April 20, 2022 – Omaha, NE

Medicare Cost Report Training

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SEIM JOHNSON

Presented by

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Objectives

- Objectives
  - Discuss the importance of the cost report
  - Increase participant's ability on how to read and understand the Medicare cost report
  - Provide education on commonly utilized cost report worksheets
  - Discuss the importance of data needed to be gathered to appropriately prepare the worksheets
  - Provide an opportunity for questions and comments

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Agenda

8:30 to 9:00 am
- Registration

9:00 to 9:45 am
- Medicare Cost Report Overview – Jeremy

9:45 to 10:30 am
- Worksheet S – Jess

10:30 to 10:45 am
- Break

10:45 to 11:30 am
- Worksheet A – Jess

11:30 to 12:00 pm
- Worksheet B – Jeremy

12:00 to 1:00 pm
- Lunch

1:00 to 2:15 pm
- Worksheet B, C – Jeremy

2:15 to 2:30 pm
- Break

2:30 to 3:00 pm
- Worksheet D, E – Jess

3:00 to 3:30 pm
- Worksheet G, M, closing – Jeremy

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Medicare Cost Report Overview

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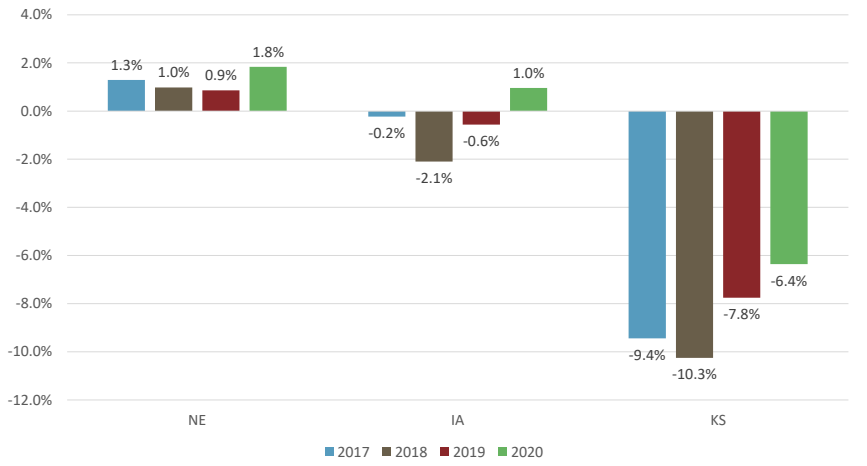
Operating Margin



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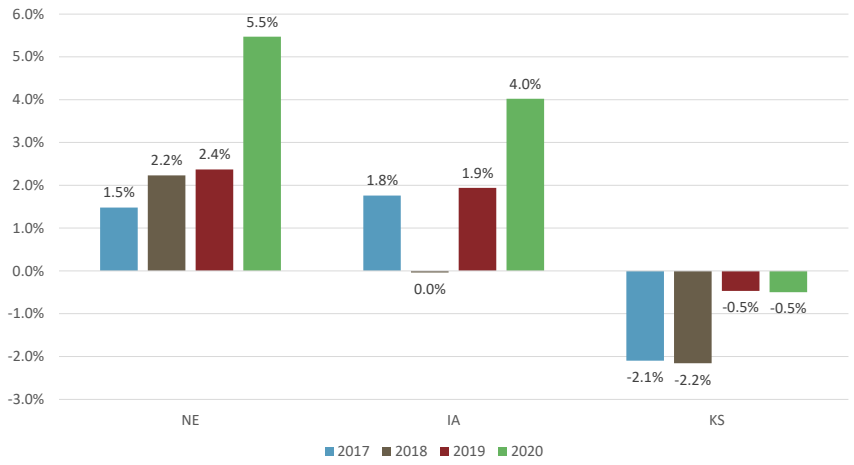
Total Margin



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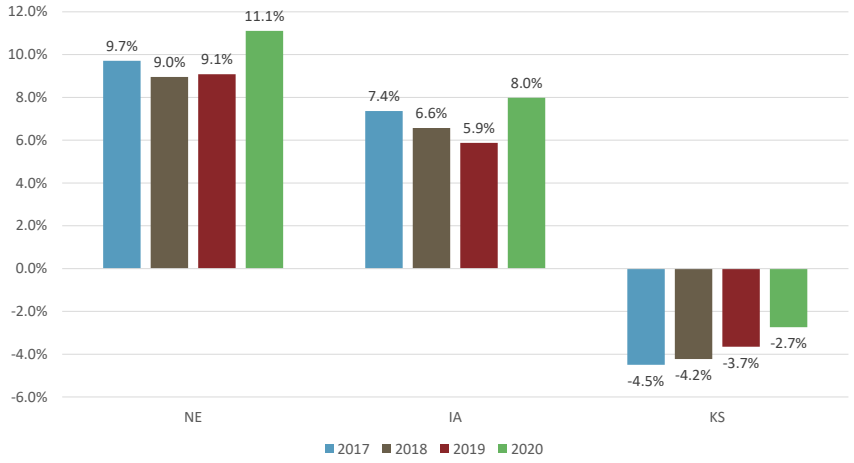
Cash Flow Margin



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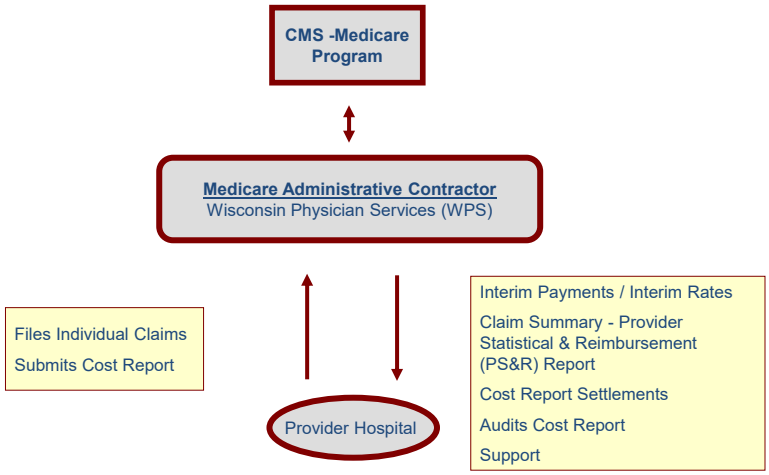
Medicare Cost Report Overview



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Medicare Cost Report Overview

- Used to determine provider settlements for services
- Used by CMS to develop hospital cost database
- Used by outside entities to evaluate hospitals –
  - state agencies, commercial insurers, research organizations, governments, peers/competitors.
- Applies to PPS and PPS exempt providers (CAH)
- Due five months after fiscal year end
- Subject to annual audits by Medicare Administrative Contractor (MAC) - WPS
  - Desk audit
  - Field audit (remote)

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Medicare Cost Report Overview

- MACs issue a Notice of Program Reimbursement (NPR) after the cost report has been audited (after Audit Adjustment Report)
- Hospitals have 180 days from the date of the NPR to appeal to PRRB
  - Three years for a reopening of a cost report to correct errors and omissions

Medicare 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

Medicare 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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Medicare 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	X 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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Medicare 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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Medicare 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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Medicare Cost Report Overview

- Commonly Used Data in a Cost Report
  - General Ledger
  - Payroll data
  - Revenue usage report – Medicare charges by department and revenue code
  - Patient census data
  - Allocation statistics
  - Provider Statistical & Reimbursement Report (PS&R)
  - Other specific data

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Medicare Cost Report Overview

- Basic Data Preparation Hints
  - Reconcile data from general ledger to supporting documents
    - Other revenue detail
    - Payroll & related hours
    - Census data to revenue and 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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Medicare Cost Report Overview

- Reimbursement Changes
  - Sequestration reduction
    - 2% of net Medicare payment effective 7/1/22
  - Meaningful use penalty
    - Up to 1% of IP cost (CAH)

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Worksheet S Series

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Worksheet S Series

- Worksheets
  - Settlement summary
  - Fraud and abuse certification
  - General hospital information
  - "Feeder" questions for later forms
  - S-2 Part 2 (f/k/a - 339 Questionnaire/Exhibits)

Worksheet S Series

- **Worksheets S, Part I**
  - Certification Statement – "Sign Here"

- PART II - CERTIFICATION

  MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.
- CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

  I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ABC HOSPITAL (XX-XXXX) for the cost reporting period beginning 01/01/2015 and ending 12/31/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

  - Signature Requirement
    - "Chief Financial Officer or Administrator" of provider
    - CEO or CFO
  - Encryption Data
    - Must match ECR file version sent
    - Attachments/support should also be encrypted
    - MCReF

Worksheet S Series

- **Worksheet S, Part I-III**
  - Summary of program settlement by provider type (IP, OP, SB, RHC…)
  - Review against balance sheet amounts
    - Reconcile settlement to your due to/from account in general ledger

Worksheet S Series

- **Worksheet S-2**

Hospital Data	Payment Methodology	Other Information
▪ Provider name(s) ▪ Provider number(s) ▪ Date(s) certified All information is compared to 855 enrollment forms "STAR" system	▪ PPS (P) ▪ TEFRA (T) ▪ Other (O) ▪ Not applicable (N) ▪ Medicaid methodology	▪ SCH, DSH, MDH… ▪ CAH ▪ Home Office ▪ CRNA pass through ▪ HIT - Meaningful user ▪ Other…

These answers will affect how the software calculates your cost report!

