3610. WORKSHEET A - RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

In accordance with 42 CFR 413.20, the methods of determining costs payable under title XVIII involve using data available from the institution's basic accounts, as usually maintained, to arrive at equitable and proper payment for services. Worksheet A provides for recording the trial balance of expense accounts from your accounting books and records. It also provides for the necessary reclassifications and adjustments to certain accounts. The cost centers on this worksheet are listed in a manner which facilitates the transfer of the various cost center data to the cost finding worksheets (e.g., on Worksheets A, B, C, and D, the line numbers are consistent). Not all of the cost centers listed apply to all providers using these forms. For example, where you furnish all radiological services in a single department and your records are maintained in that manner, enter a single entry identifying all radiological services on line 41 (Radiology-Diagnostic), and make no entry on lines 42 (Radiology-Therapeutic) and 43 (Radioisotope).

Do not include on this worksheet items not claimed in the cost report because they conflict with the regulations, manuals, or instructions but which you wish nevertheless to claim and contest. Enter amounts on the appropriate settlement worksheet (Worksheet E, Part A, line 30; Worksheet E, Part B, line 36; Worksheet E-2, line 22; and Worksheet E-3, Parts I, II, and III, lines 21, 34, and 59, respectively). For provider based facilities enter the protested amounts on line 27 of Worksheet H-7, Part II for home health agencies, line 29 of Worksheet J-3 for outpatient rehabilitation providers and line 25 of Worksheet M-3 for RHC/FQHC providers. (9/96)

If the cost elements of a cost center are separately maintained on your books, maintain a reconciliation of the costs per the accounting books and records to those on this worksheet. This reconciliation is subject to review by your intermediary.

Standard (i.e., preprinted) CMS line numbers and cost center descriptions cannot be changed. If you need to use additional or different cost center descriptions, add additional lines to the cost report. Where an added cost center description bears a logical relationship to a standard line description, the added label must be inserted immediately after the related standard line. The added line is identified as a numeric subscript of the immediately preceding line. For example, if two lines are added between lines 7 and 8, identify them as lines 7.01 and 7.02. If additional lines are added for general service cost centers, add corresponding columns for cost finding.

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

Do not use lines 32, 72 through 81, 87, and 91.

Cost center coding is a methodology for standardizing the meaning of cost center labels as used by health care providers on the Medicare cost reports. Form CMS-2552-96 provides for 90 preprinted cost center descriptions on Worksheet A. In addition, a space is provided for a cost center code. The preprinted cost center labels are automatically coded by CMS approved cost reporting software. These 90 cost center descriptions are hereafter referred to as the standard cost centers. An additional 57 nonstandard cost center descriptions have been identified through analysis of frequently used labels.

The use of this coding methodology allows providers to continue to use labels for cost centers that have meaning within the individual institution. The four digit cost center codes that are associated with each provider label in their

electronic file provide standardized meaning for data analysis. You are required to compare any added or changed label to the descriptions offered on the standard or nonstandard cost center tables. A description of cost center coding and the table of cost center codes are in §3695, table 5.

Columns 1, 2, and 3--**The expenses listed in these columns are the same as listed in your accounting books and records.**

List on the appropriate lines in columns 1, 2, and 3 the total expenses incurred during the cost reporting period. These expenses are detailed between salaries (column 1) and other than salaries (column 2). The sum of columns 1 and 2 equals column 3. Record any needed reclassifications and/or adjustments in columns 4 and 6, as appropriate.

Column 4--Enter any reclassifications among the cost center expenses in column 3 which are needed to effect proper cost allocation with the exception of the reclassification of capital related costs which are reclassified from Worksheet A-7.

Worksheet A-6 reflects the reclassifications affecting the cost center expenses. This worksheet need not be completed by all providers but is completed only to the extent that the reclassifications are needed and appropriate in the particular circumstance. Show reductions to expenses as negative numbers.

The net total of the entries in column 4 must equal zero on line 101.

Column 5--Adjust the amounts entered in column 3 by the amounts in column 4 (increase or decrease) and extend the net balances to column 5. The total of column 5 must equal the total of column 3 on line 101.

Column 6--Enter on the appropriate lines in column 6 of Worksheet A the amounts of any adjustments to expenses indicated on Worksheet A-8, column 2. The total on Worksheet A, column 6, line 101, equals Worksheet A-8, column 2, line 50.

Column 7--Adjust the amounts in column 5 by the amounts in column 6 (increase or decrease), and extend the net balances to column 7.

Transfer the amounts in column 7 to the appropriate lines on Worksheet B, Part I, column O.

Line Descriptions

The trial balance of expenses is broken down into general service, inpatient routine service, ancillary service, outpatient service, other reimbursable, special purpose, and nonreimbursable cost center categories to facilitate the transfer of costs to the various worksheets. For example, the categories ancillary service cost centers, outpatient service cost centers, and other reimbursable cost centers appear on Worksheet D, Part II, using the same line numbers as on Worksheet A.

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

Lines 1 through 24--These lines are for the general service cost centers.

Lines 1 through 4--The cost centers on lines 1 through 4 include depreciation, leases and rentals for the use of facilities and/or equipment, and interest incurred in acquiring land or depreciable assets used for patient care.

In addition, in accordance with 42 CFR 412.302(b)(4), enter all other capital-related costs, including but not limited to taxes, insurance, and license and royalty fees on depreciable assets.

NOTE: **Do not** include in these cost centers costs incurred for the repair or maintenance of equipment or facilities; amounts specifically included in rentals or lease payments for repair and/or maintenance agreements; interest expense incurred to borrow working capital or for any purpose other than the acquisition of land or depreciable assets used for patient care; general liability insurance or any other form of insurance to provide protection other than the replacement of depreciable assets; or taxes other than those assessed on the basis of some valuation of land or depreciable assets used for patient care. However, if no amount of the lease payment is identified in the lease agreement for maintenance, you are not required to carve out a portion of the lease payment to represent the maintenance portion. Thus, the entire lease payment is considered a capital-related cost subject to the provisions of 42 CFR 413.130(b).

For costs applicable to services, facilities, and supplies furnished by organizations related by common ownership or control (see 42 CFR 413.17 and HCFA Pub. 15-I, chapter 10), the reimbursable cost includes the costs for these items at the cost to the supplying organization unless the exception provided in 42 CFR 413.17(d) and HCFA Pub. 15-I, §1010 is applicable. However, if the price in the open market for comparable services, facilities, or supplies is lower than the cost to the supplier, the allowable cost does not exceed the market price.

The rationale behind this policy is that when you are dealing with a related organization, you are essentially dealing with yourself. Therefore, the costs to you are considered equal to the cost to the related organization.

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

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

If the supplying organization is not related to you (see 42 CFR 413.17), no part of the charge to you is considered a capital-related cost unless the services, facilities, or supplies are capital-related in nature. In the case of leased equipment, some factors that weigh in favor of treating a particular agreement as capital-related (see 56 FR 43388) include the following:

- The equipment is operated by personnel employed by the provider or an organization related to the provider within the meaning of 42 CFR 413.17.

- The physicians who perform the services with or interpret the tests from the equipment are associated with the provider.

o The agreement is memorialized in one document rather than in two or more documents (e.g., one titled a "Lease Agreement" and one titled a "Service Agreement").

o The document memorializing the agreement is titled a lease agreement. If one or more of the documents memorializing the agreement are titled "Service Agreements", this indicates a purchase of services.

o The provider holds the certificate of need (CON) for the services furnished with the equipment.

o The basis for determining the lease payment is units of time and is not volume sensitive (e.g., numbers of scans).

o The provider attends to such matters as utilization review, quality assurance, and risk management for the services involving the equipment.

o The provider schedules the patients for services involving the equipment.

o The provider furnishes any supplies required to be used with the equipment.

o The provider's access to the equipment is not subject to interruption without notice or interruption on very short notice.

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

Section 1886(g) of the Act, as implemented by 42 CFR, Part 412, Subpart M, requires that the reasonable cost-based payment methodology for hospital inpatient capital-related costs be replaced with a prospective payment methodology for hospitals paid under PPS, effective for cost reporting periods beginning on or after October 1, 1991. Hospitals and hospital distinct part units excluded from PPS pursuant to 42 CFR, Part 412, Subpart B, continue to be paid for capital-related costs on a reasonable cost basis. Also, rural primary care hospitals are excluded from the capital prospective payment system final rule. (See §§6003(g)(3)(B)(iii)(II) and (g)(3)(D)(x)(I) of OBRA 1989.)

NOTE: Hospitals excluded from PPS (unless as part of the complex there is a PPS subprovider) and/or a PPS hospital electing fully prospective for capital payment need only report capital costs on lines 3 and 4. Otherwise, all hospitals complete lines 1 through 4 for the complex.

Lines 1 and 2--Old capital costs are defined as allowable capital-related costs for land and depreciable assets that were put into use for patient care on or before December 31, 1990, with additional recognition of costs for capital-related items and services that are legally obligated by an enforceable contract entered into on or before December 31, 1990, and are put into patient use before October 1, 1994, subject to the exceptions explained in subsection 6 below. Old capital costs include the following:

1. Allowable depreciation on assets based on the useful life guidelines used to determine depreciation expense in the hospital's base period, which cannot be subsequently changed.

2. Allowable capital-related interest expense. Except as provided in subsections a through e below, the amount of allowable capital-related interest expense recognized as old capital is limited to the amount the hospital was legally obligated to pay as of December 31, 1990. Any allowable interest expense in excess of this limitation is recognized as new capital.

a. An increase in interest expense is recognized if the increase is due to periodic fluctuations of rates in variable interest rate loans or to periodic fluctuations of rates at the time of conversion from a variable rate loan to a fixed rate loan when no other changes in the terms of the loan are made.

b. If the terms of a debt instrument are revised after December 31, 1990, the amount of interest recognized as old capital during the transition cannot exceed the amount that would have been recognized during the same period prior to the revision of the debt instrument.

c. If short-term financing was used to acquire old capital assets and the debt is extended or rolled-over, a portion of the extended debt is recognized as old capital. The portion equals the ratio of the net book value as of the beginning of the applicable cost reporting period for depreciable assets that were in use in the base year to the net book value as of the beginning of the base year cost reporting period for those assets. Do not adjust the net book value for the base year to exclude assets fully depreciated or removed from service since the base year. If the debt is related to specific assets, determine the ratio based on the values for those assets. The ratio excludes assets acquired with other identifiable debt instruments. For purposes of this section, short term financing is a debt that becomes due in no later than the earlier of 5 years or half of the average useful life of the assets to which the debt is related.

d. If old capital indebtedness is commingled with new capital debt, the allowable interest expense is apportioned to old capital costs based on the ratio of the portion of the loan principal related to old capital indebtedness to the total loan principal.

e. Investment income (excluding income from funded depreciation accounts and other exclusions from investment income offset cited in HCFA Pub. 15-I, §202.2) is used to reduce old capital interest expense based on the ratio of total old capital interest expense to total interest expense in each cost reporting period.

3. Allowable capital-related lease and rental costs for land and depreciable assets that were obligated as of December 31, 1990.

a. The cost of lease renewals and the acquisition of assets continuously leased (e.g., capitalized leases) up to the annual lease payment level obligated as of December 31, 1990 are recognized provided that the same asset remains in use, the asset has a useful life of at least 3 years, and the annual lease payment is $1000 or more for each item or service.

b. If a hospital-owned asset is sold or given to another party and that same asset is then leased back by the hospital, the amount of allowable capital-related costs recognized as old capital costs is limited to the amount

allowed for that asset in the last cost reporting period during which it was owned by the hospital.

4. The portion of allowable costs for other capital-related expenses (including but not limited to taxes, insurance, and license and royalty fees on depreciable assets) resulting from applying the ratio of the hospital's gross old asset value to total asset value in each cost reporting period. (See line 90 instructions.)

5. The appropriate portion of the capital-related costs of related organizations under 42 CFR 413.17 that would be recognized as old capital costs if these costs had been incurred directly by the hospital.

6. Obligated capital costs recognized as old capital costs in accordance with the provisions discussed in the following paragraph.

