Health Financial Systems

The Leader in Medicare Cost Report Software

Medicare Cost Report Update

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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

MEDICARE COST REPORT UPDATE

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    - Rural Health Clinic

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

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

- 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

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

- 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

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

- Where electronic signature is elected:
  - Provider may submit the Certification and Settlement Summary page to the MAC using 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.

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

- 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

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

- 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."

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

Year	Correlation Coefficient
2010	.71
2011	.77
2012	.80
2013	.85

EXPIRATION OF MDH PROGRAM

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

EXPIRATION OF MDH PROGRAM

- MDH Program will expire 9/30/2017
  - 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

		Urban/Rural Status	Date of Geographic Reclassification		
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2			26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2			27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0			35.00
		Beginning:	Ending:		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.				36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	1			37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N			37.01
		Beginning:	Ending:		
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	01/01/2017	09/30/2017		38.00

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
    - https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2016-Transmittals-Items/R10P240.html?DLPage=1&DLEntries=10&DLFilter=R10&DLSort=1&DLSortDir=descending
  - HFS was approved by CMS for Transmittal 10 on January 30, 2017
  - HFS released Transmittal 10 on February 3, 2017

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2552-10 TRANSMITTAL 10 GENERAL

- 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.

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2552-10 TRANSMITTAL 10

- Worksheet S – As with other form sets CMS is adding the OMB expiration date.

DRAFT	FORM CMS-2552-10	4090 (Cont.)
This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).		FORM APPROVED OMB NO. 0938-0050 *EXPIRES 05-31-2019*
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	PROVIDER CCN: _____	PERIOD FROM _____ TO _____
		WORKSHEET S PARTS I, II & III

PART I - COST REPORT STATUS

Provider use only	1. [ ] Electronically filed cost report 2. [ ] Manually submitted cost report 3. [ ] If this is an amended report enter the number of times the provider resubmitted this cost report 4. [ ] Medicare Utilization. Enter "F" for full or "L" for low.	Date:	Time:
Contractor use only	5. [ ] Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No.: _____ 8. [ ] Initial Report for this Provider CCN 9. [ ] Final Report for this Provider CCN	10. NPR Date: _____ 11. Contractor's Vendor Code: _____ 12. [ ] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

2552-10 TRANSMITTAL 10

- 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.

171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	Y	140	

2552-10 TRANSMITTAL 10

- 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.

	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		350,000	0	350,000	7,000.00	50.00	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office and/or related orgainzation salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00

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2552-10 TRANSMITTAL 10

- Worksheet S-3, Part II:
  - Effective for cost reporting periods beginning on or after 10/1/2015, wage related costs reported on lines 25.50 – 25.53 and not combined above.

	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		350,000	0	350,000	7,000.00	50.00	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office and/or related orgainzation salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		2,257,063	0	2,257,063			17.00
18.00	Wage-related costs (other) (see instructions)		622,514	0	622,514			18.00
19.00	Excluded areas		440,075	0	440,075			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		25,387	0	25,387			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		73,476	0	73,476			22.01
23.00	Physician Part B		124,292	0	124,292			23.00
24.00	Wage-related costs (RHC/FQHC)		25,105	0	25,105			24.00
25.00	Interns & residents (in an approved program)		54,502	0	54,502			25.00
25.50	Home office wage-related		0	0	0			25.50
25.51	Related organization wage-related		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related		0	0	0			25.53

2552-10 TRANSMITTAL 10

- 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.

Lines 8, 8.01, 8.02, and 8.03--Effective for cost reporting periods beginning prior to August 1, 2016, complete line 8 if the hospital has purchased or self-funded insurance. Effective for cost reporting periods beginning on or after August 1, 2016, complete line 8.01 if the hospital has self-funded insurance without a TPA. Complete line 8.02 if the hospital has self-funded insurance with a TPA. Complete line 8.03 if the hospital purchases health insurance. (See the instructions under Worksheet S-3, Part II, regarding health insurance as a wage-related cost for the wage index).

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2552-10 TRANSMITTAL 10

- 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.

	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.0
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.0
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.0
8.03	Health Insurance (Purchased)	524,125	8.0
9.00	Prescription Drug Plan	75,846	9.0

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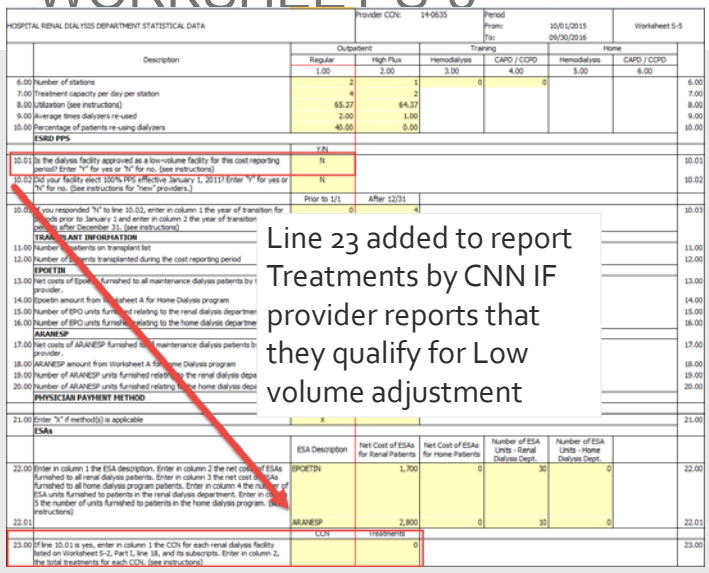
2552-10 TRANSMITTAL 10 WORKSHEET S-5



HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA — Provider CCN: 14-0635 — Period From: 10/01/2015 To: 09/30/2016 — Worksheet S-5

	Description	Outpatient Regular	Outpatient High Flux	Training Hemodialysis	Training CAPD / CCPD	Home Hemodialysis	Home CAPD / CCPD	
		1.00	2.00	3.00	4.00	5.00	6.00	
6.00	Number of stations	2	1	0	0			6.00
7.00	Treatment capacity per day per station	4	2					7.00
8.00	Utilization (see instructions)	65.37	64.27					8.00
9.00	Average times dialyzers re-used	2.00	1.00					9.00
10.00	Percentage of patients re-using dialyzers	40.00	0.00					10.00
	ESRD PPS							
		Y,N						
10.01	Is the dialysis facility approved as a low-volume facility for this cost reporting period? Enter "Y" for yes or "N" for no. (see instructions)	N						10.01
10.02	Did your facility elect 100% PPS effective January 1, 2011? Enter "Y" for yes or "N" for no. (See instructions for "new" providers.)	N						10.02
		Prior to 1/1	After 12/31					
10.03	If you responded "N" to line 10.02, enter in column 1 the year of transition for periods prior to January 1 and enter in column 2 the year of transition for periods after December 31. (see instructions)	0	4					10.03
	TRANSPLANT INFORMATION							
11.00	Number of patients on transplant list							11.00
12.00	Number of patients transplanted during the cost reporting period							12.00
	EPOETIN							
13.00	Net costs of Epoetin furnished to all maintenance dialysis patients by the provider.							13.00
14.00	Epoetin amount from Worksheet A for Home Dialysis program							14.00
15.00	Number of EPO units furnished relating to the renal dialysis department							15.00
16.00	Number of EPO units furnished relating to the home dialysis department							16.00
	ARANESP							
17.00	Net costs of ARANESP furnished to all maintenance dialysis patients by the provider.							17.00
18.00	ARANESP amount from Worksheet A for Home Dialysis program							18.00
19.00	Number of ARANESP units furnished relating to the renal dialysis department							19.00
20.00	Number of ARANESP units furnished relating to the home dialysis department							20.00
	PHYSICIAN PAYMENT METHOD							
21.00	Enter "X" if method(s) is applicable	X						21.00
	ESAs							
		ESA Description	Net Cost of ESAs for Renal Patients	Net Cost of ESAs for Home Patients	Number of ESA Units - Renal Dialysis Dept.	Number of ESA Units - Home Dialysis Dept.		
22.00	Enter in column 1 the ESA description. Enter in column 2 the net cost of ESAs furnished to all renal dialysis patients. Enter in column 3 the net cost of ESAs furnished to all home dialysis program patients. Enter in column 4 the number of ESA units furnished to patients in the renal dialysis department. Enter in column 5 the number of units furnished to patients in the home dialysis program. (see instructions)	EPOETIN	1,700	0	30	0		22.00
22.01		ARANESP	2,800	0	10	0		22.01
		CCN	Treatments					
23.00	If line 10.01 is yes, enter in column 1 the CCN for each renal dialysis facility listed on Worksheet S-2, Part I, line 18, and its subscripts. Enter in column 2, the total treatments for each CCN. (see instructions)		0					23.00

