Medicare

Provider Reimbursement Manual
Part 2, Provider Cost Reporting Forms and Instructions, Chapter 38, Form CMS-1894-99

Department of Health and Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

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HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
3810 – 3810 (Cont.)	38-9 – 38-10 (2 pp.)	38-9 – 38-10 (2 pp.)
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NEW/REVISED MATERIAL--EFFECTIVE DATE*:* **The changes are effective for Cost Reporting Periods Ending On or After 9/30/2000. This transmittal corrects the instructions and the forms for the per diem calculation.**

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

Other (Insurance) Days (87 & 27)	114
Other Patients (D & E)	/2
Average LOS (Other)	57 Days
All Patients (90+45+29+92+87+27)	370 Days
Total Number of patients	/6
Average LOS for all patients	61.67 Days

Enter the hospice's average length of stay, without regard to payer source, in column 6, line 15.

Line 16.--Enter the unduplicated census count of the hospice for all patients initially admitted and filing an election statement with the hospice within a reporting period for the appropriate payer source. Do not include the number of patients receiving care under subsequent election periods (See CMS Pub. 21 §204.) However, the patient who initially elects the hospice benefit, is discharged or revokes the benefits, and elects the benefit again within the reporting period is considered a new admission with each new election and should be counted twice.

The total under this line should equal the unduplicated number of patients served during the reporting period for each program. Thus, you would not include a patient if their stay was counted in a previous cost reporting period. If a patient enters a hospice source other than Medicare and subsequently becomes eligible for Medicare and elects the Medicare hospice benefit, then count that patient only once in the Medicare column, even though he/she may have had a period in another payer source prior to the Medicare election. A patient transferring from another hospice is considered to be a new admission and is included in the count.

Line 17.—If the hospice componentized (or fragmented) its administrative and general service costs, enter "1" for option 1 and "2" for option two. Do not respond if A&G services are not fragmented. (See §3820 for an explanation of the A&G componentization options.)

Line 18.—Are there any related organization or home office costs claimed? Enter "Y" for yes or "N" for no in column 1. If yes, enter the Chain Home Office's provider number in column 2. If yes, complete Worksheet A-8-1.

3810. WORKSHEET A - RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE EXPENSES

In accordance with 42 CFR 413.20, the methods of determining costs payable under title XVIII involve making use of 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 reclassification 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, B-1, the line numbers are consistent, and the total line is set at 100). Not all of the cost centers listed apply to all providers using these forms.

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

Standard (i.e., preprinted) CMS line numbers and cost center descriptions may not be changed. If you need to use additional or different cost center descriptions, add additional lines to the cost report. When an added cost center description bears a logical relationship to a standard line description, insert the added label immediately after the related standard line description.

Identify the added line as a numeric (only) subscript of the immediately preceding line, except when subscripting administrative and general (A&G) costs. That is, if two lines are added between lines 5 and 6, identify them as lines 5.01 and 5.02.

But if A&G costs (line 6) are subscripted, eliminate line 6 and begin subscripting with line 6.01. If additional lines are added for general service cost centers to Worksheet A, corresponding columns must be added to Worksheets B and B-1 as well as lines to Worksheet A-1, A-2, A-3, B, and B-1 for cost finding.

Cost center coding is a method for standardizing cost center labels used by health care providers on the Medicare cost reports. Form CMS 1984-99 provides for preprinted cost center descriptions on Worksheet A. 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. Nonstandard cost center descriptions are identified through analysis of frequently used labels.

Column 1.--Obtain salaries to be reported from Worksheet A-1, col. 9, line 3-100.

Column 2.--Obtain employee benefits to be reported from Worksheet A-2 col. 9 lines 3-100.

Column 3.--If the transportation costs, i.e., owning or renting vehicles, public transportation expenses, or payments to employees for driving their private vehicles can be directly identified to a particular cost center, enter those costs in the appropriate cost center. If these costs are not identified to a particular cost center enter them on line 22.

Column 4.--Obtain the contracted services to be reported from Worksheet A-3, col. 9 lines 3-100.

Column 5.--Enter in the applicable lines in column 5 all costs which have not been reported in columns 1 through 4.

Column 6.--Add the amounts in columns 1 through 5 for each cost center and enter the total in column 6.

Column 7.--Enter any reclassifications among cost center expenses in column 6 which are needed to effect proper cost allocation.

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 reclassifications are needed and appropriate in the particular circumstances. Show reductions to expenses in parentheses ( ).

The net total of the entries in column 7 must equal zero on line 100.

Column 8.--Adjust the amounts entered in column 6 by the amounts in column 7 (increases and decreases) and extend the net balances to column 8. The total of column 8 must equal the total of column 6 on line 100.

Column 9.--Enter on the appropriate lines in column 9, the amounts from Worksheet A-8. The total on Worksheet A, column 9, line 100 must equal Worksheet A-8, column 2, line 11.

Column 10.--Adjust the amounts in column 8 by the amounts in column 9, (increases or decreases) and extend the net balances to column 10.

In addition, report on line 6 the administrative and general costs reported on Worksheet B, column 6, line 6 since these costs are not included on Worksheet B-1, column 6 as an accumulated cost statistic.

For fragmented or componentized A&G cost centers, the accumulated cost center line number must match the reconciliation column number. Include in the column number the alpha character "A", i.e., if the accumulated cost center for A&G is line 6 (A&G), the reconciliation column designation must be 6A.

If A& G is not fragmented or componentized, the reconciliation column designation must be 6A.

