

4071. WORKSHEET N-1 - RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES FOR HOSPITAL-BASED FQHC

Use the N worksheet series if you operate a certified hospital-based FQHC for cost reporting periods beginning on or after October 1, 2014. Use only those cost centers that represent services for which the hospital-based FQHC is certified. If you have more than one hospital-based FQHC, complete a separate worksheet N series for each hospital-based FQHC, unless the hospital-based FQHC has received prior contractor approval to file a consolidated cost report (see CMS Pub. 100-04, chapter 9, §30).

This worksheet is for recording direct costs of the hospital-based FQHC from your accounting books and records. It also provides for the necessary reclassifications and adjustments to certain accounts. If the cost elements of a cost center are maintained separately on your accounting books, a reconciliation of costs per the accounting books and records to those on this worksheet must be maintained and are subject to review by your contractor. The cost centers listed may not apply to every hospital-based FQHC using these forms. For example, a hospital-based FQHC that does not have transportation costs will not complete line 11. Complete only those lines that are applicable.

Column Descriptions

Column 1--Enter direct salaries and wages plus related salary amounts for paid vacation, holiday, sick, other paid-time-off (PTO), severance, and bonus pay.

Column 2--Enter all costs other than salaries.

Column 3--For each cost center, add the amounts in columns 1 and 2 and enter the total in column 3.

Column 4--For each cost center, enter any reclassifications for expenses listed in column 3. The net total of the entries in column 4, line 100, must equal zero if no reclassifications were reported on Worksheet A, column 4, line 89. Show reductions to expenses as negative numbers. This column is completed only to the extent reclassifications are needed and appropriate in the particular circumstances. See §4014 for examples of reclassifications that may be needed. Submit with the cost report copies of any work papers used to compute the reclassifications reported in this column.

Column 5--For each cost center, enter the total of the amount in column 3 plus or minus the amount in column 4. The total on column 5, line 100 must equal the total on column 3, line 100, if no reclassifications were reported on Worksheet A, column 4, line 89.

Column 6--For each cost center, enter on the appropriate lines the amounts of any adjustments to expenses required under the Medicare principles of reimbursement. (See §4016.) Submit with the cost report copies of any work papers used to compute the adjustments reported in this column.

Column 7--For each cost center, enter the total of the amount in column 5 plus or minus the amount in column 6. The amount on line 100 must equal the net expenses for cost allocation on Worksheet A, column 7, line 89.

Line Descriptions

This worksheet groups the trial balance of expenses into general service cost centers, direct patient care cost centers, reimbursable pass through costs, other FQHC services, and nonreimbursable cost centers to facilitate the transfer of costs to the various worksheets.

General Service Cost Centers--

These cost centers include expenses incurred in operating the hospital-based FQHC 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, and computer hardware and software costs. General service cost centers furnish services to other general service cost centers and to reimbursable and nonreimbursable cost centers.

Lines 1 and 2 - Cap Rel Costs-Bldg & Fix and Cap Rel Costs-Mvble Equip--These cost centers include the capital-related costs for buildings and fixtures and the capital-related costs for movable equipment including depreciation, leases and rentals for the use of facilities and/or equipment, including electronic health records systems, interest incurred in acquiring land and depreciable assets used for patient care, insurance on depreciable assets used for patient care and taxes on land or depreciable assets used for patient care, and, software and hardware updates to electronic health record systems. Do not include 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).

Line 3 - Employee Benefits--This cost center includes the costs of the employee benefits department. In addition, this cost center includes the fringe benefits paid to, or on behalf of, an employee when a provider's accounting system is not designed to accumulate the benefits on a departmentalized or cost center basis. (See CMS Pub. 15-1, chapter 21, §2144.)

Line 4 - Administrative and General--A&G includes a wide variety of administrative costs such as but not limited to cost of fiscal services, legal and accounting services, facility administrative services (not already included in other general service cost centers), etc.

Line 5 - Plant Operation and Maintenance--This cost center includes expenses incurred in the plant operation and maintenance of the hospital-based FQHC. These costs include the maintenance and service of utility systems such as heat, light, water, air conditioning and air treatment. This cost center also includes costs incurred in maintaining the facility and grounds, such as costs of routine painting, plumbing, mowing, and snow removal.