Worksheet S Series

- **Worksheet S-2 Summary (Part I)**

Line	Purpose	Line	Purpose
1-21	Informational	120	SCH
22-48	PPS Information - geographical reclassification, SCH, MDH, low volume adjustment, DSH	121	Implantable devices
56-67	Teaching hospital	122	Provider taxes
70-76	Inpatient psych or rehab	125-134	Transplant centers
80-81	Long term care hospital	140-143	Home office
85-86	TEFRA	144	Provider based physicians and costs
90-98	Medicaid	146-149	Worksheet B allocations
105-112	CAH, CRNA, Therapy, Demo project	155-161	Exemptions
115-118	Miscellaneous (malpractice)	167-170	Health Information Technology

Worksheet S Series

- **Worksheet S-2 Part I Highlights**
  - **Line 91** - Allows for Medicaid to be calculated as part of the cost report (column 5 of settlement page)
  - **Line 105** - Identify cost report for "cost" reimbursement (CAH)
  - **Line 108** – CRNA professional claims will be paid based on cost as opposed to fee schedule. Generally removes the need to eliminate cost unless unreasonable costs are identified.

42 CFR 412.113(c)(2)(i)(B) - Cannot exceed 2,080 hours. Hours count includes hours spent at the hospital whether they are furnishing anesthesia services to patients, providing general services to the hospital, or on-site call (excludes off-site call and PTO)

Worksheet S Series

- **Worksheet S-2 Part I Highlights (continued)**
  - **Line 109** - Identifies outside therapy providers (CAH). Complete worksheet A-8-3 for each service to determine if amounts paid are in excess of allowable maximums
  - **Line 121** - Triggers cost report lines for implantable devices
  - **Line 140** - Identifies home office costs. Complete worksheet A-8-1 to add these costs to the cost report
  - **Line 144** - Provider based physicians.
    - Complete worksheet A-8-2 to eliminate non-allowable costs
    - Additional forms to file with the cost report

Worksheet S Series

- **Worksheet S-2 Part I Highlights (continued)**
  - **Lines 146 - 149** - Change in allocation methodology, statistical basis, or allocation order. (Worksheet B-1)
    - Must request a change from the Medicare administrative contractor (MAC) within 90 days before fiscal year end to change your current year cost report.
    - CMS has 60 days to respond. Keep stats on new and old methodology until approved.
    - New cost centers – Exhibit to instructions contains a list of standard cost centers. Must request approval for unique cost centers not included.

Worksheet S Series

- **Worksheet S-2 Part II Highlights**
  - Pass through cost identification (PPS)
  - Bad debts - Medicare has provided a form / format to be used for submission of bad debts
    - WPS has developed comprehensive template
    - Be mindful of Medicare/Medicaid dual eligible claims
    - 120 days after first billing date to beneficiary
    - Medicare indigent claims
  - New physician contracts
  - New debt
  - Home office costs
  - Preparer contact information

Worksheet S Series

FYB	1/1/2021
FYE	12/31/2021
Type of Bad Debt	Acute Hosp IP Trad

Medicare Bad Debt Listing

1	2	3	4	5	6	7	8	9	10	11
Patient Claim Information						Medicaid	Indigence	Patient Claims Payment Information		
Patient Last Name	Patient First Name	HIC No./Medicare Beneficiary # (MBI)	Patient ACCT #/Control #	Dates of Service (FROM)	Dates of Service (TO)	Medicaid #	Was this patient deemed indigent by provider (i.e. not Medicaid related)? (Y/N)	Medicare Remittance Advice Date	Medicaid Remittance Advice Date [if applicable]	Date Remittance Advice Received from Secondary Payor
Totals										

Worksheet S Series

12	13	14	15a	15	16	17	18	19
Patient Responsibility $ (Indigence Share, Medicaid Share of Cost) (Enter **QMB** for QMB patients, as they are not subject to balance billing for Medicare cost sharing)	Date First Bill sent to Bene	Internal Accounts Receivable (A/R) Write Off Date	Sent to collection agency **(Y/N)**	Date account was returned from a collection agency [if applicable]	Date all Collection Efforts Ceased (Internal and External, including Medicaid RA)	Medicare "Write Off Date" (i.e. the latest of column 14, 15 or 16). Note that this should generally NOT match the Medicaid RA date unless QMB.	**RECOVERIES ONLY** - This relates to payments made AFTER a bad debt was already written off (even if in the same cost reporting period.) **Include payments only up to the amount of the original bad debt that was reported and allowed.**	**RECOVERIES ONLY** - If column 18 contains an amount, **identify the cost reporting period in which the account was reimbursed as a Medicare bad debt.** Note that this may be the current year if the payment was made after the writeoff.
							$0	MM/DD/YYYY

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Worksheet S Series

20	21	22	23	24	25
Total Medicare Deductible	Total Medicare Coinsurance	Current Year Payments (**before** the account was written off)	Payment Type (Patient/Third Party Insurance, etc.)	Allowable Bad Debts (As Reported on Cost Report) ***Enter negative amount for recovery***	Provider Comment
$0	$0	$0		$0	

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Worksheet S Series

- **Worksheet S-3 Part 1**
  - Beds, Patient Days & Discharges
    - # of Beds – CAH report 25 max
    - Patient days in total and by Program
    - Discharges in total and by Program
    - Observation room days, line #28
  - FTEs by provider type (from payroll records)

Worksheet S Series

- **Worksheet S-3 Part 1 (continued)**
  - Counting Patient Days
    - Importance of Patient Days
      - CAH Cost per Day
      - Observation days (usually calculated based upon hours patient is in observation)
        - » Must be correct to allocate costs for this service – outpatient service
      - NF SB – Any day that is not a SNF SB Medicare Part A or C, LTCF or Acute day – must have a plan of care
    - Reconciliations monthly/weekly?
    - Issues
      - Actual census count
      - Observation days in census count (one day stays)?
      - Labor/Delivery room days?
      - Patient Admit: Count one day
      - Swing bed line 5 and 6 split (see next slide)

Worksheet S Series

- **S-3 Comments**
  - Column 1 added for worksheet A linkage
  - **Line 2 - 4**: HMO days. Should be filing "information only" claims for advantage days. Medicaid HMO will effect DSH calculation. Do not want a PS&R vs. stat difference.
  - **Line 5**: Column 6 should be PS&R and column 8 should be Medicare and Medicare advantage. Line 6: Should be all other swing bed days (NF)
  - **Line 32**: Labor and delivery – Maternity patient is in labor/delivery room at time of midnight census and is NOT included in the routine census. Used for DSH calculations and cost/day determination.
  - **Column 4**: CAH Hours - CAH must keep a log of all inpatient stays and associated time between admit and discharge.

Worksheet S Series

- **S-3 Sources**
  - Medicare Inpatient Days
    - Comes from PS&R or internal logs
  - Observation, Medicaid, and Other Days
    - Comes from internal logs
    - Errors in counts greatly change cost per day calculations, DSH eligibility
  - Discharges
    - Comes from PS&R or internal logs
    - Must be correct for CAH average length of stay calculations

Worksheet S Series

- **Worksheets S-3, Parts II-V**
  - Hospital wage index
    - IPPS only
    - Calculates labor cost of facility
    - Used to calculate labor portion of DRG payment
    - Accuracy can impact PPS reimbursement

Worksheet S Series

- **Worksheet S-8**
  - Statistical data for hospital-based RHC/FQHC
  - Includes
    - Full address of the RHC/FQHC
    - Other services provided by facility
    - Hours of service
    - Productivity standard exceptions
    - Consolidated filing?

