The ABC's of Medicare Cost Reports

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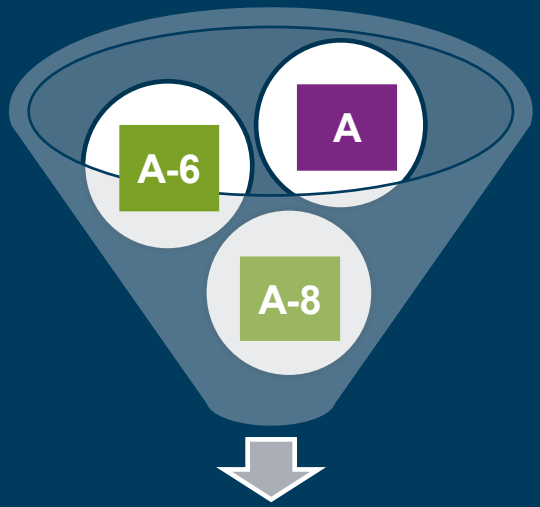
Agenda

1. Worksheet A Series: Allowable Costs
2. Worksheet B Series: Allocation of Overhead Costs
3. Worksheet C Series: Ratio of Costs to Charges
4. Worksheet D Series: Calculation of Medicare's share of allowable costs



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Worksheet A Series: Medicare Allowable Costs

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Worksheet A Series: Expenses

A

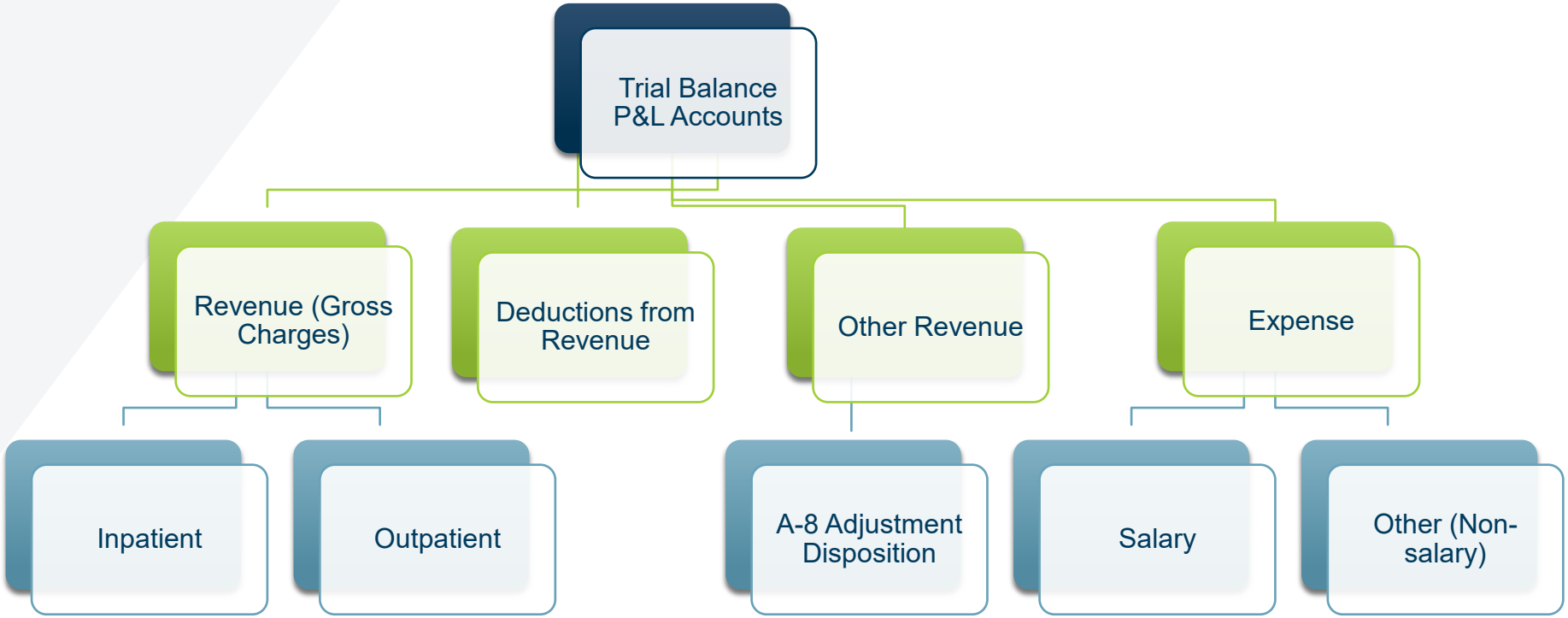
Worksheet	Description
A	Trial Balance
A-6	Reclassifications
A-7	Capital Assets & Capital-Related Costs
A-8	Adjustments
A-8-1	Related Organizations
A-8-2	Hospital Based Physicians
A-8-3	Contracted Therapy Services-CAHs

- Assign direct expenses to Medicare cost centers
- Reclassify costs for appropriate matching with charges or assign cost to overhead or non-reimbursable cost centers
- Adjust costs to remove amounts not deemed allowable by Medicare
- Calculates Net Expenses for Allocation

