

4013. 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). While providers are expected to maintain their accounting books and general ledger in a manner consistent with the standard cost centers/departments identified on this worksheet, not all of the cost centers listed apply to all providers using these forms. For example, IPPS providers may contain a Burn Intensive Care Unit, where CAHs may not furnish this type of service.

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 75; Worksheet E, Part B, line 44; Worksheet E-2, line 23; and Worksheet E-3, Parts I, II, III, IV, V, VI, and VII, lines 22, 35, 36, 26, 34, 19, and 43, respectively). For provider based-facilities, enter the protested amounts on line 35 of Worksheet H-4, Part II, for HHAs; line 30 of Worksheet J-3 for CMHCs; and line 30 of Worksheet M-3 for RHC/FQHC providers.

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 contractor.

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 (subscript) 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. Lines 24 through 29, 47 through 49, 78 through 87, 102 through 104, 119 through 189, and 195 through 199, are reserved for future use; do not use these lines.

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.

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-2552-10 provides for 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 cost center descriptions are hereafter referred to as the standard cost centers. Additionally, 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 five 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 §4095, Table 5.

Columns 1, 2, and 3--The expenses listed in these columns must be the same as listed in your accounting books and records and/or trial balance.

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).

Column 1--Report in each cost center only direct salaries and wages plus related salary amounts for paid vacation, holiday, sick, other paid-time-off (PTO), severance, and bonus pay. Refer to the instructions at Worksheet S-3, Part II, column 2, line 1, for the definition of bonus pay and PTO salary cost.

NOTE: Paid vacation, holiday, sick, other PTO, severance, and bonus pay must be reported with related direct salaries or wages in column 1. Do not report wage-related costs in column 1, as defined in §4005.4.

Column 2--Report in each cost center the cost incurred for contract labor, both wage and wage-related contract labor cost, for services contracted by the hospital, the home office, or related organizations. If necessary, reclassify contract labor costs to the cost center benefiting from the contract labor services (see column 4 instructions). In addition, all other costs not reported in column 1 must be reported in column 2.

The sum of columns 1 and 2 equals the sum of column 3. Record any needed reclassifications and/or adjustments in columns 4 and 6, as appropriate.

Column 4--With the exception of the reclassification of capital-related costs which are reclassified via Worksheet A-7, all reclassifications in this column are made via Worksheet A-6. Worksheet A-6 need not be completed by all providers and 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 200.

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. Column 5, line 200, must equal column 3, line 200.

Column 6--Enter on the appropriate lines in column 6 the amounts of any adjustments to expenses indicated on Worksheet A-8, column 2. The total on Worksheet A, column 6, line 200, 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 0.

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. The line numbers on Worksheet A are used on subsequent worksheets, for example, the categories of ancillary service cost centers, outpatient service cost centers, and other reimbursable cost centers appear on Worksheet C, Part I, 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 23--These lines are for the general service cost centers. These costs are expenses incurred in operating the facility as a whole that are not directly associated with furnishing patient care such as, but not limited to mortgage, rent, plant operations, administrative salaries, utilities, telephone charges, computer hardware and software costs, etc. General service cost centers furnish services to both general service areas and to other cost centers in the provider.

Lines 1 and 2--The capital cost centers on lines 1 and 2 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.

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).

When you are dealing with a related organization, you are essentially dealing with yourself and Medicare considers the costs to you equal to the cost to the related organization. Therefore, for costs applicable to services, facilities, and supplies furnished by organizations related by common ownership or control (see 42 CFR 413.17 and CMS Pub. 15-1, 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 CMS Pub. 15-1, chapter 10, §1010, is applicable, not to exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere in the open market.

The policy of cost incurred from related organizations applies to capital-related and non-capital-related costs. 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 the related organization as capital-related costs to you.

If the price of comparable services, facilities, or supplies that could be purchased elsewhere in the open market is lower than the cost to the supplying related organization; if the exception in CFR 413.17(d) and CMS Pub. 15-1, chapter 10, §1010, applies; or if the supplying organization is not related to you, then no part of the charge to you is a capital-related cost unless the services, facilities, or supplies are capital-related in nature.

