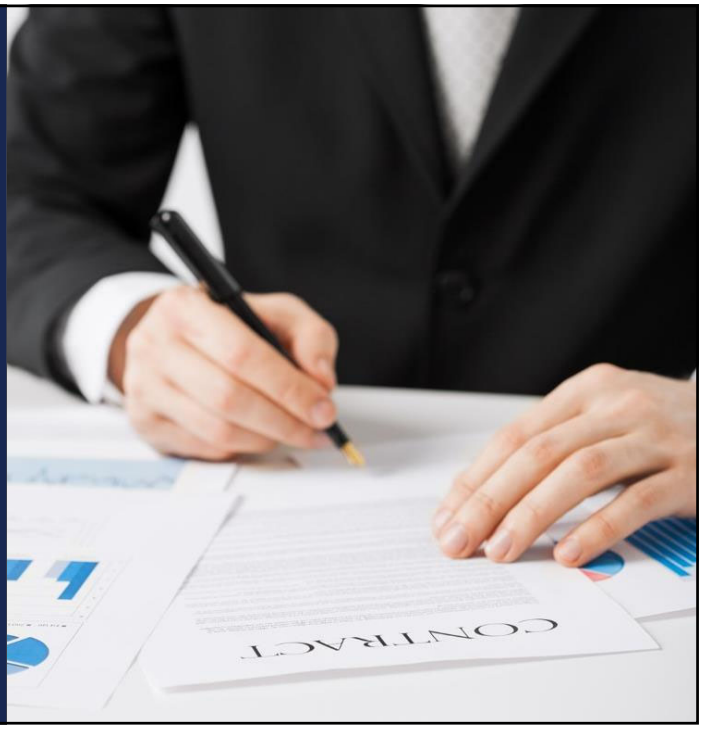
- To provide for the splitting of hospital-based physician costs between provider components and professional components.

Type & source of data

- General ledger costs
- FTE hours
- Wage and hour reports
- General ledger reports
- Internal reports and time studies
- Physician contract documents
- Internal spreadsheets

102

- Physician contracts:
  - Review contracts for responsibilities and compensation.
  - Provider based clinic physicians.
- Understand where all payments to practitioners are coded on general ledger. (Very important)
- Include Advanced Practice Providers (Midlevels) on this worksheet also.



103

WORKSHEET A-8-2

In what situations are costs (wages/benefits) paid to a physician or advanced practice provider an allowable cost on our Medicare cost report?

1. Provider-based Rural Health Clinic?
2. Provider-based Clinic?
3. Freestanding Clinic?
4. Emergency Room Availability?
5. Medical Director?
6. On-call Surgeon?
7. On-call OB practitioner(s)?
8. Hospitalists?
9. Radiologists?
10. Readings of Sleep Studies or EKGs?

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WORKSHEET A-8-2

In what situations are costs (wages/benefits) paid to a physician or advanced practice provider an allowable cost on our Medicare cost report?

1. Provider-based Rural Health Clinic? (Yes)
2. Provider-based Clinic? (Depends)
3. Freestanding Clinic (Depends)
4. Emergency Room Availability? (Yes)
5. Medical Director? (Yes)
6. On-call Surgeon? (No)
7. On-call OB practitioner(s)? (No)
8. Hospitalists? (Depends)
9. Radiologists? (No)
10. Readings of Sleep Studies or EKGs? (No)

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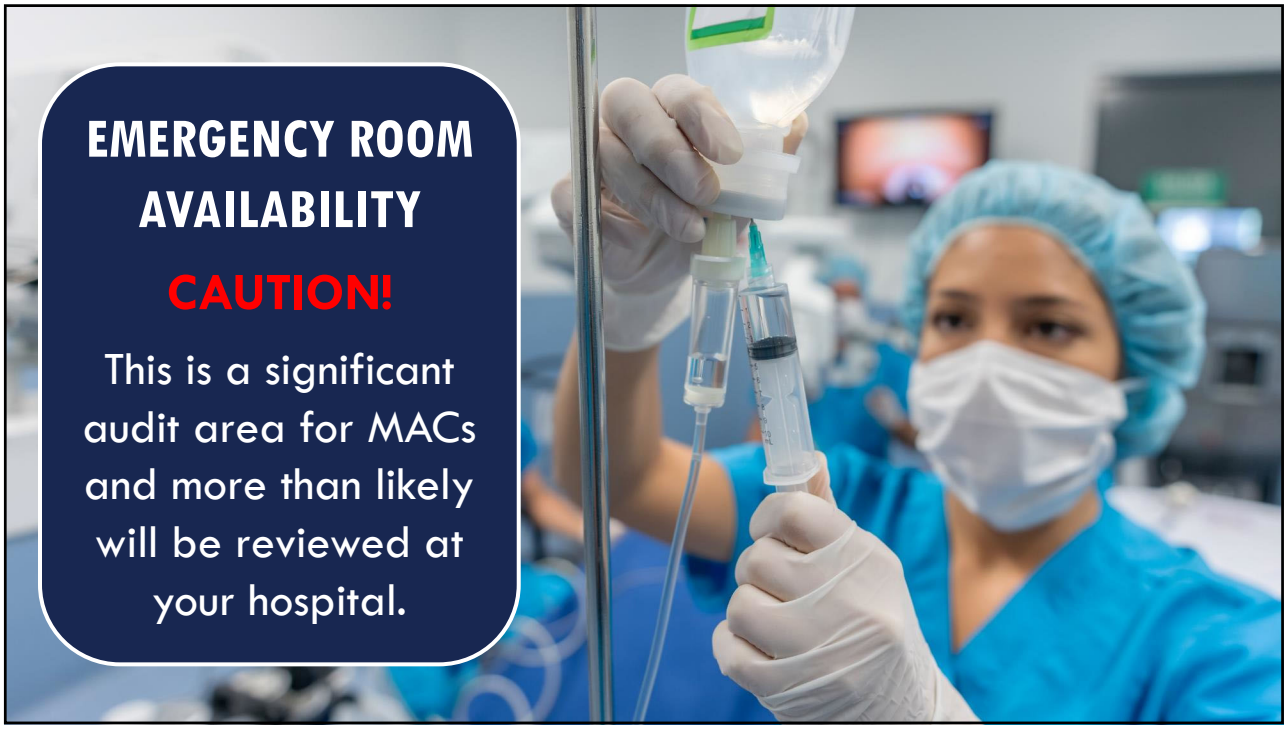

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107

ER STANDBY

The standby allowable cost seems to be only for one physician, possibly only one practitioner (physician, physician assistant, nurse practitioner).

Previous understanding – Advanced Practice Provider first call and physician back up was allowable as long as total cost did not exceed what you would pay for physician to be first call (primary).

Nothing official from MACs or CMS, but other hospitals have been questioned on this and finalization of cost reports is "pending".

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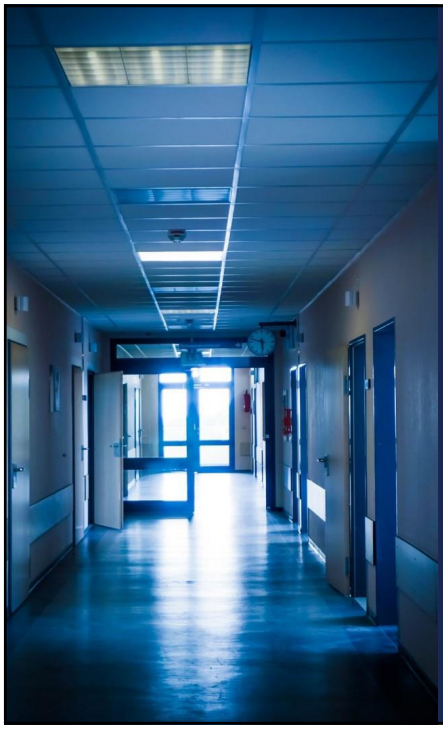

REGULATIONS FOR ER STANDBY:

- Signed contract between hospital and physicians.
- Written allocation agreement and support documentation.
- Permanent payment records
- Permanent record of all treated patients.
- Schedule of charges.
- Documentation of attempts to obtain alternative coverage/pricing.

- Medicare will share in cost of ER standby time for ER practitioners.
- Don't need to be onsite, must arrive within 30 minutes for a CAH
- Can't be on-call or providing services elsewhere
- Would expect ER professional component to have a range of around 8% to 40% in most CAH facilities.

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WORKSHEET A-8-2

Varying requirements by MACs for time studies:

- Two, two-week time studies.
- Four, two-week time studies, one each quarter.
- One week per month, alternating weeks.
- Physicians may do two, two weeks, but advanced practice providers one-week per month, rotating weeks.

- Time studies must be representative for the period of the cost report.
- What if you have intermingled practitioners, physicians and advanced practice providers, covering your emergency room?
  - Strongly recommend one week per month, alternating weeks throughout the year to ensure appropriate studies are kept.

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WHAT IS NEEDED IN THE ER TIME STUDY?

Month:	January			ER Availability Time Study - Midlevel and Physician (1 Wee						
Week:	1									
Date	Patient ID	Admit Time	Discharge Time	With Patient Start	With Patient End	Total Patient Time	Documentation Begin	Documentation End	Documentation Time	Total Patient Time
1/1/2018	123456	1:10 AM	2:15 AM	1:30	2:00	0:30	2:00	2:15	0:15	0:45
1/1/2018	123457	3:30 AM	4:50 AM	3:45	4:30	0:45	5:20	5:45	0:25	1:10
1/1/2018	123458	4:00 AM	5:30 AM	4:45	5:15	0:30	5:00	5:20	0:20	0:50
1/1/2018	123459	5:45 AM	6:35 AM	6:00	6:25	0:25	6:30	6:45	0:15	0:40
						0:00			0:00	0:00
						0:00			0:00	0:00
						0:00			0:00	0:00
						0:00			0:00	0:00
						0:00			0:00	0:00
						0:00			0:00	0:00
						0:00			0:00	0:00
						0:00			0:00	0:00
						0:00			0:00	0:00
						0:00			0:00	0:00
						0:00			0:00	0:00

- Identify back to patient ID
- Time practitioner with patient
- Documentation time
- Time study signed by practitioner

111

TIME STUDIES

Use of RTLS (Real Time Locating System)

Benefits

- Ease in documenting time with patient.
- More than meets time study requirements.

Downfalls

- Cost is sometimes prohibitive.
- Doesn't include documentation time.
- Is it conservative?
- How does Medicare view this?

- Cost is becoming more affordable
- Ways to capture documentation time
- Open to review by Medicare

Potential to be become a viable alternative to keeping manual time studies.

Each facility will need to determine cost/benefit scenario.

