Medicare
Provider Reimbursement Manual
Part 2, Provider Cost Reporting Forms and Instructions, Chapter 38, Form CMS 1984-99

Department of Health and Human Services (DHHS)

Centers for Medicare and Medicaid Services (CMS)

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NEW/REVISED MATERIAL--*EFFECTIVE DATE:* Cost reporting periods ending on or after 6/30/2006.

This transmittal updates Chapter 38, Hospice Cost Report, Form CMS-1984-99 to capture and identify continuous care costs.

REVISED ELECTRONIC SPECIFICATIONS EFFECTIVE DATE: Changes to the electronic reporting specifications are effective for cost reporting periods ending on or after June 30, 2006.

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

3800. GENERAL

The Paperwork Reduction Act of 1995 establishes the requirement that the private sector be told why information is collected and what it will be used for by the government. In accordance with 42 CFR 418.310, hospice providers of service participating in the Medicare program are required to submit annual information for health care services rendered to Medicare beneficiaries. Also, 42 CFR 418.20 requires cost reports from providers on an annual basis. The data submitted on the cost reports supports management of Federal programs. The information reported on Form CMS-1984-99, must conform to the requirements and principles set forth in the Provider Reimbursement Manual Part I (CMS Pub. 15-I) and the Hospice Manual (CMS Pub. 21). These instructions, Chapter 38, are effective for cost reporting periods beginning on or after **April 1, 1999.**

Providers receiving Medicare reimbursement must provide adequate cost data based on financial and statistical records which can be verified by qualified auditors. The cost data must be based on the accrual basis of accounting. However, where governmental institutions operate on a cash basis of accounting, cost data developed on such basis of accounting is acceptable subject to appropriate treatment of capital expenditures. Under the accrual basis of accounting, revenue is recorded in the period earned regardless of when it is collected, and expenditures for expense and asset items are recorded in the period incurred regardless of when paid. See CFR 413.24(b)(2).

Facilities meeting the conditions set forth in Chapter 1, Section 110 of the Provider Reimbursement Manual Part II (CMS Pub.15-II) can file less than a full cost report.

Form CMS-1984-99 must be used by all freestanding Hospices to which payment is made by Medicare and must be submitted to the Hospice's Medicare fiscal intermediary on or before the last day of the fifth month following the close of the cost reporting period. This form must be used for cost reporting periods beginning on or after **April 1, 1999**.

NOTE: This form is to be used by freestanding hospices only. For provider based hospices, complete the appropriate hospice schedules within those cost reports.

Cost reports are due on or before the last day of the fifth month following the close of the period covered by the report. A 30-day extension of the due date may be granted by the intermediary only when the provider's operations are significantly affected due to extraordinary circumstances over which the provider has no control such as fire or flood. (See 42 CFR 413.24 (f)(2)(ii).)

3801 ROUNDING STANDARDS FOR FRACTIONAL COMPUTATIONS

Throughout the Medicare cost report, computations result in fractions. Use the following rounding standards:

1. Round to 2 decimal places:
   Percentages
   Averages, standard work week, and payment rates
   Full time Equivalent employees
   Per diem
   Hourly rates

2. Round to 6 decimal places:
   Ratios (e.g., unit cost multipliers)

Where a difference exists within a column as a result of computing costs using a fraction or decimal, and therefore the sum of the parts do not equal the whole, the highest amount in that column must either be increased or decreased by the difference. If it should happen that there are two high numbers equaling the same amount, adjust the first high number from the top of the worksheet for which it applies.

3802. DEFINITIONS

A freestanding Hospice, as the term is used in this report, refers to a hospice that is not part of any other type of participating provider meeting the requirements of §1861(dd) of the Social Security Act. Refer to the Hospice Manual, CMS-Pub. 21 and the Provider Reimbursement Manual, Part I, CMS-Pub. 15-1, for further definitions of terms. Your intermediary will furnish any revisions to the documents cited.