In the case of leased equipment, the fact that the lease or rental is for a depreciable asset is sufficient for consideration as a capital-related item, but a distinction must be made between the lease of equipment and the purchase of services. A lease of equipment is considered a capital-related cost while a purchase of service is considered an operating cost. Generally, for the agreement to be considered a lease or rental (and therefore a capital-related cost), the agreement must convey to the provider the possession, use, and enjoyment of the asset. Each agreement must be examined on its own merits. Factors that would weigh in favor of treating a particular agreement as a lease of equipment include the following:

- The equipment is operated by personnel employed by the provider or an organization related to the provider within the meaning of CMS Pub. 15-1, chapter 10.
- The physicians who perform the services with or interpret the tests from the equipment are associated with the provider.
- 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").
- 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.
- The provider holds the certificate of need (CON) for the services furnished with the equipment.
- The basis for determining the lease payment is units of time and is not volume sensitive (e.g., numbers of scans).
- The provider attends to such matters as utilization review, quality assurance, and risk management for the services involving the equipment.
- The provider schedules the patients for services involving the equipment.
- The provider furnishes any supplies required to be used with the equipment.
- The provider's access to the equipment is not subject to interruption without notice or interruption on very short notice.

If the supplying organization is not related to you (see 42 CFR 413.17), no part of the charge to you is a capital-related cost unless the services, facilities, or supplies are capital-related in nature.

Under certain circumstances, costs associated with minor equipment are considered capital-related costs. See CMS Pub. 15-1, chapter 1, §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 an inpatient prospective payment methodology for hospitals paid under the IPPS, effective for cost reporting periods beginning on or after October 1, 1991. Hospitals and hospital distinct part units (IPFs, IRFs, and LTCH) excluded from the IPPS pursuant to 42 CFR, Part 412, Subpart B, are paid for capital-related costs under their respective PPS payment systems. Also, CAHs are reimbursed on a reasonable cost basis under 42 CFR 413.70.

Lines 1 and 2--Capital costs are defined as all allowable capital-related costs for land and depreciable assets, with additional recognition of costs for capital-related items and services that are legally obligated by an enforceable contract (See CMS Pub. 15-1, chapter 28, §2800.) Betterment or improvement costs related to capital are included in capital assets. (See 42 CFR 412.302.) Capital costs incurred as a result of extraordinary circumstances are included in capital. (See 42 CFR 412.348(g).) Direct assignment of capital costs must be done in accordance with CMS Pub. 15-1, chapter 23, §§2307 and 2313.

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 c below, the amount of allowable capital-related interest expense recognized as capital is limited to the amount the hospital was legally obligated to pay.
 - 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, the amount of interest recognized associated with the original capital cannot exceed the amount that would have been recognized during the same period prior to the revision of the debt instrument.
 - c. Investment income (excluding income from funded depreciation accounts and other exclusions from investment income offset cited in CMS Pub. 15-1, chapter 2, §202.2) is used to reduce capital interest expense based in each cost reporting period.

3. Allowable capital-related lease and rental costs for land and depreciable assets.

a. The cost of lease renewals and the acquisition of assets continuously leased (e.g., capitalized leases) 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 \$1,000 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 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 appropriate portion of the capital-related costs of related organizations under 42 CFR 413.17 that would be recognized as capital costs if these costs had been incurred directly by the hospital.

Unless there is a change of ownership, the hospital must continue the same cost finding methods for capital costs. This includes its practices for the direct assignment of capital-related costs and its cost allocation bases in. If there is a change of ownership, the new owners may request that the contractor 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 capital costs, the request for change must be made in writing to the contractor 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 contractor does not approve the change unless it determines that there is reasonable justification for the change.

Line 3--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.

PPS providers paid 100 percent Federal complete line 3, column 2, and Worksheet A-7, Parts I (if applicable), II, and III.