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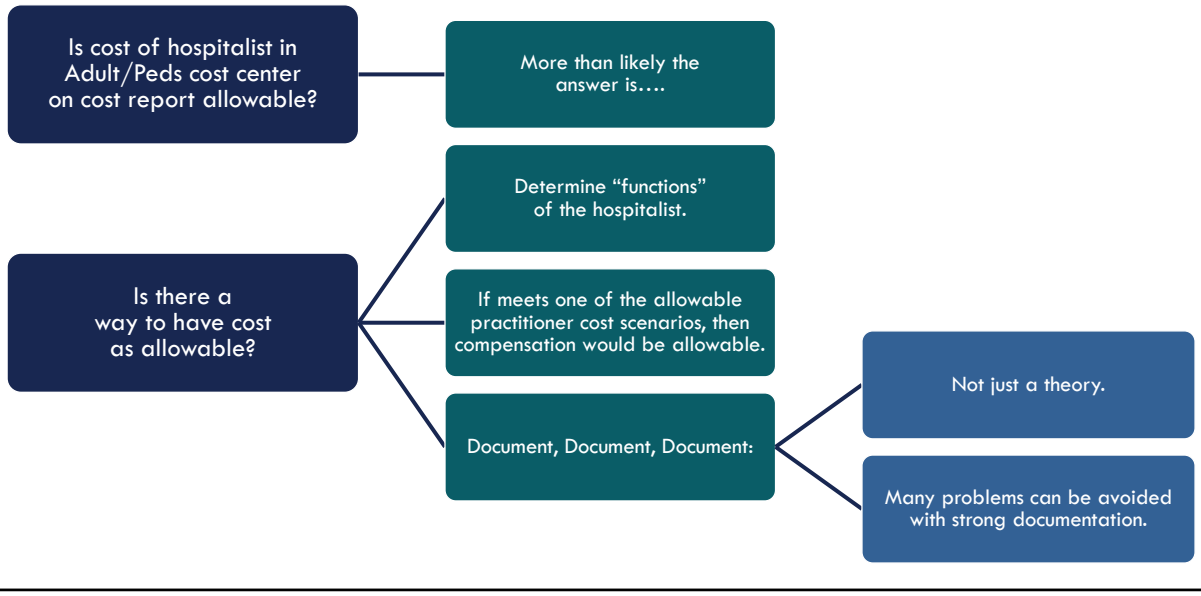
113

WORKSHEET A-8-2



114

- Review all contracts for existing opportunities to identify Part A costs.
- Consider cost report implications when negotiating new contracts.
- Code practitioner wages/fees to separate general ledger accounts as much as possible.

115

WORKSHEET A-8-3 (CAH)

116

WORKSHEET A-8-3, PARTS I – VI

Purpose

- To compute the limit for contract physical, occupational, speech, and respiratory therapy services.

Type & source of data

- General ledger costs
- Contract FTE hours
- Days of service
- General ledger reports
- Billings from the contract therapists
- Contract documents
- Internal spreadsheets
- Intermediary data

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WORKSHEET A-8-3 STRATEGIES

Monitor contracts

- Hourly
- Percentage of gross charges

Maintain detailed records

Separate equipment and supplies in contract

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WORKSHEET B PART I

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WORKSHEET B, PART I

Purpose	• To allocate the cost of the general service cost centers (overhead cost centers), based on the allocation statistics from Worksheet B-1, to the revenue-producing and non-reimbursable cost centers.
Type & source of data	• Cost Report data from Worksheet A and Worksheet B-1. • No new data.

120

WORKSHEET B, PART I

- Column 0 flows from Worksheet A, column 7.
- Review non-reimbursable cost centers to monitor impact of allocations.
- The total of column 0 and column 26 will equal.

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WORKSHEET B, PART I

- Overall Theory – Each non-overhead department is to absorb its portion of overhead costs based on their received benefit.
- Basic Cost Accounting Concept – Not so basic in application.

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WORKSHEET B-1

123

WORKSHEET B-1

Purpose

- To provide the statistical basis that the cost report will use to allocate general service cost center costs to revenue-producing and non-reimbursable cost centers on B, Part I.
- This is a major section where money is "found" or "lost".
  - Inaccurate statistics = Inaccurate reimbursement!
  - Less than optimal statistical elections = Less than optimal reimbursement!

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WORKSHEET B-1

Type & source of data

- General ledger cost data
- Depreciation schedule
- Wage and hour/FTE reports
- Plant square footage
- Laundry pounds
- Time studies
- Dietary meals
- Revenue statistics
- Patient day statistics
- Computer Counts
- Phone Counts
- Other (An opportunity to be creative)

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WORKSHEET B-1

General issues:

- Step-down method of cost finding – once a cost center is allocated to others, it may not receive any subsequent allocations:
  - More general to more specific.
  - No circular references!
- All overhead cost centers should be used versus direct assignment of costs (central supply cost directly assigned to med supplies charged to patients)
- No allocations to cost centers receiving no services from the overhead department:
  - Recommend discussion with preparer and review by facility.
- Idle space gets set up as a non-reimbursable cost center:
  - Why is space idle?
  - Think strategy here.

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WORKSHEET B-1

General issues:

- Do not directly expense and allocate to a cost center:
  - No duplication of cost allocations.
  - Watch for mixture of methods.
  - Common areas of difficulty:
    - Rural Health Clinics
    - Home Health
    - Nursing Homes
    - Hospice
- Understand the effects on allocations when making any changes!!
  - Organization chart.
  - Locations of service.

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WORKSHEET B-1

General issues:

- Costs are allocated based on unit multiplier:
  - Cost divided by total statistics.
  - Monitor trends from year to year.
- Percentage of total allocation more important than actual unit multiplier.
- Medicare recognizes alternative allocation methodologies:
  - Standard statistic required to be used for overhead cost centers.
  - Request for change in a methodology must be submitted 90 days prior to the end of the affected cost reporting period:
    - Must possess the necessary statistical information for the whole year (i.e. time studies, etc.)

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Buildings and fixed equipment

- Square footage:
  - Also used for many different areas.
  - Be sure updated statistics are maintained:
    - Including supporting documentation.
  - Engage Plant Engineering staff.
  - Reconcile back to floor plans.
  - Electronic spreadsheets work well.

Gross versus Net Square Footage

- Frequently little difference between the two.
- Need a process for splitting shared common space (i.e. shared hallways).
- Consistency is the key – Common problem areas:
  - Hospital using net – Nursing home using gross.
  - Hospital using net – Clinic using gross.

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- Subscripting for new buildings/ remodeling:
  - Can help prevent dilution of cost allocations when lower cost per foot buildings are added.
  - May help improve allocations with high-cost remodels in high Medicare utilization areas.
  - MAC will be looking for consistency.

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MOVABLE EQUIPMENT

- Square footage or actual (dollar value) are the two methodologies.
- Actual tends to work best if facility has numerous non-reimbursable cost centers or nursing home.
- If actual is used the unit multiplier should be near 1.0:
  - Difference is for interest expense.
  - Adjust for any Worksheet A-8 and A-8-1 adjustments.
  - Include impact for rental expense if reported in this cost center.

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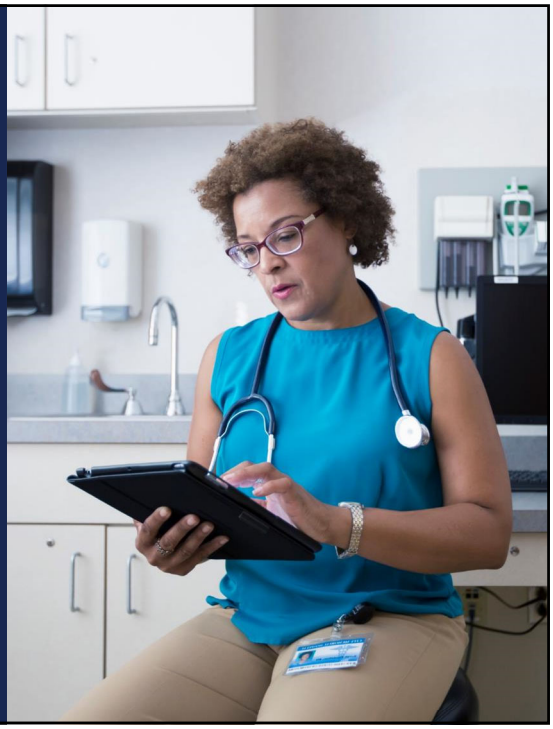
EMPLOYEE BENEFITS

- Allocated based on gross salary.
- Do not report contracted amounts in salary accounts.
- Have seen some preparers/providers attempt to allocate benefits for non-practitioners with the costs for practitioners reported directly:
  - Would tend to reduce costs to non-reimbursable or lower Medicare utilization areas.
  - Historically MACs have pushed to allocate all costs in a category in the same manner (i.e. direct or allocate).
  - Prior approval needed?
- Direct in all departments is difficult/impossible:
  - Floating staff.
  - Worker's Comp/Unemployment/Etc.



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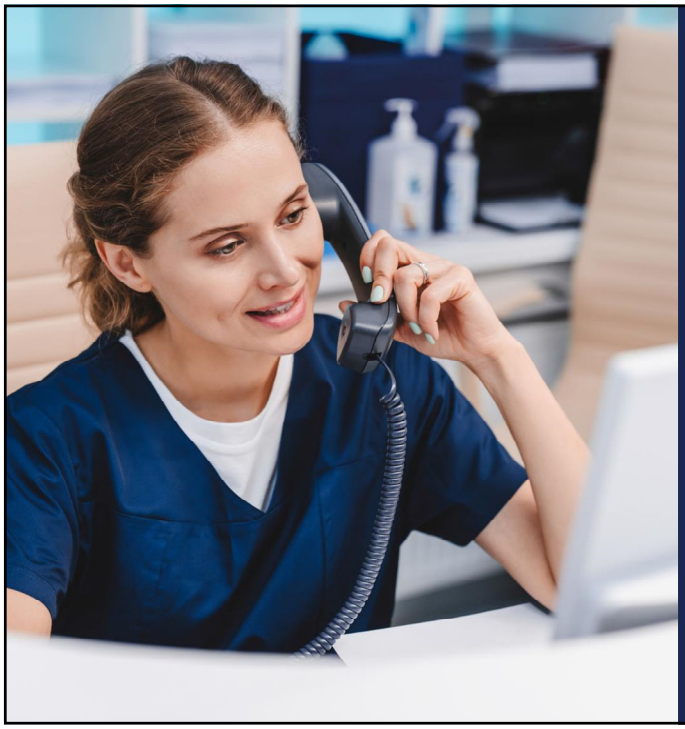

ADMINISTRATIVE & GENERAL

- Accumulated Cost if one cost center.
- Fragmented A&G may provide opportunities to improve overall reimbursement:
  - Business Office
  - Accounting
  - Purchasing & receiving
  - Communications
  - Admissions
  - Information Technology
  - Population Health
  - Administrative & General
  - More? (think outside the box!)