Worksheet S Series

- **Worksheet S-10 – Uncompensated Care Costs**
  - **Computes difference between net revenue & cost for**
    - **Medicaid**
    - **SCHIP**
    - **Other**
    - **Charity**
    - **Bad Debt**
  - **Uses overall cost to charge ratio**

Line	Purpose
1	Cost to charge
2-8	Medicaid
9-12	State Children's Health Insurance Program (SCHIP)
13-16	Other indigent care programs
17-19	Uncompensated care
20-31	Calculation

Worksheet S Series

- **Worksheet S-10 Comments**

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)
		1.00	2.00	3.00
	Uncompensated Care (see instructions for each line)			
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	1,379,627	316,325	1,695,952
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	702,513	316,325	1,018,838
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	702,513	316,325	1,018,838

  - Separately identify uninsured patients from insured patients.
  - Cost of charity care is calculated differently

Worksheet S Series

- **Worksheet S-10 Comments (continued)**
  - Important worksheet for IPPS hospitals that determines Factor 3 used to set uncompensated care payment
  - Subject to audit for 100% of Medicare DSH eligible providers
  - FFY 2023 uncompensated care payment will be average of 2018 and 2019 S-10 data (proposed). FFY 2024 proposed to be average of three cost report years. Previously only based on one year
  - CAHs are not eligible for Medicare DSH or uncompensated care payment. S-10 relevance?

Worksheet S Series

- **Other S Worksheets – not discussed today**
  - S-4 = Home Health
  - S-5 = Outpatient Renal Dialysis
  - S-6 = Rehabilitation Providers (CORFs)
  - S-7 = SNF
  - S-9 = Provider Based Hospice

Worksheet S Series - Question

Q: The Hospital billed Medicare 40 swing bed days but only 30 were paid by Medicare. What should be done with the 10 non Medicare days on S-3?

- **A: Decrease Medicare SNF by 10 and increase NF by 10**
- **B: Nothing**

Component		I/P Days / O/P Visits / Trips		
		Title XVIII	Title XIX	Total All Patients
		6.00	7.00	8.00
5.00	Hospital Adults & Peds. Swing Bed SNF	1,000	0	1,000
6.00	Hospital Adults & Peds. Swing Bed NF		25	250

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Worksheet S Series - Question

Q: The Hospital used 400 observation patient (based on admissions) instead of 350 observation equivalent days (8,400 hours / 24 hours per day).

What is the reimbursement impact of using 400 days instead of 350?

- **A: Decreased reimbursement**
- **B: Increased reimbursement**
- **C: No change**

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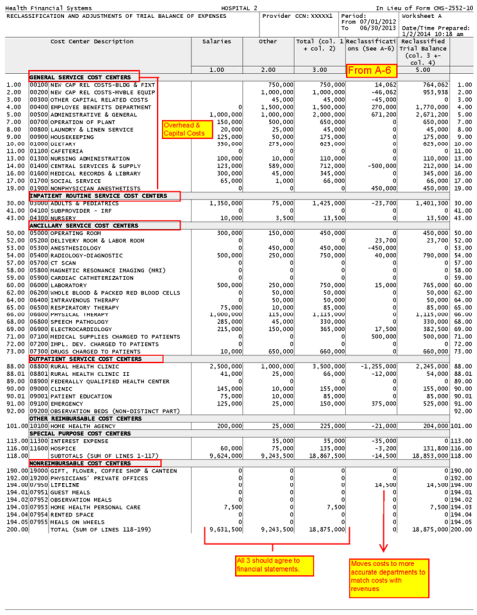
Worksheet A Series

Worksheet A Series

- A Trial Balance of Expenses
- A-6 Reclassifications
- A-7 Analysis of Capital Assets
- A-8 Adjustments to Expenses
- A-8-1 Related Organizations Costs
- A-8-2 Provider-Based Physician Adjustments
- A-8-3 Contracted Therapy Services

Worksheet A Series

Example



Health Financial Systems — HOSPITAL 2 — In Lieu of Form CMS-2552-10

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES — Provider CCN: XXXXX1 — Period: From 07/01/2012 To 06/30/2013 — Worksheet A — Date/Time Prepared: 1/2/2014 10:18 am

		Cost Center Description	Salaries	Other	Total (Col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (Col. 3 +- col. 4)	
			1.00	2.00	3.00	From A-6	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		750,000	750,000	14,062	764,062	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		1,000,000	1,000,000	-46,062	953,938	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS		45,000	45,000	-45,000	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,500,000	1,500,000	270,000	1,770,000	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,000,000	1,000,000	2,000,000	671,200	2,671,200	5.00
7.00	00700	OPERATION OF PLANT	150,000	500,000	650,000	0	650,000	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	20,000	25,000	45,000	0	45,000	8.00
9.00	00900	HOUSEKEEPING	125,000	50,000	175,000	0	175,000	9.00
10.00	01000	DIETARY	598,000	273,000	823,000	0	823,000	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	100,000	10,000	110,000	0	110,000	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	123,000	589,000	712,000	-500,000	212,000	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	300,000	45,000	345,000	0	345,000	16.00
17.00	01700	SOCIAL SERVICE	65,000	1,000	66,000	0	66,000	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	450,000	450,000	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,350,000	75,000	1,425,000	-23,700	1,401,300	30.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	10,000	3,500	13,500	0	13,500	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	300,000	150,000	450,000	0	450,000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	23,700	23,700	52.00
53.00	05300	ANESTHESIOLOGY	0	450,000	450,000	-450,000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	500,000	250,000	750,000	40,000	790,000	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	500,000	250,000	750,000	15,000	765,000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	50,000	50,000	0	50,000	62.00
64.00	06400	INTRAVENOUS THERAPY	0	50,000	50,000	0	50,000	64.00
65.00	06500	RESPIRATORY THERAPY	75,000	10,000	85,000	0	85,000	65.00
66.00	06600	PHYSICAL THERAPY	1,000,000	115,000	1,115,000	0	1,115,000	66.00
68.00	06800	SPEECH PATHOLOGY	285,000	45,000	330,000	0	330,000	68.00
69.00	06900	ELECTROCARDIOLOGY	215,000	150,000	365,000	17,500	382,500	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	500,000	500,000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,000	650,000	660,000	0	660,000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,500,000	1,000,000	3,500,000	-1,255,000	2,245,000	88.00
88.01	08801	RURAL HEALTH CLINIC II	41,000	25,000	66,000	-12,000	54,000	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	145,000	10,000	155,000	0	155,000	90.00
90.01	09001	PATIENT EDUCATION	75,000	10,000	85,000	0	85,000	90.01
91.00	09100	EMERGENCY	125,000	25,000	150,000	375,000	525,000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	200,000	25,000	225,000	-21,000	204,000	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		35,000	35,000	-35,000	0	113.00
116.00	11600	HOSPICE	60,000	75,000	135,000	-3,200	131,800	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	9,624,000	9,243,500	18,867,500	-14,500	18,853,000	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	LIFELINE	0	0	0	14,500	14,500	194.00
194.01	07951	GUEST MEALS	0	0	0	0	0	194.01
194.02	07952	OBSERVATION MEALS	0	0	0	0	0	194.02
194.03	07953	HOME HEALTH PERSONAL CARE	7,500	0	7,500	0	7,500	194.03
194.04	07954	RENTED SPACE	0	0	0	0	0	194.04
194.05	07955	MEALS ON WHEELS	0	0	0	0	0	194.05
200.00		TOTAL (SUM OF LINES 118-199)	9,631,500	9,243,500	18,875,000	0	18,875,000	200.00

Overhead & Capital Costs

All 3 should agree to financial statements.

Moves costs to more accurate departments to match costs with revenues

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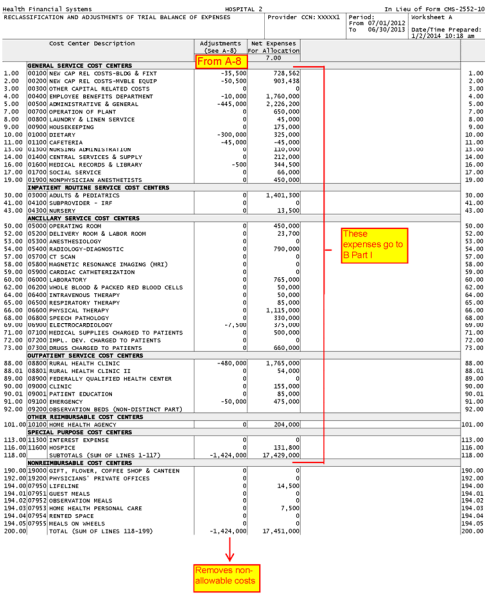
Worksheet A Series

