Medicare Cost Report Update

Eric Swanson
Provider User Meeting, 2017
New Orleans, LA

MEDICARE COST REPORT UPDATE

• Agenda
  • Regulation Changes Impacting Cost Reporting
  • Recent Cost Reporting Changes
    • Hospital
    • Provider-based Hospice and FQHC changes
    • Skilled Nursing facility
    • Home Health Agency
    • Federally Qualified Health Center
    • CMHC
    • Rural Health Clinic
    • Hospice
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REGULATION CHANGES IMPACTING COST REPORTING

• Items with potential Cost Report Impact
  • Electronic Signature and Submission of the Certification and Settlement Summary Page of the Medicare Cost Report
  • Uncompensated Care – Calculation of Proposed Factor 3 for FFY 2018
  • Expiration of MDH Program
  • Expiration of Temporary Low-Volume Payment Adjustment
  • Rural Community Hospital Demonstration Program
Currently
- Provider submits Cost Report to MAC electronically
  - CD/USB Drive
  - MAC Portal
  - Email
- Certification Statement
  - Must contain original signature
    - Facsimile or stamped copy of signature unacceptable
  - Must be mailed to MAC

Proposed
- Allow electronic signature
  - Placed on the signature line of the Certification statement
    - Any format of the original signature that contains the first and last name of the provider’s administrator or CFO (for example, photocopy or stamp) or
    - An electronic signature that must be the first and last name of the provider’s administrator or CFO entered in the “providers electronic program”
  - Cannot be “a symbol, numerical characters, or codes.”
ELECTRONIC SIGNATURE AND SUBMISSION OF THE CERTIFICATION AND SETTLEMENT SUMMARY PAGE OF THE MEDICARE COST REPORT

Where electronic signature is elected:

- CMS will add an electronic signature checkbox on the certification page
  - [ ] I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.
  - Completion of both the electronic signature checkbox and the electronic signature, placed on the signature line by the provider’s administrator or CFO under the certification statement, would together constitute an accepted electronic signature.

- Provider may submit the Certification and Settlement Summary page to the MAC using the same method/timing of EC and PI file submission
  - CD/USB Drive
  - MAC Portal
  - Email
  - Could still choose to sign the certification statement and mail to MAC.
• Final Rule Comments
  • Proposed effective date cost reporting periods beginning on or after October 1, 2017
  • Option to use for cost reporting periods ending on or after December 31, 2017
  • HFS anticipates the ability to electronically sign and submit certification for 12/31/2017 cost report period end providers

• Considerations
  • "Signing" process within SaFE
  • Possible that non-preparer to "sign"
  • HFS software submission to MAC or CMS portals

• Comment: Many commenters supported the utilization of technology to allow for the electronic signature of the Certification and Settlement Summary page of the Medicare cost report and further stated that this has been long awaited in the industry. The commenters stated that allowing providers the option to electronically sign the Certification and Settlement Summary page will make the process easier, more efficient, and allow for fewer errors than the current paper process. Commenters also supported allowing facilities an option to continue using the current paper process to manually sign the Certification and Settlement Summary page.

• Response: We appreciate the commenters’ support.
ELECTRONIC SIGNATURE AND SUBMISSION OF THE CERTIFICATION AND SETTLEMENT SUMMARY PAGE OF THE MEDICARE COST REPORT

Comment: One commenter suggested that CMS’ proposal was to change the title of the signatory to the certification statement from the provider’s administrator or “officer” to the provider’s administrator or “chief financial officer” and disagreed with this alleged change, noting that many smaller providers do not have a chief financial officer.

Response: We disagree with this commenter’s characterization of our proposal. Our proposal to allow providers the option to electronically sign the certification statement on the Certification and Settlement Summary page of the Medicare cost report, did not include a proposal to change the title of the person required to sign the certification statement. Section 413.24(f)(4)(iv) of the regulations requires that the certification statement be signed by the “provider’s administrator or chief financial officer.” We did not propose to change the title of the person required to sign the certification statement. The requirements pertaining to the title of the person required to sign the certification statement remain the same.

ELECTRONIC SIGNATURE AND SUBMISSION OF THE CERTIFICATION AND SETTLEMENT SUMMARY PAGE OF THE MEDICARE COST REPORT

Comment: One commenter suggested that CMS change the title of the person required to sign the certification statement on the Certification and Settlement Summary page of the Medicare cost report, citing that often the signor is someone other than the provider’s administrator or chief financial officer.

Response: We consider this comment to be outside the scope of the policies we proposed in the proposed rule. We note that §413.24(f)(4)(iv) of the regulations requires that the certification statement be signed by the “provider’s administrator or chief financial officer.”
**ELECTRONIC SIGNATURE AND SUBMISSION OF THE CERTIFICATION AND SETTLEMENT SUMMARY PAGE OF THE MEDICARE COST REPORT**

- **Comment:** One commenter suggested that CMS change the title of the person required to sign the certification statement on the Certification and Settlement Summary page of the Medicare cost report, citing that often the signor is someone other than the provider's administrator or chief financial officer.

- **Response:** We consider this comment to be outside the scope of the policies we proposed in the proposed rule. We note that §413.24(f)(4)(iv) of the regulations requires that the certification statement be signed by the "provider’s administrator or chief financial officer."

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**UNCOMPENSATED CARE – CALCULATION OF PROPOSED FACTOR 3 FOR FFY 2018**

- **FFY 2017 CMS did not ultimately use S-10 data**
  - **Why?**
    - Perceived lack of clarity in the S-10 instructions
    - Data should be subject to audit

- **FFY 2018 CMS is proposing to use S-10 data**
  - **Why?**
    - High correlation between S-10 Data and IRS Form 990

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<td>2013</td>
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EXPIRATION OF MDH PROGRAM

- MDH Program will expire 9/30/2017
- Previously extended by
  - ACA
  - ATRA
  - Pathway for SGR Reform
  - PAMA
  - MACRA

MDHs will be paid based on the IPPS Federal Rate effective 10/1/2017.