NOTE: This form is not used by Hospices that are provider based. Instead, they continue to use Form CMS-2552 for hospital based, Form CMS-2540 for the SNF based and Form CMS-1728 for HHA based.

In these reporting instructions the use of the term "Medicare" refers only to Medicare patients currently under a valid Medicare Hospice election. The statistics associated with Medicare patients not covered under the Medicare Hospice election should be included with other payors. Likewise, all references used throughout the reporting instructions which indicate that the "other" equals "non-Medicare" refer to patients not making the hospice election under Medicare or Medicaid.

3803. ACRONYMS AND ABBREVIATIONS

Throughout the Medicare cost report and instructions, a number of acronyms and abbreviations are used. For your convenience, commonly used acronyms and abbreviations are summarized below.

A&G	-	Administrative and General
BBA	-	Balanced Budget Act of 1997 (P.L. 105-33)
CAP-REL	-	Capital-Related
CFR	-	Code of Federal Regulations
COL	-	Column
FR	-	Federal Register
CMS Pub.	-	Health Care Financing Administration Publication
HHA	-	Home Health Agency
INPT	-	Inpatient
LOS	-	Length of Stay
MRI	-	Magnetic Resonance Imaging
NF	-	Nursing Facility
NPI	-	*National Provider Identifier*
OT	-	Occupational Therapy
PBP	-	Provider-Based Physician
PPS	-	Prospective Payment System
PRM	-	Provider Reimbursement Manual
PT	-	Physical Therapy
SNF	-	Skilled Nursing Facility
SP	-	Speech Pathology
WKST	-	Worksheet

3804. RECOMMENDED SEQUENCE FOR COMPLETING FORM CMS-1984-99

Step No.	Worksheet	Instructions
1	S	Read §3806. Complete entire worksheet.
2	S-1	Read §3807. Complete entire worksheet.
3	A-1 - A-3	Read §3811 - §3813. Complete entire worksheets.
4	A	Read §3810. Complete columns 1 - 3, lines 1 - 100.
5	A-6	Read §3816. Complete, if applicable.
6	A-7	Read §3817. Complete, if applicable.
7	A-8	Read §3818. Complete all lines.
8	A-8-1	Read §3818.1. Complete, if applicable.
9	A	Read §3810. Complete columns 4 - 7, lines 1 - 100.
10	B and B-1	Read §3820. Complete both worksheets entirely.
11	D	Read §3830. Complete entire worksheet.
12	G	Read §3850. This step is completed by all providers maintaining fund type accounting records. Non-proprietary providers which do not maintain fund type records complete the General Fund column only.
13	G-1	Complete entire worksheet.
14	G-2, Parts I & II	Complete entire worksheet.

3805. SEQUENCE OF ASSEMBLY

Submit your annual cost report worksheets in the order indicated below when using Form CMS-1984-99. Include only applicable, completed worksheets. Do not include blank worksheets.

Worksheet	Part
S	I & II
S-1	
A-1 through A-3	
A	
A-6	
A-7	
A-8	
A-8-1	
B	
B-1	
D	
G through G-2	

3806. WORKSHEET S - HOSPICE COST REPORT CERTIFICATION

The information required on this worksheet is needed to properly identify the provider. Enter the inclusive dates covered by this cost report. In accordance with 42 CFR 413.24(f), each provider must submit periodic reports of its operation, which generally cover a consecutive 12 month period.

The intermediary indicates in the appropriate box whether this is the initial cost report, final report due to termination, or a reopening. If it is a reopening, the intermediary indicates the number of times the cost report has been reopened.

3806.1 Certification.--This certification is read, completed, and signed after the cost report has been completed in its entirety.

3807. WORKSHEET S-1 - HOSPICE IDENTIFICATION DATA

3807.1 Part I --The information required on this worksheet is needed to properly identify the provider.

Line 1.--Enter the name, address, city, state and zip code of the hospice.

Line 2.--Enter the county where the Hospice is located.