Line 23 added to report Treatments by CNN IF provider reports that they qualify for Low volume adjustment

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2552-10 TRANSMITTAL 10

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.

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2552-10 TRANSMITTAL 10

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 this 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 this 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 program (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 70% of charges if the patient qualified for a 70% 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.

2552-10 TRANSMITTAL 10 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 home office, or related organizations. If necessary, reclassify 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.

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2552-10 TRANSMITTAL 10

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.*

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2552-10 TRANSMITTAL 10 WORKSHEETS B – D SERIES

- No significant changes

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2552-10 TRANSMITTAL 10

Worksheet E, Part A – New line for Islet Isolation add-on Payment. Previously in new technology payments

Line 54--Enter the special add-on payment for new technologies *(see 42 CFR §§412.87 and 412.88)*. 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 9570).

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0635	Period From: 10/01/2015 To: 09/30/2016	Worksheet E, Part A	
	Title XVIII	Hospital	PPS	
	0	1.00	1.01	2.00	
54.00 Special add-on payments for new technologies		28,000		54.00
54.01 Islet isolation add-on payment				54.01
55.00 Net organ acquisition cost (Wksh. D-4 Pt. III, col. 1, line 69)		411,606		55.00
56.00 Cost of physicians' services in a teaching hospital (see intructions)		115,419		56.00

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2552-10 TRANSMITTAL 10

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.***

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2552-10 TRANSMITTAL 10

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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2552-10 TRANSMITTAL 10

Worksheet E-3, Part IV

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 19-2007	Period From: 10/01/2015 To: 08/31/2016	Worksheet E-3, Part IV
	Title XVIII	Hospital	PPS

		1.00	
	PART IV - MEDICARE PART A SERVICES - LTCH PPS		
1.00	Net Federal PPS Payments (see instructions)	4,773,370	1.00
1.01	Full standard payment amount	2,617,280	1.01
1.02	Short stay outlier standard payment amount	927,863	1.02
1.03	Site neutral payment amount - Cost	94,960	1.03
1.04	Site neutral payment amount - IPPS comparable	437,770	1.04
2.00	Outlier Payments	301,973	2.00
3.00	Total PPS Payments (sum of lines 1 and 2)	5,075,343	3.00

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2552-10 TRANSMITTAL 10

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.

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2552-10 TRANSMITTAL 10

ANALYSIS OF RENAL DIALYSIS DEPARTMENT COSTS

Provider CCN: 14-0635 Period From: 10/01/2015 To: 09/30/2016 Worksheet I-1

Component CCN: 14-3510 Renal Dialysis

		Total Costs	Basis	Statistics	FTEs per 2080 Hours	
		1.00	2.00	3.00	4.00	
1.00	REGISTERED NURSES	150,000	HOURS OF SERVICE	7,778.00	3.74	1.00
2.00	LICENSED PRACTICAL NURSES	0	HOURS OF SERVICE	0.00	0.00	2.00
3.00	NURSES AIDES	26,130	HOURS OF SERVICE	581.00	0.28	3.00
4.00	TECHNICIANS	45,000	HOURS OF SERVICE	5,444.00	2.62	4.00
5.00	SOCIAL WORKERS	25,000	HOURS OF SERVICE	2,778.00	1.34	5.00
6.00	DIETICIANS	16,412	HOURS OF SERVICE	2,178.00	1.05	6.00
7.00	PHYSICIANS	155,509	ACCUMULATED COST			7.00
8.00	NON-PATIENT CARE SALARY	18,000	ACCUMULATED COST			8.00
9.00	SUBTOTAL (SUM OF LINES 1-8)	436,051				9.00
10.00	EMPLOYEE BENEFITS	0	SALARY			10.00
11.00	CAPITAL RELATED COSTS-BLDGS.	0	SQUARE FEET			11.00
12.00	CAPITAL RELATED COSTS-MOV. E	0	PERCENTAGE OF TIME			12.00
13.00	MACHINE COSTS & REPAIRS	370,579	PERCENTAGE OF TIME			13.00
14.00	SUPPLIES	0	REQUISITIONS			14.00
15.00	DRUGS	4,500	REQUISITIONS			15.00
16.00	OTHER	300,000	ACCUMULATED COST			16.00
17.00	SUBTOTAL (SUM OF LINES 9-16)*	1,111,130				17.00
18.00	CAPITAL RELATED COSTS-BLDGS.	15,315	SQUARE FEET			18.00
19.00	CAPITAL RELATED COSTS-MOV. E	13,149	PERCENTAGE OF TIME			19.00
20.00	EMPLOYEE BENEFITS DEPARTMENT	15,000	SALARY			20.00
21.00	ADMINISTRATIVE & GENERAL	20,136	ACCUMULATED COST			21.00
22.00	MAINT./REPAIRS-OPER-HOUSEKEEPING	35,919	SQUARE FEET			22.00
23.00	MEDICAL EDUCATION PROGRAM COSTS	0				23.00
24.00	CENTRAL SERVICE & SUPPLIES	12,477	REQUISITIONS			24.00
25.00	PHARMACY	4,649	REQUISITIONS			25.00
26.00	OTHER ALLOCATED COSTS	43,138	ACCUMULATED COST			26.00
27.00	SUBTOTAL (SUM OF LINES 17-26)*	1,275,913				27.00
28.00	LABORATORY (SEE INSTRUCTIONS)	15,094	CHARGES	25,250		28.00
29.00	RESPIRATORY THERAPY (SEE INSTRUCTIONS)	3,208	CHARGES	6,500		29.00
30.00	OTHER ANCILLARY	0	CHARGES	0		30.00
31.00	TOTAL COSTS (SUM OF LINES 27-30)	1,294,215				31.00

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.

* Line 17, column 1 should agree with Worksheet A, column 7 for line 74 or line 94 as appropriate, and line 27, column 1 should agree with Worksheet B, Part I, column 24, less the sum of columns 21 and 22, for line 74 or line 94 as appropriate.