MDH can apply for SCH status (under certain conditions)
- MUST apply for SCH status by 9/1/2017
- MUST request effective date of 10/1/2017
- If not requested by 9/1/2017 then effective date 30-days after CMS written notification of approval
EXPIRATION OF MDH PROGRAM

- **Comment:** Several commenters indicated that hospitals in their States would experience payment decreases as a result of the expiration of the MDH program. One commenter urged CMS to work with Congress to permanently extend the MDH program. Another commenter indicated that it would continue supporting congressional efforts to protect the MDH program.

- **Response:** We appreciate the commenters’ concerns about the expiration of the MDH program. However, CMS does not have the authority under current law to continue the MDH program beyond the September 30, 2017 statutory expiration date.

EXPIRATION OF TEMPORARY LOW-VOLUME PAYMENT ADJUSTMENT

- ACA modified LVA for FYs 2011 and 2012
- Extended through FY 2017 by MACRA
  - More than 15 miles from another subsection (d) hospital
  - Less than 1,600 Medicare discharges
  - Sliding scale adjustment factor
- Will revert to previous policy 10/1/2017
  - More than 25 miles from another subsection (d) hospital
  - Less than 200 discharges (not just Medicare)
EXPIRATION OF TEMPORARY LOW-VOLUME PAYMENT ADJUSTMENT

- Will revert to previous policy 10/1/2017
  - More than 25 miles from another subsection (d) hospital
  - Less than 200 discharges (not just Medicare)
- Hospital MUST request in writing prior to 9/1 of FFY
  - That it meets discharge requirements (under 200 discharges) in most recently submitted cost report
  - That it meets mileage requirements
- 25% payment adjustment will be applied within 30 days of the MAC’s low volume determination

EXPIRATION OF TEMPORARY LOW-VOLUME PAYMENT ADJUSTMENT

- Comment: One commenter questioned whether CMS would be making any claims processing or cost report changes in light of the expiration of the temporary changes to the low-volume hospital payment adjustment.
- Response: With regard to the comment regarding revisions to claims processing or the cost report, any such changes will be addressed through subregulatory guidance or other avenues, as appropriate.
RURAL COMMUNITY HOSPITAL DEMONSTRATION PROGRAM

- Qualifications
  - Located in rural area
  - Fewer than 51 beds
  - 24-hour ER care
  - Not designated as CAH
  - Located in States with low population densities
- Provisions of the 21st Century Cures Act
  - Extended for an additional 5 years
  - Will solicit additional hospitals
- Reimbursed at reasonable costs subject to a Target limit

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2552-10 TRANSMITTAL 10
GENERAL

• 2552-10 T-10
  - Effective for cost reporting periods beginning on or after 10/1/2015
    (Same as T-9)
  - Some provisions retroactive
  - CMS Published T-10 on November 17, 2016
  - HFS was approved by CMS for Transmittal 10 on January 30, 2017
  - HFS released Transmittal 10 on February 3, 2017

• 2552-10 T-10
  - Major provisions of T-10
    - New Worksheet N series for hospital-based Federally Qualified Health Centers (FQHCs), effective for cost reporting period beginning on or after October 1, 2014
    - New Worksheet O series for hospital-based hospices, effective or cost reporting periods beginning on or after October 1, 2015
      - CMS Clarification – O Series effective for cost reporting periods beginning on or after 10/1/2015 AND ENDING ON OR AFTER 9/30/2016.
Worksheet S – As with other form sets CMS is adding the OMB expiration date.

Worksheet S-2, Part I:
- Added line 171, column 2 to capture section 1876 Medicare days.
- These days will be reported on Worksheet S-3, Part I, line 2, column 6 BUT are not reported on PS&R 118 report.
Worksheet S-3, Part II:

Effective for cost reporting periods beginning on or after 10/1/2015, lines 14.01 and 14.02 replace line 14.

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WAGE RELATED COSTS

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Worksheet S-3, Part IV:
Eliminated the Wage Index Pension Cost Schedule (Exhibit 3) and the corresponding instructions from the cost reporting instructions and directed providers to use the latest published Wage Index Pension Cost Schedule on the CMS website.

www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Wage-Index-Files.html

Added lines 8.01, 8.02, and 8.03, to accommodate various categories of health insurance effective for cost reporting periods beginning on or after October 1, 2015.
Line 23 added to report Treatments by CNN IF provider reports that they qualify for Low volume adjustment

Worksheet S-10:

- Clarified instructions for line 20 for the total initial payment obligation of patients approved for charity care.
- Changed the reference to State Children’s Health Insurance Program (SCHIP) to Children’s Health Insurance Program (CHIP) in the instructions and on the worksheet.
Worksheet S-10:

Line 20:

For cost reporting periods beginning prior to October 1, 2016:

Enter the total initial payment obligation, measured at full charges, of patients who are given a full or partial discount based on the hospital’s charity care criteria for care delivered during the cost reporting period for the entire facility. Include charity care charges for all services except physician and other professional services. Do not include charges for patients given courtesy allowances. Charges for non-covered services provided to patients eligible for Medicaid or other indigent care programs (including charges for days exceeding a length of stay limit) can be included if such inclusion is specified in the hospital’s charity care policy and the patient meets the hospital’s charity care criteria. Do not include charges of uninsured patients who do not meet the hospital’s charity care criteria for a full or partial discount.

Enter in column 1, the full charges for uninsured patients and patients with coverage from an entity that does not have a contractual relationship with the provider. Enter in column 2, the deductible and coinsurance payments required by the payer for insured patients covered by a public program or private insurer with which the provider has a contractual relationship that were written off to charity care. Do not include in column 2 amounts of deductible and coinsurance claimed as Medicare bad debt.

For cost reporting periods beginning on or after October 1, 2016:

Enter the actual charge amounts for the entire facility, except physician and other professional services that were (1) determined in accordance with the hospital’s charity care criteria/policy, and (2) were written off to charity care during the cost reporting period, regardless of when the services were provided. Do not include charges for patients given courtesy discounts or charges for uninsured patients with or without full or partial discounts who do not meet the hospital’s charity care criteria. Charges for non-covered services provided to patients eligible for Medicaid or other indigent care programs (including charges for days exceeding a length of stay limit) can be included if such inclusion is specified in the hospital’s charity care policy and the patient meets the hospital’s charity care criteria.