Worksheet A Series: Mapping the Trial Balance

A

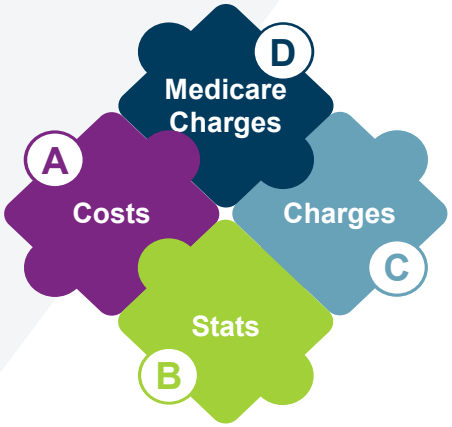
Create a mapping file to assign Trial Balance accounts to cost report worksheets, lines, and columns



Worksheet A Series: Mapping the Trial Balance, continued

A

Important to maintain consistent cost center mapping throughout the cost report!



- Establish or update a crosswalk of hospital departments to Medicare cost centers (“lines”)
  - General Service (Capital, Benefits, Admin, Plant Ops, Housekeeping, Dietary, Nursing Admin, Central Services, HIM, Social Services, etc.)
  - Inpatient Routine Costs (Med/Surg, OB, ICU, Nursery, IPF, IRF)
  - Ancillary Services (OR, Radiology, Lab, Therapy, Supplies, Drugs, etc.)
  - Outpatient Services (Clinics, ED)
  - Special Purpose (Interest)
  - Non-Reimbursable Cost Centers (Private Phys Practice, gift shop, etc.)
- Select the Medicare cost center that:
  - Best aligns the department’s costs and charges with Medicare charges by revenue code (revenue codes are the lowest common denominator)
  - Results in the most appropriate allocation of general services cost (overhead) and facilitates the application of Medicare’s principles of reimbursement

Worksheet A: Expenses from Trial Balance

A

Complete using the Mapped Trial Balance file

- Reconcile Worksheet A Total Expenses to Audit Financial Statements (filing requirement)
- Assign all expense accounts to Worksheet A lines and columns
  - Column 1 = Salaries, Column 2 = Other (all non-salary, including contracted labor)
- Review expenses by Medicare cost center line
  - Are mappings consistent with the prior year or most recent Medicare audit or review? If changes are necessary, be sure to follow the mapping change all the way through the cost report (reclassifications, adjustments, stats, charges)
  - Are overhead costs assigned to non-overhead cost centers? If so, either correct in mapping of expense accounts or reclassify in Worksheet A-6
  - Are all expenses related to patient chargeable supplies, implants, and drugs assigned to Lines 71, 72, or 73? Are supply costs NOT charged to patients assigned to the appropriate department's cost center?
  - Did you invest in new construction or renovation that warrants subscripting of capital cost center(s)?
  - Carefully review department charges by UB revenue code to determine if costs and charges align within your GL account structure

Worksheet A-6: Reclassification of Expenses

A-6

Match Costs with Charges

- Birthing Center allocated between OB, Nursery, L&D
- Imaging Costs allocated between Radiology, MRI, CT Scan
- Clinic Ancillary Service cost to Ancillary cost center (i.e.. Radiology, Lab)
- Chargeable Supplies and Drugs
- If centralized COVID-19 costs during PHE, reclassify to appropriate cost centers