Line 4--Enter in column 1, the direct salaries and salary amounts for paid vacation, holiday, sick, other paid-time-off (PTO), severance, and bonus pay incurred only for employees in the employee benefits department and/or the human resources department. In accordance with CMS Pub. 15-1, chapter 23, §2307, if your accounting system directly allocates employee benefits to individual cost centers, enter in column 2 the employee benefits cost of employees in the employee benefits and/or human resources department. If your accounting system does not directly allocate all or a portion of the employee benefits to all the individual cost centers, then enter in column 2 the total employee benefits cost and/or residual employee benefits costs of all hospital employees.

Line 5--Enter A&G costs on this line. A&G includes a wide variety of provider administrative costs such as but not limited to cost of executive staff, legal and accounting services, facility administrative services (not already included in other general service cost centers), etc. If this line is componentized into more than one cost center, eliminate line 5. Componentized A&G lines must begin with subscripted line 5.01 and continue in sequential and consecutive order except where this manual specifies otherwise.

Line 6--Maintenance and repairs are any activity to maintain the facility and grounds such as, but not limited to, costs of routine painting, plumbing and electrical repairs, mowing and snow removal.

Line 7--Operation of plant includes the cost such as, but not limited to, the internal hospital environment including air conditioning (both heating and cooling systems and ventilation) and other mechanical systems.

Line 8--Laundry and linen services includes the cost of routine laundry and linen services whether performed in-house or by outside contractors.

Line 9--Housekeeping includes the cost of routine housekeeping activities such as mopping, vacuuming, cleaning restrooms, lobbies, waiting areas and otherwise maintaining patient and non-patient care areas.

Line 10--Dietary includes the cost of preparing meals for patients.

Line 11--Cafeteria includes the cost of preparing food for provider personnel, physicians working at the provider, visitors to the provider.

Line 12--Maintenance of personnel includes the cost of room and board furnished to employees. (See CMS Pub. 15-1, chapter 7, §704.3.)

Line 13--Nursing administration 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 14--Central services and supply includes the costs of supplies and services which are requested by departments throughout the provider, including medical supplies charged to patients.

Line 15--Pharmacy includes the cost of drugs and pharmacy supplies requested by patient care departments and drugs charged to patients.

Line 16--Medical records and medical records library 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 17--Social service includes the cost of explaining health care resources and policies to patients, family and professional staff; assistance in planning for post-hospital patient needs; assisting patients and families receive needed follow-up care by referral to health care resources and providing advocacy through appropriate organizations.

Line 19--The services of a nonphysician anesthetist generally are paid for by the Part B contractor 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 19 generally are not reimbursed through the cost report.

NOTE: Any costs are included on this line are limited to salary and employee benefit costs.

However, payment for the nonphysician anesthetists on a fee basis may not apply to a qualified rural hospital or CAH if the facility employed or contracted with not more than one FTE (2080 hours) nonphysician anesthetist and, if (1) the hospital had 800 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. (42 CFR 412.113(c)(2)(i))

Payment under the fee schedule applies to qualified hospitals and CAHs unless the hospital establishes, before the beginning of each calendar year, that it did not exceed 800 surgical procedures requiring anesthesia in the previous year. (42 CFR 412.113(c)(2)(ii))

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 19. The total amount is reported on Worksheet A-8, line 28 and in column 6, line 19, of this worksheet. This removes these costs from the cost reported in column 7.

Lines 20 and 23--If you have an approved nursing or allied health education program that meets the criteria of 42 CFR 413.85(e), classroom and clinical portions of the costs may be allowable as pass-through costs as defined in 42 CFR 413.85(d)(2).

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. (See 42 CFR 413.85(c).)

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 classroom instruction. (See 42 CFR 413.85(c).)

