

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:

- o 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.
- o 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 charges requisitioned.

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 charges requisitioned. 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 subscribing 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:

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