2552-10 TRANSMITTAL 10

Worksheet I-1:

- Modified instructions for lines 10 through 16, revising the effective

ALLOCATION OF RENAL DEPARTMENT COSTS TO TREATMENT MODALITIES

Provider CCN: 14-0635 Period From: 10/01/2015
Component CCN: 14-3510 To: 09/30/2016
Worksheet I-2
Renal Dialysis

	OUTPATIENT SERVICES COMPOSITE PAYMENT RATE	Capital Related Costs		Direct Patient Care Salary		Employee Benefits Department	Drugs	Medical Supplies	Routine Ancillary Services	Subtotal (sum of cols. 1-8)	Overhead	Total (col. 9 + col. 10)	
		Building	Equipment	RNs	Other								
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	10.00	11.00	
1.00	Total Renal Department Costs	51,234	383,728	150,000	112,542	15,000	9,149	17,477	18,302	757,432	536,783	1,294,215	1.00
	MAINTENANCE												
2.00	Hemodialysis	22,064	115,118	57,855	61,493	6,818	2,100	4,369	5,764	275,581	196,468	472,049	2.00
3.00	Intermittent Peritoneal	6,457	38,373	15,004	10,054	1,432	500	2,622	1,009	75,451	53,791	129,242	3.00
	TRAINING												
4.00	Hemodialysis	22,713	230,237	77,141	40,995	6,750	2,049	10,486	11,529	401,900	286,524	688,424	4.00
5.00	Intermittent Peritoneal	0	0	0	0	0	0	0	0	0	0	0	5.00
6.00	CAPD	0	0	0	0	0	0	0	0	0	0	0	6.00
7.00	CCPD	0	0	0	0	0	0	0	0	0	0	0	7.00
	HOME												
8.00	Hemodialysis	0	0	0	0	0	0	0	0	0	0	0	8.00
9.00	Intermittent Peritoneal	0	0	0	0	0	0	0	0	0	0	0	9.00
10.00	CAPD	0	0	0	0	0	0	0	0	0	0	0	10.00
11.00	CCPD	0	0	0	0	0	0	0				0	11.00
	OTHER BILLABLE SERVICES												
12.00	Inpatient Dialysis	0	0	0	0	0	0	0				0	12.00
13.00	Method II Home Patient	0	0	0	0	0	0	0				0	13.00
14.00	ESAs (included in Renal Department)						4,500						14.00
15.00													15.00
16.00	Other	0	0	0	0	0	0	0				0	16.00
17.00	Total (sum of lines 2 through 16)	51,234	383,728	150,000	112,542	15,000	4,649	17,477	18,30			15	17.00
18.00	Medical Educational Program Costs											0	18.00
19.00	Total Renal Costs (line 17 + line 18)											1,289,715	19.00

Note that ESA not included in total allocation

- Modified line 14 description and shaded line 15.

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2552-10 TRANSMITTAL 10

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.

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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

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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

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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.

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PROVIDER-BASED HOSPICE

Worksheet S-9, Parts I - IV:

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA

Provider CCN: 14-0635 | Hospice CCN.: 14-1590 | Period From: 10/01/2015 To: 09/30/2016 | Worksheet S-9, PARTS I THROUGH IV

Hospice I

		Unduplicated Days					
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2 & 5)
		1.00	2.00	3.00	4.00	5.00	6.00
	PART I - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015						
1.00	Hospice Continuous Home Care						1.00
2.00	Hospice Routine Home Care						2.00
3.00	Hospice Inpatient Respite Care						3.00
4.00	Hospice General Inpatient Care						4.00
5.00	Total Hospice Days						5.00
	Part II - CENSUS DATA FOR COST REPORTING PERIODS BE						
6.00	Number of patients receiving hospice care						6.00
7.00	Total number of unduplicated Continuous Care hours billable to Me						7.00
8.00	Average Length of Stay (line 5 / line 6)						8.00
9.00	Unduplicated census count						9.00
	NOTE: Parts I and II, columns 1 and 2 also include the days report						
	PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015						
		Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)		
10.00	Hospice Continuous Home Care	20	0	20	40		10.00
11.00	Hospice Routine Home Care	260	0	220	480		11.00
12.00	Hospice Inpatient Respite Care	50	0	10	60		12.00
13.00	Hospice General Inpatient Care	40	0	0	40		13.00
14.00	Total Hospice Days	370	0	250	620		14.00
	PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015						
15.00	Hospice Inpatient Respite Care	12	0	4	16		15.00
16.00	Hospice General Inpatient Care	0	0	0	0		16.00

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

PROVIDER-BASED HOSPICE WORKSHEET O

ANALYSIS OF SNF-BASED HOSPICE COSTS

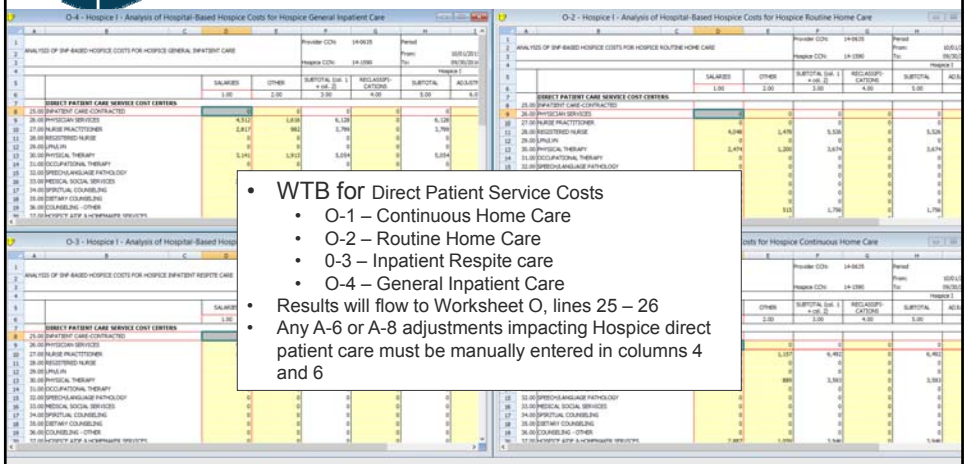
Provider CCN: 14-0635 | Hospice CCN: 14-1590 | Period From: 10/01/2015 To: 09/30/2016 | Worksheet O

Hospice I

			SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
			1.00	2.00	3.00	4.00	5.00	6.00	7.00	
		GENERAL SERVICE COST CENTERS								
1.00	0100	CAP REL COSTS-BLDG & FIXT*		25,481	25,481	0	25,481	0	25,481	1.00
2.00	0200	CAP REL COSTS-MVBLE EQUIP*		13,751	13,751	0	13,751	0	13,751	2.00
3.00	0300	EMPLOYEE BENEFITS DEPARTMENT*	14,135	7,536	21,671	0	21,671	0	21,671	3.00
4.00	0400	ADMINISTRATIVE & GENERAL*	7,353	5,422	12,775	0	12,775	0	12,775	4.00
5.00	0500	PLANT OPERATION & MAINTENANCE*	4,048	3,640	7,688	0	7,688	0	7,688	5.00
6.00	0600	LAUNDRY & LINEN SERVICE*	1,619	775	2,394	0	2,394	0	2,394	6.00
7.00	0700	HOUSEKEEPING*	1,044	500	1,544	0	1,544	0	1,544	7.00
8.00	0800	DIETARY*	200	103	303	0	303	0	303	8.00
9.00	0900	NURSING ADMINISTRATION*	3,600	1,777	5,377	0	5,377	0	5,377	9.00
10.00	1000	ROUTINE MEDICAL SUPPLIES*	2,496	906	3,402	0	3,402	0	3,402	10.00
11.00	1100	MEDICAL RECORDS*	801	432	1,233	0	1,233	0	1,233	11.00
12.00	1200	STAFF TRANSPORTATION*	721	144	865	0	865	0	865	12.00
13.00	1300	VOLUNTEER SERVICE COORDINATION*	455	292	747	0	747	0	747	13.00
14.00	1400	PHARMACY*	2,415	1,352	3,767	0	3,767	0	3,767	14.00
15.00	1500	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	0	0	0	15.00
16.00	1600	OTHER GENERAL SERVICES*						0	0	16.00
17.00	1700	PATIENT/RESIDENT								17.00
		DIRECT PATIENT CARE SE								
25.00	2500	INPATIENT CARE-C						0	1,617	25.00
26.00	2600	PHYSICIAN SERVICE						0	11,319	26.00
27.00	2700	NURSE PRACTITION						0	12,887	27.00
28.00	2800	REGISTERED NURSE						0	5,526	28.00
29.00	2900	LPN/LVN**	0	0	0	0	0	0	0	29.00
30.00	3000	PHYSICAL THERAPY**	8,319	4,002	12,321	0	12,321	0	12,321	30.00
31.00	3100	OCCUPATIONAL THERAPY**	0	0	0	0	0	0	0	31.00
32.00	3200	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	0	0	0	32.00
33.00	3300	MEDICAL SOCIAL SERVICES**	2,542	515	3,057	0	3,057	0	3,057	33.00
34.00	3400	SPIRITUAL COUNSELING**	0	0	0	0	0	0	0	34.00
35.00	3500	DIETARY COUNSELING**	0	0	0	0	0	0	0	35.00
36.00	3600	COUNSELING - OTHER**	0	0	0	0	0	0	0	36.00
37.00	3700	HOSPICE AIDE & HOMEMAKER SERVICES**	4,128	1,574	5,702	0	5,702	0	5,702	37.00