Assign Cost to Overhead

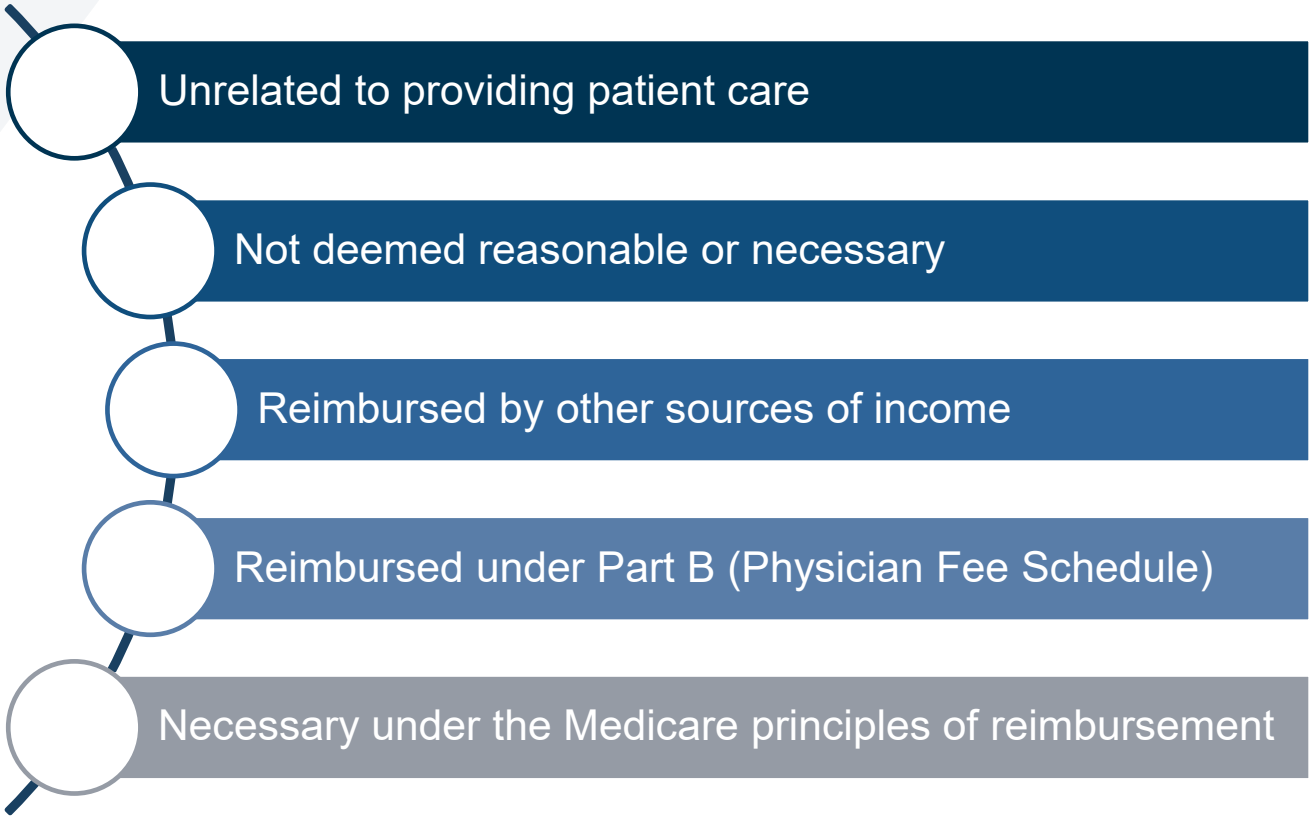
- Depreciation to appropriate capital cost centers
- Property insurance to capital cost
- Interest expense allocated to capital and administrative cost centers
- Physician cost for administrative roles (CMO, Director stipends)
- Provider benefits and malpractice insurance (Tip: use actual benefits rather than a hospital-wide benefit %)
- Cafeteria costs from Dietary to Cafeteria (or may be done via B-1 statistic)

Assign Cost to Non-Reimbursable Cost Centers

- Non-allowable marketing & development
- Employee benefit portion of Wellness, Childcare

Worksheet A-8: Adjustments

Adjustments are necessary to remove costs from the cost report for the following reasons



Worksheet A-8: Adjustments, continued

- Adjustments are entered on the basis of cost (code A) or amount received (code B).
- Capital costs adjustments are assigned a Worksheet A-7 Reference (9-14) that indicates the type of capital cost
- Generally entered as negative amount, but some adjustments may increase cost. They should be well documented
- Non-reimbursable cost centers on Lines 19x.xx are not typically adjusted

Worksheet A-8: Adjustments – Investment Income

A-8

Interest expense must be reduced by certain investment income

- Limit the interest income adjustment to no more than total allowable interest expense
- Allocate the adjustment ratably to allowable interest by cost center (Admin and Capital cost centers)
- Investment income from the following sources does not require offset:
  - Grants, gifts, and endowments, whether restricted or unrestricted
  - Funded depreciation account
  - Qualified pension or deferred compensation funds
  - Non-allowable borrowing (separately adjusted)
  - Other exclusion

Worksheet A-8: Adjustments – Other Revenue

A-8

Other operating or non-operating income required to offset cost

- Carefully review all other operating and non-operating income accounts to determine if they should offset cost. Document reasons for not offsetting
  - Do not offset income related to grants, non-reimbursable cost center, contribution revenue
  - Be careful not to have income adjustments that are greater than the costs you are offsetting
- Common revenue required to offset cost:
  - Trade discounts, refunds, rebates
  - Cafeteria meals revenue
  - Vending machine income
  - Rental revenue
  - Medical records sales
  - Sale of supplies or drugs to non-patients
  - Other miscellaneous revenue

Worksheet A-8: Unallowable Costs & Other Adjustments

A-8

Costs unrelated to patient care or deemed not allowable for reimbursement

Not an all-inclusive list. See the Provider Reimbursement Manual for more

- Patient convenience or luxury items
- Lobbying costs included in Hospital Association dues, legal fees
- Penalties, fines, and/or interest on Medicare overpayments
- Cost of unnecessary borrowing - deemed to be in excess of financial need or unrelated to patient care
- Unallowable advertising intended to increase business and attract new patients
- Defined benefit pension expenses must be adjusted to actual contributions, subject to limitation
- 340(b) retail drug program costs
- CAH HIT depreciation adjustment for amounts previously reimbursed via incentive payment

Worksheet A-8: Adjustments – Professional Costs

A-8

Professional costs are not reimbursed on a cost-basis; they are reimbursed under Medicare Part B