Line 6 - Janitorial--This cost center includes the cost of routine janitorial activities such as mopping, vacuuming, cleaning restrooms, lobbies, waiting areas and otherwise maintaining patient and non-patient care areas.

Line 7 - Medical Records--This cost center includes the cost of the medical records department where patient medical records are maintained. The general library and the medical library are not included in this cost center but are included in the A&G cost center. None of the costs associated with electronic health records systems are reported in this cost center.

Line 8 - Subtotal - Administrative Overhead--Enter the total of lines 1 through 7.

Line 9 - Pharmacy--This cost center includes only the routine costs of drugs (both prescription and over the counter), pharmacy supplies, pharmacy personnel, and pharmacy services provided incident to an FQHC visit. Drugs and pharmacy supplies that can be traced to individual patients that are paid separately (outside the FQHC PPS national encounter rate) under Part B, C, or D, of Medicare must be included on line 67 (Drugs Charged to Patients), of this worksheet. Drugs (both prescription and over the counter), pharmacy supplies, pharmacy personnel and pharmacy services provided by a retail pharmacy are reported on line 77. Do not include the cost of influenza and pneumococcal vaccines on this line as these costs are reported on lines 47 and 48, respectively.

Line 10 - Medical Supplies--This cost center includes the cost of routine supplies used in the normal course of caring for patients, such as gloves, masks, swabs, or glycerin sticks, and the non-routine medical supplies that can be traced to individual patients. Do not include the cost of medical supplies used in administering pneumococcal and influenza vaccines on this line as these costs are reported on lines 47 and 48, respectively.

Line 11 - Transportation--This cost center includes the cost of owning or renting vehicles, public transportation expenses, parking, tolls, or payments to employees for driving their private vehicles to see patients or for other hospital-based FQHC business.

Line 12 - Other General Service--Use this line to report the costs of other general service costs not previously identified on lines 1 through 11.

Line 13 - Subtotal - Total Overhead--Enter the sum of lines 8 and 9 through 12.

Lines 14 through 22--Reserved for future use.

Direct Care Cost Centers--

Line 23 - Physician--This cost center includes the costs incurred for physicians providing direct patient care services and general supervisory services, participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care, and establishment of governing policies by the governing board. Reclassify the cost for the portion of time physicians spent on general supervisory services or other hospital-based FQHC administrative activities to A&G (line 4).

Line 24 - Physician Services Under Agreement--This cost center includes the costs incurred for physicians who are providing services under agreement.

Line 25 - Physician Assistant--This cost center includes the costs incurred for PAs, including the costs for PAs providing physician services.

Line 26 - Nurse Practitioner--This cost center includes the costs of nursing care provided by nurse practitioners (NPs), including NPs providing physician services.

Line 27 - Visiting Registered Nurse--This cost center only includes the costs of nursing care provided by registered nurses (RNs), who perform visiting nurse services in accordance with CMS Pub. 100-02, chapter 13, §180. Costs associated with RNs who provide services incident to a physician, PA, NP, certified nurse midwife (CNM), CP, or clinical social worker (CSW) (see CMS Pub. 100-02, chapter 13, §§110, 120 and 140), are included in line 36.

Line 28 - Visiting Licensed Practical Nurses--This cost center includes the costs of nursing care provided by licensed practical nurses (LPNs) who perform visiting nurse services in accordance with CMS Pub. 100-02, chapter 13, §180. Costs associated with LPNs who provide services incident to a physician, PA, NP, CNM, CP or CSW (see CMS Pub. 100-02, chapter 13, §§110, 120 and 140), are included in line 36.

Line 29 - Certified Nurse Midwife--This cost center includes the costs of nursing care provided by CNM's.

Line 30 - Clinical Psychologist--This cost center includes the costs of a CP who holds a doctorate in psychology and is licensed or certified by the State in which he or she practices, for diagnostic, assessment, preventative and therapeutic services directed at individuals.

Line 31 - Clinical Social Worker--This cost center includes the costs of a CSW who possesses a master's degree or doctorate in social work and meets specified criteria established by regulation. The CSW must directly examine the patient, or directly review the patient's medical information, to provide diagnosis, treatment and consultation.