- WTB
- Direct Patient Service Costs will flow from Worksheets O-1 through O-4

PROVIDER-BASED HOSPICE WORKSHEET O-1 – O-4



- WTB for Direct Patient Service Costs
  - O-1 – Continuous Home Care
  - O-2 – Routine Home Care
  - 0-3 – 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

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PROVIDER-BASED HOSPICE WORKSHEET O-5

COST ALLOCATION - DETERMINATION OF SNF-BASED HOSPICE NET EXPENSES FOR ALLOCATION

Provider CCN: 14-0635 | Period From: 10/01/2015 | Worksheet O-5

Hospice CCN: 14-1590 | To: 09/30/2016

Hospice I

	Descriptions	HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)	TOTAL EXPENSES (sum of cols. 1 + 2)	
		1.00	2.00	3.00	
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	25,481	4,850	30,331	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	13,751	4,163	17,914	2.00
3.00	EMPLOYEE BENEFITS DEPARTMEN			24,461	3.00
4.00	ADMINISTRATIVE & GENERAL			20,297	4.00
5.00	PLANT OPERATION & MAINTENAN			17,073	5.00
6.00	LAUNDRY & LINEN SERVICE			4,567	6.00
7.00	HOUSEKEEPING			26,656	7.00
8.00	DIETARY			303	8.00
9.00	NURSING ADMINISTRATION			19,434	9.00
10.00	ROUTINE MEDICAL SUPPLIES			3,818	10.00
11.00	MEDICAL RECORDS			2,835	11.00
12.00	STAFF TRANSPORTATION	865		865	12.00
13.00	VOLUNTEER SERVICE COORDINATION	747		747	13.00
14.00	PHARMACY	3,767	1,382	5,149	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		241	241	17.00
	LEVEL OF CARE				
50.00	HOSPICE CONTINUOUS HOME CARE	15,696		15,696	50.00
51.00	HOSPICE ROUTINE HOME CARE	10,956		10,956	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	9,404		9,404	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	19,256		19,256	53.00
	NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM	1,135		1,135	60.00
61.00	VOLUNTEER PROGRAM	0		0	61.00
62.00	FUNDRAISING	0		0	62.00

- "Bridges the Gap" between Hospice Direct costs and HHA overhead.
- No input

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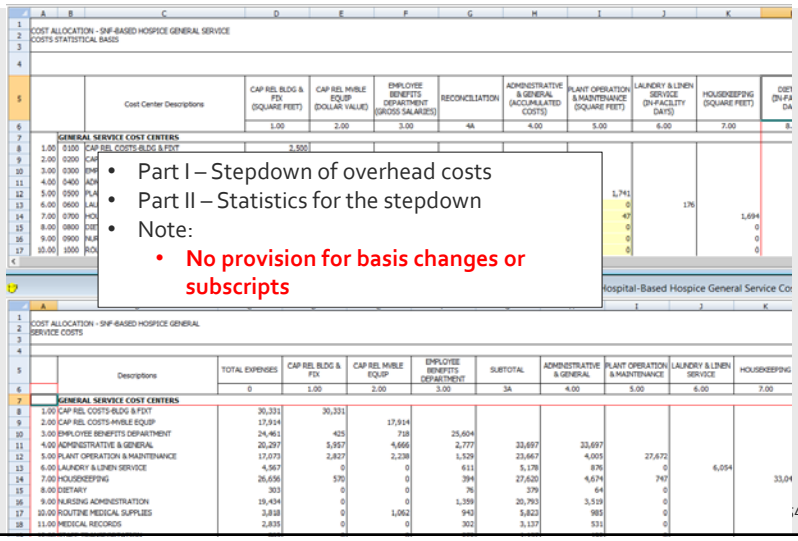
PROVIDER-BASED HOSPICE WORKSHEET O-5

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

O-5 Line	2552-10 B, Line	2540-10 B, Line	1728-94 B, Line	O-5 Line	2552-10 B, Line	2540-10 B, Line	1728-94 B, Line
1	1	1	1	10	14	10	N/A
2	2	2	2	11	16	12	N/A
3	4	3	N/A	12	N/A	N/A	4
4	5, 11 and 12	4	5	13	N/A	N/A	N/A
5	6 and 7	5	3	14	15	11	N/A
6	8	6	N/A	15	N/A	N/A	N/A
7	9	7	N/A	16	18, 20 and 23	15 and 14	N/A
8	10	8	N/A	17	17	13	

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

APPORTIONMENT OF SNF-BASED HOSPICE SHARED SERVICE COSTS BY LEVEL OF CARE

Provider CCN: 14-0635 Hospice CCN: 14-1590 Period From: 10/01/2015 To: 09/30/2016 Worksheet O-7

Hospice I

	Cost Center Descriptions	From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	Charges by LOC (from Provider Records) HCHC	HRHC	HIRC	HGIP	Shared Service Costs by LOC MCHC (col. 1 x col. 2)	MRHC (col. 1 x col. 3)	MIRC (col. 1 x col. 4)	MGIP (col. 1 x col. 5)
		0	1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00
	ANCILLARY SERVICE COST CENTERS										
1.00	PHYSICAL THERAPY	66.00	0.624652	5,461	4,220	2,177	8,025	3,411	2,636	1,360	5,013
2.00	OCCUPATIONAL THERAPY	67.00	1.749896	0	0	0	0	0	0	0	0
3.00	SPEECH PATHOLOGY	68.00	0.850536	0	0	0	0	0	0	0	0
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.516428	0	0	0	0	0	0	0	0
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00	0.637600	2,385	1,160	0	0	1,521	740	0	0
6.00	LABORATORY	60.00	0.597771	0	0	0	0	0	0	0	0
6.01	BLOOD LAB	60.01	0.860467	0	0	0	0	0	0	0	0
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0.440226	2,040	1,655	0	851	898	729	0	375
8.00	OTHER OUTPATIENT	93.00	0.000000	0	0	0	0	0	0	0	0
9.00	RADIOLOGY-THERAPEUTIC	55.00	0.607846	0	0	0	0	0	0	0	0
10.00	OTHER ANCILLARY	76.00	0.000000	0	0	0	0	0	0	0	0
11.00	Totals (sum of lines 1-11)							5,830	4,105	1,360	5,388

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

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PROVIDER-BASED HOSPICE WORKSHEET O-8