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FRAGMENTED A&G

Business Office:

- Gross revenues.
- Eliminates inappropriate allocations to cost centers not supported by the Business Office:
  - Home Health
  - Hospice
  - Nursing Home
  - Assisted Living
  - Rental properties
- Operational strategies:
  - Multiple Businesses Offices:
    - Hospital/Physicians.
    - Nursing Home/Home Health/etc.
  - Pricing strategy can also drive reimbursement through allocations.

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FRAGMENTED A&G – B.O. EXAMPLE

Assumptions:

- $5,000,000 in total A&G:
  - $4,000,000 in other
  - $1,000,000 in Business Office
- 80% of A&G to cost-based departments:
  - 40% Medicare cost-based utilization
- 20% of A&G to non-cost-based departments:
  - 0% Medicare cost-based utilization

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FRAGMENTED A&G – B.O. EXAMPLE

	Original A&G	Updated A&G	Updated B.O.	Total
Total Cost	$5,000,000	$4,000,000	$1,000,000	$5,000,000
Cost Based %	80%	80%	100%	
Cost Based $	$4,000,000	$3,200,000	$1,000,000	$4,200,000
Medicare Cost %	40%	40%	40%	40%
Reimbursed	$1,600,000	$1,280,000	$400,000	$1,680,000

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FRAGMENTED A&G

Accounting:

- Accumulated cost.
- Gross revenues:
  - Could push costs towards hospital with less to NH and HH:
    - Would better match efforts as the hospital and physician areas take the most time.
- Other?

Purchasing & receiving:

- Purchases by department.
  - Not all to billable supplies and implants
- Can push toward hospital and away from clinics, NH and HH.

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FRAGMENTED A&G

COMMUNICATIONS

- Actual phones by department.
- Eliminates inappropriate allocations to departments without phones/communications:
  - Assisted Living.
  - Nursing Homes.
  - Rental property.

ADMISSIONS

- Gross revenues.
- Eliminates inappropriate allocations to cost centers not supported by Admissions:
  - Assisted Living
  - Rental properties
- Operational strategies:
  - Internalize admission process in NH, HH, Hospice, etc.

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FRAGMENTED A&G (CONT.)

Population Health:

- Newer area to tackle:
  - Administrative vs billable
  - Thoughts:
- Patient care areas:
  - Accumulated cost
  - Revenues

Information Technology

- Area of significant increase in costs:
  - Financial Software
  - EHR
  - Business Intelligence:
    - Further fragmentation?
    - Terminals
  - Componentize and direct?
    - Be careful in this area
    - Talk this out

Administrative & General other?

- Other breakdowns – look at this creatively:
  - Education
  - Medical Staff
  - Parking/Valet
  - Other??

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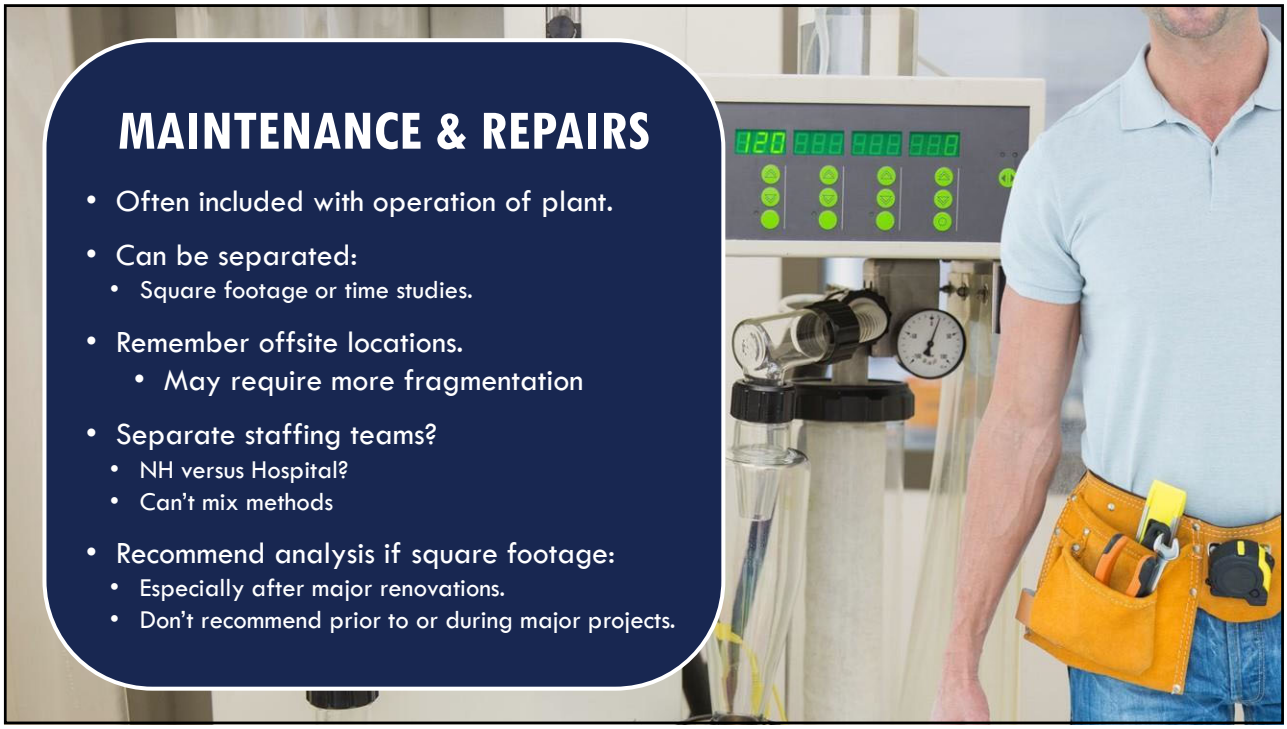
MAINTENANCE & REPAIRS

- Often included with operation of plant.
- Can be separated:
  - Square footage or time studies.
- Remember offsite locations.
  - May require more fragmentation
- Separate staffing teams?
  - NH versus Hospital?
  - Can't mix methods
- Recommend analysis if square footage:
  - Especially after major renovations.
  - Don't recommend prior to or during major projects.



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OPERATION OF PLANT

- May include maintenance & repairs.
- Square footage allocation.
- Can segments of plant or different buildings be separately metered/directly costed or fragmentated?
  - Can be helpful as many non-hospital functions are cheaper on heating, cooling, electricity consumption, etc.
- Watch cost of utilities for separate buildings:
  - We find some costs are direct (electricity) while others (i.e. water, waste removal) remain in Operation of Plant.
- Remember offsite locations.

143

LAUNDRY & LINEN SERVICE

- Allocation by Pounds.
- There should be a statistic for every department receiving laundry services.
- Develop methodology to maintain statistic if laundry performed by outside entity:
  - Outside entity doesn't always track by department.
  - Many use weights per item sent out to departments.
- Review data gathering tool annually for changes:
  - New outpatient areas tend to be the areas missed:
    - Cardiac Rehab.
    - Infusion Therapy.
    - Occupational Therapy (lumped in with Physical Therapy).
    - Labor and Delivery.
    - Nursery.

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HOUSEKEEPING

- Square footage or time studies:
  - Weighted is a new concept to explore
    - Based on cleaning schedule
    - Reduction in allocation to administrative areas?
    - Reduction in allocation to non-reimbursable cost centers?
- There should be a statistic for every department with square feet unless cleaned by department or purchased service:
  - Operating room.
  - Offsite locations.

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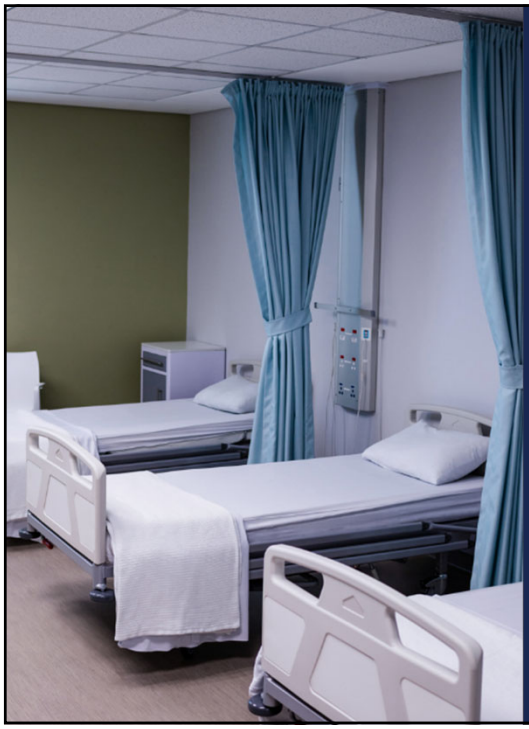

HOUSEKEEPING

- Time studies:
  - The requirement is one week per month, rotating weeks (intermediary requirements may vary).
  - May be more beneficial if periodically cleaning non-reimbursable areas.
- Direct costing – Watch for mixing of methodologies.
- Review data gathering tool annually:
  - Staff only report what they are asked to report.
  - Staff frequently don't know what areas are assigned to each line of the tool.

146

DIETARY

- Meal counts used for allocation:
  - Allocate between Med/Surg, specialty care, NH, cafeteria, & outside meals.
  - Administrative meals should be included in the cafeteria.
  - Weighting of meals:
    - Weighting is a productivity issue – not an allocation issue.
    - Meal count for cafeteria versus dollar value:
      - Strategies for using a dollar value:
        - Cost per meal – how to calculate?
        - Average price for patient meal – how to calculate?

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DIETARY

- Outpatient meals:
  - Understand what they are for.
    - Reimbursable versus non-reimbursable
- Non-reimbursable meals:
  - Free to staff versus free to public.
  - Meals on Wheels:
    - Understand reimbursement impact.
  - Other outside meals:
    - Allocate versus revenue offset?
- Divide patient/resident meals by number of days – should be close to 3.0.
- As a provider:
  - Understand each category of meals being reported.

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CAFETERIA

- FTEs (adjusted for A-6 reclassifications):
  - Include contracted staff:
    - Nursing;
    - Therapies;
    - Etc.
- Don't allocate to departments that don't receive services:
  - Offsite locations
  - Inform preparer of changes

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NURSING ADMINISTRATION

- Understand what is all in here.
  - Direct patient care?
- Hours of service for staff in departments managed.
- Nursing FTEs most common:
  - Many changes in this area due to the role of Chief Nursing Officers:
    - Larger span of control.
    - Potentially large reimbursement impacts.
    - May have a CNO AND a DON? – Now what?
      - 1 cost center?
      - 2 cost centers?