Capital-related costs attributable to assets put in use after December 31, 1990 may be recognized as old capital costs under the conditions described below in accordance with 42 CFR 412.302(c). Any allowable capital-related costs for these assets not recognized as old capital costs are recognized as new capital costs. If the hospital has a multi-phase capital project, the provisions of this section apply independently to each phase of the project.

a. Fixed Assets.--The costs of capital-related items and services defined in 42 CFR 413ff, Subpart G, for which there was a contractual obligation entered into by a hospital or related party with an outside, unrelated party for the construction, reconstruction, lease, rental, or financing of a fixed asset may be recognized as old capital costs if all the following conditions are met:

(1) The obligation must arise from a binding written agreement that was executed on or before December 31, 1990 and that obligates the hospital on or before December 31, 1990;

(2) The capital asset must be put in use for patient care before October 1, 1994 except as provided below;

(3) The hospital notifies the intermediary of the existence of obligated capital costs (see 42 CFR 412.302(c)); and

(4) The amount recognized as old capital cost is limited to the lesser of the actual allowable costs when the asset is put in use or the estimated costs of the capital expenditure at the time it was obligated.

b. Moveable Equipment.--Moveable equipment is recognized as old capital only if all of conditions (1) through (4) are met and one of conditions (5) or (6) is met:

(1) The obligation must arise from a binding written agreement that was executed on or before December 31, 1990 and that obligates the hospital on or before December 31, 1990.

(2) The capital asset must be put in use for patient care before October 1, 1994. HCFA may extend the deadline under which an asset must be put in use for patient care before October 1, 1994 to no later than September 30, 1996 for extraordinary circumstances beyond the hospital's control. Extraordinary circumstances include, but are not limited to, a construction strike or atypically severe weather that significantly delayed completion of a construction project. Normal construction delays do not constitute extraordinary circumstances.

(3) The hospital notifies the intermediary of the existence of obligated capital costs. (See 42 CFR 412.302(c).)

(4) The amount recognized as old capital cost is limited to the lesser of the actual allowable costs when the asset is put in use or the estimated costs of the capital expenditure at the time it was obligated.

(5) There was a binding contractual agreement for the lease or purchase of the item of equipment on or before December 31, 1990.

(6) There was a binding contractual agreement for financing the acquisition of the equipment prior to January 1, 1991, the item of equipment costs at least $100,000, and the item was specifically listed in an equipment purchase plan approved by the Board of Directors on or before December 31, 1990. The amount recognized as old capital costs cannot exceed the estimated cost identified in the equipment purchase plan approved by the hospital's Board of Directors.

c. Lengthy Certificate of Need Process.--If a hospital does not meet the criteria under the fixed asset or moveable equipment provisions above but meets all of the following criteria, the estimated cost for the project as of December 31, 1990 may be recognized as old capital costs.

(1) The hospital is required under State law to obtain preapproval of the capital project or acquisition by a designated State or local planning authority in the State in which it is located;

(2) The hospital filed an initial application for a certificate of need on or before December 31, 1989 that includes a detailed description of the project and its estimated cost and had not received approval or disapproval on or before September 30, 1990;

(3) The hospital expended the lesser of $750,000 or 10 percent of the estimated cost of the project on or before December 31, 1990; and

(4) The hospital put the asset into patient use on or before the earlier of September 30, 1996 or 4 years from the date the certificate of need was approved.

d. Construction in Process.--If a hospital that initiates construction on a capital project does not meet the requirements under the fixed asset, moveable equipment, or lengthy certificate of need provisions, the project costs may be recognized as old capital costs if all the following conditions are met:

(1) The hospital received any required certificate of need approval on or before December 31, 1990;

(2) The hospital's Board of Directors formally authorized the project with a detailed description of its scope and costs on or before December 31, 1990;

(3) The estimated cost of the project as of December 31, 1990 exceeds 5 percent of the hospital's total patient revenues during its base year;

(4) The capitalized cost incurred for the project as of December 31, 1990 exceeded the lesser of $750,000 or 10 percent of the estimated project cost;

(5) The hospital began actual construction or renovation (groundbreaking) on or before March 31, 1991; and

(6) The project is completed before October 1, 1994.

e. Planning, Design or Feasibility Agreements.--If these agreements do not commit the hospital to undertake a project, they are not recognized as obligating capital expenditures.

f. Cost Limitation - Leases, Rentals, or Purchases.--The amount of obligated capital costs recognized as old capital costs cannot exceed the amount specified in the lease, rental, or purchase agreement.

g. Cost Limitation - Construction Contracts.--The amount of obligated capital costs recognized as old capital costs cannot exceed the estimated construction costs for the project as of December 31, 1990. Additional costs are recognized as old capital costs only if the additional costs are directly attributable to changes in life safety codes or other building requirements established by government ordinance that became effective after the project was obligated.

h. Cost Limitation - Financing Costs.--The amount of obligated interest expense recognized as old capital costs cannot exceed the amount for which the hospital was legally obligated as of December 31, 1990 or, in the case of financing arranged after December 31, 1990 for a capital acquisition that was legally obligated as of December 31, 1990, the amount specified in a detailed financing plan approved by the hospital's Board of Directors prior to January 1, 1991.

i. Amount Recognized As Old Capital Cost.--The actual amount recognized as old capital costs is based on the lesser of the allowable costs for the asset when it is put into patient use or the amounts determined under the cost limitations above.

For cost reporting periods beginning on or after October 1, 1991 and before October 1, 2001, the hospital must follow consistent cost finding methods for classifying and allocating capital-related costs. (See 42 CFR 412.302 (d).)

Unless there is a change of ownership, the hospital must continue the same cost finding methods for old capital costs. This includes its practices for the direct assignment of capital-related costs and its cost allocation bases in effect during the hospital's last cost reporting period ending on or before October 1, 1991. If there is a change of ownership, the new owners may request that the intermediary approve a change in order to be consistent with their established cost finding practices.

If a hospital desires to change its cost finding method for the direct assignment of new capital costs, the request for change must be made in writing to the intermediary prior to the beginning of the cost reporting period for which the change is to apply. The request must include justification as to why the change will result in more accurate and more appropriate cost finding. The intermediary does not approve the change unless it determines that there is reasonable justification for the change.

When a depreciable asset has been disposed of in the base period, only that portion of the gain or loss that is allocated to the base period cost reporting period is reflected in the hospital-specific rate.

If an asset for which the Medicare program had recognized depreciation during the base period is disposed of subsequent to the base period, the hospital-specific rate is not revised to recognize the portion of the gain or loss allocated to the base period.

Lines 3 and 4--New capital costs are defined as all allowable Medicare inpatient capital-related costs that do not meet the definition of old capital costs. Betterment or improvement costs related to old capital costs are new capital assets. (See 42 CFR 412.302(a).) Capital costs incurred as a result of extraordinary circumstances are new capital. (See 42 CFR 412.348(e).) Direct assignment of new capital costs must be done in accordance with CMS Pub. 15-I, §2313.

Line 6--Enter administrative and general (A & G) costs on this line. If this line is componentized into more than one cost center, eliminate line 6. Componentized A & G lines must begin with subscripted line 6.01 and continue in sequential order (e.g., 6.01 Nonpatient Telephones; 6.02 Data Processing; 6.03 Purchasing, Receiving, Stores; 6.04 Admitting; 6.05 Cashiering, Accounts; and 6.06 Other A & G).

Line 14--This cost center normally includes only the cost of nursing administration. The salary cost of direct nursing services, including the salary cost of nurses who render direct service in more than one patient care area, is directly assigned to the various patient care cost centers in which the services were rendered. Direct nursing services include gross salaries and wages of head nurses, registered nurses, licensed practical and vocational nurses, aides, orderlies, and ward clerks.

However, if your accounting system fails to specifically identify all direct nursing services to the applicable patient care cost centers, then the salary cost of all direct nursing service is included in this cost center.

Line 17--This cost center includes the direct costs of the medical records cost center including the medical records library. The general library and the medical library are not included in this cost center but are reported in the A & G cost center.

Line 20--Effective for services rendered on or after January 1, 1989, the services of a nonphysician anesthetist generally are paid for by the Part B carrier based on a fee schedule rather than on reasonable cost basis through the cost report. As such, the salary and fringe benefit costs included on line 20 generally are not reimbursed through the cost report.

NOTE: Only such salary and fringe benefit costs are included on this line.

However, payment for the nonphysician anesthetists on a fee basis may not apply to a rural hospital during 1991 if the hospital employed or contracted with not more than one FTE nonphysician anesthetist and, if (1) in 1987, the hospital had 250 or fewer surgical procedures (including inpatient and outpatient procedures) requiring anesthesia services and (2) each nonphysician employed by or under contract with the hospital has agreed not to bill under Part B of title XVIII for professional services furnished. Further, payment under the fee schedule applies to hospitals during 1991 unless the hospital establishes, before the beginning of each of these years, that it did not exceed 800 surgical procedures requiring anesthesia in the previous year. 42 CFR 412.113(c)(2)(ii) (10/1/2002)

Hospitals which do not qualify for the exception and are therefore subject to the fee schedule payment method must remove the salary and fringe benefit costs from line 20. The total amount is reported on Worksheet A-8, line 33 and in column 6, line 20 of this worksheet. This removes these costs from the cost reported in column 7.

Lines 21 and 24--For cost reporting periods beginning on or after October 1, 1990, if you operate an approved nursing or allied health education program that meets the criteria of 42 CFR 413.85 and 412.113(b), both classroom and clinical portions of the costs are allowable as pass through costs as defined in 42 CFR 413.85.

Classroom costs are those costs associated with formal, didactic instruction on a specific topic or subject in a classroom that meets at regular, scheduled intervals over a specific time period (e.g., semester or quarter) and for which a student receives a grade.

Clinical training is defined as involving the acquisition and use of the skills of a nursing or allied health profession or trade in the actual environment in which these skills will be used by the student upon graduation. While it may involve occasional or periodic meetings to discuss or analyze cases, critique performance, or discuss specific skills or techniques, it involves no class room instruction.

For cost reporting periods beginning on or after October 1, 1990, if you do not operate the program, the classroom portion of the costs are not allowable as pass through costs and therefore not reported on lines 21 and 24 of the Form CMS-2552-96. They may, however, be allowable as routine service operating cost. (See CMS Pub. 15-I, §404.2.) The clinical portions of these costs are allowable as pass through costs if the following conditions as set forth in §4004(b) of OBRA 1990 are met:

1. The hospital must have claimed and have been paid for clinical costs (described below) during its latest cost reporting period that ended on or before October 1, 1989.

2. The proportion of the hospital's total allowable costs that is attributable to the clinical training costs of the approved program and allowable under §4004(b)(1) of OBRA 1990 during a cost reporting period does not exceed the proportion of total allowable costs that were attributable to the clinical training costs during the hospital's most recent cost reporting period ending on or before October 1, 1989.

3. The hospital receives a benefit for the support it furnishes to the education program through the provision of clinical services by nursing and allied health students participating in the program.

4. The clinical training costs must be incurred by the provider or by an educational institution related to the provider by common ownership or control as defined by 42 CFR 413.17b (cost to related organizations). Costs incurred by a third party, regardless of its relationship to either the provider or the educational institution, are not allowed.

5. The costs incurred by the hospital for the program do not exceed the costs that would have been incurred by the hospital if the program had been operated by the hospital.

Line 21--Enter the cost for the nursing school.

Line 22--Enter the cost of intern and resident salaries and salary-related fringe benefits. Do not include salary and salary-related fringe benefits applicable to teaching physicians which are included in line 23.

Line 23--Enter the other costs applicable to interns and residents in an approved teaching program.

Line 24--This line is used for a hospital or subprovider which operates an approved paramedical education program that meets the criteria of 42 CFR 413.85 and 412.113(b). Establish a separate cost center for each paramedical education program (e.g., one for medical records or hospital administration). If additional lines are needed, subscript line 24. If the direct costs are included in the costs of an ancillary cost center, reclassify them on Worksheet A-6 to line 24. Appropriate statistics are required on Worksheet B-1 to ensure that overhead expenses are properly allocated to this cost center.

Lines 25 through 36--These lines are for the inpatient routine service cost centers.

Line 25--The purpose of this cost center is to accumulate the incurred routine service cost applicable to adults and pediatrics (general routine care) in a hospital. Do not include incurred costs applicable to subproviders or any other cost centers which are treated separately.

NOTE: If a rural hospital with a certified SNF which has less than 50 beds in the aggregate for both components (excluding intensive care type and newborn beds) has made an election to use swing bed optional method for the SNF, the SNF routine costs and patient days are treated as though they were hospital swing bed-SNF type costs and patient days and are combined with the hospital adults and pediatrics cost center on line 25. (See 42 CFR 413.24(d)(5) and CMS Pub. 15-I, §2230.5B.) The SNF direct costs are reclassified from line 34 to line 25 through Worksheet A-6. On Worksheet B-1, the statistics for line 25 include the statistics for line 34.