Enter in column 1, the total charges, or the portion of the total charges, written off to charity care, for uninsured patients, and patients with coverage from an entity that does not have a contractual relationship with the provider. The portion of total charges is the amount the patient is not responsible for paying (e.g., 100% of charges if the patient qualified for 100% discount or 75% of charges if the patient qualified for a 75% partial discount). Enter in column 2, the deductible and coinsurance payments required by the payer for insured patients covered by a public program or private insurer with which the provider has a contractual relationship that were written off to charity care. Do not include in column 2 amounts of deductible and coinsurance claimed as Medicare bad debt.

Worksheet A

Wage index clarifications

- Report Contract labor costs in column 2 “other”

- And report in appropriate cost center where possible

Column 2—Report in each cost center the cost incurred for contract labor, both wage and wage-related contract labor cost, for services contracted by the hospital, the fune office, or related organizations. If necessary, recalculate contract labor costs to the cost center benefiting from the contract labor services (see column 4 instructions). In addition, all other costs not reported in column 1 must be reported in column 2.
Worksheet A-8-1 – Correct placement of contract costs (also on A)

Part A—Cost applicable to home office costs, services, facilities, and supplies furnished by organizations related to you by common ownership or control are includable in your allowable cost at the cost to the related organizations. However, such cost must not exceed the amount a prudent and cost conscious buyer pays for comparable services, facilities, or supplies that are purchased elsewhere. Costs for services provided by a home office or related party, including employee or contract labor, must be assigned to the most closely matched cost centers on Worksheet A (lines 4 through 17). When portions of home office or related party costs, including employee or contract labor costs, pertain to more than A&G, assign the applicable costs to the corresponding most closely matched cost centers on lines 4 through 17 of Worksheet A. For example, if the home office cost included contracted housekeeping services, the contract labor costs must be reported on Worksheet A, line 9, and reflected on Worksheet A-8-1, referencing Worksheet A, line 9, in column 1.

WORKSHEETS B – D SERIES

- No significant changes
Worksheet E, Part A – New line for Islet Isolation add-on Payment. Previously in new technology payments

**Line 44:** Enter the special add-on payment for new technologies (see 42 CFR 856.1207 and 413.88). Include in the add-on payment for new technologies payments associated with Model 4 BPCI.

**Line 54.01:** Enter the special add-on payment for islet isolation cell transplantation (see CR 9670).

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Worksheet E-1, Part II – HIT Payment

4031.2 **Part II - Calculation of Reimbursement Settlement for Health Information Technology**

**THIS PART IS COMPLETED BY THE CONTRACTOR FOR STANDARD COST REPORTING PERIODS AND BY THE CONTRACTOR FOR NONSTANDARD COST REPORTING PERIODS. Do not complete this worksheet for cost reporting periods beginning on or after October 1, 2016.**
Worksheet E-3, Part IV

**Line 1** - Enter the net Federal LTCH PPS payment including short stay outlier payments. Obtain this information from the PS&R and/or your records.

Complete lines 1.01 through 1.04 for discharges occurring in cost reporting periods beginning on or after October 1, 2015. See 42 CFR 412.522. These amounts may be obtained from the PS&R and/or your records.

**NOTE:** The amounts on lines 1.01 through 1.04 are for informational purposes only. The amount on line 1 above includes the amounts on lines 1.01 through 1.04, and must reconcile to line 1.

- **Line 1.01** - Enter the full standard LTCH PPS payment.
- **Line 1.02** - Enter the short stay outlier standard payment amount.
- **Line 1.03** - Enter the cost-based site neutral payment amount.
- **Line 1.04** - Enter the LTCH PPS comparable site neutral payment amount, which may include high cost outlier payments.

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**Worksheet E-3, Part IV**

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<td>3.00 Total PPS Payments (sum of lines 1 and 2)</td>
<td>5,075,345</td>
<td>3.00</td>
<td></td>
</tr>
</tbody>
</table>
Worksheet I-1:
- Modified instructions for lines 10 through 16, revising the effective date for line 15 (Drugs) to cost reporting periods beginning on or after October 1, 2015, to capture Erythropoiesis stimulating agents (ESA).
- Modified instructions for line 27 (Subtotal) to reflect the applicable reconciliation to Worksheet B, Part I, for cost reporting periods beginning prior to October 1, 2015, and on or after October 1, 2015.
- Revised edit 10050I.

Worksheet I-2 and I-3:
- Clarified instructions for lines 14 and 15 to include all ESA costs on line 14 for cost reporting periods beginning on or after October 1, 2015.
- Modified line 14 description and shaded line 15.

Previously ESAs were subtracted from Worksheet B pharmacy allocation (sometimes resulting in negative amounts on line 25). With T-10 ESA's will be included on line 15 and specifically excluded on the I-3 allocations.
Worksheet I-1:

- Modified instructions for lines 10 through 16, revising the effective date for line 15 (Drugs) to cost reporting periods beginning on or after October 1, 2015, to capture Erythropoiesis stimulating agents (ESA).
- Modified instructions for line 27 (Subtotal) to reflect the applicable reconciliation to Worksheet B, Part I, for cost reporting periods beginning prior to October 1, 2015, and on or after October 1, 2015.
- Revised edit 10050I.

Worksheet I-2 and I-3:

- Clarified instructions for lines 14 and 15 to include all ESA costs on line 14 for cost reporting periods beginning on or after October 1, 2015.
- Modified line 14 description and shaded line 15.

Note that ESA not included in total allocation.

Worksheet M series:

- Modified instructions to convey that the Worksheet M series no longer applies to hospital-based FQHCs, effective for cost reporting periods beginning on or after October 1, 2014. However, hospital-based rural health clinics still complete the "M" worksheet series.
- Revised forms and instructions to comply with the regulations at 42 CFR 413.78(a), to ensure that no separate graduate medical education (GME) payment is calculated for the hospital-based RHC or FQHC.

Worksheet N series:

- Effective for cost reporting periods beginning on or after October 1, 2014, hospital-based FQHCs complete the new Worksheet N series and are reimbursed under the FQHC prospective payment system as set forth in 42 CFR 413.65(n).

Worksheet K series:

- Modified instructions to convey that the Worksheet K series no longer applies to hospital-based hospices, effective for cost reporting periods beginning on or after October 1, 2015.