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NURSING ADMINISTRATION

- Needs to match organizational chart:
  - Analyze opportunities to change organizational chart:
    - Clinics.
    - Diagnostic departments.
    - Home Health.
  - Changes must address operational issues.

151

NURSING ADMINISTRATION – EXAMPLE

Single or dual DONs?

Before – one cost center

- $150,000 Hospital DON
- $100,000 Nursing Home DON
- $250,000 total
- Hospital 30% / Nursing Home 70%
- Hospital allocated $75,000
- Nursing Home allocated $175,000

After – two cost centers

- Hospital allocated $150,000
- Nursing Home allocated $100,000
- Increased hospital reimbursement =
  - $75,000 * Medicare utilization
- Need to understand State Nursing Home reimbursement methodology

152

Central services & supply:

- Frequently not used and Worksheet A costs bundled into Medical supplies charged.
  - Does staff support only billable supplies?
- If used, allocated based on costed requisitions:
  - Model the potential impact.
  - May be significant with all of the bundling of supplies into procedure charges.
  - Should be required if the provider is billing for implantables.

Pharmacy:

- Frequently not used and Worksheet A costs bundled into drugs charged to patients – Line 73:
  - Impact of RHCs?
- If this cost center is used, allocate by costed requisitions.
- Impact of 340B?

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MEDICAL RECORDS & LIBRARY

- Gross Revenues vs Time Studies:
  - Gross revenues:
    - Easiest
    - Allocate only to those departments receiving services from medical records
    - Pricing strategies?
  - Time studies:
    - How do you do a time study in this department?
- Separate staffing??
  - Hospital
  - Physicians
  - Nursing Home
  - Etc.

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WORKSHEET B-1

- Social services/activities:
  - Be careful not to bury within nursing home:
    - Swing bed program requires social services and activities.
  - Time studies.
  - Patient days.
  - Don't allocate and directly expense.
- Non physician Anesthetists:
  - 100% to Anesthesia – line 53.
- Nursing school:
  - Assigned time.
- I&R services – salary & fringes:
  - Assigned time to areas.
  - Use rotation schedule.
- I&R services – other program costs:
  - Assigned time.
  - Use rotation schedule.
- Paramedical education programs:
  - Assigned time.

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SIMPLIFIED COST METHOD

Mandatory Allocation Statistics

Statistics include:

Building and Fixtures	Square Footage
Movable Equipment	Square Footage
Maintenance and Repairs	Square Footage
Operation of Plant	Square Footage
Housekeeping	Square Footage
Employee Benefits	Salaries
Cafeteria	Salaries
Administrative and General	Accumulated Costs
Laundry and Linen	Patient Days
Dietary	Patient Days
Social Service	Patient Days
Maintenance of Personnel	Eliminated
Nursing Administration	Nursing Salaries
Central Services and Supply	Costed Requisitions
Pharmacy	Costed Requisitions
Medical Records and Library	Gross Patient Revenue
Interns and Residents	Assigned Time
Nonphysician Anesthetists	100% to Anesthesia

- Allows for alternative method of cost finding.
- Requires less maintenance of statistics.
- Once elected, the provider must continue to use this method for no less than 3 years (unless change of ownership occurs).
- Mandatory allocation statistics.

Some preparers using this to attempt to forego cost offsets in areas such as dietary, laundry, etc.

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WORKSHEET B-1 OVERVIEW

- Do not ignore impact on potential changes in allocation methodology.
- Review opportunities periodically and whenever there are changes in organization.
- When adding/removing a service line, understand this will have an effect on other cost centers and will impact Medicare reimbursement also, model the impact.
- Have department review allocations for appropriateness.

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WORKSHEET B-2

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WHAT IS WORKSHEET B-2 USED FOR?

- Used to offset cost of Epotien and Aranesp from dialysis cost centers.
- Also frequently used to reclassify costs from Med/Surg for non-observation outpatient services performed in Med/Surg:
- Cost report program does not adequately address issue:
  - Only addresses Observation.
  - Potential Issues:
    - Infusion therapy;
    - Injections;
    - Blood administration;
    - Chemotherapy;
    - Recovery (Phase 2);
    - Dressing changes;
    - Miscellaneous procedures.
- Can also be used for:
  - Observation performed in the ICU.
- Most common area of revenue/expense mismatching on cost report:
  - Facilities;
  - Preparers;
  - MACs.

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HOW IS IT CALCULATED? – (OUTPATIENT SERVICES)

- Replicates the observation carve out process that occurs on worksheets S-3 and D-1.
- **Step 1** – Calculate equivalent days:
  - Infusions and Chemo are billed by the hour.
  - Blood administration:
    - Billed in units of service.
    - Recommend charges based on hours to assist with data capture.
  - Recovery often billed by the hour.
  - Injections – need an estimate (often 15 minutes).
  - Other – Need to develop estimate with support to be confirmed each year.
- **Step 2** – Add equivalent days to Worksheet S-3 Line 28 Column 8 (Observation Days).
- **Step 3** – Recalculate.
- **Step 4** – Record cost per diem from Worksheet D-1 Line 38.
- **Step 5** – Calculate amount to reclassify on Worksheet B-2:
  - Equivalent days for outpatient services * cost per diem.
- **Step 6** – Reclass costs on Worksheet B-2 (frequently line 76).
- **Step 7** – Remove equivalent days added to Worksheet S-3 Line 28 Column 8.
- **Step 8** – Recalculate.
- **Step 9** – Compare current cost per diem from Worksheet D-1 Line 38 with rate recorded in Step 4:
  - Rates should be comparable.

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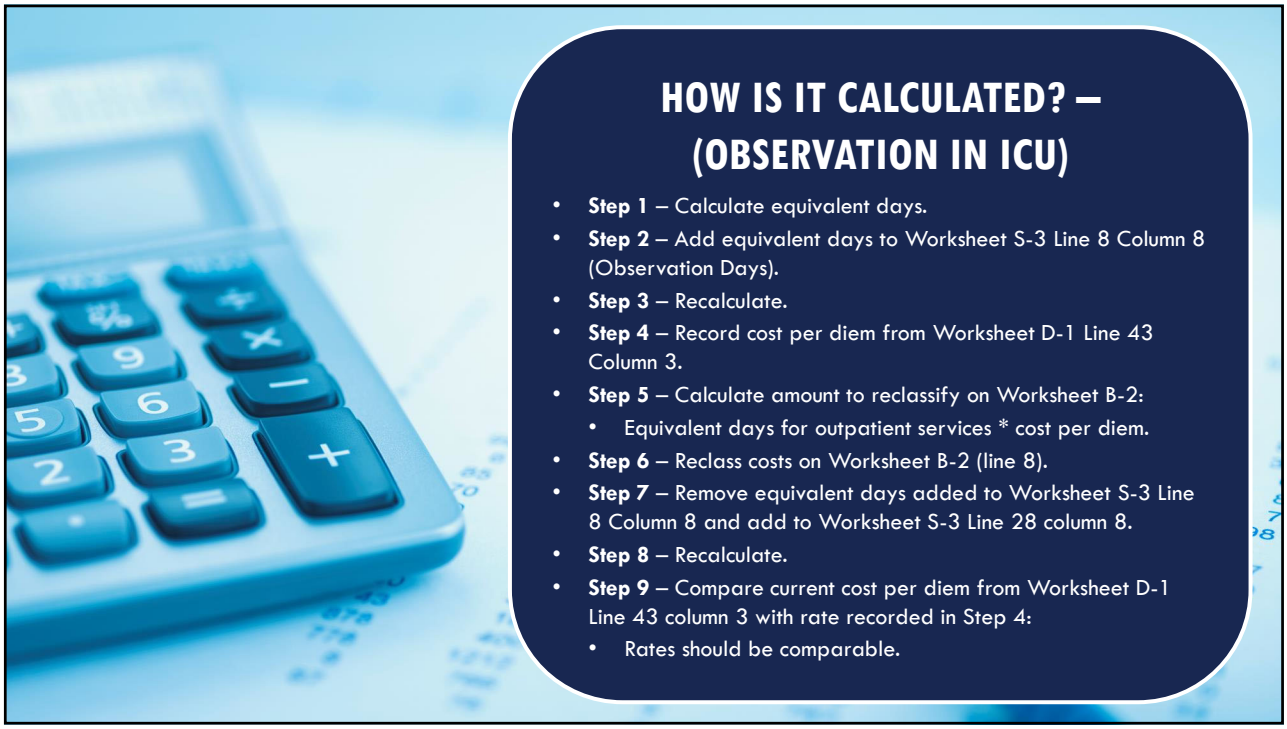

HOW IS IT CALCULATED? – (OBSERVATION IN ICU)

- **Step 1** – Calculate equivalent days.
- **Step 2** – Add equivalent days to Worksheet S-3 Line 8 Column 8 (Observation Days).
- **Step 3** – Recalculate.
- **Step 4** – Record cost per diem from Worksheet D-1 Line 43 Column 3.
- **Step 5** – Calculate amount to reclassify on Worksheet B-2:
  - Equivalent days for outpatient services * cost per diem.
- **Step 6** – Reclass costs on Worksheet B-2 (line 8).
- **Step 7** – Remove equivalent days added to Worksheet S-3 Line 8 Column 8 and add to Worksheet S-3 Line 28 column 8.
- **Step 8** – Recalculate.
- **Step 9** – Compare current cost per diem from Worksheet D-1 Line 43 column 3 with rate recorded in Step 4:
  - Rates should be comparable.

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HOW IS IT CALCULATED? – (RECOVERY, ETC. IN ICU)

- Many variations can exist:
  - Stop and map out the situation.
  - Create the plan:
    - Start with ICU and then to Med/Surg.
  - Implement the plan.

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WORKSHEET C

163

WORKSHEET C, PART I

Purpose

- To compute the ratio of cost to charges for the cost centers in the Ancillary Service Cost Centers, the Outpatient Service Cost Centers, and the Other Reimbursable Cost Centers.
- Ultimately used to calculate Medicare's portion of the costs in these departments on Worksheets D Part V and D-3.
- Medicare will reimburse its percentage of costs based on its percentages of revenues by department.

Type & source of data

- General ledger revenue.
- Cost report data from other worksheets:
- Reclassifications;
- Worksheet B-2 adjustments.
- Revenue and usage report by financial class:
- Becoming a bigger issue with many new systems.
- Internally created revenue cross-walk.