- Part B billing costs – paid on Fee Schedule
  - Don't forget to include benefit cost of employed billing staff
  - If hospital and physician practice billing are all done by the same staff, allocate based on gross charges
- Non-Physician Providers (NPPs) – CRNAs, PAs, NPs, etc.
  - Salaries, non-statutory benefits, malpractice, CME, dues, contracted NPPs
  - Benefits adjusted should not include "statutory benefits" such as FICA, workers' comp, unemployment
  - NPPs adjusted in Wkst A-8, Physicians adjusted in Wkst A-8-2

Worksheet A-8-2: Provider Based Physicians Adjustment

A-8

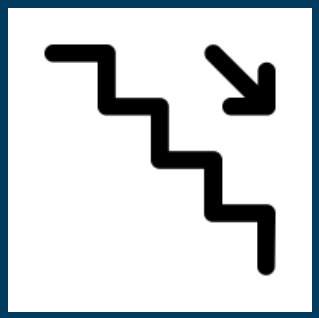
- Reports allowable provider-based physician (PBP) costs and adjusts Part B physician costs on Worksheet A-8
  - Excludes Professional component – services provided directly to patients (reimbursed under Part B, Physician Fee Schedule)
  - Allows Provider component (Part A) – administrative support services such as directorships, supervision, availability/on-call, quality management, committee assignments, etc.
  - Subject to limitation based on reasonable compensation equivalents (RCE) established for various specialties (CAH's exempt)
- Total Remuneration includes salaries, certain benefits, CME, dues, licensure, malpractice, contracted physicians
  - Benefits – do not include statutory benefits (FICA, unemployment, workers' comp)
  - Obtain actual benefit costs for each physician rather than using hospital wide percentage
- Hours must be reported for employed and contracted physician time to compute the RCE adjustment

Worksheet A-8-2: Provider Based Physicians Adjustment

- All PBP cost/time is considered Professional Part B time unless adequately documented as Provider Part A time
- Time study requirements:
  - One full work week per month of the year, using alternating weeks, not consecutive weeks (example: Week 1 in Month 1, Week 3 in Month 2, Week 2 in Month 3, etc.)
  - Alternative option for quarterly time studies
  - Must be signed by the physician or physician's chief
  - Complete Exhibit 1: Allocation of PBP Time for each physician or group of physicians in the same specialty
  - Ensure that Exhibit 1 agrees to the % of Part A time used to derive Provider component remuneration and hours on Wrkst A-8-2
- CAH's Emergency Department physician availability time
  - Time that ED physicians are not providing patient care services, but are on-call or available for patient care
  - Time study, ED log, Real-time location system (RTLS) to track availability

Worksheets A-8-1 and A-8-3

- A-8-1 Related party costs are includable as allowable costs at the cost to the related party
  - Home Office Cost Statement - allocation by cost center
  - Other related party costs – adjusted to actual allowable cost
    - Common examples: Intercompany Rent, Shared Services
- A-8-3 Limitation on Therapy Services provided by an outside supplier to CAHs
  - PT, OT, Speech Therapy, and Respiratory Therapy
  - Accumulate invoice level details for cost, hours worked, travel time, mileage, # of days onsite, etc.
  - Uses Average Hourly Salary Equivalency Amount (AHSEA)
    - CMS Pub. 15-1, Chapter 14, §1412.5, Exhibit C-1 per State
    - Monthly inflation factor from Exhibit C-3 (as of beginning of period)
  - Additional allowance for travel, overtime, supplies, and equipment



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Worksheet B Series: Allocation of General Service Costs (Overhead)

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Worksheet B Series: Allocation of General Service Costs

Column	Descriptions
Worksheet B Part 1	Cost Allocation General Service Costs
Worksheet B Part II	Allocation of Capital-Related Costs
Worksheet B-1	Cost Allocation-Statistical Bases
Worksheet B-2	Post Step-down Adjustments

Worksheet B Series: Allocation of General Service Costs

B

Referred to as the "step-down", General Services costs are allocated to Routine, Ancillary, Outpatient, and Non-Reimbursable Cost Centers using a statistical allocation.

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: [redacted] Period From: 1/1/2020 To: 12/31/2020 Worksheet B, Part I