Worksheet O series:

- Effective for cost reporting periods beginning on or after October 1, 2015, hospital-based hospices complete the new Worksheet O series in accordance with the statutory requirements of §3132 of the ACA.
MEDICARE COST REPORT UPDATE

- Agenda
  - Regulation Changes Impacting Cost Reporting
  - Recent Cost Reporting Changes
    - Hospital
    - Provider-based Hospice and FQHC changes
    - Skilled Nursing facility
    - Home Health Agency
    - Federally Qualified Health Center
    - CMHC
    - Rural Health Clinic

PROVIDER-BASED HOSPICE

- O series added for Provider-based hospice reporting effective for cost reporting periods beginning on or after 10/1/2015 and ending on or after 9/30/2016
  - Hospital – 2552-10 Transmittal 10
  - HHA – 1728-96 Transmittal 17
  - SNF – 2540-10 Transmittal 7

- Hospice Identification Worksheets also added Parts III and IV to replace I and II for cost reporting periods beginning on or after 10/1/2015 and ending on or after 9/30/2016
  - Hospital – 2552-10 Worksheet S-9
  - HHA – 1728-96 Worksheet S-5
  - SNF – 2540-10 Worksheet S-8
PROVIDER-BASED HOSPICE

- 2552-10, 2540-10 and 1728-96 all use similar Hospice forms:
  - Worksheet O – Analysis of _____-Based Hospice Costs
  - Worksheet O-1 – Analysis of _____-Based Hospice Costs for Continuous Home Care
  - Worksheet O-2 – Analysis of _____-Based Hospice Costs for Routine Home Care
  - Worksheet O-3 – Analysis of _____-Based Hospice Costs for Inpatient Respite Care
  - Worksheet O-4 – Analysis of _____-Based Hospice Costs for General Inpatient Care
  - Worksheet O-5 – Cost Allocation – Determination of _____-Based Hospice Net Expenses for Allocation
  - Worksheet O-6, Part I – Cost Allocation - _____-Based Hospice General Service Costs
  - Worksheet O-6, Part II – Cost Allocation - _____-Based Hospice General Service Costs Statistical Basis
  - Worksheet O-7 – Apportionment of _____-Based Hospice Per Diem Costs
  - Worksheet O-8 – Calculation of _____-Based Hospice Per Diem Costs

PROVIDER-BASED HOSPICE

Hospice Identification Data, Parts I - IV:

- Effective for cost reporting periods beginning on or after October 1, 2015, hospital-based hospices will no longer complete Parts I and II, but will complete the new Parts III and IV.
Effective for cost reporting periods beginning on or after October 1, 2015, hospital-based hospices will no longer complete Parts I and II, but will complete the new Parts III and IV.

Appropriate Parts will "lock" based on cost reporting period.

- WTB
- Direct Patient Service Costs will flow from Worksheets O-1 through O-4
• WTB for Direct Patient Service Costs
  • O-1 – Continuous Home Care
  • O-2 – Routine Home Care
  • O-3 – Inpatient Respite care
  • O-4 – General Inpatient Care
  • Results will flow to Worksheet O, lines 25 – 26
  • Any A-6 or A-8 adjustments impacting Hospice direct patient care must be manually entered in columns 4 and 6

• "Bridges the Gap" between Hospice Direct costs and HHA overhead.
• No input
**PROVIDER-BASED HOSPICE WORKSHEET O-5**

Worksheet O-5 combines the Hospice Direct costs (Worksheet O) with the facility overhead costs (Worksheet B).

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1</td>
<td>1</td>
<td>10</td>
<td>1</td>
<td>14</td>
<td>10</td>
<td>N/A</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>2</td>
<td>11</td>
<td>14</td>
<td>16</td>
<td>12</td>
<td>N/A</td>
</tr>
<tr>
<td>3</td>
<td>4</td>
<td>3</td>
<td>N/A</td>
<td>12</td>
<td>N/A</td>
<td>N/A</td>
<td>4</td>
</tr>
<tr>
<td>4</td>
<td>5, 11 and 12</td>
<td>4</td>
<td>5</td>
<td>13</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>5</td>
<td>6 and 7</td>
<td>5</td>
<td>3</td>
<td>14</td>
<td>15</td>
<td>11</td>
<td>N/A</td>
</tr>
<tr>
<td>6</td>
<td>8</td>
<td>6</td>
<td>N/A</td>
<td>15</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>7</td>
<td>9</td>
<td>7</td>
<td>N/A</td>
<td>16</td>
<td>18, 20 and 23</td>
<td>15 and 14</td>
<td>N/A</td>
</tr>
<tr>
<td>8</td>
<td>10</td>
<td>8</td>
<td>N/A</td>
<td>17</td>
<td>17</td>
<td>13</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**PROVIDER-BASED HOSPICE WORKSHEET O-6 PARTS I AND II**

- Part I – Stepdown of overhead costs
- Part II – Statistics for the stepdown
- Note: No provision for basis changes or subscripts
**PROVIDER-BASED HOSPICE WORKSHEET O-7**

**Purpose**
- To allocate Hospital ancillary costs to Hospice if applicable
- All charges are “total” charges, not charges from PS&R

**PROVIDER-BASED HOSPICE WORKSHEET O-8**

**Purpose**
- To compute Medicare and Medicaid cost by LOC
- No “Settlement” for Hospice payments
PROVIDER-BASED FEDERALLY QUALIFIED HEALTH CENTER

- Hospital-Based, effective for cost reporting periods beginning on or after 10/1/2014
  - Worksheet S-11 replaces Worksheet S-8
  - Worksheet N series - Effective for cost reporting periods beginning on or after October 1, 2014, hospital-based FQHCs complete the new Worksheet N series and are reimbursed under the FQHC prospective payment system as set forth in 42 CFR 413.65(n).
- SNF and HHA-Based, effective for cost reporting periods beginning on or after 10/1/2014
  - SNF and HHA-Based FQHCs must file as free-standing FQHC on Form CMS-224-14

MEDICARE COST REPORT UPDATE

- Agenda
  - Regulation Changes Impacting Cost Reporting
  - Recent Cost Reporting Changes
    - Hospital
    - Provider-based Hospice and FQHC changes
    - Skilled Nursing facility
    - Home Health Agency
    - Federally Qualified Health Center
    - CMHC
    - Rural Health Clinic
2540-10 TRANSMITTAL 7