If your program is a nonprovider-operated program under 42 CFR 413.85(g)(2), the classroom portion of the costs is not allowable as a pass-through cost and must not be reported on these lines. The clinical portions of these nonprovider-operated program costs are allowable as pass-through costs if the following conditions as set forth in 42 CFR 413.85(g)(2) are met:

1. The hospital must have claimed and have been paid for clinical costs (described above) during its latest cost reporting period that ended on or before October 1, 1989. (See 42 CFR 413.85(g)(2)(ii).)
2. In any cost reporting period, the pass-through costs are limited to the percentage of total allowable provider costs attributable to allowable clinical training costs reported in the provider's most recent cost reporting period ending on or before October 1, 1989. (See 42 CFR 413.85(g)(2)(iii).)
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. (See 42 CFR 413.85(g)(2)(iv).)
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 413.17(b) and CMS Pub. 15-1, chapter 10, §1002 (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. (See 42 CFR 413.85(g)(2)(v).)
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. (See 42 CFR 413.85(g)(2)(vi).)
6. The clinical training must occur on the premises of the hospital; i.e., in the hospital itself or in the physical area immediately adjacent to the hospital buildings or in other areas and structures located within 250 yards of the main buildings. (See 42 CFR 413.85(g)(2)(i).)

If your nonprovider-operated program was originally a provider operated program and you continued incurring the costs after the program was transferred to a wholly-owned subsidiary educational institution prior to October 1, 2003, the clinical training costs and classroom costs are eligible for pass-through payment under 42 CFR 413.85(g)(3)(ii) and (g)(3)(iii) if all of the following conditions in 42 CFR 413.85(g)(3) are met:

1. The program must have originally been provider-operated according to the criteria set forth in 42 CFR 413.85(f). (See 42 CFR 413.85(g)(3)(i).)

2. The program was transferred to a wholly owned subsidiary educational institution in order to meet accreditation standards prior to October 1, 2003. (See 42 CFR 413.85(g)(3)(i).)
3. The hospital has continuously incurred the costs of both the classroom and clinical training portions of the program at the educational institution. (See 42 CFR 413.85(g)(3)(i).)
4. The hospital received Medicare reasonable cost payment for the NAHE program both prior and subsequent to the date the hospital transferred operation of the program to its wholly owned subsidiary educational institution (and the program ceased to be provider-operated according to the criteria under 42 CFR 413.85(f). (See 42 CFR 413.85(g)(3)(ii).)

Line 20--Establish a separate cost center for each nursing school program that meets the requirements of 42 CFR 413.85(e) by subscribing line 20 for each nursing school program. If the direct costs of a nursing school program are not included in the costs on line 20, column 3, or applicable subscripts, reclassify the costs to line 20, or applicable subscripts, through a Worksheet A-6 reclassification.

Line 21--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 22.

Line 22--Enter the other costs applicable to interns and residents in an approved teaching program.

Line 23--Establish a separate cost center for each allied health/paramedical education program that meets the requirements of 42 CFR 413.85(e) (e.g., one for pharmacy, another for pastoral education, etc.) by subscribing line 23 for each allied health education program. If the direct costs of an allied health education program are not included in the costs on line 23, column 3, or applicable subscripts, reclassify the costs to line 23, or applicable subscripts, through a Worksheet A-6 reclassification.

Lines 24 through 29--Reserved for future use.

Lines 30 through 46--These lines are for the inpatient routine service cost centers.

Line 30--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.

Lines 31 through 35--Use lines 31 through 35 to record the cost applicable to intensive care type inpatient hospital units. (See 42 CFR 413.53(b) and (d) and CMS Pub. 15-1, chapter 22, §2202.7.) Label line 35 appropriately to indicate the purpose for which it is being used.

Lines 36 through 39--Reserved for future use.

Line 40--Use this line to record the IPF service costs of a subprovider. Hospital units that are excluded units from the IPPS are treated as subproviders for cost reporting purposes.

Line 41--Use this line to record the IRF service costs of a subprovider. Hospital units that are excluded units from the IPPS are treated as subproviders for cost reporting purposes.

Line 42--Use this line to record the inpatient routine service costs of other subproviders as applicable.