When the swing bed optional method is elected for the SNF, the SNF beds are not swing beds but are reimbursed as if they were swing beds.

SNF ancillary services are recorded on Worksheet D, Part III, and Worksheet D-4 as swing bed-SNF ancillary services and not as SNF ancillaries when the swing bed optional method is elected.

Lines 26 through 30--Use lines 26 through 29 to record the cost applicable to intensive care type inpatient hospital units. (See 42 CFR 413.53(b).) Label line 30 appropriately to indicate the purpose for which it is being used.

Line 31--Use this line to record the inpatient routine service costs of a subprovider. Hospital units that are excluded units from PPS are treated as subproviders for cost reporting purposes. If you have more than one subprovider, subscript line 31.

Line 34--Use this line to record the costs of SNFs certified for titles V, XVIII, or XIX if your State accepts one level of care.

Line 35--Use this line to record the cost of NFs certified for title V or title XIX but not certified as an SNF for title XVIII. Subscript this line to record the cost of ICF/MR. Do not report nursing facility costs on this subscripted line (9/96).

Line 36--Use this cost center to accumulate the direct costs incurred in maintaining long term care services not specifically required to be included in other cost centers. A long term care unit refers to a unit where the average length of stay for all patients is greater than 25 days. The beds in this unit are not certified for titles V, XVIII, or XIX.

Lines 37 through 59--Use for ancillary service cost centers.

Line 45--Use this line to record costs when a pathologist continues to bill non-program patients for clinical laboratory tests and is compensated by you for services related to such tests for program beneficiaries. When you pay the pathologist an amount for administrative and supervisory duties for the clinical laboratory for program beneficiaries only, include the cost in this cost center.

NOTE: No overhead expenses are allocated to this cost center since it relates to services for program beneficiaries only. The cost reporting treatment is similar to that of services furnished under arrangement to program beneficiaries only. (See CMS Pub. 15-I, §2314.)

These costs are apportioned among the various programs on the basis of program charges for provider clinical laboratory tests for all programs for which you reimburse the pathologist.

Line 46--Include the direct expenses incurred in obtaining blood directly from donors as well as whole blood and packed red blood cells from suppliers. Do not include in this cost center the processing fee charged by suppliers. The processing charge is included in the blood storing, processing, and transfusion cost center. Identify this line with the appropriate cost center code (Table 5 - electronic reporting specifications) for the cost of administering blood clotting factors to hemophiliacs. Enter on subscripted line 46.30 the applicable costs for blood clotting factors to hemophiliacs. (See §4452 of BBA 1997, OBRA 1989 & 1993.)

Line 47--Include the direct expenses incurred for processing, storing, and transfusing whole blood, packed red blood cells, and blood derivatives. Also include the processing fee charged by suppliers.

Line 55--Include the expense of medical supplies charged to patients. These items are low cost medical supplies generally not traceable to individual patients. Do not include high cost implantable devices on this line. This amount is generally not input on Worksheet A, but rather allocated to this cost center on Worksheet B from cost center 15 (central service and supply) based on the recommended statistic of *costed* requisitions.

Line 55.30--Include the expense of implantable devices charged to patients. The types of items includable on this line are high cost implantable devices chargeable and traceable to individual patients. Do not include low cost medical supplies on this line. When determining what costs are reported in this cost center, providers should use costs associated with implantable devices bearing revenue codes identified in the FR, Vol. 73, No. 161, page 48462, dated August 19, 2008. This amount is generally not input on Worksheet A, but rather allocated to this cost center on Worksheet B from cost center 15 (central service and supply) based on the recommended statistic of *costed* requisitions. Identify this line with the appropriate cost center code according to Table 5 of the electronic reporting specifications. This cost center is effective for cost reporting periods beginning on or after May 1, 2009.

Line 57--If you furnish renal dialysis treatments, account for such costs by establishing a separate ancillary service cost center. In accumulating costs applicable to this cost center, include no other ancillary services even though they are routinely administered during the course of the dialysis treatment. However, if you physically perform a few minor routine laboratory services associated with dialysis in the renal dialysis department, such costs remain in the renal dialysis cost center. Outpatient maintenance dialysis services rendered after July 31, 1983, are reimbursed under the composite rate reimbursement system. For purposes of determining overhead attributable to the drugs Epoetin and Aranesp include the cost of the drug in this cost center. The drug costs will be removed on worksheet B-2 after stepdown.

NOTE: ESRD physician supervisory services rendered on or after August 1, 1983, (the effective date of the composite rate reimbursement system) are not included as your costs. Supervisory services are included in the physician's monthly capitation rate.

Line 58--Enter the cost of ASCs that are not separately certified as a distinct part but which have a separate surgical suite. Do not include the costs of the ancillary services provided to ASC patients. Include only the surgical suite costs (i.e., those used in lieu of operating or recovery rooms).

Lines 60 through 63--Use these lines for outpatient service cost centers.

Line 60--Enter the cost applicable to the clinic. If you have two or more clinics which are separately costed, separately report each such clinic. Subscript this line to report each clinic. Carry forward these subscripted lines to all applicable worksheets. If you do not separately cost each clinic, you may combine the cost of all clinics on the clinic line.

NOTE: For lines 60 and 63, any ancillary service billed as clinic, RHC, and FQHC services must be reclassified to the appropriate ancillary cost center, e.g., radiology-diagnostic, PBP clinical lab services - program only. A similar adjustment must be made to program charges.

Line 61--Enter the costs of the emergency room cost center.

Line 62--Do not use this line on this worksheet. If you have an area specifically designated for observation (e.g., observation patients are not placed in a general acute care area bed), report this on a subscripted line 62.01.

NOTE: It is possible to have both a distinct observation bed area and a non-distinct part. For example, your distinct part observation bed area is only staffed from 7:00 a.m. - 10:00 p.m. Patients entering your hospital needing observation bed care after 10:00 p.m. and before 7:00 a.m. are placed in a general inpatient routine care bed. If patients entering the distinct part observation bed area are charged differently than the patients placed in the general inpatient routine care bed, separate the costs into distinct observation bed costs and non-distinct observation bed costs. However, if the charge is the same for both patients, report all costs and charges as distinct part observation beds.

Line 63--Use this line to report the costs of provider-based RHCs and FQHCs. If more than one are maintained and/or other services are reported on this line, subscript the line. See Table 5 in §3695 for the proper cost center code for RHCs and FQHCs. When reporting RHCs and FQHCs on these lines, subscript the line beginning with lines 63.50 through 63.59 and 63.85 through 63.99 for RHC and 63.60 through 63.84 for FQHC.

In accordance with CMS Pub. 27, §501, compensation paid to a physician for RHC services rendered in a hospital-based RHC is cost reimbursed. Where the physician agreement compensates for RHC services as well as non-RHC services, or services furnished in the hospital, the related compensation must be eliminated on Worksheet A-8 and billed to the Part B carrier. If not specified in the agreement, a time study must be used to allocate the physician compensation.

Lines 64 through 68 and 70--Use these lines for other reimbursable cost centers (other than HHA, CORF, and CMHC).

Line 64--Use this line to accumulate the direct costs incurred for self-care home dialysis. For purposes of determining overhead attributable to the drugs Epoetin and Aranesp include the cost of the drug in this cost center. The drug costs will be removed on worksheet B-2 after stepdown.

A Medicare beneficiary dialyzing at home has the option to deal directly with the Medicare program and make individual arrangements for securing the necessary supplies and equipment to dialyze at home. Under this arrangement, the beneficiary is responsible for dealing with the various suppliers and the Medicare program to arrange for payment. The beneficiary is also responsible to the suppliers for the deductible and 20 percent Medicare coinsurance requirement. You do not receive composite rate payment for a patient who chooses this option. However, if you provide any direct home support services to a beneficiary who selects this option, you are reimbursed on the same reasonable cost basis for these services as for other outpatient services. These costs are entered on line 63 and are notated as cost reimbursed. You may service Medicare beneficiaries who elect this option and others who deal directly with you. In this case, set up two home program dialysis cost centers (using a subscript for the second cost center) to properly classify costs between the two categories of beneficiaries (those subject to cost reimbursement and those subject to the composite rate).

Line 65--Report all ambulance costs on this line for both owned and operated services and services under arrangement. No subscripting is allowed for this line (9/96).

Lines 66 and 67--Use these lines to report durable medical equipment rented or sold, respectively.

For the hospital-based SNF, report support surfaces by subscripting line 67 and use the proper cost center code.

Line 69--This cost center accumulates the direct costs for outpatient rehabilitation providers, CORF, CMHC, OPT, OOT, and OSP. If you have multiple components, subscript this line using the proper cost center code.

Line 70--Use this line if your hospital operates an intern and resident program not approved by Medicare.

Line 71--This cost center accumulates costs specific to HHA services. If you have more than one certified hospital-based HHA, subscript line 71 for each HHA.

Provider-based HHAs are operated and managed in a variety of ways within the context of the health care complexes of which they are components. In some instances, there are discrete management and administrative functions pertaining to the HHA, the cost of which is readily identifiable from the books and records.

In other instances, the administration and management of the provider-based HHA is integrated with the administration and management of the health care complex to such an extent that the cost of administration and management of the home health agency can be neither identified nor derived from the books and records of the health care complex. In other instances, the cost of administration and management of the HHA is integrated with the administration and management of the health care complex, but the cost of the HHA administration and management can be derived through cost finding. However, in most cases, even when the cost of HHA administration and management can be either identified or derived, the extent to which the costs are applicable to the services furnished by the provider-based HHA is not readily identifiable.

Even when the costs of administration and management of a provider-based HHA can be identified or derived, such costs do not generally include all of the general service costs (i.e., overhead costs) applicable to the HHA. Therefore, allocation of general service costs through cost finding is necessary for the determination of the full costs of the provider-based HHA.

When the provider-based HHA can identify discrete management and administrative costs from its books and records, these costs are included on line 71.

Similar situations occur for the services furnished by the provider-based HHA. For example, in some instances, physical therapy services are furnished by a discrete HHA physical therapy department. In other instances, physical therapy services are furnished to the patient of the provider-based HHA by an integrated physical therapy department of a hospital health care complex in such a manner that the direct costs of furnishing the physical therapy services to the patients of the provider-based HHA cannot be readily identified or derived. In other instances, physical therapy services are furnished to patients of the provider-based HHA by an integrated physical therapy department of a hospital health care complex in such a manner that the costs of physical therapy services furnished to patients of the provider-based HHA can be readily identified or derived.

When you maintain a separate therapy department for the HHA apart from the hospital therapy department furnishing services to other patients of the hospital health care complex or when you are able to reclassify costs from an integrated therapy department to an HHA therapy cost center, make a reclassification entry on Worksheet A-6 to the appropriate HHA therapy cost center. Make a center. Make a similar reclassification to the appropriate line for other ancillaries when the HHA costs are readily identifiable.

NOTE: This cost report provides separate HHA cost centers for all therapy services. If services are provided to HHA patients from a shared hospital ancillary cost center, make the cost allocation on Worksheet H-4, Part II.

Lines 72 through 81--Do not use these lines.

Lines 82 through 93--Use these lines for special purpose cost centers. Special purpose cost centers include kidney, heart, liver, and lung acquisition costs, costs of other organ acquisitions which are nonreimbursable but which CMS requires for data purposes, cost centers which must be reclassified but which require initial identification, and ASC and hospice costs which are needed for rate setting purposes.

NOTE: Prorate shared acquisition costs (e.g., coordinator salaries, donor awareness programs) among the type of organ acquisitions. Generally, this is done based on the number of organs procured. Further, if multiple organs have been procured from a community hospital or an independent organ procurement organization, prorate the cost among the type of acquisitions involved.

Line 82--Record any costs in connection with lung acquisitions. This cost center flows through cost finding and accumulates any appropriate overhead costs.

Line 83--This cost center includes the cost of services purchased under arrangement or billed directly to the hospital in connection with kidney acquisition. Such direct costs include but are not limited to:

- Fees for physician services (preadmission for transplant donor and recipient tissue-typing and all tissue-typing services performed on cadaveric donors);
- Cost for kidneys acquired from other providers or kidney procurement organizations;
- Transportation costs of kidneys;
- Kidney recipient registration fees;
- Surgeons' fees for excising cadaveric donor kidneys; and
- Tissue-typing services furnished by independent laboratories.