- The Skilled Nursing Facility, 2540-10 was updated to Transmittal 7 by CMS, on August 19, 2016. Transmittal 7 is effective for cost reporting periods beginning on or after October 1, 2015.
- The primary purpose of the Transmittal was to incorporate Statutory reporting requirements to facilitate hospice payment reforms pursuant to Section 3132 of the Patient Protection and Affordable Care Act (ACA). In addition, this Transmittal requires SNF facilities with FQHC units to file a separate Form 224-14 cost report for cost reporting periods beginning on or after October 1, 2014.
- HFS was approved for Transmittal 7 on October 21, 2016
- Transmittal 7 software was distributed in our October 28, 2016 software update

MEDICARE COST REPORT UPDATE

- Agenda
  - Regulation Changes Impacting Cost Reporting
  - Recent Cost Reporting Changes
    - Hospital
    - Provider-based Hospice and FQHC changes
    - Skilled Nursing facility
    - Home Health Agency
    - Federally Qualified Health Center
    - CMHC
    - Rural Health Clinic
1728-94 TRANSMITTAL 17
SYSTEM CHANGES

- Published on CMS Website 10/7/2016
- Effective for cost reporting periods beginning on or after 10/1/2015 and ending on or after 9/30/2016
- CMS Clarifications
  - Providers that include provider-based hospices must complete the O series worksheets for cost reporting periods beginning on or after October 1, 2015, and ending on or after September 30, 2016.
- HFS approved 1/30/2017
- Software available for download 2/10/2017

FORM 1728-94 T-17
MAJOR CHANGES

- Form S-2-1 added and replaced Form CMS-339
- Hospice form changes (effective for cost reporting periods beginning on or after 10/1/2015)
  - Added Worksheet S-5, Parts III & IV to replace Parts I & II
  - Added O Series of Worksheets to replace the current K series
- HFS CHANGE – Transmittal 17 software introduced the “new” HFS software platform to the HHA cost report.
FORM 1728-94 T-17
HFS UPDATED PLATFORM

- Most changes transparent to users
- New platform systems
  - 2552-10
  - 2540-10
  - 265-11
  - 1984-14
  - 224-14
  - 216-94
- Future Updates
  - 222-92
  - 2088-92

FORM 1728-94 T-17
HFS UPDATED PLATFORM

- File naming – Other MCRX changes
  - MCRX file not an “index” file so more stable
  - Restore/Reorganize tool will not repair file
  - “Catastrophic” error? Send file to support@hfssoft.com for recovery of data.
    - Can occur during calculate on unstable network drives.
  - Fs~ file
Worksheet S-2-1 replaces the CMS-339

If applicable Bad Debt Listing available under "Tools|CMS 339 Questionnaire"
Worksheet S-5

- Parts I&II for (full) cost reporting periods ending before 9/30/2016
- Parts III&IV for (full) cost reporting periods ending on or after 9/30/2016
- CMS added multiple level one edits for data review
  - For Part III, for every LOC identified costs will be required
  - For Part IV, contracted days must be less than days in Part III.
Old issue but we still get inquiries

- HFS Note: Per the Worksheet A Section 3206 instructions, for cost reporting periods beginning on or after October 1, 2000, do not complete Worksheets A-1, A-2 and A-3. Enter directly on Worksheet A the total expenses for Salaries and Wages (column 1), Employee Benefits (column 2) and Contracted/Purchased Services (column 4) in the appropriate cost center.
- Effective for cost reporting periods beginning on and after October 1, 2014, FQHCs cannot file as an HHA-based FQHC, and must file as a free standing or independent FQHC on the form CMS-224-14.
Previously addressed:
- Hospice form changes (effective for cost reporting periods beginning on or after 10/1/2015)
  - Added Worksheet S-5, Parts III & IV to replace Parts I & II
  - Added O Series of Worksheets to replace the current K series

MEDICARE COST REPORT UPDATE

- Agenda
  - Regulation Changes Impacting Cost Reporting
  - Recent Cost Reporting Changes
    - Hospital
    - Provider-based Hospice and FQHC changes
    - Skilled Nursing facility
    - Home Health Agency
    - Federally Qualified Health Center
    - CMHC
    - Rural Health Clinic
FQHC PROVIDERS

- New FQHC PPS system effective for cost reporting periods beginning on or after 10/1/2014
- FQHCs will no longer be using 222-92
- Form 224-14 to be used by FQHCs for cost reporting periods beginning on or after 10/1/2014
- Edits in place to ensure completion of correct forms.

FORM CMS 224-14
WORKSHEET S-1, PART I, EDITS

- Consolidated report
  - IF CERTIFICATION DATE OF MAIN OR SUB UNIT ON OR AFTER 10/1/2014 – Must provide dates of request and approval for consolidation
  - Note – additional entities entered on subscripts of line 14 and data entered on Worksheets S-1, Part II
FORM CMS 224-14
WORKSHEET S-1, PART I, EDITS

If FQHC received a grant must report grant number and date.

FQHC Operations

25.00 What type of organization is this FQHC? If you operate as more than one sub-type of an organization enter only the applicable alpha characters in column 2. (See instructions)
26.00 Did the FQHC receive a grant under §330 of the PHS Act during this cost reporting period? If this is a consolidated cost report, did the FQHC reported on line 1, column 2 receive a grant under §330 of the PHS Act during the cost reporting period? Enter “Y” for yes or “N” for no. (Complete line 17)
27.00 If the response to line 16 is yes, indicate in column 1, the type of HRSA grant that was awarded (see instructions). Enter the date of the grant award in column 2 and enter the grant award number in column 3. If you received more than one grant sub-cspt this line accordingly.