Line 43--Use this line to record the costs associated with the nursery.

Line 44--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 45--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/IID. Do not report nursing facility costs on this subscripted line.

Line 46--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 title XVIII. Treat this area as a non-reimbursable cost center for Medicare since it is not part of the Medicare certified hospital.

Lines 47 through 49--Reserved for future use.

Lines 50 through 77--Use for ancillary service cost centers.

Line 57--Use this line to record direct costs associated with computed tomography (CT) services.

Line 58--Use this line to record direct costs associated with magnetic resonance imaging (MRI) services.

Line 59--Use this line to record direct costs associated with cardiac catheterization services.

Line 60--Use this line to record direct costs associated with laboratory services.

Line 61--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. 15-1, chapter 23, §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 62--Include the direct expenses incurred in obtaining blood directly from donors as well as obtaining 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 (06250) (Table 5 - Electronic Reporting Specifications) for the cost of administering blood clotting factors to hemophiliacs. (See §4452 of BBA 1997, OBRA 1989 & 1993.)

Line 63--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 71--Include on this line medical supplies charged to patients other than the high cost implantable devices reported on line 72. Obtain the expense amounts from your records as follows depending on how you accumulate these expenses in your general ledger (GL). (1) If the expenses for chargeable medical supplies are accumulated together with non-chargeable medical supplies in the "Central Services" GL account and are reported in that cost center (line 14 on Worksheet A), do not include the chargeable medical supplies expenses on Worksheet A, line 71. Rather, allocate the costs in column 14 of Worksheet B to line 71 (and other lines) using the recommended "costed requisitions" statistics. (2) If the expenses for chargeable medical supplies are reported in a separate GL account, include these expenses on Worksheet A, line 71, column 2. (3) If the expenses for chargeable medical supplies are reported in a specific subaccount(s) under the GL accounts for various routine and ancillary departments (i.e., operating room, adults and pediatrics, or clinic), report the sum of the balances in that subaccount(s) on Worksheet A, line 71, column 2. If you reported the total balance (i.e., including the amounts for chargeable medical supplies) of the various GL accounts (i.e., operating room, adults and pediatrics, or clinic), in those respective cost centers in column 2 of Worksheet A, reclassify the cost of the chargeable medical supplies from those cost centers to the "medical supplies charged to patients" cost center (line 71). (See CMS Pub. 15-1, chapter 22, §2200.1, and 42 CFR 413.53(a)(1).)

Line 72--Include on this line high cost implantable devices charged to patients bearing the revenue codes established by the NUBC as indicated in the 73 FR 48462 (August 19, 2008), and not reported on line 71. Obtain the expense amounts from your records as follows depending on how you accumulate these expenses in your general ledger (GL). (1) If the expenses for chargeable implantable devices are accumulated together with non-chargeable implantable devices in the "Central Services" GL account and are reported in that cost center (line 14 on Worksheet A), do not include the high cost chargeable implantable devices expenses on Worksheet A, line 72. Rather, allocate the costs in column 14 of Worksheet B to line 72 (and other lines) using the recommended "costed requisitions" statistics. (2) If the expenses for high cost chargeable implantable devices are reported in a separate GL account, include these expenses on Worksheet A, line 72, column 2. (3) If the expenses for high cost chargeable implantable devices are reported in a specific subaccount(s) under the GL accounts for various routine and ancillary departments (i.e., operating room, adults and pediatrics, or clinic), report the sum of the balances in that subaccount(s) on Worksheet A, line 72, column 2. If you reported the total balance (i.e., including the amounts for high cost chargeable implantable devices) of the various GL accounts (i.e., operating room, adults and pediatrics, or clinic), in those respective cost centers in column 2 of Worksheet A, reclassify the cost of the high cost chargeable implantable devices from those cost centers to the "implantable devices charged to patients" cost center (line 72). (See CMS Pub. 15-1, chapter 22, §2200.1, and 42 CFR 413.53(a)(1).)