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS					ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT-MOB	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Res	Total
				NEW BLDG & FIXT	MOB	NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal														
			0	1	1.01	2	4	4A	5	7	7.01	8	9	10	11	13	15	16	17	24	25	26
		GENERAL SERVICE COST CENTERS																				
1	100	NEW CAP REL COSTS-BLDG & FIXT	240,729	240,729																		
1	101	CAP REL COSTS-MOB	33,006	0	33,006																	
2	200	NEW CAP REL COSTS-MVBLE EQUIP	159,323			159,323																
4	400	EMPLOYEE BENEFITS DEPARTMENT	1,341,078	1,551	0	0	1,342,629															
5	500	ADMINISTRATIVE & GENERAL	2,615,591	13,814	0	26,013	244,078	2,899,496	2,899,496													
7	700	OPERATION OF PLANT	791,431	22,561	0	2,179	46,939	863,110	201,808	1,064,918												
7	701	OPERATION OF PLANT-MOB	6,284	0	0	0	0	6,284	1,469	0	7,753											
8	800	LAUNDRY & LINEN SERVICE	38,609	2,267	0	0	5,060	45,936	10,741	11,902	0	68,579										
9	900	HOUSEKEEPING	184,369	1,781	0	265	30,407	216,822	50,696	9,351	0	19,758	296,627									
10	1000	DIETARY	179,889	9,980	0	1,364	30,405	221,638	51,822	52,407	0	1,294	14,714	341,875								
11	1100	CAFETERIA	0	0	0	0	0	0	0	0	0	0	0	0	0							
13	1300	NURSING ADMINISTRATION	17,414	0	0	0	3,392	20,806	4,865	0	0	0	0	0	0	25,671						
15	1500	PHARMACY	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0					
16	1600	MEDICAL RECORDS & LIBRARY	210,860	4,403	0	0	32,704	247,967	57,978	23,118	0	0	5,189	0	0	0	0	334,252				
17	1700	SOCIAL SERVICE	131,984	820	0	0	20,212	153,016	35,777	4,306	0	0	1,207	0	0	0	0	0	194,306			
		INPATIENT ROUTINE SERVICE COST CENTERS																				
30	3000	ADULTS & PEDIATRICS	1,453,418	50,999	0	18,905	243,774	1,767,096	413,174	267,793	0	21,253	74,862	341,875	0	13,810	0	20,659	175,712	3,096,234	0	3,096,234
		ANCILLARY SERVICE COST CENTERS																				
50	5000	OPERATING ROOM	479,461	45,494	0	65,461	67,973	658,389	153,941	238,888	0	5,988	66,967	0	0	3,791	0	34,227	0	1,162,191	0	1,162,191
53	5300	ANESTHESIOLOGY	369,821	0	0	0	0	369,821	86,470	0	0	0	0	0	0	0	0	0	0	456,291	0	456,291
54	5400	RADIOLOGY-DIAGNOSTIC	806,520	12,095	0	15,247	51,468	885,330	207,003	63,513	0	2,936	17,805	0	0	0	0	25,593	0	1,202,180	0	1,202,180
57	5700	CT SCAN	158,227	2,444	0	0	30,623	191,294	44,727	12,834	0	62	3,598	0	0	0	0	0	0	252,515	0	252,515
58	5800	MAGNETIC RESONANCE IMAGING (MRI)	204,597	0	0	0	0	204,597	47,838	0	0	788	0	0	0	0	0	0	0	253,223	0	253,223
60	6000	LABORATORY	1,140,067	8,293	0	6,257	101,286	1,255,903	293,649	43,549	0	0	11,993	0	0	0	0	38,544	0	1,643,638	0	1,643,638
63	6300	BLOOD STORING, PROCESSING, & TRANS.	31,807	0	0	0	0	31,807	7,437	0	0	0	0	0	0	0	0	0	0	39,244	0	39,244
65	6500	RESPIRATORY THERAPY	38,116	3,139	0	2,042	4,493	47,790	11,174	16,482	0	0	3,421	0	0	0	0	7,092	0	85,959	0	85,959
66	6600	PHYSICAL THERAPY	655,220	35,153	0	5,202	132,442	828,017	193,603	184,589	0	4,145	0	0	0	0	0	0	0	1,210,354	0	1,210,354
71	7100	MEDICAL SUPPLIES CHARGED TO PATIENTS	352,275	7,479	0	0	26,161	385,915	90,233	39,271	0	0	10,939	0	0	0	0	0	0	526,358	0	526,358
72	7200	IMPL. DEV. CHARGED TO PATIENT	26,132	0	0	0	0	26,132	6,110	0	0	0	0	0	0	0	0	0	0	32,242	0	32,242
73	7300	DRUGS CHARGED TO PATIENTS	765,319	4,773	0	475	8,731	779,298	182,212	25,065	0	0	7,026	0	0	0	0	0	0	993,601	0	993,601
		OUTPATIENT SERVICE COST CENTERS																				
88	8800	RURAL HEALTH CLINIC	525,141	0	11,996	1,482	87,733	626,352	146,450	0	2,818	0	21,279	0	0	0	0	0	0	796,899	0	796,899

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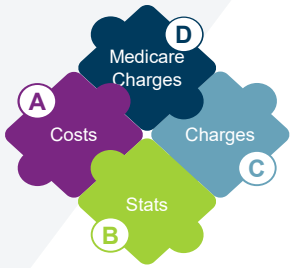
Worksheet B-1: Cost Allocation Statistics

B

Purpose: Statistical basis used for allocating General Service costs to various cost centers



- Standard Order and Medicare-approved Statistics
  - Approval for changes may be requested through the MAC at least 90 days prior the close of your fiscal year
  - Must demonstrate that change is more accurate, easier to maintain
- Must be current, accurate, and capable of being audited
  - Remember to maintain consistent cost center mapping for departmental statistics, including reclassifications and adjustments from Wrkst A Series
  - Review and update statistics every year. Collect stats monthly or quarterly to ensure they are being properly documented.
  - Include department heads on your stat collection team and provide them with the tools and formats you require
- Consider direct costing vs. cost allocations of expense
  - Understand your cost structure and purpose of statistical allocations
  - Example: If you allocate IT by number of computers, do not also directly cost IT equipment to individual departments