Example



Health Financial Systems — HOSPITAL 2 — In Lieu of Form CMS-2552-10

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES — Provider CCN: XXXXX1 — Period: From 07/01/2012 To 06/30/2013 — Worksheet A — Date/Time Prepared: 1/2/2014 10:18 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses for Allocation		
			From A-8	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-35,500	728,562		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-50,500	903,438		2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-10,000	1,760,000		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-445,000	2,226,200		5.00
7.00	00700	OPERATION OF PLANT	0	650,000		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	45,000		8.00
9.00	00900	HOUSEKEEPING	0	175,000		9.00
10.00	01000	DIETARY	-300,000	325,000		10.00
11.00	01100	CAFETERIA	-45,000	-45,000		11.00
13.00	01300	NURSING ADMINISTRATION	0	110,000		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	212,000		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-500	344,500		16.00
17.00	01700	SOCIAL SERVICE	0	66,000		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	450,000		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,401,300		30.00
41.00	04100	SUBPROVIDER - IRF	0	0		41.00
43.00	04300	NURSERY	0	13,500		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	450,000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	23,700	These expenses go to B Part I	52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	790,000		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	765,000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	50,000		62.00
64.00	06400	INTRAVENOUS THERAPY	0	50,000		64.00
65.00	06500	RESPIRATORY THERAPY	0	85,000		65.00
66.00	06600	PHYSICAL THERAPY	0	1,115,000		66.00
68.00	06800	SPEECH PATHOLOGY	0	330,000		68.00
69.00	06900	ELECTROCARDIOLOGY	-7,500	373,000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	500,000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	660,000		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-480,000	1,765,000		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	54,000		88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	0	155,000		90.00
90.01	09001	PATIENT EDUCATION	0	85,000		90.01
91.00	09100	EMERGENCY	-50,000	475,000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	204,000		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
116.00	11600	HOSPICE	0	131,800		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-1,424,000	17,429,000		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
194.00	07950	LIFELINE	0	14,500		194.00
194.01	07951	GUEST MEALS	0	0		194.01
194.02	07952	OBSERVATION MEALS	0	0		194.02
194.03	07953	HOME HEALTH PERSONAL CARE	0	7,500		194.03
194.04	07954	RENTED SPACE	0	0		194.04
194.05	07955	MEALS ON WHEELS	0	0		194.05
200.00		TOTAL (SUM OF LINES 118-199)	-1,424,000	17,451,000		200.00

These expenses go to B Part I

Removes non-allowable costs

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Worksheet A Series

- Trial Balance of Expenses
  - Matching is **crucial** – Who codes your expenses?
  - Do you have the right detail in your general ledger?
  - Report trial balance of expenses
    - Salaries (column 1)
    - Other (column 2)
    - Total (column 3)
  - Convert to net allowable expenses for allocation
  - Changes result from impact of:
    - Reclassifications (column 4)(Worksheet A-6)
    - Adjustments to expenses (column 6) (Worksheet A-8)

Worksheet A Series

- Expenses entered into seven types of cost centers:
  - 1. General Service Cost Centers
    - Overhead departments/support services
      - » Capital Costs, Employee Benefits, Administration, Laundry
  - 2. Inpatient Routine Service Cost Centers
    - A & P, ICU, Nursery, SNF
  - 3. Ancillary Service Cost Centers
    - Operating Room, Radiology, Physical Therapy
  - 4. Outpatient Service Cost Centers
    - Provider Based Clinic, ER, RHC, OP Psych

Worksheet A Series

- Seven types of cost centers (continued):
  - 5. Other Reimbursable Cost Centers
    - Home Health Agency
  - 6. Special Purpose Cost Centers
    - Interest, Hospice
  - 7. Non-Reimbursable Cost Centers
    - Retail Pharmacy, Free Standing Physician Clinic, Wellness Center

Worksheet A Series

- Cost centers serve to facilitate transfer of departmental expenses to worksheets used in determining costs payable under Medicare
  - Important that expenses are grouped in the general ledger by cost center to facilitate preparation

Worksheet A Series

- **Worksheet A-6 - Reclassifications**
  - To move expenses not properly grouped on Worksheet A
  - Matching of cost and revenue
  - Reclassifications on Worksheet A, column 4
    - Can the amount be directly assigned on A?
  - If time studies used – must be approved and accurate (PRM pt. I section 2313)
  - Worksheet A-7 reference, if capital related, column 10
  - Example A-6 reclassifications – See next slide

Worksheet A Series

- Worksheet A-6 Examples

Cost Type	From Cost Center	To Cost Center
Implantable devices	Billable supplies	Implantable devices
Interest expense	Interest expense	Capital
ER Call Pay – Physicians / Midlevels	RHC / physician clinic	Emergency
Labor & delivery	A&P	Delivery rm & labor rm
CRNA expenses	Anesthesiology	Nonphysician anesth.
PB clinic lab & x-ray costs	Clinics	Laboratory, radiology

Worksheet A Series

- **Worksheet A-6 – Complex Issues**
  - Matching costs with revenue
    - Salaries
      - Routine nurses cover ER
      - Purchasing functions
      - Nursery and LDRP allocation
    - Medical supplies
      - Billable supply cost matched with revenue

Worksheet A Series

- **Worksheet A-7 – Analysis of Capital Assets**
  - Purpose – Track changes in capital asset balances during current reporting period
  - Part I – Analysis of Changes in Capital Asset Balances
    - Should match fixed asset disclosure in financial statements
  - Part II – Reconciliation of amounts from Worksheet A

Worksheet A Series

- **Worksheet A-7 – Analysis of Capital Assets (continued)**
  - Part III – Allocation of capital expenditures based on capital from parts I & II
    - Taxes, insurance, other capital

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Worksheet A Series

- **Worksheet A-8 – Adjustments to Expenses**
  - Purpose – Identify and offset costs not related to patient care
    - HFMA non-allowable costs compliance checklist
    - http://www.hfma.org/Content.aspx?id=7132
  - Types of adjustments
    - Cost (expense) adjustments reflect different treatment of expenses in accordance with Medicare principles of reimbursement
      - To reflect actual expenses incurred
    - Revenue adjustments reflect offsets to related expenses
      - Constitute recovery of expenses through sales, charges, fees, etc.
  - Adjustments flow to Worksheet A column 6

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Worksheet A Series

- **Worksheet A-8 – Adjustments to Expenses (continued)**
  - Made on the basis of:
    - Cost – "A" in column 1
    - Amount received (revenue) – "B" in column 1
  - Affected cost center indicated in column 4
  - Worksheet A-7 column reference, if capital related, in column 5

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Worksheet A Series

- **Worksheet A-8 – Adjustments to Expenses (continued)**
  - Examples of adjustments to cost:
    - 340B program costs
    - Unallowable advertising expenses
    - Lobbying expenses
    - CRNA costs – unless rural exception
  - Examples of revenue offsets:
    - Investment income
    - Cafeteria revenue
    - Sale of medical records
    - Sale of billable supplies to non patients

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Worksheet A Series

- **Worksheet A-8 – Adjustments to Expenses (continued)**
  - Investment Income
    - Recovery of interest expense (offset limited to interest expense)
    - Unrestricted vs. Restricted
    - Funded Depreciation
  - Important to note
    - Revenue associated with cost removed from a reimbursable cost center should be removed from Worksheet C (matching of cost and revenue)
      - Example – Physician costs and billing costs
        - » Charges associated with professional/Medicare Part B services should be removed from Worksheet C

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Worksheet A Series

- **Worksheet A-8-1 – Related Organization Expenses**
  - Purpose – provides for the computation of any needed adjustments to costs applicable to services, facilities and supplies furnished to the hospital by related organizations or costs associated with the home office
  - Related Party Transactions
    - General Rule
      - Costs for 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.

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Worksheet A Series

- **Worksheet A-8-1**
  - Indicate cost center
  - Describe cost and indicate amount of allowable cost and total included on Worksheet A
  - Example
    - Member of an imaging group with mobile MRI
      - Record pro rata portion of group costs based on number of procedures performed for each member in column 4
      - Record fees paid to imaging group in column 5
    - Allocated home office costs similar

Worksheet A Series

- **Worksheet A-8-2 – Provider-Based Physician Adjustments**
  - Purpose – provides for the computation of the allowable provider-based physician cost incurred
    - Claim as allowable costs only those which are incurred for physician services that benefit the general patient population of the provider or which represent availability services in the ER
  - 42 CFR 415.70 imposes limits on the amount of physician compensation which may be recognized as reasonable provider cost (CAHs not subject to limitations)

Worksheet A Series

- **Worksheet A-8-2**
  - Professional component – direct patient care (professional/Medicare Part B services not reimbursable through cost report)
    - Hospitalist
    - Surgeon
  - Provider component – indirect patient care (technical/Medicare Part A services reimbursable through cost report)
    - Administrative duties – Medical Director
    - ER On-Call

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Worksheet A Series

- **Worksheet A-8-2**
  - Needed information for physician adjustment
    - Identification of Part A vs. Part B
      - Time studies, contracts
      - Unless noted as Part A time, all time is assumed to be Part B
    - Compensation paid to all physicians by cost center
      - Salary, benefits, malpractice insurance, CME
    - Calculate Part A vs. B
      - Total paid hours
      - Total compensation

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Worksheet A Series

- **Worksheet A-8-2**
  - ER Call pay for CAHs
    - Must offset the portion of the cost related to when the physicians and mid-levels are actually seeing patients, including charting
      - Must do a time study (PRM pt. I section 2182.3)
      - Can use Medical Record of ER visit for time study

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Worksheet A Series

- **Worksheet A-8-3 – Therapy Services (CAH)**
  - Purpose – determine if adjustment needed to remove excess cost over reasonable cost (limits)
    - Respiratory, occupational, speech, and physical therapy
      - Applicable only if services provided by outside suppliers
    - Compare cost of services against AHSEA (adjusted hourly salary equivalency amount)
    - Have you reviewed your agreements with contracted therapy providers?