NOTE: No amounts or fees paid to a donor, their estate, heirs, or assigns in exchange for a kidney or for the right to remove or transplant a kidney are included in kidney acquisition costs. Also, such amounts or fees are not included in any other revenue producing or general service cost center.

Only hospitals which are certified transplant centers are reimbursed directly by the Medicare program for organ acquisition costs. All such costs are accumulated on Worksheet D-6.

Hospitals which are not certified transplant centers are not reimbursed by the Medicare program for organ acquisition costs. Such hospitals sell any organs excised to a certified transplant center or an organ procurement organization. The costs are accumulated in this cost center and flow through cost finding to properly allocate overhead costs to this cost center. However, only a certified transplant center completes Worksheet D-6.

Line 84--Record any costs in connection with liver acquisitions. This cost center flows through cost finding and accumulates any appropriate overhead costs.

Line 85--Record any costs in connection with heart acquisitions. This cost center flows through cost finding and accumulates any appropriate overhead costs.

Line 85.01--Record any costs in connection with pancreas acquisitions. This cost center flows through cost finding and accumulates any appropriate overhead costs (8/99).

Line 85.02 -- Record any costs in connection with intestinal acquisitions. This cost center flows through cost finding and accumulates any appropriate overhead costs.

Line 85.03--Record the costs associated with the acquisition of the pancreas that is used to isolate the islet cells that are used for transplant. Do not include in this cost any costs associated with the isolation of the islet cells as these costs will be included as an add-on to the DRG payment. (See CR 5505 dated March 2, 2007 with an effective date for discharges on or after 10/1/04). Use non-standard cost center code 8530 to identify this cost center.

Line 86--Record any costs related to organ acquisitions, which are not already recorded on lines 82, 83, 84, 85 and subscripts. This cost center flows through cost finding and accumulates any appropriate overhead costs (8/99).

Line 87--Do not use this line.

Line 88--Enter all interest paid by the facility. After reclassifications in column 4 and adjustments in column 6, the balance in column 7 must equal zero. This line cannot be subscripted.

NOTE: If capital-related and working capital interest are commingled on this line, reclassify working capital interest to A & G expense. Reclassify capital-related interest to lines 1 through 4, as appropriate, in accordance with the instructions for those lines.

Line 89--Include only utilization review costs of the hospital-based SNF. All costs are either reclassified or adjusted in total depending on the scope of the review. If the scope of the review covers all patients, all allowable costs are reclassified in column 4 to A & G expenses (line 6). If the scope of the review covers only Medicare patients or Medicare, title V, and title XIX patients, then (1) in column 4, reclassify to A & G expenses all allowable costs other than physicians' compensation and (2) deduct in column 6 the compensation paid to the physicians for their personal services on the utilization review committee. The adjusted amount is then reinstated on Worksheet D-1, line 81 for each program. The sum of the amounts reported on each Worksheet D-1 and/or the amount reported on Worksheet E-2, column 1, line 7 must equal the amount adjusted on Worksheet A-8 (9/96).

Line 90--In accordance with 42 CFR 412.302(b)(4), enter all other capital-related costs, including but not limited to taxes, insurance, and license and royalty fees on depreciable assets. This line also includes any directly allocated home office other capital cost. After reclassifications in column 4 and adjustments in column 6, the balance in column 7 must equal zero. This line cannot be subscripted.

A **PPS hospital** or **a complex with a PPS excluded unit** which is paid for PPS inpatient capital using the hold harmless method is required to allocate the costs in this cost center between old and new capital and between buildings and fixtures and movable equipment on the basis of the ratio of the hospital's gross old asset value to total asset value in each cost reporting period on Worksheet A-7, Part III.

For cost reporting periods beginning on or after October 1, 2001, PPS providers paid 100 percent Federal do not complete line 90, columns 1 and 2 and Worksheet A-7, Parts III and IV. Complete Worksheet A-7, Parts I (if applicable) and II for cost reporting periods ending on or after February 29, 2004. However, for cost reporting periods ending on or after April 30, 2005, PPS providers paid 100 percent Federal will again complete line 90, column 2 and Worksheet A-7, Parts I (if applicable), II , III and IV.

Line 91--Do not use this line.

Line 92--Enter the direct costs of an ASC as defined in 42 CFR 416.2. An ASC operated by a hospital must be a separately identifiable entity, physically, administratively, and financially independent and distinct from other operations of the hospital. In addition, the ASC must have an agreement with HCFA as required by 42 CFR 416.25. Under this restriction, hospital outpatient departments providing ambulatory surgery (among other services) are not eligible to be classified as ASCs. Those ASCs which meet the definition in 42 CFR 416.2 and are currently treated as an outpatient cost center on the hospital's Medicare cost report are reimbursed through a prospectively determined standard overhead amount. For cost reporting purposes, an eligible ASC is treated as a nonreimbursable cost center to ensure that overhead costs are properly allocated since the cost is not reimbursable in this cost report.

Line 93--42 CFR Part 418 provides for coverage of hospice care for terminally ill Medicare beneficiaries who elect to receive care from a participating hospice.

Line 94--Enter other special purpose cost centers not previously identified. Review Table 5 in §3695 for the proper cost center code.

Lines 96 through 100--Record the costs applicable to nonreimbursable cost centers to which general service costs apply. If additional lines are needed for nonreimbursable cost centers other than those shown, subscript one or more of these lines with a numeric code. The subscripted lines must be appropriately labeled to indicate the purpose for which they are being used. However, when the expense (direct and all applicable overhead) attributable to any nonallowable cost area is so insignificant as not to warrant establishment of a nonreimbursable cost center and the sum total of all such expenses is so insignificant as not to warrant the establishment of a composite nonreimbursable cost center, these expenses are adjusted on Worksheet A-8. (See HCFA Pub. 15-I, §2328.)

Line 100--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.

3611. WORKSHEET A-6 - RECLASSIFICATIONS

This worksheet provides for the reclassification of certain costs to effect proper cost allocation under cost finding. For each reclassification adjustment, assign an alpha character, e.g., A, B, C. DO NOT USE NUMERIC DESIGNATIONS. In column 10, indicate the column of Worksheet A-7 impacted by the reclassification. If more than one column is impacted by one reclassification, report each entry as a separate line to properly report each column impacted on Worksheet A-7. If you directly assign the capital-related costs, i.e., insurance, taxes, and other, reclassify these costs to line 90. Do not reclassify other capital-related costs reported or reclassified to line 90 of Worksheet A back to the other capital lines 1-4 of Worksheet A. This is accomplished through Worksheet A-7.

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

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

If there is any reclassification to general service cost centers for compensation of provider-based physicians, make the appropriate adjustment for RCE limitation on Worksheet A-8-2. (See §3615.)

Examples of reclassifications that may be needed are:

- Reclassification of related organization rent expenses included in the A & G cost center which are applicable to lines 1 through 4 of Worksheet A. See instructions for Worksheet A-8-1 for treatment of rental expenses for related organizations.

- Reclassification of interest expense included on Worksheet A, column 3, line 88, which is applicable to funds borrowed for A & G purposes (e.g., operating expenses) or for the purchase of buildings and fixtures or movable equipment. Allocate interest on funds borrowed for operating expenses with A & G expenses.

- Reclassification of employee benefits expenses (e.g., personnel department, employee health service, hospitalization insurance, workers compensation, employee group insurance, social security taxes, unemployment taxes, annuity premiums, past service benefits, and pensions) included in the A & G cost center.

- Reclassification of utilization review cost applicable to the hospital-based SNF to A & G costs. If the scope of the utilization review covers the entire population, reclassify the total allowable utilization review cost included on Worksheet A, column 3, line 89. However, if the scope of the utilization review in the hospital-based SNF covers only Medicare patients or Medicare and title XIX patients, only the allowable utilization review costs included on Worksheet A, column 3, line 89 (other than the compensation of physicians for their personal services on utilization review committees) are reclassified to A & G costs.

The appropriate adjustment for physicians' compensation is made on Worksheet A-8. For further explanations concerning utilization review in skilled nursing facilities, see HCFA Pub. 15-I, §2126.2.

- Reclassification of any dietary cost included in the dietary cost center which is applicable to the cafeteria, nursery, and to any other cost centers such as gift, flower, coffee shops, and canteen.

o Reclassification of any direct expenses included in the central service and supply cost center which are directly applicable to other cost centers such as intern-resident service, intravenous therapy, and oxygen (inhalation) therapy.

o Reclassification of any direct expenses included in the laboratory cost center which are directly applicable to other cost centers such as whole blood and packed red blood cells or electrocardiology.

o Reclassification of any direct expenses included in the radiology-diagnostic cost center which are directly applicable to other cost centers such as radiology-therapeutic, radioisotope, or electrocardiology.

o When you purchase services (e.g., physical therapy) under arrangements for Medicare patients but do not purchase such services under arrangements for non-Medicare patients, your books reflect only the cost of the Medicare services. However, if you do not use the grossing up technique for purposes of allocating overhead and if you incur related direct costs applicable to both Medicare and non-Medicare patients (e.g., paramedics or aides who assist a physical therapist in performing physical therapy services), reclassify the related costs on Worksheet A-6 from the ancillary service cost center. Allocate them as part of A & G expense. However, when you purchase services that include performing administrative functions such as completion of medical records, training, etc. as described in CMS Pub. 15-1, §1412.5, the overall charge includes the provision of these services. Therefore, for cost reporting purposes, these related services are NOT reclassified to A & G.

o If a beneficiary receives outpatient renal dialysis for an extended period of time and you furnish a meal, the cost of this meal is not an allowable cost for Medicare. Make an adjustment on Worksheet A-8. However, the dietary counseling cost attributable to a dialysis patient is an allowable cost. Reclassify this cost from the dietary cost center, line 11, to the renal dialysis cost center, line 57.

o When interns and residents are employed to replace anesthetists, you must reclassify the related direct costs from the intern and resident cost center to the anesthesiology cost center. (See 42 CFR 413.85(d)(7) and 49 FR 296 dated January 3, 1984.)

NOTE: These interns and residents do not qualify for the indirect medical education adjustment and must be excluded for the intern and resident FTE for that purpose. (See 42 CFR 412.113(c).)

o If you incur costs for an unpaid guarantee for emergency room physician availability, attach a separate worksheet showing the computation of the necessary reclassification. (See CMS Pub. 15-I, §2109.)

o Reclassification of the costs of malpractice insurance premiums, self-insurance fund contributions, and uninsured malpractice losses incurred either through deductible or coinsurance provisions, as a result of an award in excess of reasonable coverage limits, or as a government provider to the A & G cost center.

3612. WORKSHEET A-7 - ANALYSIS OF CAPITAL ASSETS

This worksheet consists of four parts:

Part I	-	Analysis of Changes in Old Capital Asset Balances
Part II	-	Analysis of Changes in New Capital Asset Balances
Part III	-	Computation of Old Capital for Insurance, Taxes, and Other Capital-Related Costs.
Part IV	-	Reconciliation of amounts from worksheet A, column 2, lines 1 through 4.

See the instructions for Worksheet A for a definition of old and new capital. **A non-PPS provider does not have to complete Part I.** For cost reporting periods beginning on and after October 1, 2001, hospitals receiving 100 percent Federal prospective payment for capital are no longer required to complete Parts III and IV of this Worksheet if worksheet S-2, column 2, line 36 = "Y". However, Parts I through IV must be completed in all situations for cost reporting periods ending on or after February 29, 2004. (2/29/2004) Additionally, complete parts III and IV for cost reporting periods ending on or after April 30, 2005. (4/30/2005)

NOTE: Include assets which are directly allocated to the provider from the home office or related organization and the related other capital costs in Parts I, II, and III of this worksheet.

The intent of Worksheet A-7, Parts I and II, is to reflect assets which relate to the hospital. However, examine the cost finding elections made at the time you submit the cost report to consider the cost finding treatment of SNF, HHA, hospice, subproviders, CORF, CMHC, the physician office building, and any other nonallowable cost centers.

Where you have elected to cost find any of these areas through the cost report, related assets must be included in Worksheet A-7, Parts I and II, as appropriate, to properly allocate the related insurance, taxes, etc. This cost finding treatment must comply with the consistency rule in 42 CFR 412.302(d).

3612.1 Part I - Analysis of Changes in Old Capital Asset Balances and Part II - Analysis of Changes in New Capital Asset Balances.--These parts enable the Medicare program to analyze the changes that occurred in your capital asset balances during the current reporting period. Complete this worksheet only once for the entire hospital complex (certified and non-certified components). However, only include in Parts I and II assets that relate to hospital services or are commingled and cannot be separated.