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Column 1 comes from Worksheet B, Part 1

Total inpatient and outpatient charges are entered in columns 6 & 7

Exclude professional revenue billed to Part B

Hospital departments need to be combined in the same manner as expenses for proper matching of revenue and expenses

Total revenue must reconcile to the audited financials with adjustments noted

The revenue for observation must meet the same definition as discussed on Worksheet S-3, Part I

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- Must eliminate all professional charges:
  - Identify all professional charges.
    - Hospitalists
    - Surgeons
    - Interpretations
    - Emergency Room
    - Provider Based Clinics
  - Worksheet A-8-2 offsets should be matched with professional charge offsets:
    - EKG and Imaging interpretations are common problem areas.
  - Look for "professional fees" in general ledger as revenues may be buried in departmental revenues.
  - Look for revenue codes 96x, 97x and/or 98x in crosswalks.
  - Recommend separate general ledger departments for all professional charges!!!
- Reclass revenues to match any reclasses noted in Worksheets A-6 and/or B-2, prior to input.

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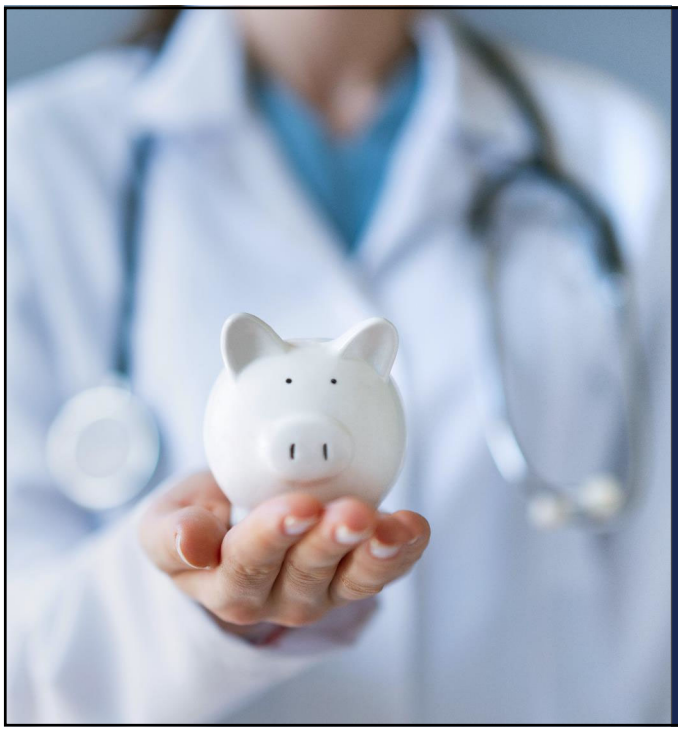

- Must gross up charges if services are offered at a lower fee to payers other than Medicare (e.g., laboratory done for a local clinic when hospital bills the clinic directly):
  - May also require gross up of charges on PS&R if billed lower for all payors (often reversed by MAC.)
  - Lab in clinic.
  - Pharmacy in nursing homes and/or inpatient versus outpatient.
  - Inpatient versus outpatient pricing differentials have seemed to be growing.

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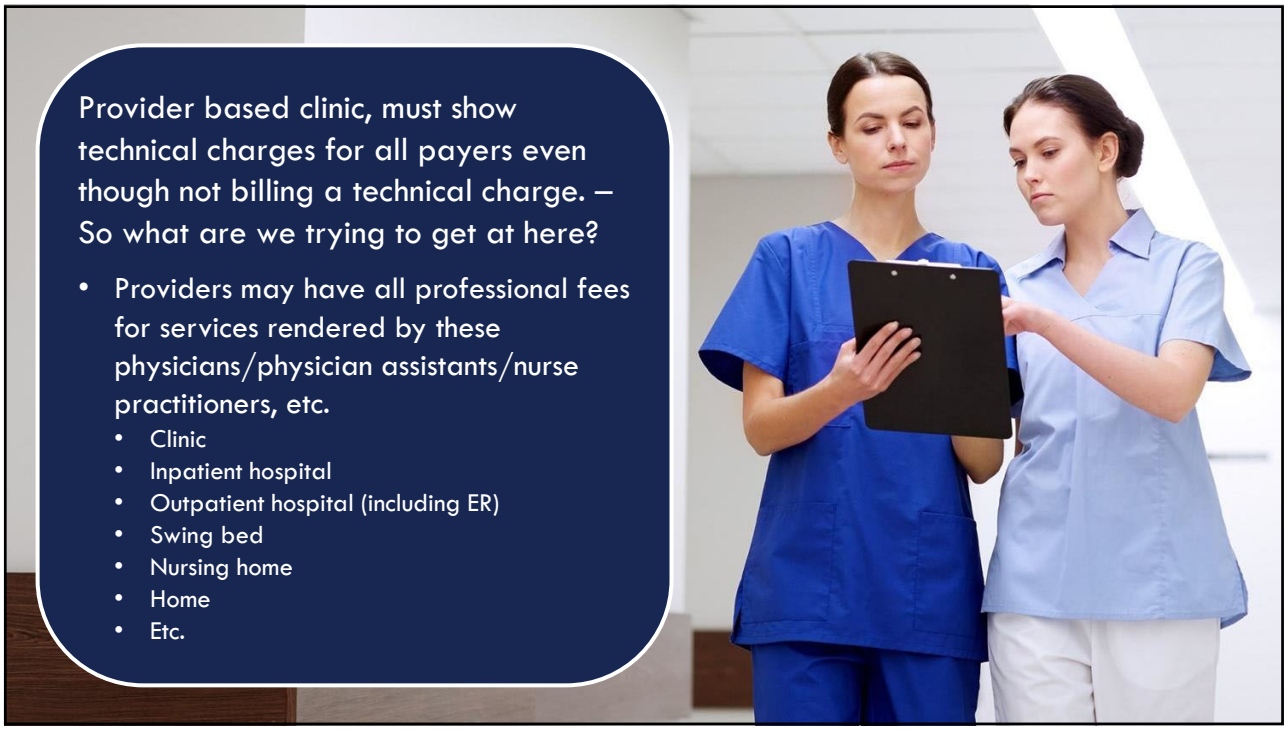

Provider based clinic, must show technical charges for all payers even though not billing a technical charge. – So what are we trying to get at here?

- Providers may have all professional fees for services rendered by these physicians/physician assistants/nurse practitioners, etc.
  - Clinic
  - Inpatient hospital
  - Outpatient hospital (including ER)
  - Swing bed
  - Nursing home
  - Home
  - Etc.

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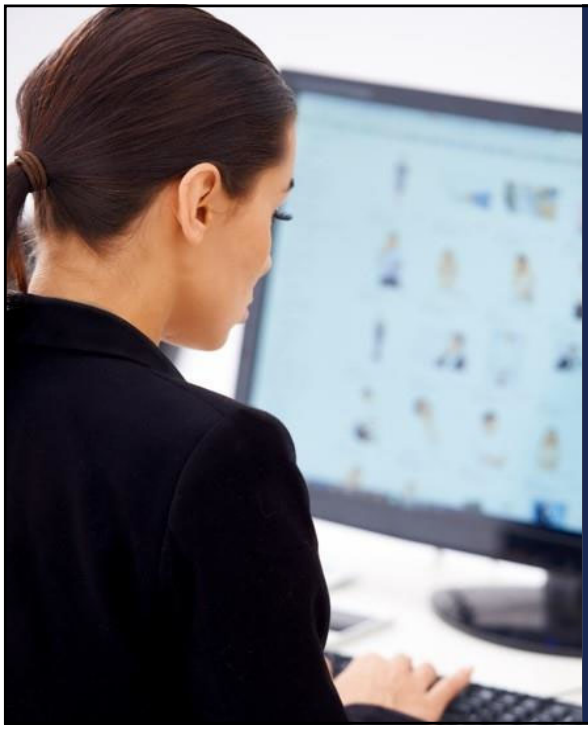


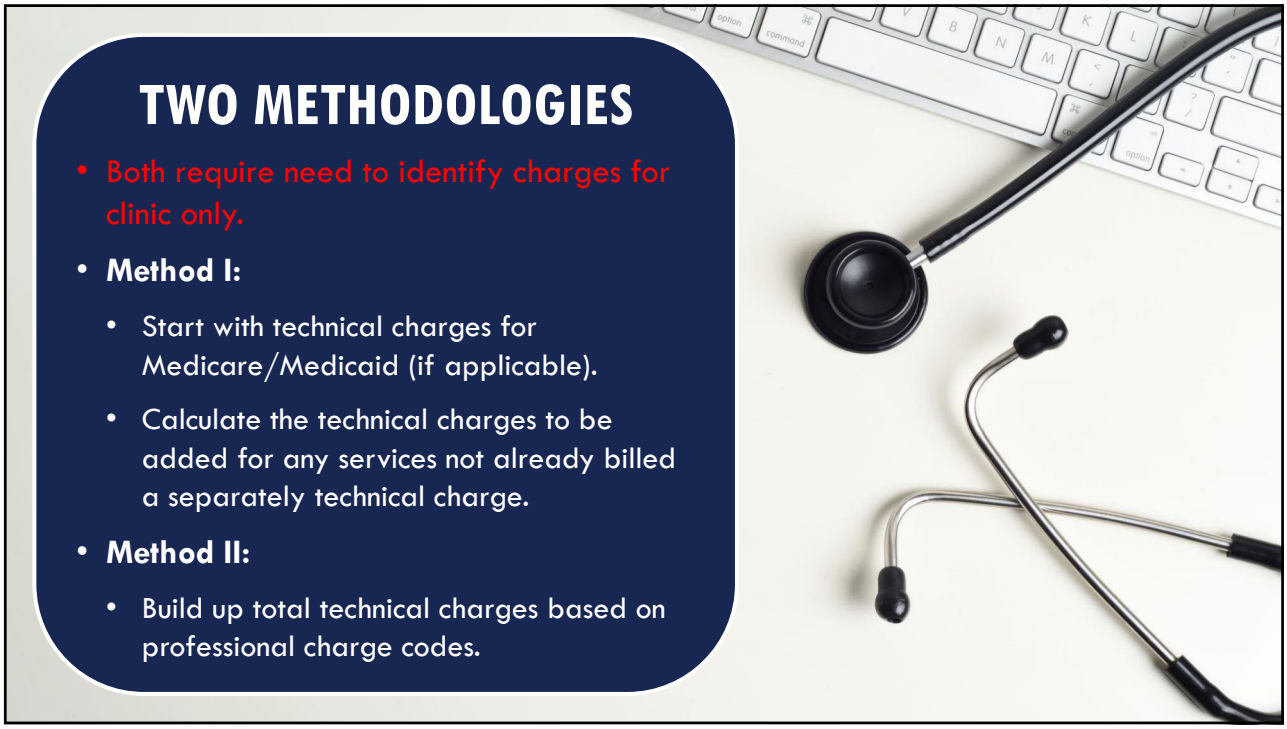
- Providers bill as follows in clinic:
  - Commercials:
    - Professional only
  - Medicare:
    - Professional and technical
  - Medicaid:
    - Varies by State – one of the two options above

Need to calculate the technical fee that would have been billed for clinic only if all payers would have been billed in the same manner as Medicare.