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Worksheet A Series

- **AHSEA Rates – Adjusted Hourly Salary Equivalency Amount**
  - Determine reasonable cost of therapy services performed by outside suppliers
  - Guidelines & monthly inflation factors published in PRM pt I, chapter 14
  - Behind on updating inflation factors-through 12/31/20

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Worksheet A Series

- **AHSEA Rates**

Adjusted Hourly Salary Equivalency Amounts By Locality For Physical Therapists (PT), Occupational Therapists (OT), Speech-Language Pathologists (SLP) and Respiratory Therapists (RT)(Full-Time, Regular Part-Time) 1/

This schedule is effective for services furnished on or after April 10, 1998. For a 12 month cost reporting period beginning on or after May 1, 1998, the published guideline amount will be adjusted by factors contained in Exhibit C-2. 2/ The standard travel allowance is one half of the adjusted hourly salary equivalency amount.

ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNTS

Locality Name	PT	OT	SLP	RT
IOWA	47.19	44.72	42.98	37.06
KANSAS*	48.13	45.62	43.85	37.82
MONTANA	46.95	44.49	42.75	36.86
NEBRASKA	46.44	44.01	42.30	36.47
NEVADA	51.14	48.54	46.71	40.46
NEW HAMPSHIRE	50.55	48.00	46.19	40.06

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Worksheet A Series

- **AHSEA Rates**

REASONABLE COST OF THERAPY AND OTHER SERVICES
01-18 FURNISHED BY OUTSIDE SUPPLIERS 1499 (Cont.)

Exhibit C-3 (Cont.)

Month-Year	Factor
Jan-2018	1.72518
Feb-2018	1.73143
Mar-2018	1.73404
Apr-2018	1.73667
May-2018	1.73929
Jun-2018	1.74399
Jul-2018	1.74871
Aug-2018	1.75343
Sep-2018	1.75477

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Worksheet A Series

- **Calculation of AHSEA Rates - Nebraska**

		PT		OT		SLP		RT
Per CMS Pub 15-1	Nebraska	46.44		44.01		42.3		36.47
Adjustment Factor per Exh C-3	Jan - 18	1.72518		1.72518		1.72518		1.72518
		80.12		75.93		72.98		62.92
Supervisors	115%	92.13	110%	83.52	120%	87.57	115%	72.35
Therapists	100%	80.12	100%	75.93	100%	72.98	100%	62.92
Assistants	65%	52.08	69%	52.39	75%	54.73	75%	47.19

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Worksheet A Series

- **Worksheet A-8-3**
  - Potential for limitation and amount of payment received for outside supplier therapy services depends on factors:
    - Reasonableness of rates charged
    - Services based upon part-time or full-time
    - Location of services rendered
    - Time and mileage records maintained by service provider
    - Add-ons for supervisory functions, aides, overtime, equipment & supplies

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Worksheet A Series

- **Worksheet A-8-3 (continued)**
  - Needed information for contract therapy services
    - Number of weeks services performed – Part I
    - Number of unduplicated days provider (therapist, assistant) was onsite – Part I
    - Total hours worked by each provider (therapist, assistant) – Part I
    - AHSEA rates for therapies – Part I
    - Overtime hours worked – Part V
    - Total cost of contracted services – Part VI

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Worksheet A Series - Question

Q: Worksheet A-8 adjustments can be made for which of the following types?

- **A: Revenue offset**
- **B: Expense offset**
- **C: Revenue or expense offset**

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Worksheet A Series - Question

Q: Which of the following call types are allowable on the cost report?

- **A: CRNA call**
- **B: ER call**
- **C: Hospitalist call**
- **D: All are allowable**
- **E: None are allowable**

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Worksheet B Series

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Worksheet B Series

- Purpose
  - Allocate overhead cost center costs to revenue producing cost centers **and** non-reimbursable cost centers
- Process
  - Allocate overhead costs via "Step Down"
  - Allocated based on "statistics"

	Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY
		5.00	7.00	8.00	9.00	10.00
	GENERAL SERVICE COST CENTERS					
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT					
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP					
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					
5.00	00500 ADMINISTRATIVE & GENERAL	2,871,798				
7.00	00700 OPERATION OF PLANT	169,450	1,032,351			
8.00	00800 LAUNDRY & LINEN SERVICE	27,765	88,996	258,149		
9.00	00900 HOUSEKEEPING	49,782	53,397	13,369	370,057	
10.00	01000 DIETARY	80,039	17,799	891	7,401	513,718
11.00	01100 CAFETERIA	0	0	0	0	314,522
13.00	01300 NURSING ADMINISTRATION	27,015	8,900	0	3,701	0
14.00	01400 CENTRAL SERVICES & SUPPLY	56,976	53,397	0	22,203	0
16.00	01600 MEDICAL RECORDS & LIBRARY	85,714	35,598	0	14,802	0
17.00	01700 SOCIAL SERVICE	15,296	0	0	0	0
19.00	01900 NONPHYSICIAN ANESTHETISTS	88,368	0	0	0	0

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Worksheet B Series

- Designed to accommodate the step-down method of cost finding versus direct assignment
- For each General Services Cost Center line (1.00 through 23.00) on Worksheet A, there is a corresponding column on the B series
- Each General Service Cost Center is assigned a statistical basis for allocation to other general services, revenue producing and non-reimbursable cost centers

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Worksheet B Series

General Service Cost Center	Typical Basis of Allocation	Other Common Basis
Capital Building & Fixtures	Square Feet	Direct Cost
Capital Equipment	Square Feet	Direct Cost
Employee Benefits	Gross salaries	
Administration & General	Accumulated Costs	
Operation of Plant	Square Feet	Time Study
Laundry/Linen	Pounds of Laundry	
Housekeeping	Square Feet	Time Study
Dietary	Meals served	
Cafeteria	FTE's	
Nursing Administration	Direct Nursing Hours	
Central Supply	Cost Requisitions	
Medical Records	Revenues	Time Study
Social Services	Time Spent	
Non-physician Anesthetists	Assigned Time	

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Worksheet B Series

- **Worksheet B Part I (Costs)**
  - Allocates the expenses of each general service cost center to those cost centers which receive services.
  - Cost centers serviced by the general service cost centers include:
    - Other general service cost centers (lines 1-23)
    - Inpatient routine service cost centers (lines 30-46)
    - Ancillary service cost centers (lines 50-76)
    - Outpatient service cost centers (lines 88-92)
    - Other reimbursable cost centers (line 94-101)
    - Special purpose cost centers (line 105-117)
    - Non-reimbursable cost centers (lines 190-194)

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Worksheet B Series

- **Worksheet B Part I (Costs) (continued)**
  - Column 0 of B Part I is direct expenses from Worksheet A, column 7 (expenses include reclassifications and adjustments)
  - Columns 1-23 allocate the general service cost centers
  - Column 26 is the total direct and allocated costs after allocation of general service cost centers

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Worksheet B Series

- **Worksheet B Part I (Costs) (continued)**
  - Cost report transfers the totals in column 26, lines 30-46 (inpatient routine service cost centers), lines 50-76 (ancillary service cost centers), lines 88-92 (outpatient service cost centers) to Worksheet C, Parts I and II, column 1, lines 30-92.
  - Lines 88.xx transfer to Worksheet M-2 (RHC schedules).

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Worksheet B Series

- **Worksheet B-1 (Statistical Basis)**
  - Summarizes, by cost center, statistical data used to allocate the expenses of the general service cost centers on Worksheet B, Part I.
  - The general format of Worksheets B, Part I and B-1 are identical.
    - Each general service cost center has the same line number as its respective column number across the top.
    - The column and line numbers for each general service cost center are identical on the two worksheets
    - The line numbers for each routine service, ancillary outpatient service, other reimbursable, special purpose, and non-reimbursable cost center are identical on the two worksheets.
    - Cost centers and line numbers are also consistent with Worksheet A.