Columns 1 and 6--Enter the balance recorded in your books of accounts at the beginning of your cost reporting period (column 1) and at the end of your cost reporting period (column 6). You must submit a reconciliation demonstrating that the sum of Parts I and II, column 6, line 9, agree with the total fixed assets on Worksheet G, plus any directly allocated assets from the home office or related organization, less any assets not allocated through the cost finding method on Worksheet B. Include fully depreciated assets still used for patient care.

Columns 2 through 4--Enter the cost of capital assets acquired by purchase in column 2 and the fair market value at date acquired of donated assets in column 3. Enter the sum of columns 2 and 3 in column 4.

NOTE: The amounts in Part I, column 2, represent transfers from obligated capital and/or a transfer of assets from a change of ownership.

Column 5--Enter the cost or other approved basis of all capital assets sold, retired, or disposed of in any other manner during your cost reporting period.

The sum of columns 1 and 4 minus column 5 equals column 6.

Line Descriptions

Line 8--If you have included in lines 1 through 6 of Parts I and II any of the following, enter those amounts on line 8.

- Capitalized a lease in accordance with generally accepted accounting principles (GAAP) and included it in the assets reported on Worksheet G,

- Excess of amounts paid for the acquisition of assets over their fair values or the amount recognized under §2314 of DEFRA for transactions after July 18, 1984, or

- Construction in progress at the end of the cost reporting period.

Line 9--Enter line 7 minus line 8.

3612.2 Part III - Reconciliation of Capital Cost Centers.--Use this part to allocate allowable insurance, taxes, and other capital expenditures (not including depreciation, lease, and interest expense) to the capital-related cost centers. This part also summarizes the amounts in the capital-related cost centers on Worksheet A, lines 1 through 4, column 7.

Lines 1 through 4--In accordance with 42 CFR 412.302(b)(4), allowable costs for other capital-related expenses (including but not limited to taxes, insurance, and license and royalty fees on depreciable assets) are apportioned to old capital by applying the ratio of the hospital's gross old asset value to total asset value in each cost reporting period. These lines compute the appropriate gross asset ratios used in allocating other capital-related costs in columns 5 through 7.

Line 5--Enter the sum of lines 1 through 4. Column 4 must equal 1.000000.

Columns 1 through 4, Lines 1 through 4--Use these columns and lines to compute ratios of new and old gross asset values to total gross asset values. Use these ratios on columns 5 through 7 to allocate other capital costs (insurance, taxes, and other) to the capital-related cost center lines (Worksheet A, lines 1 through 4).

Column 1--Enter on line 1 your gross asset value (asset value before accumulated depreciation) for old buildings and fixtures (which also includes old land and land improvements). Enter on line 2 your gross asset value for old movable equipment. Enter on line 3 your gross asset value for new buildings and fixtures (which also includes new land and land improvements). Enter on line 4 your gross asset value for new movable equipment.

NOTE: Part III, column 1, line 5, must agree with the sum of Parts I and II, column 6, line 7.

Column 2--Enter in column 2, line as appropriate, any amounts that you have included in column 1, lines 1 through 4, and which were reported on line 8 of Parts I and II, as appropriate.

Column 3--Enter column 1 less column 2.

Column 4--Enter on lines 1 through 4 the amount in column 3, lines as applicable, divided by the amount in column 3, line 5. Round the resulting ratio to six decimal places.

Columns 5 through 7--These columns provide for the allocation of other capital-related costs (taxes, insurance, and other) to the capital-related cost center lines (Worksheet A, lines 1 through 4).

Line 5--Enter in column 5 capital expenditures relating to insurance. Enter in column 6 capital expenditures relating to State and local taxes on property and equipment. Enter in column 7 other capital expenditures (not including taxes, insurance, depreciation, lease, and interest expense). Enter in column 8 the sum of the amounts reported in columns 5 through 7.

Lines 1 through 4--Apply the ratios developed in column 4, line as applicable, to allocate the other capital costs reported in line 5.

Column 8--Line 5 must be equal to or less than the amount on Worksheet A, line 90, column 3. The amount reported becomes the reclassification entry on Worksheet A, column 4 which will zero-out the balance on line 90. If you directly assign the capital related costs, see Part IV for proper disclosure of these costs.

Columns 9 through 15--These lines summarize the amounts in the capital-related cost centers (Worksheet A, lines 1 through 4, column 7).

NOTE: The amount entered in these columns must be net of reclassifications and adjustments identified on Worksheets A-6, A-8 and A-8-1.

Column 9--Enter the amount reported in Part IV below, from column 9, lines 1 through 4, adjusted by the amounts identified on Worksheets A-6, A-8 and A-8-1.

Column 10--Enter the amount reported in Part IV, column 10, lines 1 through 4, relating to capital-related lease expense, adjusted by the amounts identified on Worksheets A-6, A-8, and A-8-1. (See HCFA Pub. 15-I, §2806.1.) Report insurance, taxes, and license and royalty fees associated with leased assets in columns 12, 13, and 14 of this worksheet, respectively.

Column 11--Enter the amount reported in Part IV, column 11, lines 1 through 4, relating to capital-related interest expense, adjusted by the amounts identified on Worksheets A-6, A-8, and A-8-1

Column 12--Enter the amount from column 5 plus any additional amounts reported in Part IV, column 12 adjusted by amounts identified on Worksheets A-6, A-8, and A-8-1.

Column 13--Enter the amount from column 6 plus any additional amounts reported in Part IV, column 13 adjusted by amounts identified on Worksheets A-6, A-8, and A-8-1.

Column 14--Enter the amount from column 7 plus any additional amounts reported in Part IV, column 14 adjusted by amounts identified on Worksheets A-6, A-8, and A-8-1.

Column 15--Enter the sum of columns 9 through 14. The amounts from column 15, lines 1 through 4, must equal the amounts on Worksheet A, column 7, lines 1 through 4.

3612.3 Part IV - Reconciliation of Amounts From Worksheet A, Column 2, Lines 1 Through 4.--The purpose of this worksheet is to segregate and specifically identify the depreciation and capital related costs which are directly assigned to Worksheet A, column 2, lines 1 through 4.

Columns 9 through 14--Enter in columns 9 through 14, the depreciation and other capital related costs. (Do not report in columns 12 through 14 any amounts previously reported in Part III, columns 5 through 7). The sum of columns 9 through 14 of this part, which is reported in column 15, lines 1 through 4 must agree with the amounts reported on Worksheet A, column 2, lines 1 through 4.

3613. WORKSHEET A-8 - ADJUSTMENTS TO EXPENSES

In accordance with 42 CFR 413.9(c)(3), if your operating costs include amounts not related to patient care, these amounts are not reimbursable under the program. If your operating costs include amounts flowing from the provision of luxury items or services (i.e., those items or services substantially in excess of or more expensive than those generally considered necessary for the provision of needed health services), such amounts are not allowable.

This worksheet provides for the adjustments in support of those listed on Worksheet A, column 6. 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. If the total direct and indirect cost can be determined, enter the cost. Submit with the cost report a copy of any work papers used to compute a cost adjustment. Once an adjustment to an expense is made 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. Enter the following symbols in column 1 to indicate the basis for adjustment: "A" for cost or "B" for amount received. Line descriptions indicate the more common activities which affect allowable costs or result in costs incurred for reasons other than patient care and, thus, require adjustments.

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

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

NOTE: When adjustments affect capital, they must be appropriately split between old and new capital. If these adjustments affect other capital-related costs, indicate in column 5 the capital related cost category shown on Worksheet A-7, Part III, columns 9 through 14.

Enter additional costs as positive amounts. Enter reductions of cost as a negative number. Enter a net total (if a reduction of cost) as a negative number.

Line Descriptions

Lines 1 through 5--Enter the investment income to be applied against interest expense. (See HCFA Pub. 15-I, §202.2 for an explanation.)

Line 9--For patient telephones, make an adjustment on this line or establish a nonreimbursable cost center. When this line is used, base the adjustment on cost. Revenue is not used. (See HCFA Pub. 15-I, §2328.)

Line 12--Enter the total provider-based physician adjustments for personal patient care services and RCE limitations. Obtain this amount from Worksheet A-8-2, column 18, sum of all lines.

NOTE: Make the adjustment to Worksheet A, column 6 for each applicable cost center from Worksheet A-8-2, column 18, line as appropriate.

Line 14--Obtain this amount from section A, column 6 of Worksheet A-8-1. **NOTE** that Worksheet A-8-1 represents the detail of the various cost centers on Worksheet A which must be adjusted.

Line 23--Enter the cash received from the imposition of interest, finance, or penalty charges on overdue receivables. Use this income to offset the allowable administration and general costs. (See HCFA Pub. 15-I, §2110.2.)

Line 24--Enter the interest expense imposed by the intermediary on Medicare overpayments. Also, enter interest expense on borrowing made to repay Medicare overpayments.

Line 25--Enter, if applicable, the sum of the amounts from Worksheet A-8-3, Part VII, line 76 for respiratory therapy services prior to April 10, 1998 and Worksheet A-8-4, line 69 for services on and after April 10. For cost reporting periods beginning on or after April 10, 1998 use A-8-4 only. For reporting the adjustment for providers within the complex, subscript this line in accordance with the prescribed subscripting instructions on Worksheet A-8-4, line 69.

Line 26--Enter, if applicable, the sum of the amounts from Worksheet A-8-3, Part VII, line 76 for physical therapy services prior to April 10, 1998 and Worksheet A-8-4, line 69 for services on and after April 10, 1998. For cost reporting periods beginning on or after April 10, 1998 use Worksheet A-8-4 only. (See line 25 above for proper subscripting of this line)

Line 27--Obtain this amount from Worksheet A-8-3, Part VII, line 77, as appropriate. If you have multiple hospital-based HHAs, subscript this line to accommodate the adjustment for each HHA. This line is not applicable for reasonable cost adjustments to therapy services on and after April 10, 1998.

Line 28--This line pertains to the hospital-based SNF only. When the utilization review covers only Medicare patients or Medicare and title XIX patients, allocate 100 percent of the reasonable compensation paid to the physicians for their services on utilization review committees to the health care programs. Include the amount attributable to Medicare and titles V and XIX patients on Worksheet D-1, Part III, line 81. Apportion all other allowable costs applicable to utilization review which cover only health care program patients among all users of the hospital-based SNF. Reclassify such other costs on Worksheet A-6. Enter the physicians' compensation for service on utilization review committees which cover only health care program patients in the hospital-based SNF. The amount entered equals the amount shown on Worksheet A, column 6, line 89. (See HCFA Pub. 15-I, §2126.2.) If the utilization review costs pertain to more than one program, the sum of the amounts reported on Worksheet D-1 or the amount entered on Worksheet E-2, column 1, line 7 (if Worksheet S-2, line 29 is AY@) (9/96) must equal the amount adjusted on Worksheet A-8.

Lines 29 through 32--When depreciation expense computed in accordance with the Medicare principles of reimbursement differs from depreciation expenses per your books, enter the difference on lines 29 through 32, as applicable. Use lines 29 and 30 for old capital costs and lines 31 and 32 for new capital costs. (See HCFA Pub. 15-I, chapter 1.) Personal use of assets requires adjustment to depreciation expense, e.g., automotive used 50% for business and 50% personal.

Line 33--This adjustment is required for salaries and fringe benefits paid to nonphysician anesthetists reimbursed on a fee schedule. (See the instructions for Worksheet A, line 20.)

Line 34--Sections 1861(s)(2)(K), 1842(b)(6)(C), and 1842(b)(12) of the Act provide for coverage of and separate payment for services performed by a physician assistant. The physician assistant is an employee of the hospital and payment is made to the employer of the physician assistant. Make

an adjustment on Worksheet A-8 for any payments made directly to the physician assistant for services furnished on or after January 1, 1987. This avoids any duplication of payments

Line 35--Enter, if applicable, the sum of the amounts from Worksheet A-8-3, Part VII, line 76 for occupational therapy services prior to April 10, 1998 and Worksheet A-8-4, line 69 for services on and after April 10. For cost reporting periods beginning on or after April 10, 1998, use A-8-4 only. (See line 25 above for proper subscripting of this line.)

Line 36---Enter, if applicable, the sum of the amounts from Worksheet A-8-3, Part VII, line 76 for speech pathology services prior to April 10, 1998 and Worksheet A-8-4, line 69 for services on and after April 10. For cost reporting periods beginning on or after April 10, 1998, use A-8-4 only. (See line 25 above for proper subscripting of this line.)