Line 32 - Laboratory Technician--This cost center includes the costs of a person who, under the supervision of a medical technologist or physician, performs microscopic and bacteriologic tests of human blood, tissue, and fluid for diagnostic and research purposes.

Line 33 - Reg Dietician/Cert DSMT/MNT Educator--This cost center includes the costs of a person who is either a registered dietician or nutritionist who meets specified criteria for providing diabetes self-management training (DSMT) or medical nutrition therapy (MNT) services under the Program.

Line 34 - Physical Therapist--This cost center includes the costs of physical or corrective treatment of bodily or mental conditions by the use of physical, chemical, and other properties of heat, light, water, electricity, sound massage, and therapeutic exercise by or under the direction of a registered physical therapist as prescribed by a physician. Physical therapy services may be provided for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

Line 35 - Occupational Therapist--This cost center includes the costs of purposeful goal-oriented activities in the evaluation, diagnosis, and/or treatment of persons whose function is impaired by physical illness or injury, emotional disorder, congenital or developmental disability, or the aging process, in order to achieve optimum functioning, to prevent disability, and to maintain health. Occupational therapy services may be provided for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

Line 36 - Other Allied Health Personnel--This cost center includes the cost of RNs and LPNs who provide services incident to a physician, PA, NP, CNM, CP, or CSW in accordance with CMS Pub. 100-02, chapter 13, §§110, 120 and 140 and the cost of other allied health personnel that provide diagnostic, technical, therapeutic and direct patient care and support services to the other health professionals they work with and the patients they serve. An example of other allied health personnel is a medical assistant.

Line 37 - Subtotal Direct Patient Care Services--Enter the total of lines 23 through 36.

Lines 38 through 46--Reserved for future use.

Reimbursable Pass Through Costs--

Line 47 - Pneumococcal Vaccines & Med Supplies--This cost center includes the cost of the pneumococcal vaccines and the medical supplies attributable to pneumococcal vaccinations.

Line 48 - Influenza Vaccines & Med Supplies--This cost center includes the cost of the influenza vaccines and the medical supplies attributable to influenza vaccinations.

Line 49 - Subtotal - Reimbursable Pass Through Costs--Enter the total of lines 47 through 48.

Lines 50 through 59--Reserved for future use.

Other FQHC Services--

Line 60 - Medicare Excluded Services--This cost center includes the cost of routine dental care, hearing tests, eye exams, etc., that are excluded from coverage under the Program.

Line 61 - Diagnostic & Screening Lab Tests--This cost center includes the technical component cost of diagnostic and laboratory tests such as electrocardiograms and certain preventative services authorized by the Medicare statute or the national coverage determination process. This cost center does not include venipuncture, which is included in the pharmacy cost center when furnished by the hospital-based FQHC.

Line 62 - Radiology - Diagnostic--This cost center includes the technical component of radiological diagnostic tests such as x-rays and imaging services.

Line 63 - Prosthetic Devices--This cost center includes the costs of devices (other than dental) which replace all or part of an internal body organ including colostomy bags and supplies directly related to colostomy care, replacement of such devices, and one pair of conventional eyeglasses or contact lenses furnished subsequent to each cataract surgery with the insertion of an intraocular lens.

Line 64 - Durable Medical Equipment--This cost center includes the direct costs of DME rented or sold (DME, as defined in 42 CFR 410.38) furnished to an individual patient and all direct expenses incurred in requisitioning and issuing DME to patients.

Line 65 - Ambulance Services--Report all ambulance costs on this line for both owned and operated services and services under arrangement.

Line 66 - Telehealth--This cost center includes the cost of telehealth distant-site services as described in CMS Pub. 100-02, chapter 13, §190.

Line 67 - Drugs Charged to Patients--This cost center includes only those costs associated with drugs (both prescription and over the counter), pharmacy supplies, pharmacy personnel and pharmacy services that can be traced to individual patients that are paid separately (outside the FQHC PPS national encounter rate) under Medicare Parts B, C, or D.