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Worksheet B Series

- **Worksheet B-1 (Statistical Basis) (continued)**
  - Statistical basis used is shown at the top of each column on B-1
  - Recommended statistical basis contained in form must be used by all providers unless change request submitted 90 days before CR year end
  - General service cost centers are ordered by cost centers that render the most services to and receive the least services from other cost centers.
  - A statistic is entered for all cost centers to which the general service cost center provides services.

Worksheet B Series

- **Worksheet B-1**
  - B-1 – Development of Unit Cost Multiplier
    - Unit cost multiplier = total allocated costs/total statistic
    - The top line of each column and line 202 develop the unit cost multiplier for that general service cost center
    - Line 202 amounts are pulled from Worksheet B, Part I.

Worksheet B Series

- **Worksheet B-1 (continued)**
  - **Example 1:**
    - **Operation of Plant – Column 7**

Direct Costs from W/SA, Column 7		650,000
Allocated Capital Building and Fixtures		84,373
Allocated Capital Equipment		104,625
Allocated Employee Benefits		28,159
Allocated Administrative and General		171,491
Total Plant to be allocated (B-1, Column 7, Line 202)		1,038,648
Total Statistic, square feet (B-1, Column 7, Line 7)		56,350
Calculated Unit Cost Multiplier B-1, Column 7, Line 203 (1,039,372/58,000)		18,432,085
B-1, Column 7, Line 30 Adults and Pediatrics	X	9,000
Calculated amount on B, Part I, Column 7, Line 30		165,892

Worksheet B Series

- **Worksheet B-1 (Statistics)**
  - New Capital Building and Fixtures, New Capital Equipment, Plant Operation, Housekeeping
    - Statistic Used = Square footage
      - Internal space only
      - Tie back to floor plans
      - Track yearly changes
      - Statistics may change based on usage of general service cost center

Worksheet B Series

- **Worksheet B-1 (Statistics) (continued)**
  - Example of square footage misclassification
    - During the year, sample hospital reduces Home Health square footage by 750 and uses the 750 for Administrative and General
      - B-1 square footage statistic misclassification impact
        - » CAH Reimbursement impact – Approximately $7,900 increase
        - » Impact on allocated costs to Home Health – Approximately $16,800 decrease

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Worksheet B Series

- **Worksheet B-1 (Statistics) (continued)**
  - Employee Benefits
    - Statistic used = Gross Salaries
    - Account for reclassifications (A-6) and eliminations (A-8, A-8-2)
      - **Example:** Sample hospital A-6 code "CC" to reclassify $375K of ER call out of RHC to the ER is not reclassified in statistic
    - If not changed in B-1 statistic
      - Allocated costs to RHC – Approximately $82,000 increase
      - Allocated costs to ER – Approximately $82,000 decrease
      - CAH Reimbursement impact – Approximately $12,800

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Worksheet B Series

- **Worksheet B-1 (Statistics) (continued)**
  - Administrative and General
    - The administrative and general expenses are allocated on the basis of accumulated costs.
      - Statistic used in A&G - direct costs plus allocated costs on B Part I, prior to A&G allocation
      - Exclude negative balances from the allocation statistics
      - Review individual A&G departments for utilization for potential reclassifications

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Worksheet B Series

- **Worksheet B-1 (Statistics) (continued)**
  - Laundry and Linen
    - Pounds of Laundry
  - Dietary
    - Meal counts
      - Employee meal counts are allocated to Cafeteria
  - Cafeteria
    - FTE's
      - Only departments that utilize cafeteria (on-site vs off-site)(on-call)
  - Nursing Administration
    - Direct Nursing Hours
      - Only departments supervised/scheduled by DON
  - Central Supply
    - Cost Acquisitions
      - Only departments that Central Supply is doing the ordering
  - Medical Records
    - Revenue
      - Only departments using Medical Records

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Worksheet B Series

- **Worksheet B-1 (Statistics) (continued)**
  - Operational Issues
    - Educate department directors
      - Stats for all departments
    - Maintain/accumulate stats monthly
    - Review monthly
    - Overall accuracy issues
      - Do the statistics reflect reality?
      - Reasonable?

93

Worksheet B Series

- **Worksheet B-1 (Statistics) (continued)**
  - Time Studies
    - Must request approval 90 days prior to year end
  - PRM 15-1 § § 2313.2E, Special Applications – Time Studies states:
    - Acceptable time studies must encompass one week per month
    - Each week must be a full work week (M-F, M-Sa or Su-Sa)
    - The weeks must be equally distributed among the months (ex 3 of the weeks must be first week in month, 3 weeks the 2nd week of the month, 3 weeks the 3rd and 4th)
    - Consecutive months cannot utilize the same week

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Worksheet B Series

- **Worksheet B-1 (Statistics) (continued)**
  - Provider can elect to change the order of allocation and/or statistics if a request is received by the MAC 90 days prior to the end of that reporting period.
    - The MAC has 60 days to make a decision and notify the provider of that decision or the change is automatically accepted.
    - The change must be shown to more accurately allocate the overhead or should demonstrate simplification in maintaining the changed statistics.

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Worksheet B Series - Question

Q: You can elect different statistical basis to allocate overhead costs on worksheet B-1?

- **A: True**
- **B: False**

96

Worksheet B Series - Question

Q: How many days before your fiscal year end do you have to request a statistical basis change from WPS?

- **A: 30 days**
- **B: 60 days**
- **C: 90 days**
- **D: 120 days**

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Worksheet C Series

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Worksheet C Series

- **Computation of Ratio of Cost to Charges**
  - **Purpose** – To calculate the cost to charge ratio (CCR) for each ancillary cost center based on total hospital patient revenues
  - CCR is not computed for routine services (A&P, nursery, ICU)
    - Routine cost per day (see Worksheet D Series)
  - CCRs are used on Worksheet D Series to determine Medicare costs
  - Data for ancillary cost centers are from Worksheet B Part I (fully allocated costs)
  - General ledger charges by cost center are input
  - Reconcile Worksheet C to financial statements

99

Worksheet C Series

- Reclassifications to charges:
  - Chargeable supplies: Properly match costs, charges, and Medicare charges in the correct department(s)
  - RHC ancillary services: Services billed as hospital outpatient but included in the general ledger as RHC (radiology)
- Adjustments to charges:
  - Physician professional revenues
    - ER, radiology, surgery, etc.
  - CRNA revenues *(unless granted a rural exception)*

100

Worksheet C Series

- Charge Structure / Capture Issues
  - Fragment services (radiology)
    - Evaluate whether to fragment similar services or report on one cost report line – mark-up/utilization
  - Chargeable supplies
    - Costs/Charges/Medicare Charges (oxygen, surgery, etc.)
  - Large CCR?
    - CCR > 1.0000 (clinics, ER, etc.)
  - WS C charges < Medicare charges?
    - Cross-walk issues
  - CS line for implantable devices
    - Codes 0275,0276,0278

101

Worksheet C Series

Cost to Charge Ratio (CCR)

	Radiology
Direct Cost (WS A)	790,000
Depreciation (WS B Part I)	56,700
Benefits (WS B Part I)	100,810
A&G (WS B Part I)	187,381
Plant (WS B Part I)	55,296
Laundry (WS B Part I)	18,211
Housekeeping (WS B Part I)	23,242
Cafeteria (WS B Part I)	31,522
Med Records (WS B Part I)	143,566
Total Costs	1,406,728
Total Charges (WS C)	5,500,000
Cost to Charge Ratio	.255769

Medicare Utilization

	Radiology
Medicare IP Charges (WS D-3)	300,000
Medicare SB Charges (WS D-3)	15,000
Medicare OP Charges (WS D Pt V)	2,300,000
Total Medicare Charges	2,615,000
Total Charges (WS C)	5,500,000
Medicare Utilization	.476

Which ratio is more important?

102

Worksheet C Series

Charge Center Apportionment/Utilization

Radiology – Medicare utilization same

	Radiology as Distinct Cost Ctr.	Cat Scan as Distinct Cost Ctr.	Total	Combine Rad and Cat Scan on CR
Costs	1,000	406		1,406
Revenues	4,500	1,000		5,500
Cost to Charge Ratio	22%	41%		25.5%
Medicare Charges	2,137	475		2,615
Medicare Costs	475	193	668	668

Assumption: Medicare Utilization identical in Radiology and Cat Scan Departments (47.5%)
Comments: Since Utilization identical combining or reporting departments in separate cost centers has no impact on reimbursement.