Lines 37 - 49--Enter any additional adjustments which are required under the Medicare principles of reimbursement. Label the lines appropriately to indicate the nature of the required adjustments. If the number of blank lines is not sufficient, subscript lines 37 through 49. The grossing up of costs in accordance with provisions of CMS Pub. 15-I, §2314 is an example of an adjustment entered on these lines and is explained below.

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

In the foregoing situation, do not allocate indirect costs to the cost center unless your intermediary determines that you are able to gross up both the costs and the charges for services to non-health care program patients so that both costs and charges for services to non-health care program patients are recorded as if you had provided such services directly. See the instructions for Worksheet C, Part I for grossing up of your charges.

Meals furnished by you to an outpatient receiving dialysis treatment also require an adjustment. These costs are nonallowable for title XVIII reimbursement. Therefore, the cost of these meals must be adjusted.

In accordance with CMS Pub. 27, §501, compensation paid to a physician for RHC services rendered in a hospital-based RHC is cost reimbursed. Where the physician agreement compensates for RHC services as well as non-RHC services, or services furnished in the hospital, the related compensation must be eliminated on Worksheet A-8 and billed to the Part B carrier. If not specified in the agreement, a time study must be used to allocate the physician compensation.

If the hospital performs ESRD services and costs are reported on either lines 57, 64, or both, these costs should include the cost of the drugs Epoetin and Aranesp. Do not report the cost of these drugs claimed in any other cost center. These costs will be removed later on Worksheet B-2 (10/00).

If the hospital is paying membership dues to an organization which perform lobbying and political activities, the portion of the dues associated with these non-allowable activities must be removed from costs.

Line 50--Enter the sum of lines 1 through 49. Transfer the amounts in column 2 to Worksheet A, column 6, line as appropriate.

3614. WORKSHEET A-8-1 - STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

In accordance with 42 CFR 413.17, costs applicable to services, facilities, and supplies furnished to you by organizations related to you by common ownership or control are includable in your allowable cost at the cost to the related organization, except for the exceptions outlined in 42 CFR 413.17(d). This worksheet provides for the computation of any needed adjustments to costs applicable to services, facilities, and supplies furnished to the hospital by organizations related to you or costs associated with the home office. In addition, it shows certain information concerning the related organizations with which you have transacted business as well as home office costs. (See CMS Pub. 15-I, chapter 10, and §2150 respectively.)

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

Part B--Use this part to show your relationship to organizations identified in Part A. Show the requested data relative to all individuals, partnerships, corporations, or other organizations having either a related interest to you, a common ownership with you, or control over you as defined in CMS Pub. 15-I, chapter 10 in columns 1 through 6, as appropriate.

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

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

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

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

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

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

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

Column 7--Enter the specific column of Worksheet A-7, Part III columns 9 through 14 impacted by the adjustment (10/97).

3615. WORKSHEET A-8-2 - PROVIDER-BASED PHYSICIAN ADJUSTMENTS

In accordance with 42 CFR 413.9, 42 CFR 415.55, 42 CFR 415.60, 42 CFR 415.70, and 42 CFR 415.102(d), you may claim as allowable cost only those costs which you incur for physician services that benefit the general patient population of the provider or which represent availability services in a hospital emergency room under specified conditions. (See 42 CFR 415.150 and 42 CFR 415.164 for an exception for teaching physicians under certain circumstances.) 42 CFR 415.70 imposes limits on the amount of physician compensation which may be recognized as a reasonable provider cost.

Worksheet A-8-2 provides for the computation of the allowable provider-based physician cost you incur. 42 CFR 415.60 provides that the physician compensation paid by you must be allocated between services to individual patients (professional services), services that benefit your patients generally (provider services), and nonreimbursable services such as research. Only provider services are reimbursable to you through the cost report. This worksheet also provides for the computation of the reasonable compensation equivalent (RCE) limits required by 42 CFR 415.70. The methodology used in this worksheet applies the RCE limit to the total physician compensation attributable to provider services reimbursable on a reasonable cost basis. Enter the total provider-based physician adjustment for personal care services and RCE limitations applicable to the compensation of provider-based physicians directly assigned to or reclassified to general service cost centers. RCE limits are not applicable to a medical director, chief of medical staff, or to the compensation of a physician employed in a capacity not requiring the services of a physician, e.g., controller. RCE limits also do not apply to critical access hospitals, however the professional component must still be removed on this worksheet. CAHs need only complete columns 1 through 5 and 18 (10/1/97b). Transfer for CAHs the amount from column 4 to column 18.

NOTE: 42 CFR 415.70(a)(2) provides that limits established under this section do not apply to costs of physician compensation attributable to furnishing inpatient hospital services paid for under the prospective payment system implemented under 42 CFR Part 412.

Limits established under this section apply to inpatient services subject to the TEFRA rate of increase ceiling (see 42 CFR 413.40), outpatient services for all titles, and to title XVIII, Part B inpatient services.

Since the methodology used in this worksheet applies the RCE limit in total, make the adjustment required by 42 CFR 415.70(a)(2) on Worksheet C, Part I. Base this adjustment on the RCE disallowance amounts entered in column 17 of Worksheet A-8-2.

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

NOTE: The adjustments generated from this worksheet for physician compensation are limited to the cost centers on Worksheet A, lines 5-69, 82-86, and 92 and subscripts as allowed (9/96).

Column Descriptions

Columns 1 and 10--Enter the line numbers from Worksheet A for each cost center that contained compensation for physicians who are subject to RCE limits.

Columns 2 and 11--Enter the description of the cost center used on Worksheet A. When RCE limits are applied on an individual basis to each physician in a department, list each physician on successive lines directly under the cost center description line, or list the first physician on the same line as the cost center description line and then each successive line below for each additional physician in that cost center (10/97).

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

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

Column 3--Enter the total physician compensation paid by you for each cost center. Physician compensation means monetary payments, fringe benefits, deferred compensation, costs of physician membership in professional societies, continuing education, malpractice, and any other items of value (excluding office space or billing and collection services) that you or other organizations furnish a physician in return for the physician's services. (See 42 CFR 415.60(a).) Include the compensation in column 3 of Worksheet A or, if necessary, through appropriate reclassifications on Worksheet A-6 or as a cost paid by a related organization through Worksheet A-8-1.

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

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

NOTE: 42 CFR 405.481(b) requires that physician compensation be allocated between physician services to patients, the provider, and nonallowable services such as research. Physicians' nonallowable services must not be included in columns 4 or 5. The instructions for column 18 insures that the compensation for nonallowable services included in column 3 is correctly eliminated on Worksheet A-8.

Column 6--Enter for each line of data, as applicable, the reasonable compensation equivalent (RCE) limit applicable to the physician's compensation included in that cost center. The amount entered is the limit applicable to the physician specialty as published in the **Federal Register** before any allowable adjustments. The final notice on the annual update to RCE limits published in the **Federal Register**, Vol. 50, No. 34, February 20, 1985, on page 7126 contains Table 1, Estimates of FTE Annual Average Net Compensation Levels for 1984. An update was published in the **Federal Register** on May 5, 1997. Another update was published in the **Federal Register** on August 1, 2003, Vol. 68, No. 148 on page 45459. Obtain the RCE applicable to the specialty from this table. If the physician specialty is not identified in the table, use the RCE for the total category in the table. The beginning date of the cost reporting period determines which calendar year (CY) RCE is used. Your location governs which of the three geographical categories are applicable: non-metropolitan areas, metropolitan areas less than one million, or metropolitan areas greater than one million.

Column 7--Enter for each line of data the physician's hours allocated to provider services. For example, if a physician works 2080 hours per year and 50 percent of his/her time is spent on provider services, then enter 1040 in this column. The hours entered are the actual hours for which the physician is compensated by you for furnishing services of a general benefit to your patients. If the physician is paid for unused vacation, unused sick leave, etc., exclude the hours so paid from the hours entered. Time records or other documentation that supports this allocation must be

available for verification by your intermediary upon request. (See HCFA Pub. 15-I, §2182.3E.)

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

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

Column 12--You may adjust upward, up to five percent of the computed limit (column 9), to take into consideration the actual costs of membership for physicians in professional societies and continuing education paid by you.

Enter for each line of data the actual amounts of these expenses paid by you.
Column 13--Enter for each line of data the result of multiplying column 5 by column 12 and dividing that amount by column 3.

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

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

Column 15--Enter for each line of data the result of multiplying column 5 by column 14 and dividing that amount by column 3.

Column 16--Enter for each line of data the sum of columns 8 and 15 plus the lesser of columns 9 or 13.

Column 17--Compute the RCE disallowance for each cost center by subtracting the RCE limit in column 16 from your component remuneration in column 5. If the result is a negative amount, enter zero. Transfer the amounts for each cost center to Worksheet C, Part I, column 4 for all hospitals subject to PPS. (See 42 CFR Part 412.)

Column 18--The adjustment for each cost center entered represents the PBP elimination from costs entered on Worksheet A-8, column 2, line 12 and on Worksheet A, column 6 to each cost center affected. Compute the amount by deducting, for each cost center, the lesser of the amounts recorded in column 5 (provider component remuneration) or column 16 (adjusted RCE limit) from the total remuneration recorded in column 3.

NOTE: If you incur cost for unpaid guarantee for emergency room physician availability, attach a separate worksheet showing the computation of the necessary reclassification. (See HCFA Pub. 15-I, §2109.)

Line Descriptions

Line 101--Enter the total of lines 1 through 11 for columns 3 through 5, 7 through 9, and 12 through 18.

3616. WORKSHEET A-8-3 - REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS PRIOR TO APRIL 10, 1998

This worksheet provides for the computation of any needed adjustments to costs applicable to therapy services furnished by outside suppliers for all components. The information required on this worksheet provides, in the aggregate, all data for therapy services furnished prior to April 10, 1998 by all outside suppliers in determining the reasonableness of therapy costs. (See HCFA Pub. 15-I, chapter 14.) Prorate, based on total charges, any statistics and costs for purposes of calculating standards, allowances, or the actual reasonable cost determination, if your cost report overlaps April 10, 1998, i.e., overtime hours. This form is not applicable for services on or after April 10, 1998.

NOTE: When reimbursement for such therapy services is subject to the provisions of PPS or the TEFRA rate of increase ceiling, adjust costs subsequently on Worksheet C, Part I.

If you contract with an outside supplier for therapy services, the potential for limitation and the amount of payment you receive depend on several factors:

- o An initial test to determine whether these services are categorized as intermittent part-time or full-time services;
- o The location where the services are rendered, i.e, at your site or HHA home visit;
- o For HHA services, whether detailed time and mileage records are maintained by the contractor and HHA;
- o Add-ons for supervisory functions, aides, overtime, equipment, and supplies; and
- o Intermediary determinations of reasonableness of rates charged by the supplier compared with the going rates in the area.

3616.1 Part I - General Information.--This part provides for furnishing certain information concerning therapy services furnished by outside suppliers.

Columns 1 through 11--Columns 1-3, 5-7, 10, and 11 are completed for respiratory therapy. Columns 4, 8, 9, and 10 are completed for physical therapy,.

Line 1--Enter the number of weeks that services were performed on site. Count only those weeks during which a registered therapist supervisor, certified therapist supervisor, nonregistered and noncertified therapist supervisor, supervisor, registered therapist, certified therapist, therapist, or an assistant was on site. For services performed at the patient's residence, count only those weeks during which services were rendered by supervisors, therapists, or assistants to patients of the HHA. Weeks when services were performed both at your site and at the patients home are only counted once. (See HCFA Pub. 15-I, chapter 14.)

Line 2--Multiply the amount on line 1 by 15 hours per week. This calculation is used to determine whether services are full-time or intermittent part-time.

Lines 3 through 7--Enter the number of days in which the supervisor, therapist, or assistant was on site. Only count one day when both the supervisor and therapist were at the site during the same day. Enter the number of days in which the therapy assistant was on site. Do not include days when either the supervisor or therapist was also at the site during the same day.

NOTE: Count an unduplicated day for each day the contractor has at least one

employee on site. For example, if the contractor furnishes a supervisor, therapist and assistant on one day, count one therapist day. If the contractor provides two assistants on one day (and no supervisors or therapists), count one assistant day.

Line 8--Enter the number of unduplicated HHA visits made by the supervisor or therapist. Only count one visit when both the supervisor and therapist were present during the same visit (physical therapy only).

Line 9--Enter the number of unduplicated HHA visits made by the therapy assistant. Do not include in the count the visits when either the supervisor or therapist were present during the same visit (physical therapy only).