Line 68 - Chronic Care Management (CCM)--This cost center includes the structured recording of patient health information, an electronic health care plan addressing all health issues, access to chronic care management services, managing care transitions, and coordinating and sharing patient information with practitioners and providers outside the practice. CCM services are reimbursed as an add-on payment based on the Medicare Physician Fee Schedule (MPFS). See 80 FR 71080 (November 16, 2015).

Line 69 - Other--Use this line to report the costs of other FQHC services not previously identified on lines 60 through 68.

Line 70 - Subtotal Other FQHC Services--Enter the total of lines 60 through 69.

Lines 71 through 76--Reserved for future use.

Nonreimbursable Cost Centers--

Line 77 - Retail Pharmacy--This cost center includes only those costs associated with drugs (both prescription and over the counter), pharmacy supplies, pharmacy personnel and pharmacy services that are sold through a retail pharmacy.

Line 78 - Other Nonreimbursable--Use this line to record the costs applicable to other nonreimbursable cost centers not provided for on this worksheet.

Line 80 through 99--Reserved for future use.

Line 100 - Total--Enter the sum of lines 13, 37, 49, 70, and 79.

4071.1. WORKSHEET N-2 - CALCULATION OF HOSPITAL-BASED FQHC COST PER VISIT

The purpose of Worksheet N-2 is to summarize (1) the hospital-based FQHC medical and mental health visits furnished by practitioners, including health care staff and physicians under agreement, and (2) apportion overhead costs to hospital-based FQHC services to determine the average cost per visit for a medical visit and a mental health visit, by practitioner.

Column 1--Enter the total cost for each practitioner from Worksheet N-1, column 7 as indicated on the worksheet.

Column 2--Enter the total medical and mental health visits actually furnished to all patients by each practitioner during the cost reporting period. Each visit to the hospital-based FQHC by the beneficiary counts as a single visit, even in the case where a beneficiary returns to the hospital-based FQHC in the same day for a subsequent illness or injury. A beneficiary can have up to three medical visits in a day to include the initial visit and two subsequent visits for illness or injury.

NOTE: Column 2, line 11 must equal Worksheet S-11, Part III, column 5, sum of lines 2 and 4. For each line 1 through 10, column 2 must equal the sum of columns 7 and 8.

Column 3--Use this column to allocate costs associated with other direct care costs, sum of Worksheet N-1, column 7, lines 9, 32, 34, 35, and 36. Calculate the UCM related to other direct care costs by dividing the sum of Worksheet N-1, column 7, lines 9, 32, 34, 35, and 36, by Worksheet N-2, column 2, line 11, total medical and mental health visits, and enter the result on line 12. Calculate the costs for lines 1 through 10 by multiplying the visits on each corresponding line, column 2 times the UCM on line 12.

Column 4--Use this column to allocate general service costs, sum of Worksheet N-1, column 7, line 13, minus line 9, plus Worksheet B, Part I, line 89, column 26, minus Worksheet B, Part I, line 89, column zero. Calculate the UCM by dividing Worksheet N-1, column 7, line 13, minus line 9, plus Worksheet B, Part I, line 89, column 26, minus Worksheet B, Part I, line 89, column zero, by Worksheet N-1, column 7, line 100, minus Worksheet N-1, column 7, line 13, plus line 9, and enter the result on line 12. Allocate the general service cost attributable to each practitioner on lines 1 through 10, by multiplying the UCM times the sum of the amounts in columns 1 and 3, for each corresponding line.

Column 5--Enter the sum of columns 1, 3 and 4, for each practitioner.

Column 6--Calculate the average cost per visit by each practitioner by dividing the total cost in column 5 by the total visits in column 2. Enter the result in column 6.

Column 7--Enter the total number of medical visits included in column 2, provided to all patients by each practitioner during the cost reporting period.

Column 8--Enter the total number of mental health visits included in column 2, provided to all patients by each practitioner during the cost reporting period.

Column 9--Enter the total number of medical visits provided to Medicare beneficiaries by each practitioner during the cost reporting period.

Column 10--Enter the total number of mental health visits provided to Medicare beneficiaries by each practitioner during the cost reporting period.

NOTE: Worksheet S-11, Part III, column 2, line 2, must equal column 9, line 11; and Worksheet S-11, Part III, column 2, line 4, must equal column 10, line 11.