Line 3.--Enter the date the hospice began operation. Enter the date of State licensure if the hospice is located in a State that requires a state hospice license for operation.

Line 4.--Enter the date the hospice was certified for Title XVIII, Medicare and Title XIX, Medicaid.

Line 5.--Enter the inclusive dates covered by this cost report. In accordance with 42 CFR 413.24(f), you are required to submit periodic reports of operations, which generally cover a consecutive 12-month period. (See §§102.1 - 102.3 for situations when you may file a short period cost report.)

Cost reports are due on or before the last day of the fifth month following the close of the period covered by the report. The ONLY provision for an extension of the cost report due date is identified in 42 CFR 413.24(f)(2)(ii).

Line 6.--Enter the provider identification number.

Line 6.01.--Reserved for future use.

Line 7.--Indicate the type of control or auspice under which the hospice is conducted as indicated.

1 = Voluntary Nonprofit, Church	8 = Governmental, City-County
2 = Voluntary Nonprofit, Other	9 = Governmental, County
3 = Proprietary, Individual	10 = Governmental, State
4 = Proprietary, Corporation	11 = Governmental, Hospital District
5 = Proprietary, Partnership	12 = Governmental, City
6 = Proprietary, Other	13 = Governmental, Other
7 = Governmental, Federal	

- Voluntary - A voluntary hospice is usually financed by earnings and contributions and governed by a community-based board of directors. The primary function is the care of the terminally ill in the home. Some voluntary hospices are operated under church auspices.

The maintenance of grounds such as landscape and paved areas, streets on the property, sidewalk, fenced areas, fencing, external recreation areas and parking facilities are part of this cost center. The care or cleaning of the interior physical plant, including the care of floors, walls, ceilings, partitions, windows (inside and outside), fixtures and furnishings, and emptying of trash containers, as well as the costs of similar services purchased from an outside organization which maintains the safety and well-being of personnel, visitors and the provider's facilities, are all included in this cost center.

Line 4 - Transportation-Staff.--Enter all of the cost of transportation except those costs previously directly assigned in column 3. This cost is allocated during the cost finding process.

Line 5 - Volunteer Service Coordination.--Enter all of the cost associated with the coordination of service volunteers. This includes recruitment and training costs.

Line 6 - Administrative and General.--Use this cost center to record expenses of several costs which benefit the entire facility. Examples include fiscal services, legal services, accounting, data processing, taxes, and malpractice costs. If the option to componentize administrative and general costs into more than one cost center is elected, eliminate line 6. Componentized A&G lines must begin with subscripted line 6.01 and continue in sequential order (i.e., 6.01 A&G shared costs, in this order only.) See §3820. For complete instructions.

Line 10 - Inpatient - General Care.--This cost center includes costs applicable to patients who receive this level of care because their condition is such that they can no longer be maintained at home. Generally, they require pain control or management of acute and severe clinical problems which cannot be managed in other settings. The costs incurred on this line are those direct costs of furnishing routine and ancillary services associated with inpatient general care for which other provisions are not made on this worksheet.

Costs incurred by a hospice in furnishing direct patient care services to patients receiving general inpatient care either directly from the hospice or under a contractual arrangement in an inpatient facility is to be included in the visiting service costs section.

For a hospice that maintains its own inpatient beds, these costs include (but are not limited to) the costs of furnishing 24 hours nursing care within the facility, patient meals, laundry and linen services, and housekeeping. Plant operation and maintenance cost would be recorded on line 3.

For a hospice that does not maintain its own inpatient beds, but furnishes inpatient general care through a contractual arrangement with another facility, record contracted/purchased costs on Worksheet A-3. Do not include any costs associated with providing direct patient care. These costs are recorded in the visiting services section.

Line 11 - Inpatient - Respite Care.--This cost center includes costs applicable to patients who receive this level of care on an intermittent, nonroutine and occasional basis. The costs included on this line are those direct costs of furnishing routine and ancillary services associated with inpatient respite care for which other provisions are not made on this worksheet. Costs incurred by the hospice in furnishing direct patient care services to patients receiving inpatient respite care either directly by the hospice or under a contractual arrangement in an inpatient facility are to be included in visiting service costs section.