<table>
<thead>
<tr>
<th>1 - Organization receiving a grant(y)</th>
<th>2 - Y</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - Community health Center</td>
<td>12/01/2014</td>
</tr>
</tbody>
</table>

CMS clarification – HRSA/Commercial malpractice insurance

Medical Malpractice

20.00 Did the FQHC submit an initial filing or annual filing application for medical malpractice coverage under the PCIA with HRSA? Enter “Y” for yes or “N” for no in column 1. If column 1 is yes, enter the effective date of coverage in column 2.
21.00 Does the FQHC carry commercial malpractice insurance? Enter “Y” for yes or “N” for no.
22.00 Is the malpractice insurance a claims-made or occurrence policy? Enter “Y” for claims-made or “N” for occurrence policy.

<table>
<thead>
<tr>
<th>1 -</th>
<th>2 -</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 -</td>
<td>01/01/2015</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Premiums</th>
<th>Paid Losses</th>
<th>Self Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>45,675</td>
<td>12,000</td>
<td>0</td>
</tr>
</tbody>
</table>

If “Y” for yes or “N” for no. (See instructions)
• Separate S-1, Part II for each consolidated facility identified on S-1, Part I, subscripts of line 14

What if single grant or malpractice premium for consolidated entities? Repeat information for each additional facility.
· Only the following cost centers can be subscripted.

<table>
<thead>
<tr>
<th>GENERAL SERVICE COST CENTERS</th>
<th>CODE</th>
<th>USE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other General Service (specify)</td>
<td>1200</td>
<td>(20)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OTHER FHHC SERVICES</th>
<th>CODE</th>
<th>USE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other (specify)</td>
<td>6800</td>
<td>(20)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NONREIMBURSABLE COST CENTERS</th>
<th>CODE</th>
<th>USE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Nonreimbursable (specify)</td>
<td>7900</td>
<td>(20)</td>
</tr>
</tbody>
</table>

· Descriptions can (must) be changed and 19 subscripts available.
**Form CMS 224-14 Worksheet B**

**Accumulated cost type allocation of Other direct and General Service cost centers.**

No allocation basis changes accommodated.

---

<table>
<thead>
<tr>
<th>Worksheet, A, col. 7, line</th>
<th>Direct Cost for Practitioner from Worksheet, A</th>
<th>Total Medical &amp; Mental Health Visits by Practitioner</th>
<th>Other Direct Care Costs (see Instructions)</th>
<th>General Service Cost (see Instructions)</th>
<th>Total Costs by Practitioner</th>
<th>Average Cost Per Visit by Practitioner</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2.00</td>
<td>448,028</td>
<td>58,650</td>
<td>170,015</td>
<td>251,703</td>
<td>920,946</td>
<td>35.52</td>
</tr>
<tr>
<td>0.00</td>
<td>384,246</td>
<td>2,600</td>
<td>17,228</td>
<td>79,695</td>
<td>284,213</td>
<td>10.72</td>
</tr>
<tr>
<td>0.00</td>
<td>301,401</td>
<td>7,834</td>
<td>31,908</td>
<td>93,002</td>
<td>138,401</td>
<td>42.94</td>
</tr>
<tr>
<td>0.00</td>
<td>301,502</td>
<td>4,688</td>
<td>15,596</td>
<td>71,636</td>
<td>230,736</td>
<td>12.08</td>
</tr>
<tr>
<td>8.00</td>
<td>301,612</td>
<td>1,747</td>
<td>24,612</td>
<td>46,377</td>
<td>74,877</td>
<td>46.66</td>
</tr>
<tr>
<td>7.00</td>
<td>47,088</td>
<td>3,095</td>
<td>20,142</td>
<td>23,192</td>
<td>93,781</td>
<td>30.48</td>
</tr>
<tr>
<td>6.00</td>
<td>112,991</td>
<td>1,952</td>
<td>12,989</td>
<td>28,512</td>
<td>103,176</td>
<td>54.92</td>
</tr>
<tr>
<td>9.00</td>
<td>311,074</td>
<td>4,400</td>
<td>29,104</td>
<td>55,566</td>
<td>100,774</td>
<td>45.64</td>
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<tr>
<td>8.00</td>
<td>33,312</td>
<td>1,490</td>
<td>11,304</td>
<td>55,900</td>
<td>75,690</td>
<td>46.10</td>
</tr>
<tr>
<td>6.00</td>
<td>1,302,747</td>
<td>53,992</td>
<td>348,360</td>
<td>688,422</td>
<td>2,415,429</td>
<td>41.88</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td><strong>1,532,747</strong></td>
<td><strong>57,992</strong></td>
<td><strong>386,360</strong></td>
<td><strong>758,822</strong></td>
<td><strong>2,530,210</strong></td>
<td><strong>41.88</strong></td>
</tr>
</tbody>
</table>

**Part I - Calculation of Allowable**

<table>
<thead>
<tr>
<th>Total Cost (Worksheet, A, col. 7, line 4)</th>
<th>Total I &amp; R Visits</th>
<th>Title Y293 &amp; Y43</th>
<th>Ratio of Title Y293 Visits to Total Visits</th>
<th>Allowable Title Y293 Direct GME Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>6,829,727</td>
<td></td>
<td></td>
<td></td>
<td>41.88</td>
</tr>
</tbody>
</table>

**Column 3** - Use this column to allocate costs associated with other direct care costs, columns of Worksheet A, columns 7, lines 9, 32, and 34 through 36. Calculate the unit cost multiply the unit cost that is to be allocated by other direct care costs by dividing the sum of cost Worksheet A, columns 7, lines 9, 32, 34, and 36, by Worksheet B, Part 1, columns 2, line 11, total medical and mental health days and enter the result on line 12. Calculate the costs for lines 1 through 13 by multiplying the visits on each corresponding line, column 2, times the ICM on line 12.

**Column 4** - Use this column to allocate general service costs, on Worksheet A, columns 7, line 13, minus line 9. Calculate the ICM by dividing Worksheet A, columns 7, line 13, minus line Worksheet A, columns 7, line 100, minus line 12, and enter the result on line 12. Allocate the general service cost attributable to each physician on lines 1 through 12, by multiplying the result by the sum of the amounts in columns 3 and 4, for each corresponding line.