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Worksheet C Series

Charge Center Apportionment/Utilization

Radiology – Medicare utilization different

	Radiology as Distinct Cost Ctr.	Cat Scan as Distinct Cost Ctr.	Total	Combine Rad and Cat Scan on CR
Costs	1,000	406		1,406
Revenues	4,500	1,000		5,500
Cost to Charge Ratio	22%	41%		25.5%
Medicare Charges	1,800	815		2,615
Medicare Costs	400	331	731	668

Assumption: Medicare Utilization is ~40% in Radiology and ~80% in Cat Scan
Comments: Combining departments on a single line of the cost can cause reduction in reimbursement due to underlying differences in utilization and cost report averaging methodology. This also applies within individual items within specific departments.

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Worksheet C Series

Cost to Charge Ratio (CCR) – Revenue Utilization vs Cost?

Base Line	Radiology
Direct Cost (WS A)	790,000
Depreciation (WS B Part I)	56,700
Benefits (WS B Part I)	100,810
A&G (WS B Part I)	187,381
Plant (WS B Part I)	55,296
Laundry (WS B Part I)	18,211
Housekeeping (WS B Part I)	23,242
Cafeteria (WS B Part I)	31,522
Med Records (WS B Part I)	143,566
Total Costs	1,406,728
Total Charges (WS C)	5,500,000
Cost to Charge Ratio	.2557

Base Line	Radiology
Medicare IP Charges (WS D-3)	300,000
Medicare SB Charges (WS D-3)	15,000
Medicare OP Charges (WS D Pt V)	2,300,000
Total Medicare Charges	2,615,000
Cost to charge ratio	.2557
Medicare Costs	668,656
Medicare Utilization	.476

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Worksheet C Series

Cost to Charge Ratio (CCR) – Add $100K of Cost

Added Cost	Radiology
Direct Cost (WS A)	890,000
Depreciation (WS B Part I)	56,700
Benefits (WS B Part I)	100,810
A&G (WS B Part I)	193,421
Plant (WS B Part I)	55,296
Laundry (WS B Part I)	18,211
Housekeeping (WS B Part I)	23,242
Cafeteria (WS B Part I)	31,522
Med Records (WS B Part I)	143,566
Total Costs	1,512,768
Total Charges (WS C)	5,500,000
Cost to Charge Ratio	.275

Added Cost	Radiology
Medicare IP Charges (WS D-3)	300,000
Medicare SB Charges (WS D-3)	15,000
Medicare OP Charges (WS D Pt V)	2,300,000
Total Medicare Charges	2,615,000
Cost to Charge Ratio	.275
Medicare Costs	719,125
Medicare Utilization	.476

Reimbursement increased $50,469 on added cost of $106,040 (47.6%)

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Worksheet C Series

Cost to Charge Ratio (CCR) – Add $100K of Charges

Added Charges	Radiology
Direct Cost (WS A)	790,000
Depreciation (WS B Part I)	56,700
Benefits (WS B Part I)	100,810
A&G (WS B Part I)	187,381
Plant (WS B Part I)	55,296
Laundry (WS B Part I)	18,211
Housekeeping (WS B Part I)	23,242
Cafeteria (WS B Part I)	31,522
Med Records (WS B Part I)	143,566
Total Costs	1,406,728
Total Charges (WS C)	5,600,000
Cost to Charge Ratio	.2512

Added Charges	Radiology
Medicare IP Charges (WS D-3)	300,000
Medicare SB Charges (WS D-3)	15,000
Medicare OP Charges (WS D Pt V)	2,400,000
Total Medicare Charges	2,715,000
Cost to Charge Ratio	.2512
Medicare Costs	682,008
Medicare Utilization	.4848

Reimbursement increased $13,352 on added charges of $100,000 (13.3%)

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Worksheet C Series

So what is better – Costs or Utilization?

	Base Line	Added Cost	Added Charges
Cost to charge	.256	.275	.251
Medicare utilization	.476	.476	.485
Medicare reimbursement	668,656	719,125	682,008

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Worksheet C Series

- **Analyzing the Cost Report**
  - Compare current year & prior year CCR's for reasonableness
    - Big increases or decreases should be easily explained
  - Be cognizant of operational issues for:
    - New/Removed services
      - New pro fees to remove?
    - Volume changes
      - Change in payor mix?
    - Cost changes
      - New contracts?

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Worksheet C Series

- **Analyzing the Cost Report (continued)**
  - Other issues
    - Charge master review changes
    - Rate studies / price changes
    - New doctors hired / practice acquisition
    - ER physician contract revisions
    - System conversions / general ledger mapping
- MATCHING PRINCIPLE IS KEY

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Worksheet C Series - Question

Q: What happens to your cost to charge ratio if you do not remove professional fee revenue from worksheet C?

- **A: Cost to charge ratio increases**
- **B: Cost to charge ratio decreases**
- **C: No change**

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Worksheet D & E Series

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Worksheet D Series

- **Worksheet D, Parts I,II** – Apportionment of Inpatient Capital Cost from B, part II (PPS)
- **Worksheet D, Parts III,IV** – Inpatient pass-through costs (PPS-nursing school, allied health)

113

Worksheet D Series

- **Worksheet D-1** – Computation of Inpatient Operating Cost
  - Purpose – computes Medicare inpatient cost per day
  - Total inpatient routine cost from Worksheet B, Part I
  - Swing-Bed Adjustment (carve out of swing-bed services)
  - Take the adjusted total and divide by the total of acute, swing-bed SNF and observation days, exclude swing-bed NF days
  - Result is general inpatient cost per day
  - Multiply the per day amount by Medicare acute and swing-bed days to arrive at Medicare routine cost

$$\frac{\text{A\&P Costs B Pt I Col 26 - (NF days x NF rate)}}{\text{A\&P days + SNF days + Obs days}}$$

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Worksheet D Series

- **Worksheet D-3** – Inpatient Ancillary Service Cost
  - Purpose – To compute Medicare inpatient and swing-bed ancillary costs
  - CCR for each cost center is multiplied by the Medicare inpatient and swing-bed ancillary charges in each cost center to determine Medicare ancillary cost
    - Hospital (Inpatient)
    - Swing Bed SNF
  - Thoroughly review revenue code groupings for proper matching of costs and charges

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Worksheet D Series

- **Worksheet D, Part V** – Apportionment of Medical and Other Health Services and Vaccine Costs
  - Purpose – To determine Medicare outpatient ancillary costs
  - Must input outpatient Medicare charges grouped by cost center (PS&R report or Medicare logs)
  - CCR for each cost center is multiplied by the Medicare outpatient charges in each cost center to determine Medicare outpatient cost
  - Thoroughly review revenue code groupings for proper matching of costs and charges

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Worksheet D Series

Room and Board (cost per day) vs Ancillary (cost per charge)

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	X 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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Worksheet D Series

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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Worksheet D Series

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%)

Worksheet D Series

- Cross-walk of Medicare revenue codes to cost center lines should be provided to Medicare during submission
  - Matching general ledger charges on worksheet C with Medicare revenue codes entered from PS&R on D Series for proper Medicare cost apportionment

PS&R Example

CHARGE SECTION

*** ACCOMMODATION CHARGES ***

REV CODE	DESCRIPTION
0120	ROOM-BOARD/SEMI
0122	OB/2BED
0210	CORONARY CARE or (CCU)
TOTAL ACCOMMODATIONS	

*** ANCILLARY CHARGES ***

REV CODE	DESCRIPTION
0250	PHARMACY
0255	DRUGS/INCIDENT RAD
0258	IV SOLUTIONS
0260	IV THERAPY
0270	MED-SUR SUPPLIES
0271	NONSTER SUPPLY
0272	STERILE SUPPLY
0278	SUPPLY/IMPLANTS
0279	SUPPLY/OTHER
0300	LABORATORY or (LAB)
0301	LAB/CHEMISTRY

Rev Code	Description	Charges	Description	CR Line
120	Room & Board/Semi Prvt	250,000	Adults & Peds	30
200	Intensive Care Unit		ICU	31
250	Pharmacy	150,000	Pharmacy	73
258	IV Solutions	6,000	Pharmacy	73
260	IV Therapy	1,000	Observation beds	92
270	MED- Surg Supplies	7,000	Medical Supplies	71
271		0	Medical Supplies	71
272	MED - Sterile Supply	1,000	Medical Supplies	71
274	Prosth/Orth Devices	50	Medical Supplies	71
279	Other	0	Medical Supplies	72
300	Laboratory	12,000	Lab	60

	Summary	Reclasses	Total	MCR Line
Adults & Peds	250,000		250,000	30
Operating Room	0		0	50
Special Proc.	0		0	
Lithotripsy	0		0	
RR	0		0	51
Delivery & Labor	0		0	52
Anesthesiology	0		0	53
Radiology	19,200		19,200	54