CALCULATION OF SNF-BASED HOSPICE PER DIEM COST

Provider CCN: 14-0635 Hospice CCN: 14-1590 Period From: 10/01/2015 To: 09/30/2016 Worksheet O-8

Hospice I

		TITLE XVIII MEDICARE	TITLE XIX MEDICAID	TOTAL	
		1.00	2.00	3.00	
	HOSPICE CONTINUOUS HOME CARE				
1.00	Total cost (Wkst. O-6, Part I, col. 18, line 50 plus Wkst. O-7, col. 6, line 11)			39,102	1.00
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)			40	2.00
3.00	Total average cost per diem (line 1 divided by line 2)			977.55	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)	20	0		4.00
5.00	Program cost (line 3 times line 4)	19,551	0		5.00
	HOSPICE ROUTINE HOME CARE				
6.00	Total cost (Wkst. O-6, Part I, col. 18, line 51 plus Wkst. O-7, col. 7, line 11)			34,589	6.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			480	7.00
8.00	Total average cost per diem (line 6 divided by			72.06	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as				9.00
10.00	Program cost (line 8 times line 9)				10.00
	HOSPICE INPATIENT RESPITE CARE				
11.00	Total cost (Wkst. O-6, Part I, col. 18, line 52 p			38,088	11.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line			60	12.00
13.00	Total average cost per diem (line 11 divided by			634.80	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as				14.00
15.00	Program cost (line 13 times line 14)	31,740	0		15.00
	HOSPICE GENERAL INPATIENT CARE				
16.00	Total cost (Wkst. O-6, Part I, col. 18, line 53 plus Wkst. O-7, col. 9, line 11)			121,592	16.00
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			40	17.00
18.00	Total average cost per diem (line 16 divided by line 17)			3,039.80	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	40	0		19.00
20.00	Program cost (line 18 times line 19)	121,592	0		20.00
	TOTAL HOSPICE CARE				
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			233,371	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			620	22.00
23.00	Average cost per diem (line 21 divided by line 22)			376.40	23.00

- 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

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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

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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

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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.

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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

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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

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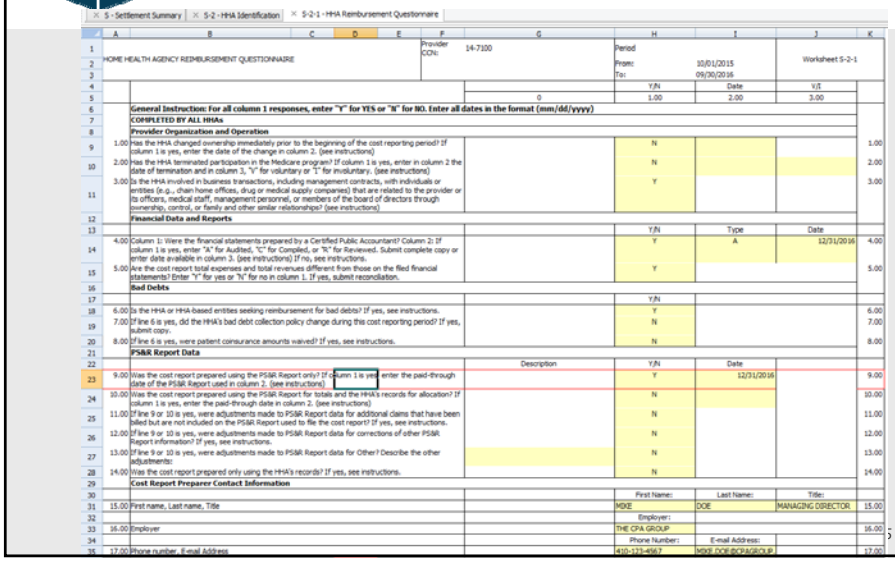
FORM 1728-94 T-17 WORKSHEET S-2-1



HOME HEALTH AGENCY REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-7100 | Period From: 10/01/2015 To: 09/30/2016 | Worksheet S-2-1

General Instruction: For all column 1 responses, enter "Y" for YES or "N" for NO. Enter all dates in the format (mm/dd/yyyy)

COMPLETED BY ALL HHAs

Provider Organization and Operation

1.00 Has the HHA changed ownership immediately prior to the beginning of the cost reporting period? If column 1 is yes, enter the date of the change in column 2. (see instructions) — N

2.00 Has the HHA terminated participation in the Medicare program? If column 1 is yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary. (see instructions) — N

3.00 Is the HHA involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions) — Y

Financial Data and Reports

4.00 Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If column 1 is yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. — Y | A | 12/31/2016

5.00 Are the cost report total expenses and total revenues different from those on the filed financial statements? Enter "Y" for yes or "N" for no in column 1. If yes, submit reconciliation. — Y

Bad Debts

6.00 Is the HHA or HHA-based entities seeking reimbursement for bad debts? If yes, see instructions. — Y

7.00 If line 6 is yes, did the HHA's bad debt collection policy change during this cost reporting period? If yes, submit copy. — N

8.00 If line 6 is yes, were patient coinsurance amounts waived? If yes, see instructions. — N

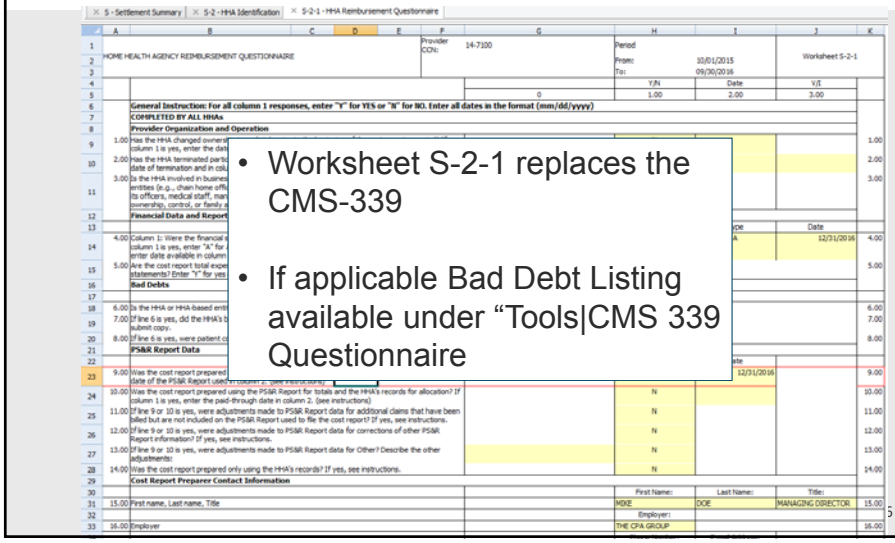
PS&R Report Data

		Description	Y/N	Date
9.00	Was the cost report prepared using the PS&R Report only? If column 1 is yes, enter the paid-through date of the PS&R Report used in column 2. (see instructions)		Y	12/31/2016
10.00	Was the cost report prepared using the PS&R Report for totals and the HHA's records for allocation? If column 1 is yes, enter the paid-through date in column 2. (see instructions)		N	
11.00	If line 9 or 10 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file the cost report? If yes, see instructions.		N	
12.00	If line 9 or 10 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N	
13.00	If line 9 or 10 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	
14.00	Was the cost report prepared only using the HHA's records? If yes, see instructions.		N	