Line 10--Enter the standard travel expense rate applicable. (See HCFA Pub. 15-I, chapter 14.)

Line 11--Enter the optional travel expense rate applicable. (See HCFA Pub. 15-I, chapter 14.) Use this rate only for home health patient services for which time records are available.

Line 12--Enter in the appropriate columns the total number of hours worked for each category.

Line 13--Enter in each column the appropriate adjusted hourly salary equivalency amount (AHSEA). This amount is the prevailing hourly salary rate plus the fringe benefit and expense factor described in HCFA Pub. 15-I, chapter 14. This amount is determined on a periodic basis for appropriate geographical areas and is published as an exhibit at the end of HCFA Pub. 15-I, chapter 14. Use the appropriate exhibit for the period of this cost report.

Enter in columns 1 through 4 the supervisory AHSEA, adjusted for administrative and supervisory responsibilities. Determine this amount in accordance with the provisions of HCFA Pub. 15-I, §1412.5. Enter in columns 5 through 11 (for therapists, assistants, aides, and trainees respectively) the AHSEA from either the appropriate exhibit found in HCFA Pub. 15-I, chapter 14 or from the latest publication of rates. If the going hourly rate for assistants in the area is unobtainable, use no more than 75 percent of the therapist AHSEA. The cost of services of a therapy aide or trainee is evaluated at the hourly rate, not to exceed the hourly rate paid to your employees of comparable classification and/or qualification, e.g., nurses' aides. (See HCFA Pub. 15-I, §1412.2.)

Line 14--Enter the standard travel allowance equal to one half of the AHSEA. Enter in columns 1 through 4, line 14 one half of the amount in columns 5 through 8, line 13. Enter in columns 5 through 8, line 14 one half of the amount in columns 5 through 8, line 13. Enter in column 9 one half of the amount in column 9, line 13. (See HCFA Pub. 15-I, §1402.4.)

Lines 15 and 16--Enter, for HHA services only, the number of travel hours and number of miles driven, respectively, if time records of visits are kept. (See HCFA Pub. 15-I, §§1402.5 and 1403.1.)

NOTE: There is no travel allowance for aides employed by outside suppliers.

3616.2 Part II - Salary Equivalency Computation.--This part provides for the computation of the full-time or intermittent part-time salary equivalency.

When you furnish therapy services from outside suppliers to health care program patients but simply arrange for such services for non-health care program patients and do not pay the non-health care program portion of such services, your books reflect only the cost of the health care program portion. Where you can gross up costs and charges in accordance with provisions of HCFA Pub. 15-I,

§2314, complete Part II, lines 14 through 19 and 22 in all cases and lines 20 and 21, where appropriate. See §3610 for instructions regarding grossing up costs and charges. However, where you cannot gross up costs and charges, complete lines 14 through 19 and 22.

Lines 17 - 28--To compute the total salary equivalency allowance amounts, multiply the total hours worked (line 12) by the adjusted hourly salary equivalency amount for supervisory registered therapists, supervisory certified therapists, nonregistered, noncertified supervisory therapists, supervisors, therapists, assistants, aides, and trainees.

Line 26--For respiratory therapy, enter the sum of lines 18 through 20 and lines 22 through 24. For physical therapy, enter the sum of lines 17, 21, and 25.

Line 29--For respiratory therapy, enter the sum of lines 26 through 28. For physical therapy, enter the sum of lines 26 and 27.

Lines 30 through 32--If the sum of hours in columns 1 through 3 and 5 through 7, line 12 for respiratory therapy and columns 4, 8, and 9, line 12 for physical therapy is less than or equal to the product found on line 2, complete these lines.

Line 30-- For physical therapy, divide line 26 by the sum of columns 4, 8, and 9, line 12. For respiratory therapy, divide line 26 by the sum of columns 1 through 3 and 5 through 7, line 12. (See the exception above where you cannot gross up costs and charges, and services are provided to program patients only.)

Line 31--Enter the result of line 2 times line 30.

Line 32--If there are no entries on lines 30 and 31, enter the amount on line 29. Otherwise, enter the sum of the amounts on lines 27 and 31 for physical therapy and the sum of lines 27, 28, and 31 for respiratory therapy.

3616.3 Part III - Standard Travel Allowance and Standard Travel Expense Computation - Provider Site.--This part provides for the computation of the standard travel allowance and standard travel expense for services rendered on site.

Lines 33 - 37--Complete these lines for the computation of the standard travel allowance and standard travel expense for therapy services performed at your site for registered therapists, certified therapists, and nonregistered, noncertified therapists for respiratory therapy and therapists and assistants for physical therapy. The travel allowance for supervisors does not take into account the additional allowance for administrative and supervisory responsibilities. Therefore, supervisory therapists are combined with the appropriate category of therapists (e.g., a supervisory registered therapist is included with registered therapists).

One standard travel allowance is recognized for each day an outside supplier performs skilled therapy services at your site. For example, if a contracting organization sends three therapists to you each day, only one travel allowance is recognized per day. (See HCFA Pub. 15-I, §1403.1 for a discussion of standard travel allowance and §1412.6 for a discussion of standard travel expense.)

Line 38--For respiratory therapy, enter the sum of lines 34 through 36. For physical therapy, enter the sum of lines 33 and 37.

Line 39--For respiratory therapy, multiply line 10 by the sum of lines 5 through 7. For physical therapy, multiply line 10 by the sum of lines 3 and 4.

Line 40--Enter the sum of lines 38 and 39.

3616.4 Part IV - Standard Travel Allowance and Standard Travel Expense - HHA Services.--This part provides for the computation of the standard travel allowance, the standard travel expense, the optional travel allowance, and the optional travel expense. This is completed for physical therapy only. (See HCFA Pub. 15-I, §§1402ff, 1403.1, and 1412.6.) If there are multiple HHAs, subscript lines where appropriate.

Lines 41 - 44--Complete these lines for the computation of the standard travel allowance and standard travel expense for physical therapy services performed in conjunction with HHA visits. Only use these lines if you do not use the optional method of computing travel. A standard travel allowance is recognized for each visit to a patient's residence. If services are furnished to more than one patient at the same location, only one standard travel allowance is permitted, regardless of the number of patients treated.

Lines 45 - 48--Complete the optional travel allowance and optional travel expense computations for physical therapy services in conjunction with home health services only. Compute the optional travel allowance on lines 44 through 46. Compute the optional travel expense on line 48.

Lines 49 - 51--Choose and complete only one of the options on lines 49 through 51. However, use lines 50 and 51 only if you maintain time records of visits. (See HCFA Pub. 15-I, §1402.5.) If there are multiple HHAs, subscript these lines as follows: 49, 49.01, and 49.02 if all the HHAs elect the same method or 49, 50.01, and 51.02 if they each elect a different method.

3616.5 Part V - Overtime Computation.--This part provides for the computation of an overtime allowance when an individual employee of the outside supplier performs services for you in excess of your standard work week. No overtime allowance is given to a therapist who receives an additional allowance for supervisory or administrative duties. (See HCFA Pub. 15-I, §1412.4.)

Line 52--Enter in the appropriate columns the total overtime hours worked. Where the total hours in column 8 are either zero or equal to or greater than 2080, the overtime computation is not applicable. Make no further entries on lines 53 through 60. Enter zero in each column of line 61. Enter in column 8 the sum of the hours recorded in columns 1 through 3, 6, and 7 for respiratory therapy and columns 4 through 6 for physical therapy.

Line 53--For physical therapy, enter in columns 4, 5, and 6 the result of multiplying 1.5 by the amounts entered in columns 8, 9, and 10 of line 13, respectively. For respiratory therapy, enter in columns 1 through 3, 6, and 7 the result of multiplying 1.5 by the amounts entered in columns 5 through 7, 10, and 11, line 13, respectively.

Line 54--Multiply line 52 by line 53.

Line 55--Enter the percentage of overtime hours by class of employee. Determine this amount by dividing each column on line 52 by the total overtime hours in column 8, line 52. Round to two decimal places.

Line 56--Use this line to allocate your standard work year for one full-time employee. Enter the numbers of hours in your standard work year for one full-time employee in column 8. Multiply the standard work year in column 8 by the percentage on line 55, and enter the result in the corresponding columns. Round to two decimal places.

Line 57--Enter in columns 1 through 3 and 5 through 7 for respiratory therapy the AHSEA from Part I, line 13, columns 5 through 7 and 9 through 11, as appropriate. Enter in columns 4 through 6 for physical therapy the AHSEA from Part I, line 13, columns 8 through 10.

Line 58--Multiply line 56 by line 57 and round to a whole number.

Line 59--Enter the lesser of line 54 or line 58.

Line 60--Multiply line 52 by line 57 and round to a whole number.

Line 61--Enter in column 8 the sum of the hours recorded in columns 1 through 3, 6, and 7 for respiratory therapy and columns 4 through 6 for physical therapy.

3616.6 Part VI - Computation of Therapy Limitation and Excess Cost Adjustment.--This part provides for the calculation of the adjustment to therapy service costs in determining the reasonableness of therapy cost.

Line 64--Enter the amount reported on lines 49, 50, or 51. If there are multiple home health agencies, subscript the line in accordance with the reporting on lines 49, 50, and/or 51.

Lines 66 and 67--When the outside supplier provides the equipment and supplies used in furnishing direct services to your patients, the actual cost of the equipment and supplies incurred by the outside supplier (as specified in HCFA Pub. 15-I, §1412.1) is considered an additional allowance in computing the limitation.

Line 69--Enter the amounts paid and/or payable to the outside suppliers for the hospital and home health agency, if applicable, for therapy services rendered during the period as reported in the cost report. This includes any payments for supplies, equipment use, overtime, or any other expenses related to supplying therapy services for you. Add all subscripted lines together for purposes of calculating the amount to be entered on this line.

Line 70--Enter the excess cost over the limitation, i.e., line 69 minus line 68. If the amount is negative, enter a zero.

3616.7 Part VII - Allocation of Physical Therapy Excess Cost Over Limitation for Non-Shared Physical Therapy Department Services.--This part provides for the computation of the excess cost of both hospital services and HHA services over the limitation for outside suppliers.

Lines 71 and 72--Enter the total cost of services supplied by the outside suppliers for your services and HHA services, respectively, from your records. If you have more than one hospital-based HHA that contracts therapy services, subscript line 72 to report the cost of services supplied by the outside suppliers for each hospital-based HHA.

Line 74 - Divide line 71 by line 73.

Line 75--Divide line 72 by line 73. If you subscripted line 72, subscript this line to accommodate more than one hospital-based HHA.

Line 76--This line identifies the excess of the supplier's therapy costs for services at your site over the limitation. Transfer this amount to Worksheet A-8, line 25 for respiratory therapy and line 26 for physical therapy.

Line 77--This line identifies the excess of the HHA physical therapy costs over the limitation. Multiply line 70 by line 75. If you have more than one hospital-based HHA, report the excess cost applicable to each HHA by multiplying line 70 by the ratio reported on line 75 and enter the result on line 77. Transfer this/these amount(s) to Worksheet A-8, line 27.

3616.8 Worksheet A-8-4 - Reasonable Cost Determination for Therapy Services Furnished on and after April 10, 1998 by Outside Suppliers.--This worksheet provides for the computation of any needed adjustments to costs applicable to therapy services furnished by outside suppliers. The information required on this worksheet provides, in the aggregate, all data for therapy services furnished by all outside suppliers in determining the reasonableness of therapy costs. When reimbursement for such therapy services is subject to the provisions of PPS and TEFRA rate of increase ceiling, adjust costs subsequently on Worksheet C, Part I. (See PRM-I, chapter 14.) Prorate, based on total charges, any statistics and costs for purposes of calculating standards, allowances, or the actual reasonable cost determination, if your cost report overlaps April 10, 1998, i.e., overtime hours. This form is not applicable for services prior to April 10, 1998. Therapy services rendered on or after January 1, 1999, are subject to a fee schedule. Therefore, for cost reporting periods beginning on or after January 1, 1999, this form is no longer required for all hospitals except CAHs, hospitals with respiratory therapy services through June 30, 2000, and hospital complexes with hospital based-CMHCs and HHA's, through June 30, 2000 and September 30, 2000, respectively (1/99).

If you contract with an outside supplier for therapy services, the potential for limitation and the amount of payment you receive depend on several factors:

- o An initial test to determine whether these services are categorized as intermittent part time or full time services;
- o The location where the services are rendered, i.e., at your site or HHA home visit;
- o Whether detailed time and mileage records are maintained by the contractor;
- o Add-ons for supervisory functions, aides, overtime, equipment and supplies; and
- o Intermediary determinations of reasonableness of rates charged by the supplier compared with the going rates in the area.