For a hospice that maintains its own inpatient beds, these costs include (but are not limited to) the costs of furnishing 24 hours nursing care within the facility, patient meals, laundry and linen services and housekeeping. Plant operation and maintenance costs would be recorded on line 3.

For a hospice that does not maintain its own inpatient beds, but furnishes inpatient respite care through a contractual arrangement with another facility, record contracted/purchased costs on Worksheet A-3. Do not include any costs associated with providing direct patient care. These costs are recorded in the visiting service costs section**.**

Line 15 - Physician Services.--In addition to the palliation and management of terminal illness and related conditions, hospice physician services also include meeting the general medical needs of the patients to the extent that these needs are not met by the attending physician. The amount entered on this line includes costs incurred by the hospice or amounts billed through the hospice for physicians' direct patient care services.

Line 16 - Nursing Care .--Generally, nursing services are provided as specified in the plan of care by or under the supervision of a registered nurse at the patient's residence. *Enter the routine, general inpatient and respite portions of costs for nursing services provided by a registered nurse, licensed practical nurse or licensed vocational nurse as specified in the plan of care by or under the supervision of a registered nurse at the patient's residence.*

Line 16.01 - Nursing Care -- Continuous Home Care .--Enter the continuous home care portion of costs for nursing services provided by a registered nurse, licensed practical nurse or licensed vocational nurse as specified in the plan of care by or under the supervision of a registered nurse at the patient's residence.

Line 17 - Physical Therapy.--Physical therapy is the provision 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. Therapy and speech-language pathology 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 18 - Occupational Therapy.--Occupational therapy is the application of purposeful goal-oriented activity in the evaluation, diagnostic, for the persons whose function is impaired by physical illness or injury, emotional disorder, congenial or developmental disability, and to maintain health. Therapy and speech-language pathology 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 19 - Speech/Language Pathology .--These are physician-prescribed services provided by or under the direction of a qualified speech-language pathologist to those with functionally impaired communications skills. This includes the evaluation and management of any existing disorders of the communication process centering entirely, or in part, on the reception and production of speech and language related to organic and/or nonorganic factors. Therapy and speech-language pathology 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 20 - Medical Social Services.--This cost center includes only direct expenses incurred in providing Medical Social Services. Medical Social Services consist of counseling and assessment activities which contribute meaningfully to the treatment of a patient's condition. These services must be provided by a qualified social worker, under the direction of a physician.

Lines 21-23 - Counseling.--Counseling Services must be available to both the terminally ill individual and family members or other persons caring for the individual at home. Counseling, including dietary counseling, may be provided both for the purpose of training the individual's family or other care giver to provide care, and for the purpose of helping the individual and those caring for him or her to adjust to the individual's approaching death. This includes dietary, spiritual, and other counseling services provided while the individual is enrolled in the hospice. Costs associated with the provision of such counseling is accumulated in the appropriate counseling cost center. Costs associated with bereavement counseling are recorded on line 50.

Line 24 - Home Health Aide And Homemaker.--Enter *the routine, general inpatient and respite portions of costs for* home health aide and homemaker services. Home health aide services are provided under the general supervision of a registered professional nurse and may be provided by only individuals who have successfully completed a home health aide training and competency evaluation program or competency evaluation program as required in 42 CFR 484.36.

Home health aides may provide personal care services. Aides may also perform household services to maintain a safe and sanitary environment in areas of the home used by the patient, such as changing the bed or light cleaning and laundering essential to the comfort and cleanliness of the patient.

Homemaker services may include assistance in personal care, maintenance of a safe and healthy environment and services to enable the individual to carry out the plan of care.

Line 24.01- Home Health Aide And Homemaker – Continuous Home Care.--Enter the continuous care portion of cost for a home health aide and/or homemaker services provided as specified in the plan of care and under the supervision of a registered nurse.