Line 74--If you furnish renal dialysis treatments, account for such costs by establishing this separate ancillary service cost center. In accumulating costs applicable to the 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 are reimbursed under the composite rate reimbursement system. For purposes of determining overhead attributable to ESAs, include the cost of the drug in this cost center. The drug costs will be removed on Worksheet B-2 after stepdown.

Effective for services rendered on or after January 1, 2011, ESRD services are paid under the ESRD PPS.

NOTE: ESRD physician supervisory services are not included as your costs under the composite rate reimbursement system or ESRD PPS. Supervisory services are included in the physician's monthly capitation rate.

Line 75--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).

Line 77--Effective for services rendered on or after January 1, 2017, enter the hospital acquisition costs for allogeneic stem cell transplants (when stem cells are obtained from a donor rather than from the recipient) as defined in CMS Pub. 100-04, chapter 4, §231.11. Do not include costs for autologous transplants (when transplanted stem cells are obtained from the recipient (CMS Pub. 100-04, chapter 4, §231.10)).

Lines 78 through 87--Reserved for future use.

Lines 88 through 93--Use these lines for outpatient service cost centers.

NOTE: For lines 88 through 90 and 93, any ancillary service billed as clinic, RHC, and FQHC services must be reclassified to the appropriate ancillary cost center, e.g., radiology-diagnostic, laboratory.

Line 88--Use this line to report the costs of hospital-based RHCs. If more than one is maintained, subscript the line. See Table 5 in §4095 for the proper cost center code for hospital-based RHCs.

In accordance with CMS Pub. 100-04, chapter 9, §40A, 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 contractor. If not specified in the agreement, a time study must be used to allocate the physician compensation.

Line 89--Use this line to report the costs of hospital-based FQHCs. If more than one is maintained, subscript the line. See Table 5 in §4095 for the proper cost center code for FQHCs.

In accordance with CMS Pub. 100-04, chapter 9, §40, compensation paid to a physician for FQHC services rendered in a hospital-based FQHC is cost-reimbursed. Where the physician agreement compensates for FQHC services as well as non-FQHC services, or services furnished in the hospital, the related compensation must be eliminated on Worksheet A-8 and billed to the Part B contractor. If not specified in the agreement, a time study must be used to allocate the physician compensation.

Line 90--Enter the cost applicable to the clinic not included on lines 88 and 89. If you have two or more clinics which are separately costed, separately report each such clinic. Subscript this line to report each clinic. If you do not separately cost each clinic, you may combine the cost of all clinics on the clinic line.

Line 91--Enter the costs of the emergency room cost center.

Line 92--Do not use this line on this worksheet. If you have a distinct part area specifically designated for observation (e.g., where observation patients are not placed in a general acute care area bed), report this on a subscripted line 92.01.

NOTE: It is possible to have both a distinct observation bed area and a non-distinct area (for example, where 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 93--Use this line to report the costs of other outpatient services not previously identified on lines 88 through 90. If more than one other service is offered, subscript the line. See Table 5 in §4095 for the proper cost center code for this line.

Line 93.99--Effective for cost reporting periods ending on or after September 30, 2017, enter the costs of providing hospital-based partial hospitalization program (PHP) services as defined in the Act §1861(ff).

Lines 94 through 98 and 100--Use these lines for other reimbursable cost centers (other than HHA and CMHC).

Line 94--Use this line to accumulate the direct costs incurred for self-care home dialysis. For purposes of determining overhead attributable ESAs, 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 directly 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 93 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).

Effective for services rendered on or after January 1, 2011, ESRD services are paid under the ESRD PPS.

Line 95--Report all ambulance costs on this line for both owned and operated services and services under arrangement. No subscripting is allowed for this line.

Lines 96 and 97--Use these lines to report durable medical equipment (DME) rented or sold, respectively. Enter the direct expenses incurred in renting or selling DME items to patients. Also, include all direct expenses incurred by you in requisitioning and issuing DME to patients.