169

TWO METHODOLOGIES

- Both require need to identify charges for clinic only.
- **Method I:**
  - Start with technical charges for Medicare/Medicaid (if applicable).
  - Calculate the technical charges to be added for any services not already billed a separately technical charge.
- **Method II:**
  - Build up total technical charges based on professional charge codes.



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PROVIDER BASED CLINIC (PBC) TECHNICAL CALCULATION EXAMPLE

	Medicare/Medicaid(?)	Other	Total
Total Charges	$1,000,000	$1,500,000	$2,500,000
Non-PBC (inpatient, other outpatient, ER, nursing home, etc.)	$200,000	$300,000	$500,000
PBC Charges	$800,000	$1,200,000	$2,000,000
Professional	$720,000	$1,200,000	$1,800,000
Technical	$80,000	$0	$80,000

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PBC TECHNICAL CALCULATION EXAMPLE – ASSUME 90/10

	Medicare/Medicaid(?)	Other	Total
Total Charges	$1,000,000	$1,500,000	$2,500,000
Non-PBC (inpatient, other outpatient, ER, nursing home, etc.)	$200,000	$300,000	$500,000
PBC Charges	$800,000	$1,200,000	$2,000,000
Professional	$720,000	$1,080,000	$1,800,000
Technical	$80,000	$120,000	$200,000*

* To Worksheet C

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Worksheet C overall monitoring of trends:

- Make sure you can answer and document reasons for large variations.
  - Increased volumes
  - Reduction in expenses
  - Inappropriate inclusion of professional fees
  - Movement of where services are rendered without moving of revenues and/or expenses.

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WORKSHEET D

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WORKSHEET D, PART V

PURPOSE

- To compute the amount of program costs for ancillary services, outpatient services and certain other services.

TYPE & SOURCE OF DATA

- Cost report data from other worksheets
- PS&R charge data
- Hospital internal spreadsheets
- PS&R crosswalk (from hospital records)
- Revenue and Usage Report:
  - By financial class – Medicare!
  - By Patient Type – Inpatient, Outpatient, Swingbed
  - If PB Clinic, must include this revenue

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GENERAL POINTS – WORKSHEET D, PART V

Data flows from Worksheet C, Parts I & II.

PPS hospitals use column 2. CAH hospitals use columns 3 & 4 for OP charges.

Vaccines reported on this worksheet:

- RHC and Home Health vaccines reported in their own cost centers.

The crosswalk/revenue usage is very important – Common problems areas:

- Revenue Code 391 (Blood Administration) – reported in blood bank or lab.
- Revenue Code 260 (IV Therapy) – reported in pharmacy.
- Revenue Code 331/335 (Chemotherapy) – reported in pharmacy.
- Revenue Code 710 (Recovery) – reported in recovery room or operating room.
- Revenue Code 921 (Peripheral Vascular Lab) – reported in lab.

Another major area of concern on revenue/expense matching:

Why all the work on Worksheets A, B and C if D is not correct?

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SAMPLE REVENUE & USAGE REPORT

DEPT	PRCEDURE	PROCEDURE DESCRIPTION	CHARGE CAT	CPT	MEDICARE CHARGES	MCARE CNT	MEDICA CHARGE	MDRP CNT	MEDICAI CHARGE	MCD CNT	MEDIC CHARG	MCDR CNT	BLUE CHARGE	BC CNT	COMM CHARGE	COMM CNT	MANAGED CHARGES	MGDC CNT	SELF-PA CHARGE	SP CNT	OTHER CHARG	OTH CNT	TOTAL AMOUNT	TOTAL COUNT
75000	34000099	KINEVEC 5UG IV	636																					
75000	41000114	CONTRAST ECHO AGENT LUMASO	636																					
75000	9530000163	SVS PROFESSIONAL SERV-PHAR	999SVS																					
75005	9530000170	SVS PHARMACY 340B CONTRACT	999SVS																					
76000	46000013	DEBRIDE NON-SELECTIVE	420	97602																				
76000	46000017	DEBRIDE SELECTIVE 20 SQ CM	420	97597																				
76000	46000028	IONTOPHORESIS PT 15 MIN	420	97033																				
76000	46000031	HOT/COLD PACKS PT	420	97010																				
76000	46000037	THERAPEUTIC EXER PT AQ	420	97113																				
76000	46000038	THERAPEUTIC EXER PT	420	97110																				
76000	46000040	TRACTION CERVICAL/PELVIC	420	97012																				
76000	46000041	THERAPY MANUAL PT EACH 15	420	97140																				
76000	46000042	ULTRASOUND PT	420	97035																				
76000	46000052	GAIT TRAINING	420	97116																				
76000	46000070	THERAPEUTIC ACTIVITY PT	420	97530																				
76000	46000183	FUNCTIONAL TESTING PT 15 M	420	97750																				
76000	46000195	ELECTRICAL STIM UNATTENDED	420	97014																				
76000	46000203	PHONOPHORESIS PT	420	97035																				
76000	46000219	APPLICATION UNNA BOOT	420	29580																				
76000	46000221	NEUROMUSCULAR RE-EDUC PT	420	97112																				
76000	46000237	MANUAL THERAPY LYMPHEDEMA	420	97140																				
76000	46000292	CANALITH REPOSITIONING PRO	420	95992																				
76000	46000350	MOBILITY WALK & MOVE CURRE	420																					
76000	46000351	MOBILITY WALK & MOVE GOAL	420																					
76000	46000352	MOBILITY WALK & MOVE DISCH	420																					
76000	46000353	CHANGE & MNTAIN POSIT CURR	420																					
76000	46000354	CHANGE & MNTAIN POSITION G	420																					
76000	46000355	CHANGE & MNTAIN POSIT DISC	420																					
76000	46000356	CARRY MOVE OBJECTS CURRENT	420																					
76000	46000357	CARRY MOVE OBJECTS GOAL	420																					

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WORKSHEET D-1, PARTS I - IV

Purpose

- To provide for the computation of hospital inpatient operating costs (net of swing bed costs):
  - Separate worksheets for sub-providers and nursing home.

Type & source of data

- Cost report data from other worksheets.
- State Medicaid rates.

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GENERAL POINTS – WORKSHEET D-1, PARTS I - IV

Used to compute Medicare costs, primarily routine costs

- Carve out NF Swingbed costs (Medicaid average rate)
- Observation costs

Private room differential – not used much

Line 38 = routine cost per day

- Great to use for comparisons
- Specialty beds calculated in lines 42-47

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WORKSHEET D-3 – HOSPITAL

- Purpose:
  - To compute the Medicare costs for inpatient ancillary service.
- General points:
  - The total flows to Worksheet D-1, Part II.
  - Similar revenue/expense matching issues as identified under D Part V.
- Type & source of data:
  - Cost report data from other worksheets.
  - PS&R charge data.
  - Internally generated crosswalk – if needed.
  - Revenue and Usage Report by financial class.
  - Areas of concern.
    - Same as outpatient:
    - How to handle ancillaries performed in Med/Surg floor:
      - Revenue code 260 (IV Therapy);
      - Revenue codes 331 and 335 (Chemotherapy);
      - Revenue code 391 (Blood Administration).

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WORKSHEET D-3 – SWING BED

Purpose	• To compute the Medicare costs for swing bed ancillary services.
General points	• The total flows to Worksheet E-2.
Type of data	• Cost report data from other worksheets. • PS&R charge data. • Internally generated crosswalk – if needed. • Revenue and Usage Report by financial class.

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WORKSHEET E

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WORKSHEET E, PART A

Purpose	• To compute the settlement for inpatient Part A services (PPS.)
Type & source of data	• Cost report data from other worksheets. • PS&R payment data. • Payment add on calculations • Bad debt records.

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WORKSHEET E, PART B

Purpose	• To compute the settlement for outpatient Part B services.
Type & source of data	• Cost report data from other worksheets. • PS&R payment data. • Bad debt records.

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- CAH Coinsurance:
  - 20% of Medicare outpatient covered charges.
  - PPS (20% of APC payment).
- What if Medicare outpatient CCR is below 20%?
  - Potential of eliminating Medicare as a payer for outpatient business.

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13.94% cost to charge ratio

	Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)
		1.00	2.00	3.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.316164	0	1,094,451
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.080901	0	4,158,727
60.00	06000 LABORATORY	0.247564	0	1,103,584
65.00	06500 RESPIRATORY THERAPY	0.097734	0	1,081,329
66.00	06600 PHYSICAL THERAPY	0.446008	0	260,442
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.071747	0	1,017,499
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1.075460	0	48,122
73.00	07300 DRUGS CHARGED TO PATIENTS	0.156639	0	834,946
76.00	03951 OTHER OUTPATIENT SERVICES	0.030442	0	1,091,784
	OUTPATIENT SERVICE COST CENTERS			
91.00	09100 EMERGENCY	0.142556	0	2,427,452
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.147820	0	1,863,348
200.00	Subtotal (see instructions)		0	14,981,684
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0
202.00	Net Charges (line 200 +/- line 201)		0	14,981,684

	Cost Center Description	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)
		6.00
	ANCILLARY SERVICE COST CENTERS	
50.00	05000 OPERATING ROOM	346,026
54.00	05400 RADIOLOGY-DIAGNOSTIC	336,445
60.00	06000 LABORATORY	273,208
65.00	06500 RESPIRATORY THERAPY	105,683
66.00	06600 PHYSICAL THERAPY	116,159
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	73,003
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	51,753
73.00	07300 DRUGS CHARGED TO PATIENTS	130,785
76.00	03951 OTHER OUTPATIENT SERVICES	33,236
	OUTPATIENT SERVICE COST CENTERS	
91.00	09100 EMERGENCY	346,048
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	275,440
200.00	Subtotal (see instructions)	2,087,786
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0
202.00	Net Charges (line 200 +/- line 201)	2,087,786

$2,087,786 / $14,981,684 = 13.94%

Eliminated Medicare as a Payer

21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	2,108,664	2
22.00	Interns and residents (see instructions)	0	2
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	2
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	2
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	2
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,227,295	2
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	-118,631	2

$2,087,786 x 101% = $2,108,664

Increase charges, but not so much that eliminates Medicare as a payer.