Cost Report Preparer Contact Information

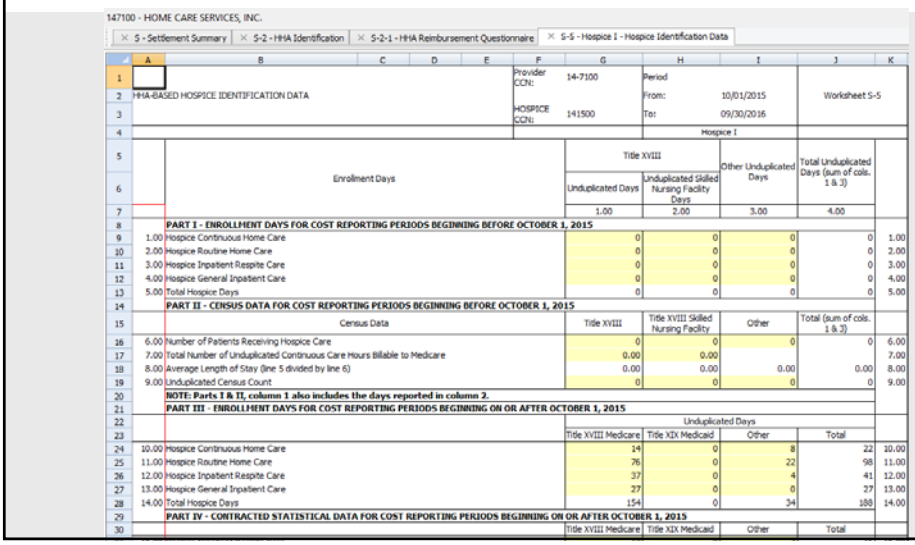
		First Name:	Last Name:	Title:
15.00	First name, Last name, Title	MIKE	DOE	MANAGING DIRECTOR
		Employer:		
16.00	Employer	THE CPA GROUP		
		Phone Number:	E-mail Address:	
17.00	Phone number, E-mail Address	410-123-4567	MIKE.DOE@CPAGROUP	

FORM 1728-94 T-17 WORKSHEET S-2-1



- Worksheet S-2-1 replaces the CMS-339
- If applicable Bad Debt Listing available under "Tools|CMS 339 Questionnaire

FORM 1728-94 T-17 WORKSHEET S-5

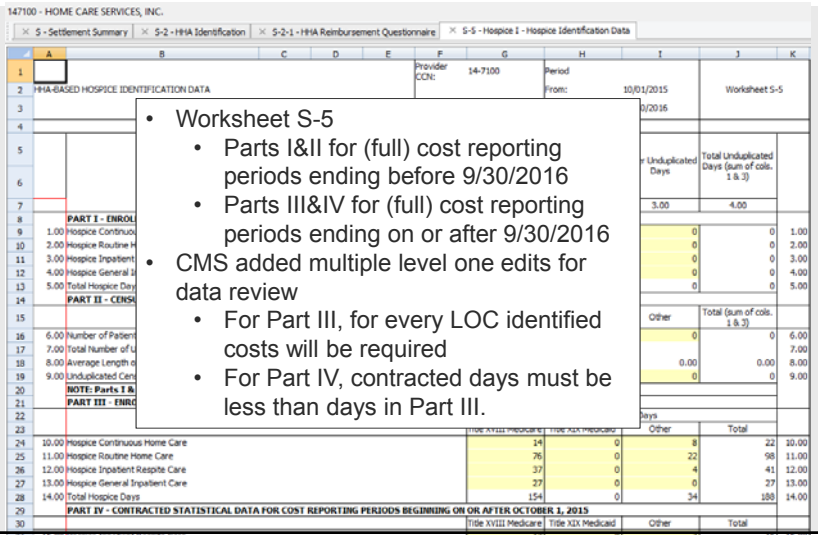


147100 - HOME CARE SERVICES, INC.

S - Settlement Summary | S-2 - HHA Identification | S-2-1 - HHA Reimbursement Questionnaire | S-5 - Hospice I - Hospice Identification Data

1					Provider CCN:	14-7100	Period			
2	HHA-BASED HOSPICE IDENTIFICATION DATA						From:	10/01/2015	Worksheet S-5	
3					HOSPICE CCN:	141500	To:	09/30/2016		
4							Hospice I			
5						Title XVIII		Other Unduplicated Days	Total Unduplicated Days (sum of cols. 1 & 3)	
6			Enrollment Days			Unduplicated Days	Unduplicated Skilled Nursing Facility Days			
7						1.00	2.00	3.00	4.00	
8		PART I - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015								
9	1.00	Hospice Continuous Home Care				0	0	0	0	1.00
10	2.00	Hospice Routine Home Care				0	0	0	0	2.00
11	3.00	Hospice Inpatient Respite Care				0	0	0	0	3.00
12	4.00	Hospice General Inpatient Care				0	0	0	0	4.00
13	5.00	Total Hospice Days				0	0	0	0	5.00
14		PART II - CENSUS DATA FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015								
15			Census Data			Title XVIII	Title XVIII Skilled Nursing Facility	Other	Total (sum of cols. 1 & 3)	
16	6.00	Number of Patients Receiving Hospice Care				0	0	0	0	6.00
17	7.00	Total Number of Unduplicated Continuous Care Hours Billable to Medicare				0.00	0.00			7.00
18	8.00	Average Length of Stay (line 5 divided by line 6)				0.00	0.00	0.00	0.00	8.00
19	9.00	Unduplicated Census Count				0	0	0	0	9.00
20		NOTE: Parts I & II, column 1 also includes the days reported in column 2.								
21		PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015								
22						Unduplicated Days				
23						Title XVIII Medicare	Title XIX Medicaid	Other	Total	
24	10.00	Hospice Continuous Home Care				14	0	8	22	10.00
25	11.00	Hospice Routine Home Care				76	0	22	98	11.00
26	12.00	Hospice Inpatient Respite Care				37	0	4	41	12.00
27	13.00	Hospice General Inpatient Care				27	0	0	27	13.00
28	14.00	Total Hospice Days				154	0	34	188	14.00
29		PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015								
30						Title XVIII Medicare	Title XIX Medicaid	Other	Total	

FORM 1728-94 T-17 WORKSHEET S-5

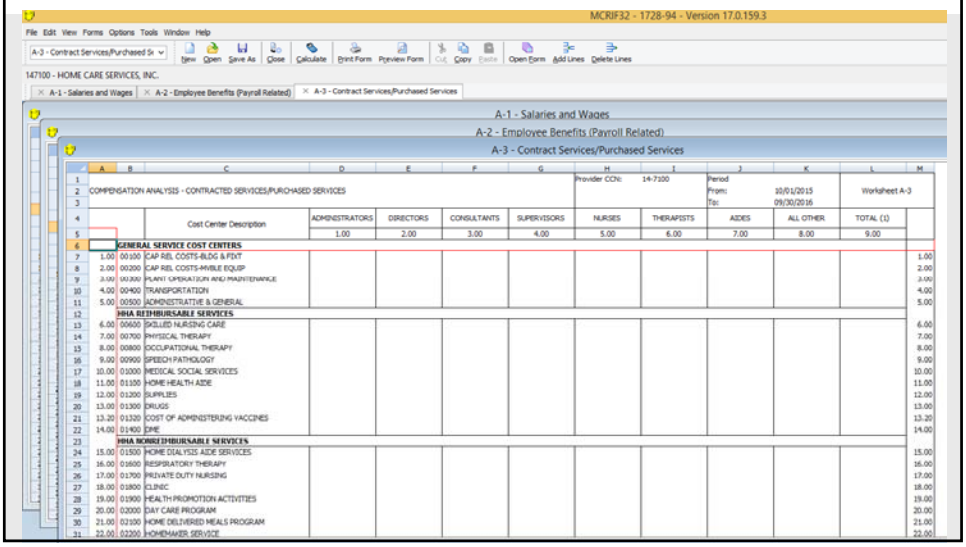


147100 - HOME CARE SERVICES, INC.