Worksheet B-1: Cost Allocation Statistics, continued

- Square Feet – Building & fixed equipment, Maintenance, Plant Operations, and Housekeeping*
  - Plant Operations should maintain a log of square footage changes including effective date of room movement, room closure/vacancy, additions from renovation or new construction, etc.
  - Be sure to weigh changes in square footage for mid-year space changes, and don't forget to adjust the weighted square footage of prior year changes
  - Exclude any non-owned square footage
  - Consider fragmentation to separately allocate the cost of new building additions or renovations, or physician practice sites
  - Square footage statistics used to allocate maintenance, plant operations, and housekeeping* can be different than square footage for depreciation
    - Include rented areas if they are maintained by hospital facilities staff
  - Review square footage – question the accuracy of cost centers that have FTEs or equipment, but no square feet

* Housekeeping – MAC may require time study unless square feet has been approved.

Worksheet B-1: Cost Allocation Statistics, continued

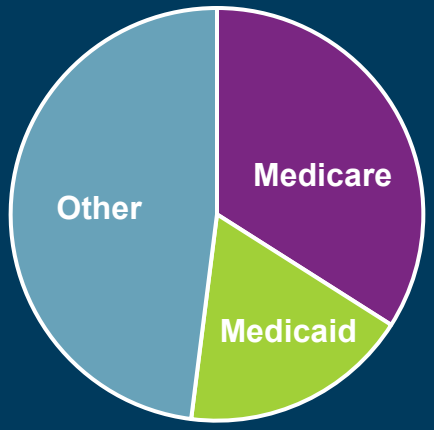
- Major Movable equipment – Dollar value of Depreciation
  - Obtain a fixed asset detail by department that reconciles to the trial balance
  - Map departments to Medicare cost centers consistent with mapping of Worksheet A and adjust for A-6 reclassifications and A-8 adjustments
- Employee Benefits – Gross Salaries
  - Begin with Salaries in Worksheet A, Column 1, and adjust for A-6 reclassifications and A-8 adjustments
  - Exclude all physician and non-physician provider salaries – their benefits should have already been reclassified to cost centers in Worksheet A-6
- Admin & general – accumulated cost
  - Analyze the financial impact of fragmented A&G cost centers – can result in more accurate costing and less cost allocation to non-reimbursable cost centers
    - Common examples: PFS allocated on gross charges, Patient Access allocated on outpatient admissions, IT costs allocated by number of computers serviced

Worksheet B-1: Cost Allocation Statistics, continued

- Laundry – pounds of laundry
  - If outsourcing laundry, make sure your invoices include pounds and not pieces. Alternatively, estimate pounds from pieces or request a change a statistical allocation method
- Dietary – Meals served
  - Review patient meals – are they more than 3 meals a day?
- Cafeteria – FTEs
  - Adjust FTE counts for A-6 reclassifications
  - Be sure to exclude FTEs for staff that are not located on campus or those who for other reasons do not utilize the cafeteria
- Nursing Admin – Nursing Hours or FTEs
  - Only include staff being managed by Nursing Administration. If you have a nursing home or physician practices managed by a separate admin team, they should be excluded
  - Incorporate any A-6 reclassifications

Worksheet B-1: Cost Allocation Statistics, continued

- Central Supply – Costed Requisitions
  - Use internal records for cost of supplies requisitioned from material management by ordering department
  - If using trial balance supplies expense, exclude departments that do their own ordering (i.e.. lab, pharmacy, etc.)
- Pharmacy – Costed Requisitions or %
  - Most commonly all allocated to Line 73 where all chargeable drugs are reported
- Medical Records – Time Study or Gross Revenue
  - Report observation on Line 30 instead of Line 92
  - If using Gross Revenue, exclude any cost centers that HIM does not provide services to (i.e.. does clinic have their own coding staff?)
- Social Service – Time Study or Patient Days



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Worksheet C Series: Ratio of Costs to Charges

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Worksheet C Series: Ratio of Costs to Charges

C

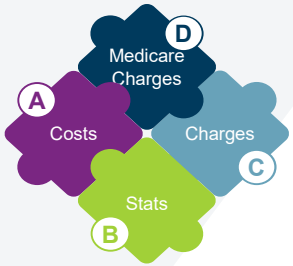
Computation of Ratio of Costs to Charges (RCC) for inpatient and outpatient ancillary services

Column	Description
Column 1	Hospital costs by revenue producing cost center flow from Worksheet B Part I Column 27 lines 30 through 91. Cost center line numbers correspond to those on Worksheet B. Observation bed costs on line 92 flow from Worksheet D-1 line 89
Column 2	Flow of therapy adjustments from Worksheet A-8
Column 4	Flow of RCE disallowances from Worksheet A-8-2, column 17 (PPS hospitals)
Column 5	Total costs by cost center (PPS hospitals and sub providers)
Column 6	Total Inpatient Gross Charges
Column 7	Total Outpatient Gross Charges
Column 8	Total Inpatient and Outpatient Gross Charges
Column 9-11	Cost/PPS RCCs are calculated