For a hospital-based SNF, report support surfaces by subscribing line 97, and use the proper cost center code.

Line 99--This cost center accumulates the direct costs for outpatient rehabilitation providers (CORFs and OPTs) and CMHCs. However, only CMHCs complete the J series worksheets. Use lines 99 through 99.09 for CMHCs, 99.10 through 99.19 for CORFs, 99.20 through 99.29 for OPTs, lines 99.30 through 99.39 for OOTs, and lines 99.40 through 99.49 for OSPs. If you have multiple components, subscript this line using the proper cost center code.

Line 100--Use this line if your hospital operates an intern and resident program not approved by Medicare.

Line 101--This cost center accumulates costs specific to HHA services. If you have more than one certified hospital-based HHA, subscript line 101 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.

Hospital-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 hospital-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 HHA 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 hospital-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 hospital-based HHA.

When the hospital-based HHA can identify discrete management and administrative costs from its books and records, these costs are included on line 101.

Similar situations occur for the services furnished by the hospital-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 hospital-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 hospital-based HHA cannot be readily identified or derived. In other instances, physical therapy services are furnished to patients of the hospital-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 hospital-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 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-1, Part II.

Lines 102 through 104--Reserved for future use.

Lines 105 through 117--Use these lines for special purpose cost centers. Special purpose cost centers include kidney, heart, liver, lung, pancreas, intestinal, and islet acquisition costs as well as 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.

These cost centers include the cost of services purchased under arrangement or billed directly to the hospital in connection with the acquisition of organs. 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 organs acquired from other providers or organ procurement organizations;
- Transportation costs of organs;
- Organ recipient registration fees;
- Surgeons' fees for excising cadaveric donor organs; 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 an organ or for the right to remove or transplant an organ are included in organ 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-4.

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 the applicable organ acquisition 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-4.

Line 105--Record any costs in connection with kidney acquisitions. This cost center flows through cost finding and accumulates any appropriate overhead costs.

Line 106--Record any costs in connection with heart acquisitions. This cost center flows through cost finding and accumulates any appropriate overhead costs.

Line 107--Record any costs in connection with liver acquisitions. This cost center flows through cost finding and accumulates any appropriate overhead costs.

Line 108--Record any costs in connection with lung acquisitions. This cost center flows through cost finding and accumulates any appropriate overhead costs.

Line 109--Record any costs in connection with pancreas acquisitions. This cost center flows through cost finding and accumulates any appropriate overhead costs.

Line 110--Record any costs in connection with intestinal acquisitions. This cost center flows through cost finding and accumulates any appropriate overhead costs.

Line 111--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 change request (CR) 5505, dated March 2, 2007).

Line 112--Record any costs related to organ acquisitions, which are not already recorded on lines 105 through 111 and subscripts. This cost center flows through cost finding and accumulates any appropriate overhead costs.

Line 113--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 and 2, as appropriate, in accordance with the instructions for those lines.

Line 114--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 5). 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 amount reported on Worksheet E-2, column 1, line 7, must equal the amount adjusted on Worksheet A-8.

Line 115--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 CMS 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 116--Record the costs applicable to hospice care for terminally ill Medicare beneficiaries who elect to receive care from a participating hospice. If you have a contractual arrangement with a hospice for the use of general inpatient routine beds, do not to report those costs on this line. Rather, report the contractual arrangement costs on line 30, Adults and Pediatrics (General Routine Care). Additionally, report amounts received under the contract with the hospice on Worksheet A-8, line 30.99, and enter the applicable days on Worksheet S-3, Part I, line 24.10.

Line 117--Enter other special purpose cost centers not previously identified. Review Table 5 in §4095 for the proper cost center code.

Lines 119 through 189--Reserved for future use.

Lines 190 through 194--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, these expenses are adjusted on Worksheet A-8. (See CMS Pub. 15-1, chapter 23, §2328.)

Line 194--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.

Lines 195 through 199--Reserved for future use.

Line 200--Sum of lines 118 through 199.