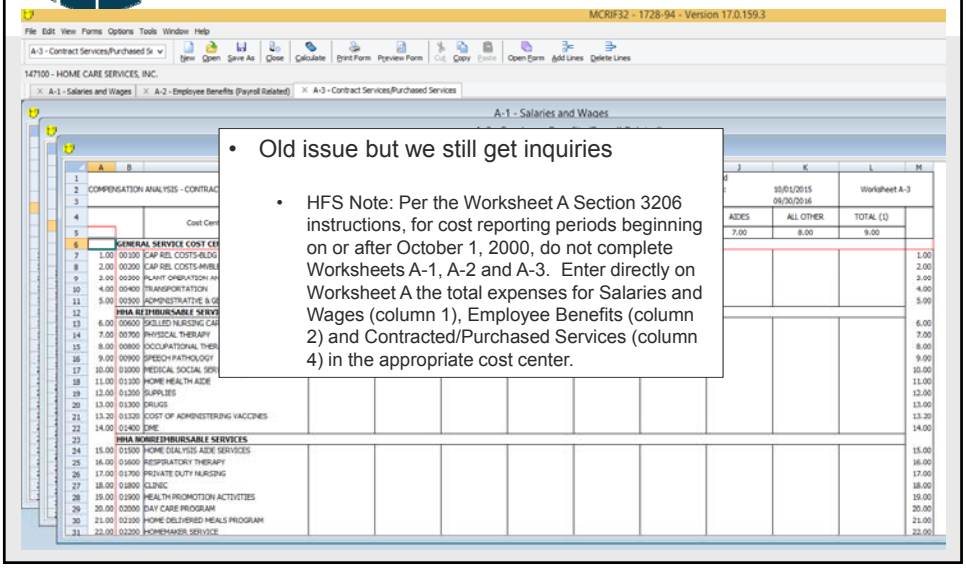
S - Settlement Summary | S-2 - HHA Identification | S-2-1 - HHA Reimbursement Questionnaire | S-5 - Hospice I - Hospice Identification Data

- 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.

FORM 1728-94 T-17 WORKSHEETS A-1/A-2/A-3

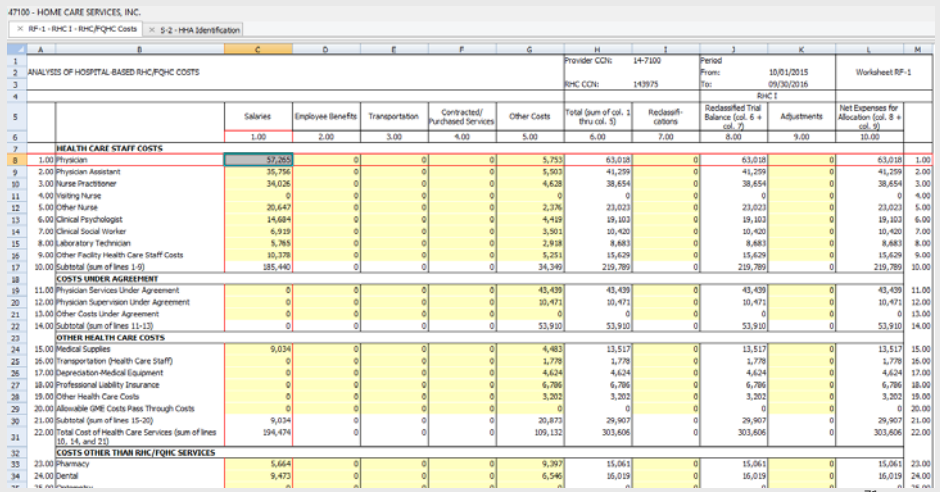


FORM 1728-94 T-17 WORKSHEETS A-1/A-2/A-3



- 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.

FORM 1728-94 T-17 WORKSHEETS RF-1 THROUGH RF-5



47100 - HOME CARE SERVICES, INC.

RF-1 - RHC I - RHC/FQHC Costs | S-2 - HHA Identification

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-7100 | RHC CCN: 143975 | Period From: 10/01/2015 To: 09/30/2016 | Worksheet RF-1

RHC I

		Salaries	Employee Benefits	Transportation	Contracted/ Purchased Services	Other Costs	Total (sum of col. 1 thru col. 5)	Reclassifi-cations	Reclassified Trial Balance (col. 6 + col. 7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	10.00	
	HEALTH CARE STAFF COSTS											
1.00	Physician	57,265	0	0	0	5,753	63,018	0	63,018	0	63,018	1.00
2.00	Physician Assistant	35,756	0	0	0	5,503	41,259	0	41,259	0	41,259	2.00
3.00	Nurse Practitioner	34,026	0	0	0	4,628	38,654	0	38,654	0	38,654	3.00
4.00	Visiting Nurse	0	0	0	0	0	0	0	0	0	0	4.00
5.00	Other Nurse	20,647	0	0	0	2,376	23,023	0	23,023	0	23,023	5.00
6.00	Clinical Psychologist	14,684	0	0	0	4,419	19,103	0	19,103	0	19,103	6.00
7.00	Clinical Social Worker	6,919	0	0	0	3,501	10,420	0	10,420	0	10,420	7.00
8.00	Laboratory Technician	5,765	0	0	0	2,918	8,683	0	8,683	0	8,683	8.00
9.00	Other Facility Health Care Staff Costs	10,378	0	0	0	5,251	15,629	0	15,629	0	15,629	9.00
10.00	Subtotal (sum of lines 1-9)	185,440	0	0	0	34,349	219,789	0	219,789	0	219,789	10.00
	COSTS UNDER AGREEMENT											
11.00	Physician Services Under Agreement	0	0	0	0	43,439	43,439	0	43,439	0	43,439	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	10,471	10,471	0	10,471	0	10,471	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	0	0	0	53,910	53,910	0	53,910	0	53,910	14.00
	OTHER HEALTH CARE COSTS											
15.00	Medical Supplies	9,034	0	0	0	4,483	13,517	0	13,517	0	13,517	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	1,778	1,778	0	1,778	0	1,778	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	4,624	4,624	0	4,624	0	4,624	17.00
18.00	Professional Liability Insurance	0	0	0	0	6,786	6,786	0	6,786	0	6,786	18.00
19.00	Other Health Care Costs	0	0	0	0	3,202	3,202	0	3,202	0	3,202	19.00
20.00	Allowable GME Costs Pass Through Costs	0	0	0	0	0	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	9,034	0	0	0	20,873	29,907	0	29,907	0	29,907	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	194,474	0	0	0	109,132	303,606	0	303,606	0	303,606	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES											
23.00	Pharmacy	5,664	0	0	0	9,397	15,061	0	15,061	0	15,061	23.00
24.00	Dental	9,473	0	0	0	6,546	16,019	0	16,019	0	16,019	24.00

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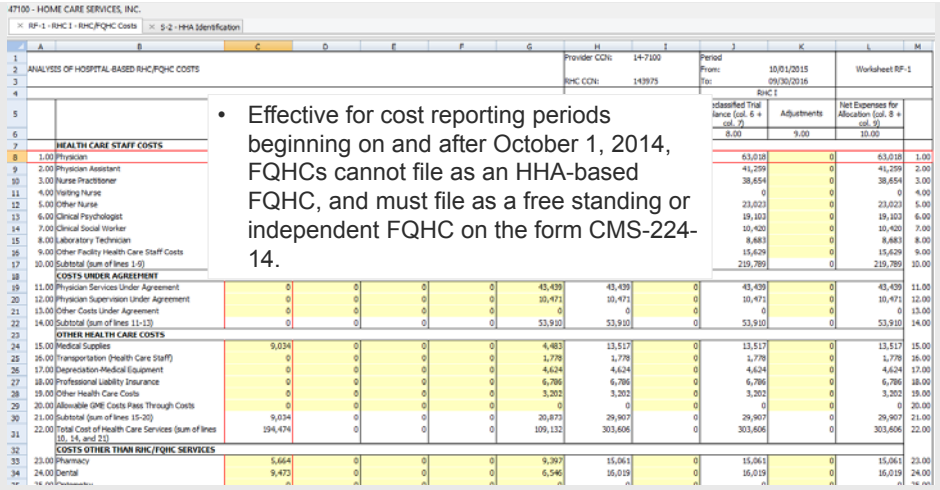
FORM 1728-94 T-17 WORKSHEETS RF-1 THROUGH RF-5



47100 - HOME CARE SERVICES, INC.