---

Just a reminder, visits must agree between Worksheet S-3, Part I and Worksheet B (CMS Level One Edits). Worksheet S-3, Part I days from the PS&R but detail for Worksheet B not available on PS&R.
MEDICARE COST REPORT UPDATE

• Agenda
  • Regulation Changes Impacting Cost Reporting
  • Recent Cost Reporting Changes
    • Hospital
    • Provider-based Hospice and FQHC changes
    • Skilled Nursing facility
    • Home Health Agency
    • Federally Qualified Health Center
    • CMHC
    • Rural Health Clinic

DRAFT FORM 2088-17

• Draft 2088-17 cost report notice published in July 20, 2017 Federal Register

• Will replace previous 2088-92
  • 2088-17 for CMHCs ONLY
  • No proposed effective date
DRAFT FORM 2088-17
WORKSHEET S

- Cost report status data consistent with other form sets
- Instructions state that Low Utilization "requires prior contractor approval, see CMS Pub. 15-2, chapter 1, §110"

DRAFT FORM 2088-17
WORKSHEET S-1, PART I

- Worksheet S-1 Part I
- Street address required (Lines 1-5 previously on Worksheet S)
- Lines 5-8 Chain Identification
  - Entity will allocate costs to facilities
  - Entity that files a Home Office Cost Statement
# DRAFT FORM 2088-17
## WORKSHEET S-1, PART II

### PART B - STATISTICAL DATA

<table>
<thead>
<tr>
<th>Reimbursable</th>
<th>Visits</th>
<th>Patient Days</th>
<th>FTEs</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Data previously reported on Worksheet S, Part IV
- Visits
- Patient Days
- FTEs

### PART C - REIMBURSEABLE COST CENTERS

<table>
<thead>
<tr>
<th>Visits</th>
<th>Patient Days</th>
<th>FTEs</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Worksheet S-2
- Replaces Form 339
**DRAFT FORM 2088-17**

**WORKSHEET A**

- **Working Trial Balance – Similar to 2088-92**
  - Only CMHC Cost Centers from 2088-92
  - Lines 1-13 – General Service (Overhead) costs
  - Lines 23 – 32 – Reimbursable Cost Centers
  - Lines 42-58 – Nonreimbursable Cost centers
  - Lines 40 – 48 – Overhead
  - Lines 60 – 68 – Administrative
  - Lines 75 – 80 – Non RHC services
  - Lines 87 – 89 – Non Allowable

---

**DRAFT FORM 2088-17**

- Worksheet A-1 – Now A-6
- Worksheet A-2 – Now A-8
- Worksheet A-2-1 – Now A-8-1
  - Part I “Are there any costs…” eliminated as now on Worksheet S-2, line 3
**DRAFT FORM 2088-17 WORKSHEET A-8-2**

- RCE adjustment applied to physician salaries for provider services

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**DRAFT FORM 2088-17 WORKSHEET B/B-1**

- Similar to 2088-92
- CMHC Cost Centers Only
### DRAFT FORM 2088-17

**WORKSHEET C**

**APPORTIONMENT OF PATIENT SERVICE COSTS**

<table>
<thead>
<tr>
<th>PROVIDER CCN</th>
<th>PERIOD FROM</th>
<th>WORKSHEET C</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**REIMBURSABLE COST CENTERS**

- **23. Drugs & Biologicals**
- **24. Occupational Therapy**
- **25. Behavioral Health Treatment Services**
- **26. Individual Therapy**
- **27. Group Therapy**
- **28. Activity Therapy**
- **29. Family Therapy**
- **30. Psychiatric Testing**
- **31. Education Testing**
- **32. Other (specify)**
- **50. TOTAL (Lines 23 through 32)**

- **Simplified**
- **No A/B lines**

### DRAFT FORM 2088-17

**WORKSHEET D**

**CALCULATION OF REIMBURSEMENT ENSURENT**

<table>
<thead>
<tr>
<th>PROVIDER CCN</th>
<th>PERIOD FROM</th>
<th>WORKSHEET D</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**DESCRIPTION**

- **1. Gross A/B/C payments**
- **2. Outlier payments**
- **3. Outlier reconciliation amount (transfer from line 53)**
- **4. Gross reinsurance amount (sum of lines 1 through 3)**
- **5. Primary payer payments**
- **6. Activities billed to program patients (do not include reimbursement)**
- **7. Reimbursement paid to program patients (see instructions)**
- **8. Hospital/lost revenue lines 5, 6, and 7**
- **9. Reimbursement paid to hospitals (see instructions)**
- **10. Adjusted reimbursement due hospitals**
- **11. Reimbursement paid to dual-eligible beneficiaries (see instructions)**
- **12. Hospital (line 4 plus line 10)**
- **13. Other adjustments (see instructions)**
- **14. Amount due prior to the reconciliation adjustment (line 2 plus line 13)**
- **15. Reconciliation adjustment (see instructions)**
- **16. Amount after reconciliation adjustment (see instructions)**
- **17. Interest payments**
- **18. Transfer settlement (if contract is used only)**
- **19. Balance due provider (sum of lines 14 minus lines 17 and 18) (indicate repayment in brackets)**
- **20. Interest amounts (unreimbursed costs reported in accordance with CMB Pub. 15-2, chapter 1, §1152)**

**TO BE COMPLETED BY CONTRACTOR**

- **30. Original claims amount (see instructions)**
- **31. Outlier reconciliation adjustment amount (see instructions)**
- **32. The rate used to calculate the Time Value of Money**
- **33. Time Value of Money (see instructions)**
- **34. Total (sum of lines 31 and 33)**

- **Similar to 2088-92**
- **Simplified**
  - **No “TOPs”**
  - **No LCC**
  - **Lines 50 – 54 added for outlier reconciliation**
• Previously Worksheet S-1
• Line 5, tentative settlement payments, can only be input by providers on Amended reports (Not in draft)

• Similar to 2088-92
• Was Worksheet G
MEDICARE COST REPORT UPDATE

• Agenda
  • Regulation Changes Impacting Cost Reporting
  • Recent Cost Reporting Changes
    • Hospital
    • Provider-based Hospice and FQHC changes
    • Skilled Nursing facility
    • Home Health Agency
    • Federally Qualified Health Center
    • CMHC
    • Rural Health Clinic

DRAFT FORM 222-17

• Draft 222-17 cost report notice published in July 19, 2017 Federal Register
  • Comments due prior to 09/18/2017