Line 25 - Other.--Enter on this line any other visiting cost which can not be appropriately identified in the services already listed.

Line 30 - Drugs, Biological and Infusion Therapy.--Only drugs as defined in §1861(t) of the Act and which are used primarily for the relief of pain and symptom control related to the individual's terminal illness are covered. The amount entered on this line includes costs incurred for drugs or biologicals provided to the patients while at home. *Do not include costs for Analgesics or for Sedatives/Hypnotics; rather include those costs on the designated lines.* If a pharmacist dispenses prescriptions and provides other services to patients while the patient is both at home and in an inpatient unit, a reasonable allocation of the pharmacist cost must be made and reported respectively on line 30 (drugs and Biologicals) and line 10 (Inpatient General Care) or line 11 (Inpatient Respite Care) of Worksheet A.

A hospice may, for example, use the number of prescriptions provided in each setting to make that allocation, or may use any other method that results in a reasonable allocation of the pharmacist's cost in relation to the service rendered.

Infusion therapy may be used for palliative purposes if you determine that these services are needed for palliation. For the purposes of a hospice, infusion therapy is considered to be the therapeutic introduction of a fluid other than blood, such as saline solution, into a vein.

Line 30.01 - Analgesics.--Enter the cost of analgesics.

Line 30.02 - Sedatives/Hypnotics.--Enter the cost of sedatives/hypnotics.

Line 30.03 - Other -- Specify.-- Specify the type and enter the cost of any other drugs which cannot be appropriately identified in the drugs already listed.

Line 31 - Durable Medical Equipment/Oxygen.--Durable medical equipment as defined in 42 CFR 410.38 as well as other self-help and personal comfort items related to the palliation or management of the patient's terminal illness are covered . Equipment is provided by the hospice for use in the patient's home while he or she is under hospice care.

Line 32 - Patient Transportation.--Enter all of the cost of transportation except those costs previously directly assigned in column 3. This cost is allocated during the cost finding process.

Line 33 - Imaging Services.--Enter the cost of imaging services including MRI.

Line 34 - Labs and Diagnostics.--Enter the cost of laboratory and diagnostic tests.

Line 35 - Medical Supplies.--The cost of medical supplies reported in this cost center are those costs which are directly identifiable supplies furnished to individual patients. These supplies are generally specified in the patient's plan of treatment and furnished under the specific direction of the patient's physician.

Line 36 - Outpatient Services.--Use this line for any outpatient services costs not captured elsewhere. This cost can include the cost of an emergency room department.

Lines 37-38 - Radiation Therapy and Chemotherapy.--Radiation, chemotherapy and other modalities may be used for palliative purposes if you determine that these services are needed for palliation. This determination is based on the patient's condition and your care giving philosophy.

Line 39 - Other (Specify).--Enter any additional costs involved in providing visiting services which has not been provided for in the previous lines.

Lines 50-53 - Non Reimbursable Costs.--Enter in the appropriate lines the applicable costs. Bereavement program costs consist of counseling services provided to the individual's family after the individual's death. In accordance with §1814 (I)(1) (A) of the Social security Act bereavement counseling is a required hospice service, but it is not reimbursable.

3811. WORKSHEET A-1 - COMPENSATION ANALYSIS - SALARIES AND WAGES

Enter all salaries and wages for the hospice on this worksheet for the actual work performed within the specific area or cost center in accordance with the column headings. For example, if the administrator also performs visiting services which account for 25 percent of that person's time, then enter 75 percent of the administrator's salary on line 6 (A&G) and 25 percent of the administrator's salary enter on line 16 (nursing care).

The records necessary to determine the split in salary between two or more cost centers must be maintained by the hospice and must adequately substantiate the method used to split the salary. These records must be available for audit by the intermediary and the intermediary can accept or reject the method used to determine the split in salary. When approval of a method has been requested in writing and this approval has been received prior to the beginning of a cost reporting period, the approved method remains in effect for the requested period and all subsequent periods until you request in writing to change to another method or until the intermediary determines that the method is no longer valid due to changes in your operations.