Worksheet C, Part 1: Ancillary Ratio of Costs to Charges

C

Input inpatient and outpatient charges, excluding professional fees



- Start with your Mapped Trial Balance
  - Revenue departments should be mapped consistently with Wrkst A expenses and align with reporting of Medicare charges
  - Assign gross revenue accounts to Worksheet C columns
    - Column 6 = inpatient charges Column 7 = outpatient charges
- Obtain a detailed revenue and usage report that breaks down charges by:
  - Patient status (i.e.. inpatient, outpatient, physician clinic, etc.)
  - UB revenue code – categorizes type of service billed and helps identify professional fees that need to be excluded
  - Department where charges were posted in the Trial Balance
    - Reconcile to the Trial Balance

Worksheet C, Part 1: Ratio of Costs to Charges, continued

C

- Establish or update a crosswalk of UB revenue codes to Medicare cost centers
  - Also used with Medicare charges from PS&R to maintain consistent mapping
  - Medicare has a standard revenue code crosswalk – better to tailor it to hospital. Submit the revenue code crosswalk with the cost report at the time of filing
  - Person responsible for assigning UB Revenue Codes in the Chargemaster should be in tune with the cost center structure in the Cost Report
    - Common challenges for CDM manager: Minor Procedure, Treatment Room, Clinics, Other Diagnostic Service, Other Therapeutic Services
- Review cost center assignment for UB revenue code vs Department
  - Identify reclassifications necessary to align Costs with Charges and Medicare Charges. Common reclassifications:
    - Chargeable Supplies and Implants, Drugs Sold
    - Observation charges to Line 92
    - Laboratory charges, EKG technical charges
    - Ancillary charges within clinics (Radiology, Lab)

Worksheet C, Part 1: Ratio of Costs to Charges, continued

C

- Remove all professional fees reimbursed under Part B Fee Schedule
  - Physicians and non-physician providers (CRNA, NP, PA, etc.)
  - UB Revenue codes 960-989 are professional fees
  - If all professional fees are not eliminated, reimbursement will be impaired
- Provider-based Clinics (Revenue Code 510)
  - CAH optional "Method II" Billing – billing clinic charges on UB-04 claim form instead of 1500. Allows split billing of:
    - Facility/Technical services reimbursed at 101% of allowable cost (RC 510)
    - Professional services paid at 115% of the Physician Fee Schedule (RC 960-989)
  - Split billing is often only done for Medicare claims, but total facility portion of charges for *all payors* should be reported for accurate RCC
    - Study Medicare Charges - Compute % of Medicare 510 Charges compared to Total Medicare Clinic Charges with Revenue codes 510 or 960-989
    - If split-billing is occurring in your billing system, but not in your revenue report, use the assumptions built into the billing tables / Chargemaster

Worksheet C, Part 1: Ratio of Costs to Charges, continued

C

Review calculated Ratios of Cost to Charge, including comparison to prior year

RCC Greater than 1.0

- Means costs are greater than charges
- Review costs in Wkst A Series
  - Consistent mapping of department with Medicare cost center?
  - Missing adjustment for professional cost?
- Review overhead allocations in Wkst B, Part I
  - Does overhead assigned to that cost center make sense?
- Is it a low-volume and/or high-cost cost service?

RCC Close to 0

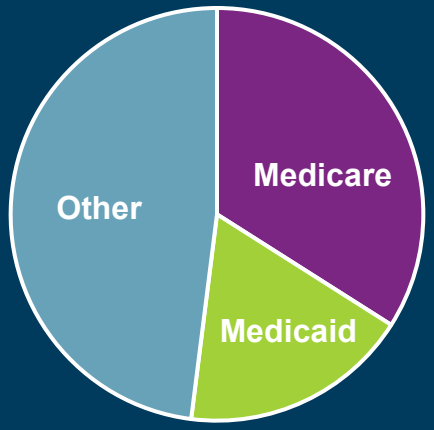
- Means charges greatly exceed cost
- Review cost structure of the service
  - Ensure that all necessary reclassifications are made to properly match costs with charges
- Review charges by revenue code
  - Missing a reclassification of charges?
  - Missing an adjustment to remove professional fees from Wrkst C?
- Is it a high-volume and/or low-cost cost service?