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WORKSHEET E, BAD DEBTS

- Medicare Bad Debts:
  - PRM I §308 – a debt must meet these criteria to be an allowable bad debt:
    - The debt must be related to covered services and derived from deductible and coinsurance amounts. (Medicare Fee Schedule payments not included)
    - Must be able to establish that reasonable collections efforts were made.
    - The debt was actually uncollectible when claimed as worthless.
    - Sound business judgment established that there was no likelihood of recovery at any time in the future.
  - Medicaid cross over Bad Debt
  - Medicare indigent Bad Debt
  - Traditional Medicare only, no MA claims
- Medicare Bad Debts:
  - Paid 65% of allowable bad debts.

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- Reasonable Collection Effort:
  - C/R periods after 10/1/20, must issue bill with 120 days after the later of 1) date of remit advice, 2) date of remit advice of secondary payer, or 3) date of notice that secondary payer doesn't cover services.
  - After 10/1/20 hospitals may not write off Medicare bad debt until have tried to collect for at least 120 days. Period starts over each time partial payment is made.
  - Must also employ similar collection efforts between Medicare and non-Medicare patients.
- Medicare finalization of Exhibit 2A – after 10/1/22.

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EXHIBIT 2A

LISTING OF MEDICARE BAD DEBTS

PROVIDER NAME: _____	CCN: _____	FYE: _____	PREPARED BY: _____
BAD DEBTS FOR (CHOOSE ONE): ___ INPATIENT ___ OUTPATIENT			DATE PREPARED: _____
CLAIM TYPE (CHOOSE ONE): ___ NON-DUALLY ELIGIBLE ____ DUALLY ELIGIBLE/CROSSOVER			

MEDICARE BENEFICIARY						MEDI-CAID NO.	DEEM-ED INDI-GENT	REMITTANCE ADVICE DATE		SECON. PAYER REMIT. ADV. REC'D DATE	BENE-FICIARY RESON-SIBILITY AMT.	DATE FIRST BILL SENT TO BENE.	A/R WRITE OFF DATE
BENEFICIARY NAME LAST	BENEFICIARY NAME FIRST	MBI OR HICN	PATIENT ACCT. NO.	DATES OF SERVICE FROM	DATES OF SERVICE TO			MEDI-CARE	MEDI-CAID				
1	2	3	4	5	6	7	8	9	10	11	12	13	14
TOTAL													

LISTING OF MEDICARE BAD DEBTS (CONT.)

COLLECTION AGENCY INFORMATION		COL-LECT. EFFT. CEASE DATE	MEDI-CARE WRITE OFF DATE	RECOVERIES ONLY		MEDICARE DEDUCTIBLE AND COINSURANCE AMOUNTS*		CURRENT YEAR PAYMENTS RECEIVED		ALLOW-ABLE BAD DEBTS	COMMENTS
SENT (Y/N)	RETURN DATE			AMOUNT RE-CEIVED	MCR FYE DATE	DEDUCT.	COINS.	AMOUNT	SOURCE		
15a	15	16	17	18	19	20	21	22	23	24	25
TOTAL											

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WORKSHEET E-1

- Save all correspondence from the MAC.
- Interim settlements, lump-sum adjustments, etc.:
  - Including all correspondence after year end prior to submission of cost report.
- Remember any bi-weekly pass-through payments:
  - Bad debts, education.

If provided a letter from MAC on due date of cost report and includes lump sum adjustments, please provide to your cost report preparer!

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WORKSHEET E-2

Purpose	• To compute the settlement for swing bed services.
Type & source of data	• Cost report data from other worksheets. • PS&R payment data. • Bad debt records.

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WORKSHEET E-3, PTS. II-IV

Purpose

- To compute the settlement for inpatient services
- Pt. II – IPF; Pt. III – IRF; IV – LTCH

Type & source of data

- Cost report data from other worksheets.
- PS&R payment data.
- Bad debt records.

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WORKSHEET E-3, PT. V

Purpose

- To compute the settlement for inpatient services (CAH.)

Type & source of data

- Cost report data from other worksheets.
- PS&R payment data.
- Bad debt records.

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WORKSHEET G

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WORKSHEET G SERIES

Purpose	Type of data	General points
• Report client financial information.	• Year-end financial statements. • Trial balance.	• Informational. • Worksheet G and G-3 from financial statements. • Worksheet G-2 from trial balance. • Worksheet G-1 from financials and other worksheets. • Other Income. • COVID PHE Funding to be reported on G-3, Line 24.50. • Reconcile to audited financial stmts. • Data used by data miners.

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DATA FROM FLEX MONITORING REPORT

Profitability Indicators

Profitability is the net result of a large number of reimbursement and managerial policies and decisions and it reflects the combined effects of liquidity, asset management, and debt on operating results. *Profitability indicators* measure the ability to generate the financial return required to replace assets, meet increases in service demands, and compensate investors (in the case of a for-profit organization).

Total Margin measures the control of expenses relative to revenues.

Total margin formula: $\frac{\text{Net income}}{\text{Total revenue}}$

Cash Flow Margin measures the ability to generate cash flow from providing patient care services.

Cash flow margin formula:

$$\frac{\text{Net income} - (\text{Contributions, investments, and appropriations} + \text{Depreciation expense} + \text{Interest expense})}{\text{Net patient revenue} + \text{Other income} - \text{Contributions, investments, and appropriations}}$$

Return on Equity measures the net income generated by equity investment (net assets).

State	Total Margin	Cash Flow Margin	Return on Equity	Operating Margin
	%	%	%	%
US	5.41	8.45	9.89	3.62
AK	8.97	8.88	10.33	7.99
AL	-1.16	5.54	-15.80	-1.16
AR	6.35	10.61	40.12	7.14
AZ	5.23	9.23	14.50	5.22
CA	9.98	10.26	14.75	6.38
CO	6.87	10.13	16.26	4.86
FL	7.21	9.26	33.03	4.74
GA	4.52	5.11	17.43	-0.36
HI	1.86	0.96	12.50	-2.05
IA	4.29	7.77	7.31	1.46
ID	5.63	6.61	9.00	2.48
IL	4.99	11.08	9.63	5.07
IN	5.93	10.33	8.01	6.29
KS	1.91	0.46	12.82	-4.14
KY	9.09	10.23	23.67	5.69
LA	8.91	12.81	13.54	6.92
MA	13.27	14.13	27.33	10.78
ME	3.58	4.81	6.45	1.31
MI	3.31	7.26	10.23	3.15
MN	6.41	11.76	8.43	4.82
MO	2.27	3.44	2.74	-0.26
MS	0.84	-0.82	26.88	-2.69
MT	5.99	9.45	13.39	2.83
NC	1.00	4.64	5.27	1.25
ND	3.06	7.91	4.85	1.90
NE	5.96	12.33	7.14	4.84
NH	5.23	8.53	7.11	4.30

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WORKSHEET M

RURAL HEALTH CLINICS

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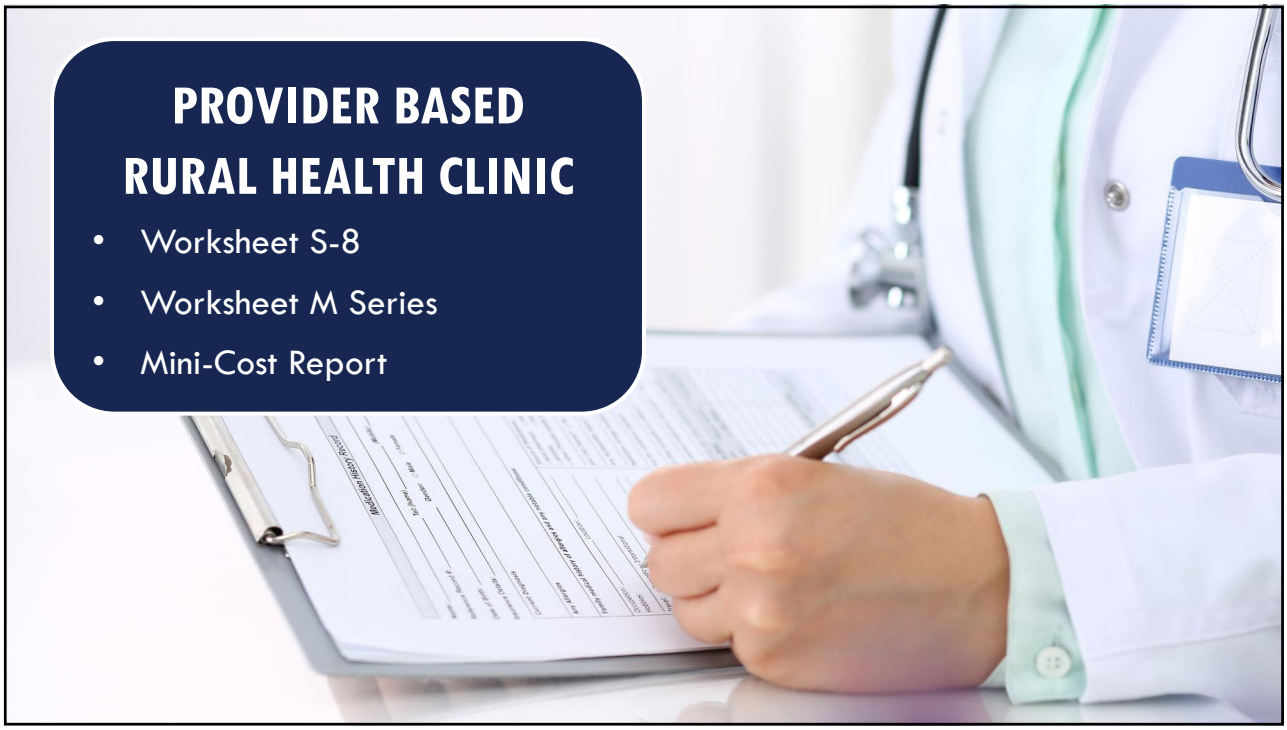
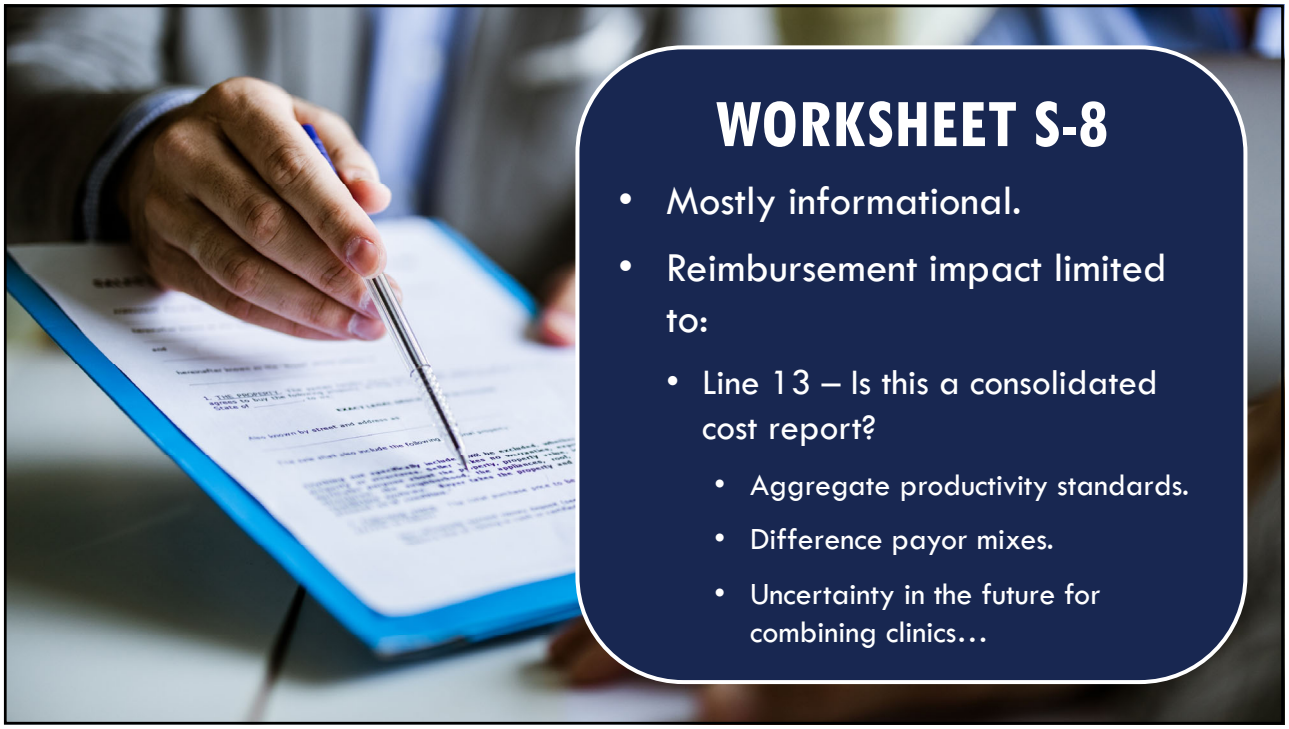