3616.9 Part I - General Information.--This part provides for furnishing certain information concerning therapy services furnished by outside suppliers.

Line 1--Enter the number of weeks that services were performed on site. Count only those weeks during which a supervisor, therapist or an assistant was on site. For services performed at the patient's residence, count only those weeks during which services were rendered by supervisors, therapists, or assistants to patients of the HHA. Weeks when services were performed both at your site and at the patients home are counted only once. (See PRM-I, chapter 14.)

Line 2--Multiply the amount on line 1 by 15 hours per week. This calculation is used to determine whether services are full-time or intermittent part-time.

Line 3--Enter the number of days in which the supervisor or therapist (only report the therapists for respiratory therapy) was on site. Count only one day when both the supervisor and therapist were at the site during the same day.

Line 4--Enter the number of days in which the therapy assistant (PT, OT, or SP only) was on site. Do not include days when either the supervisor or therapist was also at the site during the same day.

NOTE: Count an unduplicated day for each day the contractor has at least one employee on site. For example, if the contractor furnishes a supervisor, therapist and assistant on one day, count one therapist day. If the contractor provides two assistants on one day (and no supervisors or therapists), count one assistant day.

Line 5--Enter the number of unduplicated visits made by the supervisor or therapist. Count only one visit when both the supervisor and therapist were present during the same visit.

Line 6--Enter the number of unduplicated visits made by the therapy assistant. Do not include in the count the visits when either the supervisor or therapist was present during the same visit.

Line 7--Enter the standard travel expense rate applicable. (See CMS Pub. 15-I, chapter 14.)

Line 8--Enter the optional travel expense rate applicable. (See CMS Pub. 15-I, chapter 14.) Use this rate only for services for which time records are available.

Line 9--Enter in the appropriate columns the total number of hours worked for each category.

Line 10--Enter in each column the appropriate adjusted hourly salary equivalency amount (AHSEA). This amount is the prevailing hourly salary rate plus the fringe benefit and expense factor described in CMS Pub 15-I, chapter 14. This amount is determined on a periodic basis for appropriate geographical areas and is published as an exhibit at the end of CMS Pub. 15-I, chapter 14. Use the appropriate exhibit for the period of this cost report.

Enter in column 1 the supervisory AHSEA, adjusted for administrative and supervisory responsibilities. Determine this amount in accordance with the provisions of PRM-I, §1412.5. Enter in columns 2, 3, and 4 (for therapists, assistants, aides, and trainees respectively) the AHSEA from either the appropriate exhibit found in CMS Pub. 15-I, chapter 14 or from the latest publication of rates. If the going hourly rate for assistants in the area is unobtainable, use no more than 75 percent of the therapist AHSEA. The cost of services of a therapy aide or trainee is evaluated at the hourly rate, not to exceed the hourly rate paid to your employees of comparable classification and/or qualification, e.g., nurses' aides. (See CMS Pub. 15-I, §1412.2.)

Line 11--Enter the standard travel allowance equal to one half of the AHSEA. Enter in columns 1 and 2 one half of the amount in column 2, line 10. Enter in column 3 one half of the amount in column 3, line 10. (See CMS Pub 15-I, §1402.4.)

Lines 12 and 13--Enter the number of travel hours and number of miles driven, respectively, if time records of visits are kept. (See CMS Pub. 15-I, §§1402.5 and 1403.1.) Subscript this line into two categories of, provider site and provider offsite.

NOTE: There is no travel allowance for aides employed by outside suppliers.

3616.10 Part II - Salary Equivalency Computation.--This part provides for the computation of the full-time or intermittent part-time salary equivalency.

When you furnish therapy services from outside suppliers to health care program patients but simply arrange for such services for non health care program patients and do not pay the non health care program portion of such services, your books reflect only the cost of the health care program portion. Where you can gross up costs and charges in accordance with provisions of CMS Pub. 15-I, §2314, complete Part II, lines 14 through 20 and 23 in all cases and lines 21 and 22 where appropriate. See §2810 for instructions regarding grossing up costs and charges. However, where you cannot gross up costs and charges, complete lines 14 through 20 and 23.

Line 14 - 20--To compute the total salary equivalency allowance amounts, multiply the total hours worked (line 9) by the adjusted hourly salary equivalency amount for supervisors, therapists, assistants, aides and trainees (for respiratory therapy only).

Line 17--Enter the sum of lines 14 and 15 for respiratory therapy or sum of lines 14 through 16 for all others.

Line 20--Enter the sum of lines 17 through 19 for respiratory therapy or sum of lines 17 and 18 for all other.

Lines 21 and 22--If the sum of hours in columns 1 and 2 for respiratory therapy or 1 through 3 for all others, line 9 is less than or equal to the product found on line 2, complete these lines. (See the exception above where you cannot gross up costs and charges, and services are provided to program patients only.)

Line 21--Enter the result of line 17 divided by the sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others.

Line 22--Enter the result of line 2 times line 21.

Line 23--If there are no entries on lines 21 and 22, enter the amount on line 20. Otherwise, enter the sum of the amounts on lines 18, 19, and 22 for respiratory therapy or lines 18 and 22 for all others.

3616.11 Part III - Standard and Optional Travel Allowance and Travel Expense Computation - Provider Site.--This part provides for the computation of the standard and optional travel allowance and travel expense for services rendered on site.

Lines 24 - 28--Complete these lines for the computation of the standard travel allowance and standard travel expense for therapy services performed at your site. One standard travel allowance is recognized for each day an outside supplier performs skilled therapy services at your site. For example, if a contracting organization sends three therapists to you each day, only one travel allowance is recognized per day. (See HCFA Pub.15-I, §1403.1 for a discussion of standard travel allowance and §1412.6 for a discussion of standard travel expense.)

Line 24--Include the standard travel allowance for supervisors and therapists. This standard travel allowance for supervisors does not take into account the additional allowance for administrative and supervisory responsibilities. (See HCFA Pub.15-I, §1402.4.)

Line 25--Include the standard travel allowance for assistants for physical therapy, occupational therapy, and speech pathology.

Line 26--Enter the amount from line 24 for respiratory therapy or the sum of lines 24 and 25 for physical therapy, occupational therapy, or speech pathology.

Line 27--Enter the result of line 7 times line 3 for respiratory therapy or line 7 times the sum of lines 3 and 4 for all others.

Lines 29 - 35--Complete these lines for computing the optional travel allowance and expense when proper records are maintained.

Line 31--Enter the amount on line 29 for respiratory therapy or the sum of lines 29 and 30 for all others.

Line 32--Enter the result of line 8 times the sum of columns 1 and 2, line 13 for respiratory therapy or columns 1, 2, and 3, line 13 for all other.

Lines 33 through 35--Enter an amount in one of these lines depending on the method utilized.

3616.12 Part IV - Standard Travel Allowance and Standard Travel Expense - Provider offsite Services.--This part provides for the computation of the standard travel allowance, the standard travel expense, the optional travel allowance, and the optional travel expense. (See HCFA Pub.15-I, §§1402ff, 1403.1 and 1412.6.)

Lines 36-39--Complete these lines for the computation of the standard travel allowance and standard travel expense for therapy services performed in conjunction with offsite visits. Only use these lines if you do not use the optional method of computing travel. A standard travel allowance is recognized for each visit to a patient's residence. If services are furnished to more than one patient at the same location, only one standard travel allowance is permitted, regardless of the number of patients treated.

Lines 40 - 43--Complete the optional travel allowance and optional travel expense computations for physical therapy, occupational therapy, and speech pathology services in conjunction with home health services only. Compute the optional travel allowance on lines 40 through 42. Compute the optional travel expense on line 43.

Lines 44 - 46--Choose and complete only one of the options on lines 44 through 46. However, use lines 45 and 46 only if you maintain time records of visits. (See HCFA Pub 15.I, §1402.5.)

3616.13 Part V - Overtime Computation.--This part provides for the computation of an overtime allowance when an individual employee of the outside supplier performs services for you in excess of your standard work week. No overtime allowance is given to a therapist who receives an additional allowance for supervisory or administrative duties. (See HCFA Pub 15.I, §1412.4.)

Line 47--Enter in the appropriate columns the total overtime hours worked. Where the total hours in column 5 are either zero or, equal to or greater than 2080, the overtime computation is not applicable. Make no further entries on lines 48 through 55 (If there is a short period prorate the hours). Enter zero in each column of line 56. Enter in column 5 the sum of the hours recorded in columns 1, 3 and 4 for respiratory therapy, and columns 1 through 3 for physical therapy, speech pathology, and occupational therapy.

Line 48--Enter in the appropriate column the overtime rate (the AHSEA from line 10, column as appropriate, multiplied by 1.5).

Line 50--Enter the percentage of overtime hours by class of employee. Determine this amount by dividing each column on line 47 by the total overtime hours in column 5, line 47.

Line 51--Use this line to allocate your standard work year for one full-time employee. Enter the numbers of hours in your standard work year for one full-time employee in column 5. Multiply the standard workyear in column 5 by the percentage on line 50 and enter the result in the corresponding columns.

Line 52--Enter in columns 1 through 3 for physical therapy, speech pathology, and occupational therapy the AHSEA from Part I, line 10, columns 2 through 4, as appropriate. Enter in columns 1, 3 and 4 the AHSEA from Part I, line 10, columns 2, 4 and 5, for respiratory therapy.

Line 56--Enter in column 5 the sum of the amounts recorded in columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for physical therapy, speech pathology, and occupational therapy.

3616.14 Part VI - Computation of Therapy Limitation and Excess Cost Adjustment.--This part provides for the calculation of the adjustment to the therapy service costs in determining the reasonableness of therapy cost.

Line 58--Enter the amount reported on lines 33, 34, or 35.

Line 59--Enter the amount reported on lines 44, 45, or 46.

Lines 61 and 62--When the outside supplier provides the equipment and supplies used in furnishing direct services to your patients, the actual cost of the equipment and supplies incurred by the outside

supplier (as specified in HCFA Pub 15-I, §1412.1) is considered an additional allowance in computing the limitation.

Line 64--Enter the amounts paid and/or payable to the outside suppliers for the hospital and home health agency, if applicable, for therapy services rendered during the period as reported in the cost report. This includes any payments for supplies, equipment use, overtime, or any other expenses related to supplying therapy services for you. Add all subscripted lines together for purposes of calculating the amount to be entered on this line.

Line 65--Enter the excess cost over the limitation, i.e., line 64 minus line 63. If the amount is negative, enter a zero.

3616.15 Part VII - Allocation of Therapy Excess Cost Over Limitation for Non-Shared Therapy Department Services.--This part provides for the computation of the excess cost over the limitation for outside suppliers of hospital services and other providers within the complex.

Line 66--Enter on line 66 the total cost of services supplied by the outside suppliers for the hospital services and subscript line 66 to report the other provider costs within the complex. Subscript as follows: lines 66.01 to 66.10 for CORF; 66.11 to 66.20 for CMHC; 66.21 to 66.30 for OPT; 66.31 through 66.40 for HHA services; 66.41 to 66.50 for OOT; and 66.51 to 66.60 for OSP respectively, from your records.

Line 67--Enter the sum of line 66 and subscripts.

Line 68--Enter the result of dividing the amount on line 66 and subscripts by the amount on line 67. Subscript this line in the same manner as line 66.

Line 69--Enter the amount of excess applicable to each provider within the complex by multiplying the ratio for each provider on line 68 and subscripts by the excess reported on line 65. Subscript this line in the same manner as line 66 above. Transfer this amount to Worksheet A-8, line 25 for respiratory therapy; line 26 for physical therapy; line 35 for occupational therapy; and line 36 for speech pathology. Except for respiratory therapy, do not transfer any excess adjustment for hospital, hospital-based SNF, CORF, OOT, OSP, OPT for services rendered on and after January 1, 1999, since therapy services are paid based on a fee schedule. Respiratory therapy for services rendered on and after July 1, 2000, is subject to payment based on the fee schedule, therefore no transfer will be required after that date. CAHs transfer the excess always, and hospital based home health agencies continue for services rendered through September 30, 2000. CAH's therapy services under arrangement are not subject to the payment of the fee schedule. Home health agencies are paid under a prospective payment system beginning October 1, 2000.

Line 70--Enter the total of line 69 through 69.60. This line should agree with line 65.