Worksheet C, Part 1: Ratio of Costs to Charges, continued

C

Review calculated Ratios of Cost to Charge, including comparison to prior year

- Be able to explain significant changes from year to year
  - Increased/decreased volume
    - new service, winding down a service
    - provider turnover impacting referrals/orders
  - Increased/decreased cost
    - Staff recruitment, turnover, travelers
    - Investment in technology and equipment
    - Cost containment efforts
    - Home office cost allocation changes
  - If you can't explain a significant trend, go back and review alignment of costs, stats, charges, and Medicare charges



5

Worksheet D Series: Calculation of Medicare's share of allowable costs

hfma™

northern new england chapter

Worksheet D Series: Medicare Charges, Cost Apportionment

D

Calculates Medicare's cost for service provided to Medicare beneficiaries

Worksheet	Description
Worksheet D Parts I-IV	Apportionment of Inpatient Routine and Ancillary Service Capital Costs and Other Pass Through Costs (PPS hospitals and PPS components)
Worksheet D Part V	Apportionment of Medical and Other Health Service Costs and Vaccine Cost Apportionment
Worksheet D-1	Computation of Inpatient Operating Costs
Worksheet D-2	Apportionment of Costs of Services rendered by I&Rs
Worksheet D-3	Inpatient Ancillary Cost Apportionment
Worksheet D-4	Computation of Organ Acquisition Costs and Charges
Worksheet D-5	Apportionment of cost for Services of Teaching Physicians/RCE Computation for PPS Hospitals

Medicare's share of allowable costs, simplified

D

Gross charges and patient days are used as a proxy to apportion allowable cost to Medicare

Inpatient Routine Cost per Day x Medicare Days

Routine cost per day is calculated in Worksheet D-1, using days reported in S-3, Part I:

$$\frac{[\text{ Fully Allocated Routine Costs} - \text{Cost of Swing Bed NF Days }]}{[\text{ Acute Days} + \text{Swing Bed SNF Days} + \text{Observation Days Equivalent }]}$$

Ancillary Ratio of Cost to Charges x Medicare Ancillary Charges

*Ancillary Ratio of Cost to Charges is calculated in Worksheet C, Part I for **each individual cost center**:*

$$\frac{[\text{ Fully Allocated Costs} - \text{Therapy Adjustments} - \text{RCE Disallowance}]}{[\text{ Inpatient Charges} + \text{Outpatient Charges} - \text{Professional Fees }]}$$

Medicare Days & Charges from the PS&R

D

PS&R data comes from Institutional (Part A) Medicare claims processed. For each Type of Bill, it summarizes patient days, gross charges by revenue code, payments, deductibles and coinsurance, sequestration, and more.

- Run the PS&R as late as possible to ensure you have enough lag time for claims processing
  - In some circumstances, you may need to run an additional PS&R with different service dates to capture activity relevant to a rate change or other reasons
- Map PS&R charges by revenue to Medicare cost centers
  - Be sure to use the same crosswalk as you used for Worksheet C charges
  - Some revenue codes may require allocation to various cost centers to properly match with costs. Use internal records of Medicare charges to allocate PS&R charges. Common examples:
    - Clinic Charges – allocate among various provider-based clinics reported on separate cost report lines
    - Therapy charges – allocate to offsite rehab departments on subscripted lines
    - IV Therapy – allocate to various cost centers because you don't have dedicated IV Therapy unit/staff

Medicare Cost Apportionment – Ancillary Services Example

		Medicare Charges						Medicare
	C, I Col 8	D, V	D-3	D-3	Total	Medicare	C, I Col 9	Ancillary
Ancillary Department	Total Charges	Outpatient	Inpatient	Swing Bed	Medicare	Utilization	RCC	Cost
	(A)				(B)	(B)/(A)	(C)	(B)*(C)
50 OPERATING ROOM	13,923,000	5,252,000	501,000		5,753,000	41%	0.396666	2,282,019
53 ANESTHESIOLOGY	4,421,000	1,373,000	99,000		1,472,000	33%	0.135800	199,898
54 RADIOLOGY-DIAGNOSTIC	8,878,000	2,139,000	105,000	8,000	2,252,000	25%	0.360528	811,909
57 CT SCAN	7,195,000	2,976,000	200,000		3,176,000	44%	0.166367	528,382
58 MAGNETIC RESONANCE IMAGING (MRI)	3,137,000	1,135,000	67,000		1,202,000	38%	0.541310	650,655
60 LABORATORY	13,384,000	3,889,000	437,000	35,000	4,361,000	33%	0.402207	1,754,025
65 RESPIRATORY THERAPY	3,969,000	1,803,000	310,000	10,000	2,123,000	53%	0.124294	263,876
66 PHYSICAL THERAPY	2,238,000	666,000	93,000	18,000	777,000	35%	0.777047	603,766
67 OCCUPATIONAL THERAPY	873,000	60,000	95,000		155,000	18%	0.314927	48,814
71 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,253,000	240,000	199,000	5,000	444,000	35%	0.485414	215,524
72 IMPL. DEV. CHARGED TO PATIENT	4,520,000	1,270,000	169,000		1,439,000	32%	0.588936	847,479
73 DRUGS CHARGED TO PATIENTS	15,788,000	5,196,000	284,000	35,000	5,515,000	35%	0.613043	3,380,932
90 CLINIC	3,091,000	1,055,000	4,000		1,059,000	34%	2.274857	2,409,074
91 EMERGENCY	6,194,000	2,031,000	128,000		2,159,000	35%	0.608753	1,314,298
92 OBSERVATION BEDS (NON-DISTINCT PART)	1,576,000	598,000	22,000		620,000	39%	0.881749	546,684
TOTALS	90,440,000	29,683,000	2,713,000	111,000	32,507,000	36%		15,857,333

Questions?

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