199

WORKSHEET S-8

- Mostly informational.
- Reimbursement impact limited to:
  - Line 12 – Have you received an approval for an exception to the productivity standard?

200



WORKSHEET S-8

- Mostly informational.
- Reimbursement impact limited to:
  - Line 13 – Is this a consolidated cost report?
    - Aggregate productivity standards.
    - Difference payor mixes.
    - Uncertainty in the future for combining clinics…

201

WORKSHEET M-1

Purpose	• To provide direct costs of operating the RHC. • To provide for the reclassifications and adjustments to direct costs.
Type & source of data	• General ledger cost data. • Cost report data.

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GENERAL POINTS

- The amounts need to agree to Worksheet A:
  - Identification of non-RHC costs
  - Physician/Mid-Level
  - Other staff
- The more detail the better as some external sources are starting to "mine" the data for information.
- Physician/Mid-Level non-RHC costs:
  - Emergency Room call
  - Inpatient/outpatient hospital
  - Hospital administrative
  - Other

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GENERAL POINTS (CONT.)

- Pharmacy – This is for retail pharmacy only – not included in AIR.
- Telehealth:
  - Billable as the originating site (not approved for a distant provider site.)
  - Not considered as RHC service.
  - Payment on fee schedule.
  - Cost needs to be identified.
- Chronic Care Management:
  - Billable by RHC.
  - Not considered as RHC service.
  - Payment on fee schedule.
  - Cost needs to be identified.
- Other:
  - Dental.
  - Optometry.
- Cost for diagnostic ancillaries:
  - Lab.
  - X-ray.
  - EKG.
  - Respiratory therapy diagnostics.
- Cost for therapeutic ancillaries:
  - Respiratory therapy treatments.
  - PT/OT/Speech.
  - Are these part of the AIR?

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WORKSHEET M-1

Non-RHC carve out:

- A-8 adjustment versus A-6 reclassification.
- If based on visits – Worksheet A-8 offset.
- Time for hospital administrative function – Worksheet A-6 reclass.
- Cost for Emergency Room Standby:
  - During office hours – Worksheet A-8 offset;
  - Outside RHC hours – Worksheet A-6 reclassification.
- Time studies and contracts beneficial in identifying Worksheet A-6 reclassification components.

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WORKSHEET M-2

Purpose

- To compute the productivity standards.
- To add overhead allocations from Worksheet B pt.1.

Type & source of data

- Data from other cost report worksheets.
- Wage and hour data.
- Internally generated logs.
- Time studies.
- Revenue and usage reports.

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WORKSHEET M-2

Determining the FTE numbers:

- In clinic versus out of clinic.
- Time logs versus hours of operation.
- Time logs can greatly assist in determining clinic administrative time for physicians:
  - Midlevel oversight;
  - General administrative.

Determining the visit numbers:

- RHC visits versus non RHC visits.
- What is RHC?
  - RHC location;
  - Swing bed;
  - Nursing Home;
  - Patient Home;
  - Scene of an accident.
- What is a visit?
  - Medically necessary;
  - Face-to-face;
  - Physician, PA, NP, CNM, CP, CSW;
  - TCM;
  - Visiting Nurse
  - Mental Health - Telehealth
  - **NOTICE – Does not include CRNA!!**

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WORKSHEET M-2

Productivity standards:

- 4200 Visits per Physician FTE.
- 2100 Visits per Mid-Level FTE.
- Exceptions:
  - New provider;
  - Downturn in economy;
  - Low rate of influenza, etc. documented;
- Strategies if hit by productivity:
  - Hours;
  - Emergency call;
  - Mix of providers.

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WORKSHEET M-2

No productivity standard:

- Visiting Nurse:
  - Requires approval.
- Clinical Psychologist – area of growth.
- Clinical Social Worker – area of growth.
- Minimum visits:
  - Productivity standard times the FTE count.
- Total visits:
  - The "greater of" in column 5, is in total so one provider can make up for the other.
- Physician services under arrangements:
  - What qualifies?
  - The total of column 5 flows to Worksheet M-3.

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WORKSHEET M-3

Purpose	• To compute the reimbursement settlement for RHC services.
Type & source of data	• Data from other cost report worksheets. • PS&R data. • RHC rate notice.

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WORKSHEET M-3 – GENERAL POINTS

- Vaccine costs flow from Worksheet M-4 to Line 2 (total costs) and Line 21 (Medicare costs).
- Total visits flow from Worksheet M-2.
- Adjusted cost per visit:
  - Typically, between $150 to $225 for PB RHC.
- Per visit limit:
  - Applies to all RHC starting in 2021:
    - Grandfathered PB = lesser of:
      - 2020 AIR adjusted for MEI.
      - Actual cost/visit.

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WORKSHEET M-3 – GENERAL POINTS

- Per visit limit for new PB and all free standing RHCs:
  - 1/1/2021 = $87.52
  - 4/1/2021 = $100.00
  - 1/1/2022 = $113.00
  - 1/1/2023 = $126.00
  - 1/1/2024 = $139.00
  - 1/1/2025 = $152.00
  - 1/1/2026 = $165.00
  - 1/1/2027 = $178.00
  - 1/1/2028 = $190.00

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RHC – UPPER PAYMENT LIMITS

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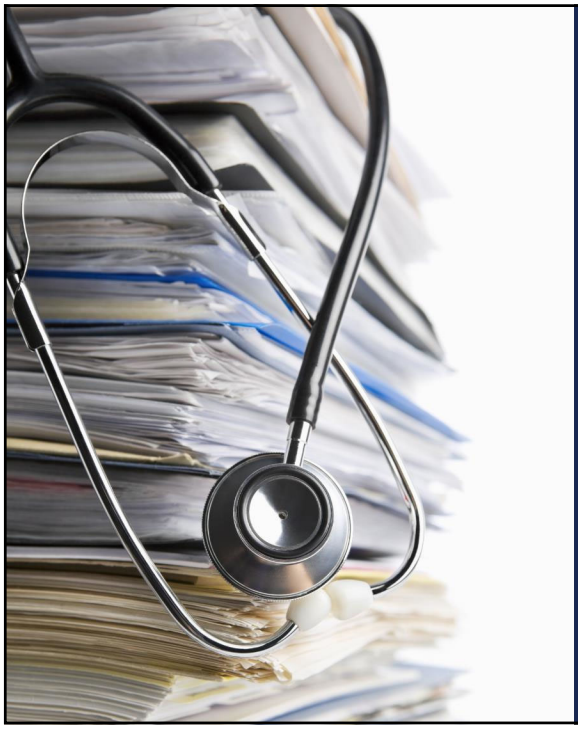

WORKSHEET M-3 – GENERAL POINTS

- Medicare visits from the PS&R.
- Annual rate notice for cost/visit limitation.
- Carves out cost attributable to preventative visits.
- Coinsurance issues:
  - Charges are typically lower than costs.
  - Recommend review of charges if significant.
- Interim payments flow in from Worksheet M-5.
- Settlement flows to Worksheet S.

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WORKSHEET M-4

Purpose

- To compute the cost of pneumococcal, influenza, and COVD-19 vaccine costs in the RHC:
  - Can subscript column 2.0 if needed for other than seasonal influenza vaccines that are covered by Medicare are provided:
    - May provide for improved reimbursement based on payor mix.

Type & source of data

- Data from other cost report worksheets.
- Internal wage and cost data.
- Time estimates.
- Cost of vaccines and medical supplies.

General points

- These costs are paid dollar for dollar outside of the cost per visit or limit per visit.
- Both direct costs and overhead costs are paid.
- Be sure staff are not submitting charges for these services:
  - Happens when business office staff do not understand how services are reimbursed through cost report.
- Recommend facility review cost carve out for reasonableness
  - Significant variations in cost

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WORKSHEET M-5

Purpose

- To compute the total interim payments for RHC services.

Type & source of data

- PS&R payment data.
- Intermediary letters or notices.

General points

- Save all correspondence from the Intermediary.
- Interim settlements, adjustments, etc.
  - Including all after year end prior to submission of cost report.
- Data flows to Worksheet M-3.

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