Definitions

Salary.--This is gross salary paid to the employee before taxes and other items are withheld, includes deferred compensation, overtime, incentive pay, and bonuses. (See CMS Pub. 15-I, Chapter 21.)

Administrator (Column 1).--

Possible Titles: President, Chief Executive Officer

Duties: This position is the highest occupational level in the agency. This individual is the chief management official in the agency. The administrator develops and guides the organization by taking responsibility for planning, organizing, implementing, and evaluating. The administrator is responsible for the application and implementation of established policies. The administrator may act as a liaison among the governing body, the medical staff, and any departments. The administrator provides for personnel policies and practices that adequately support sound patient care and maintains accurate and complete personnel records. The administrator implements the control and effective utilization of the physical and financial resources of the provider.

Director (Column 2).--

Possible Titles: Medical Director, Director of Nursing, or Executive Director

Duties: The medical director is responsible for helping to establish and assure that the quality of medical care is appraised and maintained. This individual advises the chief executive officer on medical and administrative problems and investigates and studies new developments in medical practices and techniques.

If both sets are not maintained and the request is denied, the provider reverts back to the previously approved methodology. The provider must include with the request all supporting documentation and a thorough explanation of why the alternative approach should be used. (See CMS Pub. 15-I, §2313.)

If the amount of any cost center on Worksheet A, column 10, has a credit balance, show this amount as a credit balance on Worksheet B, column 0. Allocate the costs from the applicable overhead cost centers in the normal manner to the cost center showing a credit balance. After receiving costs from the applicable overhead cost centers, if a general service cost center has a credit balance at the point it is allocated, do not allocate the general service cost center. Rather, enter the credit balance on the first line of the column and on line 100. This enables column 6, line 100, to cross foot to columns 0 and 5A, line 100. After receiving costs from the applicable overhead cost centers, if a revenue producing cost center has a credit balance on Worksheet B, column 6, do not carry forward a credit balance to any worksheet.

On Worksheet B-1, enter on the first line in the column of the cost center the total statistics applicable to the cost center being allocated (e.g., in column 1, capital-related cost - buildings and fixtures, enter on line 1 the total square feet of the building on which depreciation was taken). Use accumulated cost for allocating administrative and general expenses.

Such statistical base does not include any statistics related to services furnished under arrangements except where both Medicare and non-Medicare costs of arranged-for services are recorded in your records.

For all cost centers (below the cost center being allocated) to which the service rendered is being allocated, enter that portion of the total statistical base applicable to each.

The total sum of the statistical base applied to each cost center receiving the services rendered must equal the total statistics entered on the first line.

Enter on Worksheet B-1, line 100, the total expenses of the cost center to be allocated. Obtain this amount from Worksheet B from the same column and line number of the same column. In the case of capital-related costs - buildings and fixtures, this amount is on Worksheet B, column 1, line 1.

Divide the amount entered on line 100 by the total statistical base entered in the same column on the first line. Enter the resulting unit cost multiplier on line 101. Round the unit cost multiplier to at least the nearest six decimal places.

Multiply the unit cost multiplier by that portion of the total statistical base applicable to each cost center receiving the services rendered. Enter the result of each computation on Worksheet B in the corresponding column and line.

After the unit cost multiplier has been applied to all the cost centers receiving costs, the total expenses (line 100) of all of the cost centers receiving the allocation on Worksheet B must equal the amount entered on the first line of the cost center being allocated.

The preceding procedures must be performed for each general service cost center. Each cost center must be completed on both Worksheets B and B-1 before proceeding to the next cost center.

After all the costs of the general service cost centers have been allocated on Worksheet B, enter in column 7 the sum of the expenses on lines 10 through 99. The total expenses entered in column 7, line 100, must equal the total expenses entered in column 0, line 100.