• Replaces Previous 222-92
  • 222-92 for RHC/FQHCs
  • 224-14 issued for FQHCs
    • Effective for cost reporting periods beginning on or after 10/1/2014
    • Implement's FQHC PPS
  • 222-17 for RHCs ONLY
  • No proposed effective date
**Worksheet S**

Instructions state that Low Utilization "requires prior contractor approval, see CMS Pub. 15-2, chapter 1, §110"

Title XVIII settlement amount added to Worksheet S

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**Worksheet S-1, Part I**

Worksheet S-1 Part I completed for Primary RHC if consolidated

- Street address required
- Lines 5-8 Owning or Controlling entity
- Lines 9-12 Chain Identification
  - Entity will allocate costs to facilities
  - Entity that files a Home Office Cost Statement
Worksheet S-1 Part I lines 13 – 14, for consolidated reports

- Line 13 – Are you filing consolidated and if so when did you request and when did you receive approval for consolidation.
- For 224-14 the Approval dates were only required where the Certification date was after the effective date of the form (10/1/2014)
- Line 13, column 4 will drive subscripting of line 14.
- Line 14 subscripts
  - Main facility data not reported (thus line 14 shaded)
  - Each additional facility reported on subscripts
  - Subscripts will drive creation of applicable Worksheets S-1, Part IIs

Lines 15 – 18, Malpractice Information
Lines 19 – 23, Approved I&R training
Lines 23 and 24 Hours of Operation
Line 25 – Payment Demonstration Information
Line 26 – Are there costs from Related Organizations
  • If no related organization costs on Worksheet A, “N”
**DRAFT FORM 222-17 WORKSHEET S-2**

- Worksheet S-2
- Replaces Form 339
- Lines 17 – 19 – Cost Report Preparer
  - Individual that will be contacted regarding cost report

**DRAFT FORM 222-17 WORKSHEET S-3**

- Lines 1, 3 and 5
- Subscripted for each consolidated RHC
- Line 1 – Medical Visits
- Line 3 – Mental Health Visits
- Line 5 – I&R visits
  - Not reported on PS&R
  - Also reported on lines 1 or 3 as applicable
**Worksheet A**

- Working Trial Balance – Similar to 222-92
  - Lines 1-10 – Staff costs (by position)
  - Lines 15 – 16 - “Under Arrangement”
  - Lines 25-32 - “Other Health Care Costs”
  - Lines 40 – 48 – Overhead
  - Lines 60 – 68 – Administrative
  - Lines 75 – 80 – Non RHC services
  - Lines 87 – 89 – Non Allowable

**Worksheet A-1** – Now A-6

**Worksheet A-2** – Now A-8

**Worksheet A-2-1** – Now A-8-1

- Part I “Are there any costs…” eliminated as now on Worksheet S-1, Part I, line 26.
### WORKSHEET B, PART I

#### PART I - VISITS AND PRODUCTIVITY

<table>
<thead>
<tr>
<th>Position</th>
<th>Number of FTE Full-time Equivalent</th>
<th>Total Visits</th>
<th>Productivity Score (1)</th>
<th>Minimum Voids (col. 1 x col. 2)</th>
<th>Greater of Col. 2 or Col 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>6756</td>
<td>4290</td>
<td></td>
<td>2</td>
<td></td>
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<tr>
<td>2.</td>
<td>2100</td>
<td></td>
<td></td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>2100</td>
<td></td>
<td></td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>2100</td>
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<td></td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>5.</td>
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<td>6.</td>
<td>2100</td>
<td></td>
<td></td>
<td>6</td>
<td></td>
</tr>
</tbody>
</table>

- Similar to 222-92
- Productivity exception reported on Worksheet S-1, Part I, line 20

### WORKSHEET B, PART II

#### PART II - DETERMINATION OF TOTAL ALLOWABLE COST APPLICABLE TO HHC SERVICES

<table>
<thead>
<tr>
<th>Number</th>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>Cost of HHC services - excluding overhead and allocable GME costs</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Cost of other than HHC - excluding overhead</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Cost of all services - excluding overhead - (sum of lines 12 and 13)</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Ratio of HHC (line 12 divided by line 14)</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Total overhead (Worksheet A, column 1, line 15)</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Overhead applicable to HHC services (line 13 times line 15) (see instructions)</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Total allowable cost of HHC services (sum of lines 17 and 17)</td>
<td></td>
</tr>
</tbody>
</table>
**DRAFT FORM 222-17 WORKSHEET B-1**

- Similar to 222-92
- Lines 8-9 – Two columns printed but a third provided in the instructions if applicable

**DRAFT FORM 222-17 WORKSHEET C, PART I**

- Similar to 222-92
- Lines 8-9 – Two columns printed but a third provided in the instructions if applicable
DRAFT FORM 222-17 WORKSHEET C, PART II

- Similar to 222-92
- New Lines
  - Line 29 “Other demonstration payment adjustment amount before sequestration”
  - Line 33 “Other demonstration payment adjustment amount after sequestration”

DRAFT FORM 222-17 WORKSHEET C-1

- New worksheet
  - Analysis of Payments required on all other form sets
  - Line 5, tentative settlement payments, can only be input by providers on Amended reports
MEDICARE COST REPORT UPDATE

• Agenda
  • Regulation Changes Impacting Cost Reporting
  • Recent Cost Reporting Changes
    • Hospital
    • Provider-based Hospice and FQHC changes
    • Skilled Nursing facility
    • Home Health Agency
    • Federally Qualified Health Center
    • CMHC
    • Rural Health Clinic
    • Hospice

HOSPICE
1984-14 TRANSMITTAL 2

• Major Hospice cost reporting changes effective for cost reporting periods beginning on or after 10/1/2014.
• This is the second year 12/31 Hospice providers are filing under the revised forms
• Major changes from the previous 1984-99 and the new 1984-14 include:
  • Data previously reported on the Provider Cost Report Reimbursement Questionnaire, Form CMS-339, has been incorporated into a Worksheet S-2.
  • The Worksheet A and B series will now require the separate identification and reporting of patient care service costs by level of care (Continuous Home Care, Routine Home Care, Inpatient Respite Care and General Inpatient)
• HFS has a recorded WebEx detailing the Hospice cost reporting changes
  • https://www.hfssoft.com/doc/Hospice%201984-14.zip