Worksheet B-1, Column 6--The administrative and general expenses are allocated on the basis of accumulated costs. Therefore, the amount entered on Worksheet B-l, column 6, line 6, is the difference between the amounts entered on Worksheet B, column 5A and Worksheet B-1, column 6A. A negative cost center balance in the statistics for allocating administrative and general expenses causes an improper distribution of this overhead cost center. Exclude negative balances from the allocation statistics.

Hospices may establish multiple A&G cost centers (referred to as componentized or fragmented) by using one of two methods. The rationale for allocating the shared A&G service cost center first is that shared A&G cost centers service all other cost centers, while 100 percent of the hospice A&G reimbursable and 100 percent of hospice A&G nonreimbursable only service their respective cost centers. That is consistent with 42 CFR 413.24(d)(1), which states, in part, that the cost of nonrevenue-producing cost centers serving the greatest number of other centers, while receiving benefits from the least number of centers, is apportioned first.

Under the first method (also referred to as option 1), the hospice must classify all A&G costs as either A&G shared costs, A&G reimbursable costs, or A&G nonreimbursable costs. That is, 100 percent of the componentized A&G costs relate exclusively to either the hospice reimbursable or the hospice nonreimbursable cost centers. The remaining costs are classified as A&G shared costs. The componentized A&G costs are allocated through cost finding to their respective cost centers in aggregate.

First, allocate A&G shared costs to all applicable cost centers, including to the A&G reimbursable and A&G nonreimbursable cost centers on the basis of accumulated costs. Then allocate hospice A&G reimbursable costs to all applicable Hospice reimbursable cost centers (not including special purpose cost centers) on the basis of accumulated costs, and allocate hospice A&G nonreimbursable costs to all applicable hospice nonreimbursable cost centers on the basis of accumulated costs. Only A&G shared costs are allocated to the special purpose cost centers.

The following three A&G cost center categories will be created: (1) A&G shared costs, (2) 100 percent hospice reimbursable costs, and (3) 100 percent Hospice nonreimbursable costs, in this order only. Do not allocate A&G reimbursable costs to the A&G nonreimbursable cost center. Calculate the accumulated cost statistics as follows:

A&G Cost Center	Sum of Worksheet B	Transfer to Worksheet B-1
A&G Shared Costs	Col. 0-5, lines 6.02-100	Col. 6.01, lines 6.02-100
A&G Reimb. Costs	Col. 0-6.01, lines 7-40	Col. 6.02, lines 7-40
A&G Nonreimb. Costs	Col. 0-6.01, lines 50-100	Col. 6.03, lines 50-100

Under the second method (also referred to as option 2), unique A&G cost centers may be created (see CMS Pub. 15-I, §2313.1) to further refine the allocation process. The statistical basis upon which to allocate fragmented A&G costs must represent, as accurately as possible, the consumption or usage of A&G services by the benefiting cost centers.

Hospices wishing to use an alternative allocation method (i.e., a change in allocation basis or the sequence of cost center allocation) must do so in accordance with CMS Pub. 15-I, §2313. The fragmentation of A&G costs constitutes a direct assignment of A&G costs and as such must follow the policy established under §2307 of CMS Pub. 15-I.

3830. WORKSHEET D - CALCULATION OF PER DIEM COST

Worksheet D calculates the average cost per days in providing care for a hospice patient. It is only an average and should not be misconstrued as the absolute.

Line 1.--Total cost from Worksheet B, line 100, column 7, less line 53, column 7. This line reflects the true cost without any non-hospice-related cost.

Line 2.--Total unduplicated days from Worksheet S-1, line 12, col. 6.

Line 3.--Average cost per day. Divide the total cost from line 1 by the total number of days from line 2.

Line 4.--Unduplicated Medicare days from Worksheet S-1, line 12, column 1.

Line 5.--Average Medicare cost. Multiply the average cost from line 3 by the number of unduplicated Medicare days on line 4 to arrive at the average Medicare cost.

Line 6.---Unduplicated Medicaid days from Worksheet S-1, line 12, column 2.

Line 7.---Average Medicaid cost. Multiply the average cost from line 3 by the number of unduplicated Medicaid days on line 6 to arrive at the average Medicaid cost.

Line 8.--Unduplicated SNF days from Worksheet S-1, line 12, column 3.

Line 9.--Average SNF cost. Multiply the average cost from line 3 by the number of unduplicated SNF days on line 8 to arrive at the average SNF cost.

Line 10.--Unduplicated NF days from Worksheet S-1, line 12, column 4.

Line 11.--Average NF cost. Multiply the average cost from line 3 by the number of unduplicated NF days on line 10 to arrive at the average NF cost.

Line 12.---Unduplicated Other days from Worksheet S-1, line 12, column 5.

Line 13.--Average Other cost. Multiply the average cost from line 3 by the number of unduplicated Other days on line 12 to arrive at the average Other cost.

DO NOT COMPLETE LINE 14 OR 15 FOR COST REPORTING PERIODS ENDING ON OR AFTER 9/30/2000.

Line 14.--Total cost add lines 5, col. 1 plus line 7 col. 2 and line 13, col. 3. Line 14 must equal line 1 col. 4. Line 9, col. 1 average SNF cost is already accounted for in the total Medicare cost for Title XVIII. Similarly line 11, col. 2, is already accounted for on line 7, col. 2 for Medicaid cost for Title XIX.

Line 15.---Total days add lines 4, col. 1 plus line 6 col. 2 and line 12, col. 3. Line 15 must equal line 2 col. 4. Line 8, col. 1 unduplicated SNF days is already accounted for in the total Medicare cost for Title XVIII. Similarly line 10, col. 2, is already accounted for on line 6, col. 2 for Medicaid cost for Title XIX.