Column Descriptions

Column 1--Depreciation on buildings and fixtures and expenses pertaining to buildings and fixtures such as insurance, interest, rent, and real estate taxes are combined in this cost center to facilitate cost allocation.

Allocate all expenses to the cost centers on the basis of square feet of area occupied. The square footage may be weighted if the person who occupies a certain area of space spends their time in more than one function. For example, if a person spends 10 percent of time in one function, 20 percent in another function, and 70 percent in still another function, the square footage may be weighted according to the percentages of 10 percent, 20 percent, and 70 percent to the applicable functions.

Column 2--Allocate all expenses (e.g., interest, personal property tax) for movable equipment to the appropriate cost centers on the basis of square feet of area occupied or dollar value.

Column 4--The cost of vehicles owned or rented by the agency and all other transportation costs which were not directly assigned to another cost center on Worksheet A, column 3, is included in this cost center. Allocate this expense to the cost centers to which it applies on the basis of miles applicable to each cost center.

This basis of allocation is not mandatory and a provider may use weighted trips rather than actual miles as a basis of allocation for transportation costs which are not directly assigned. However, a hospice must request the use of the alternative method in accordance with CMS Pub. 15-I, §2313. The hospice must maintain adequate records to substantiate the use of this allocation.

Column 6--The A&G expenses are allocated on the basis of accumulated costs after reclassifications and adjustments.

Therefore, obtain the amounts to be entered on Worksheet B-1, column 6, from Worksheet B, columns 0 through 5.

A negative cost center balance in the statistics for allocating A&G expenses causes an improper distribution of this overhead cost center. Negative balances are excluded from the allocation statistics when A&G expenses are allocated on the basis of accumulated cost.

A&G costs applicable to contracted services may be excluded from the total cost (Worksheet B, column 0) for purposes of determining the basis of allocation (Worksheet B-1, column 5) of the A&G costs. This procedure may be followed when the hospice contracts for services to be performed for the hospice and the contract identifies the A&G costs applicable to the purchased services.

The contracted A&G costs must be added back to the applicable cost center after allocation of the hospice A&G cost before the reimbursable costs are transferred to Worksheet D. A separate worksheet must be included to display the breakout of the contracted A&G Costs from the applicable cost centers before allocation and the adding back of these costs after allocation. Intermediary approval does not have to be secured in order to use the above-described method of cost finding for A&G.

Worksheet B-1, Column 6A--Enter the costs attributable to the difference between the total accumulated cost reported on Worksheet B, column 5A, line 100 and the accumulated cost reported on Worksheet B-1, column 6, line 6. Enter any amounts reported on Worksheet B, column 5A for (1) any service provided under arrangements to program patients that is not grossed up and (2) negative balances. *Enter a negative one (-1) in the accumulated cost column to identify the cost center that should be excluded from receiving any A&G costs. If some of the costs from that cost center are to receive A&G costs, then enter in the reconciliation column the amount not to receive A&G costs to assure that only those costs to receive overhead receive the proper allocation.* Including *a statistical cost which does not relate to the allocation of* administrative and general expenses causes an improper distribution of overhead. 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.

3850. WORKSHEET G - BALANCE SHEET

3850.1 Worksheet G-1 - Statement of Changes in Fund Balances.

3850.2 Worksheet G-2 - Statement of Patient Revenues and Net Income.

Part I.--General Inpatient and Home Care Service Locations—Lines 1 through 4 reflects patients revenues from the various locations where a patient may reside. Attach schedule to reflect the following: hospice inpatient revenue and any other revenues received from other sources such as donations or contributions.

Part II.--Operating Expenses.—Reflects the operating expenses for the cost reporting period.

Prepare these worksheets from your accounting books and records. Additional Worksheets may be submitted, if necessary.

All providers maintaining fund-type accounting records complete worksheets G and G-1. Nonproprietary providers who do not maintain fund-type accounting records complete general fund columns