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Worksheet D Series

- Impact of incorrect groupings
  - Assume $50K of supplies revenue was incorrectly grouped to OR (no PS&R reclass identified)
  - Lost $14K of reimbursement (28%)

ORIGINAL:

		RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS
50.00	OPERATING ROOM	0.430652	250,000	107,663
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.713268	750,000	534,951
				642,614

CORRECTED:

		RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS
50.00	OPERATING ROOM	0.430652	200,000	86,130
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.713268	800,000	570,614
				656,745
	TOTAL DIFFERENCE			14,131

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Worksheet E Series

- Used to report amounts received from Medicare and Medicaid (from PS&R)
  - Including coinsurance, deductibles, lump-sum adjustments, pass through payments…
  - Be sure everything is included
- Used to calculate final settlement
  - Compare to internal estimates

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Worksheet E Series

- Worksheet E, Part A – Inpatient (PPS)
  - DRG and outlier payments
  - DSH and uncompensated care payments
  - SCH, MDH, pass through
  - Reimbursable bad debts
- Worksheet E, Part B – Outpatient
  - Carryover of 100% of costs from Worksheet D, Part V
    - Line 1 = 100%
    - Line 21 = 101%
  - Coinsurance & deductibles from PS&R – line 25 & 26
  - Reimbursable bad debts – line 34
  - Sequestration – line 40.01
  - Interim payments – line 41 - carryover from Worksheet E-1
  - Settlement to Worksheet S - Line 43

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Worksheet E Series

- Worksheet E-1
  - PS&R payments, lump sum/interim payments
- Worksheet E-2 – Swing-Bed
  - Inpatient routine cost – line 1
    - From Worksheet D-1, line 64 (101%)
  - Ancillary cost - line 3
    - From Worksheet D-3, line 200 (101%)
  - Medicare bad debts – line 17
  - Sequestration – Line 19.01 (calculated)
  - Interim payments – line 20 - from E-1
  - Settlement – line 22 - to Worksheet S
- Worksheet E-3, Part V – Inpatient (CAH)
  - Cost – line 1 (from D-1, Line 49)
  - Total cost – line 6
    - Behind the scenes calculation of 101% of cost
    - Behind the scenes calculation of HIT penalty
  - Medicare bad debts – Line 25

Worksheet M Series

Worksheet M Series

- **Provider-Based RHC/FQHC**
  - Purpose – To calculate Medicare Rural Health Clinic (RHC)/Federally Qualified Health Center (FQHC) reimbursement
  - Reimbursed on a cost per visit basis

Worksheet	Purpose
M-1	Summary of costs
M-2	Allocation of costs
M-3	Reimbursement settlement
M-4	Vaccine costs
M-5	Interim reimbursement

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Worksheet M Series

- **Worksheet M-1 – Analysis of Provider-Based RHC/FQHC Costs**
  - Direct costs from hospital trial balance
  - Split by provider (Physician, PA, NP, other)
  - Split by type (Salary and other)
  - Includes Reclassifications (A-6) and Adjustments (A-8)
  - Amounts must agree with Worksheet A, line 88.xx or line 89.xx

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Worksheet M Series

- **Worksheet M-2 – Allocation of Overhead to RHC/FQHC Services**
  - FTEs and visits reported
    - FTE based upon time spent by providers seeing patients or scheduled to see patients
      - » Does not include administrative time
    - Visit defined as a face to face encounter with a physician or midlevel
      - » Must be an RHC defined service
  - Visits subject to productivity standard which is calculated based on FTE
    - 4,200 for physician FTE
    - 2,100 for PA or NP FTE
  - Costs include direct costs from M-1 plus overhead from hospital (Worksheet B, part I)

Worksheet M Series

- **Worksheet M-3 – Calculation of Reimbursement Settlement**
  - Total cost from M-2 divided by total visits (subject to the productivity standard) to determine the cost per visit
  - Cost per visit limits for all facilities effective 4/1/21
    - No longer eligible for uncapped AIR
    - Grandfathered PBRHC assigned base rate from 2020 CR
    - Adjusted annually 1/1 using the Medicare Economic Index
      - 2.1% effective 1/1/22
    - Reimbursement lesser of actual cost or base rate/visit

Worksheet M Series

- **Worksheet M-3 – Calculation of Reimbursement Settlement**
  - Free standing RHCs and newly certified RHCs after 1/1/21 paid at federal rate

> The RHC payment limit per visit over an 8-year period is as follows:
>
> - in 2021, after March 31, at $100 per visit;
> - in 2022, at $113 per visit;
> - in 2023, at $126 per visit;
> - in 2024, at $139 per visit;
> - in 2025, at $152 per visit;
> - in 2026, at $165 per visit;
> - in 2027, at $178 per visit; and
> - in 2028, at $190 per visit.

Worksheet M Series

- **Worksheet M-3 – Calculation of Reimbursement Settlement**
  - Cost per visit is multiplied by the total Medicare visits to determine Medicare costs
  - Deductibles are subtracted from total Medicare costs and the remaining amount is multiplied by 80% (coinsurance)
  - Preventative care charges adjustment – reduces calculated coinsurance amount resulting in additional reimbursement (make sure your properly billing preventative services
  - Interim payments (from M-5) are compared and settlement is derived and taken to Worksheet S

Worksheet M Series

- **Worksheet M-4 – Computation of Pneumococcal, Influenza and COVID 19 Vaccine Cost**
  - Influenza, pneumonia and COVID 19 vaccines are logged and reimbursed through the cost report based upon a cost per vaccine injection
- **Worksheet M-5 – Analysis of Payments to Hospital-Based RHC/FQHC**
  - Interim payments reported (to M-3)

Worksheet M Series - Question

Q: What is the productivity standard limit for 1 FTE provider in the RHC?

- **A: 4,200 visits**
- **B: 2,100 visits**
- **C: No limit**

Q: What is the productivity standard limit for 1 FTE physician assistant in the RHC?

- **A: 4,200 visits**
- **B: 2,100 visits**
- **No limit**

What are we seeing?

What We Are Seeing

- MAC desk reviews / field audits
  - CRNA reasonableness
  - Calculation of ER compensation using S-2, part II exhibit
  - Comingling of ancillary services in one cost center
  - Medicare bad debts
  - PS&R revenue code grouping
  - Contract therapy
  - Variance analysis
  - Non-standard cost center approval letters
  - Other

What We Are Seeing

Availability Services (ER Call)

- Contract spelling out costs (may need to prove reasonableness based on vendor quotes, or other data - MGMA)
- Provide written "allocation agreement" to CMS for cost report period
- Allocated based on time studies or ER logs
  - Provider time studies cover, at least, two full weeks per quarter
  - Both should incorporate –
    - All time the physician spent diagnosing and treating the patient's illness or injury
    - CMS / WPS requiring this to include prep and charting time

What We Are Seeing

Availability Services (ER Call)

- Example Allocation
  - Supervision
  - Medical and surgical services to individual patients
  - Non covered
  - Keep in mind, a CAH physician allocation will be different
    - PBRHC services
    - Hospital rounds
    - Outpatient procedures
    - Nursing home rounds
    - ER call
    - ER patient services
    - Vacation, PTO, CPE, etc.
- Cost Report Exhibit
  - Signed by physician or department head
  - No longer CFO or CEO

What We Are Seeing

PBRHC

- Hours of operations
- Track time physicians and mid-levels are available to see patients (includes nursing home and home visits)
- Allocation of physicians and mid-levels compensation to non-RHC services
- RHC rate per visit does not include lab, xray, EKG or hospital professional services

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What We Are Seeing

PB Clinics

- Proper tracking of tech versus pro charges
  - Standard rate per visit
  - Percent of charge
- Allocation of costs to match revenue codes
- Splitting of revenue code 510 between several clinics

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What We Are Seeing

Medicare Bad Debts

- Excludes physician pro services
- Reasonable collection effort
- Sound business judgment established there was no likelihood of recovery
  - After returned by collection agency
- Accounting for bad debts will differ from when allowed by CMS
- Listing must comply with CMS Form Exhibit 2

What We Are Seeing

Medicare Bad Debts

- Middle Class Tax Relief and Job Creation Act of 2012 -
  - CAH hospital bad debt reimbursement reduced to 65% for CRP beginning on or after 10/1/14
- Considerations
  - Review internal and contractor policies on the return of accounts from collection agencies
  - Track all Medicare bad debts for proper inclusion on the cost report when returned
  - Tracking dual eligible claims and Medicare indigent claims
    - WPS is sampling as part of desk reviews

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