RF-1 - RHC I - RHC/FQHC Costs | S-2 - HHA Identification

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-7100 | RHC CCN: 143975 | Period From: 10/01/2015 To: 09/30/2016 | Worksheet RF-1

RHC I

- 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.

		Reclassified Trial Balance (col. 6 + col. 7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)	
		8.00	9.00	10.00	
	HEALTH CARE STAFF COSTS				
1.00	Physician	63,018	0	63,018	1.00
2.00	Physician Assistant	41,259	0	41,259	2.00
3.00	Nurse Practitioner	38,654	0	38,654	3.00
4.00	Visiting Nurse	0	0	0	4.00
5.00	Other Nurse	23,023	0	23,023	5.00
6.00	Clinical Psychologist	19,103	0	19,103	6.00
7.00	Clinical Social Worker	10,420	0	10,420	7.00
8.00	Laboratory Technician	8,683	0	8,683	8.00
9.00	Other Facility Health Care Staff Costs	15,629	0	15,629	9.00
10.00	Subtotal (sum of lines 1-9)	219,789	0	219,789	10.00
	COSTS UNDER AGREEMENT				
11.00	Physician Services Under Agreement	43,439	0	43,439	11.00
12.00	Physician Supervision Under Agreement	10,471	0	10,471	12.00
13.00	Other Costs Under Agreement	0	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	53,910	0	53,910	14.00
	OTHER HEALTH CARE COSTS				
15.00	Medical Supplies	13,517	0	13,517	15.00
16.00	Transportation (Health Care Staff)	1,778	0	1,778	16.00
17.00	Depreciation-Medical Equipment	4,624	0	4,624	17.00
18.00	Professional Liability Insurance	6,786	0	6,786	18.00
19.00	Other Health Care Costs	3,202	0	3,202	19.00
20.00	Allowable GME Costs Pass Through Costs	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	29,907	0	29,907	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	303,606	0	303,606	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	15,061	0	15,061	23.00
24.00	Dental	16,019	0	16,019	24.00

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FORM 1728-94 T-17

- 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.

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

- Consolidated report

	Consolidated Cost Report	Y/N	Date Requested	Date Approved	Number of FQHCs	
13.00	Is this FQHC filing a consolidated cost report per CMS Pub. 100-04, chapter 9, §30.8? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, complete columns 2 through 4, and line 14, beginning with subscripted line 14.01. If column 1 is no, leave line 14 blank. (see instructions)	Y			1	
		Site Name	CCN	CBSA	Date Requested	Date Approved
14.00	FQHC Site Information:					
14.01	FQHC Site Information:	FQHC PLUS CARE	141851	16974		

- Line 13 – filing 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

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

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

	FQHC Operations			
15.00	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)	1 - Organization receiving a grant(s) u	ABD	
16.00	Did this 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 this cost reporting period? Enter "Y" for yes or "N" for no. (complete line 17)	Y		
17.00	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 subscript this line accordingly.	1 - Community Health Center	12/01/2014	330-PHS-20

77

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

- CMS clarification – HRSA/Commercial malpractice insurance

	Medical Malpractice			
18.00	Did this FQHC submit an initial deeming or annual redeeming application for medical malpractice coverage under the FTCA 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.	Y	01/01/2005	
19.00	Does this FQHC carry commercial malpractice insurance? Enter "Y" for yes or "N" for no.	Y		
20.00	Is the malpractice insurance a claims-made or occurrence policy? Enter "1" for claims-made or "2" for occurrence policy.	2		
		Premiums	Paid Losses	Self Insurance
21.00	List amounts of malpractice premiums, paid losses or self-insurance in the applicable columns.	45,825	12,000	0
22.00	Are malpractice premiums, paid losses or self-insurance reported in a cost center other than Administrative and General? Enter "Y" for yes or "N" for no. (see instructions)	N		

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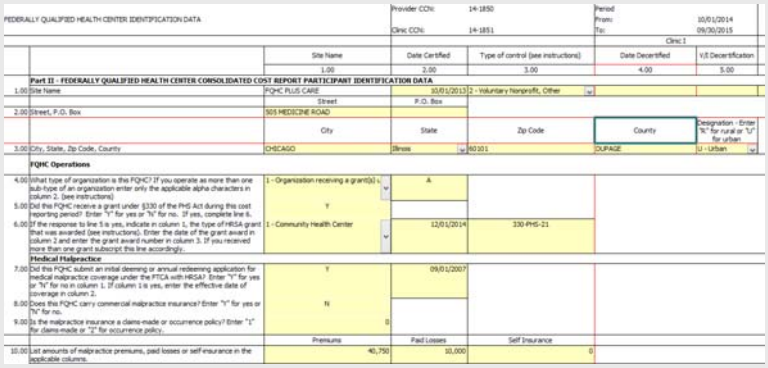
FORM CMS 224-14 WORKSHEET S-1, PART II

- Separate S-1, Part II for each consolidated facility identified on S-1, Part I, subscripts of line 14



FEDERALLY QUALIFIED HEALTH CENTER IDENTIFICATION DATA

Provider CCN: 14-1850 Clinic CCN: 14-1851 Period From: 10/01/2014 To: 09/30/2015 Clinic 1

		Site Name	Date Certified	Type of control (see instructions)	Date Decertified	V,E Decertification
		1.00	2.00	3.00	4.00	5.00
	Part II - FEDERALLY QUALIFIED HEALTH CENTER CONSOLIDATED COST REPORT PARTICIPANT IDENTIFICATION DATA					
1.00	Site Name	FQHC PLUS CARE	10/01/2013	2 - Voluntary Nonprofit, Other		
	Street		P.O. Box			
2.00	Street, P.O. Box	505 MEDICINE ROAD				
	City		State	Zip Code	County	Designation - Enter "R" for rural or "U" for urban
3.00	City, State, Zip Code, County	CHICAGO	Illinois	60101	DUPAGE	U - Urban
	FQHC Operations					
4.00	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)	1 - Organization receiving a grant(s) u	A			
5.00	Did this FQHC receive a grant under §330 of the PHS Act during this cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete line 6.	Y				
6.00	If the response to line 5 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 subscript this line accordingly.	1 - Community Health Center	12/01/2014	330-PHS-21		
	Medical Malpractice					
7.00	Did this FQHC submit an initial deeming or annual redeeming application for medical malpractice coverage under the FTCA 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.	Y	09/01/2007			
8.00	Does this FQHC carry commercial malpractice insurance? Enter "Y" for yes or "N" for no.	N				
9.00	Is the malpractice insurance a claims-made or occurrence policy? Enter "1" for claims-made or "2" for occurrence policy.	0				
		Premiums	Paid Losses	Self Insurance		
10.00	List amounts of malpractice premiums, paid losses or self-insurance in the applicable columns.	40,750	10,000	0		

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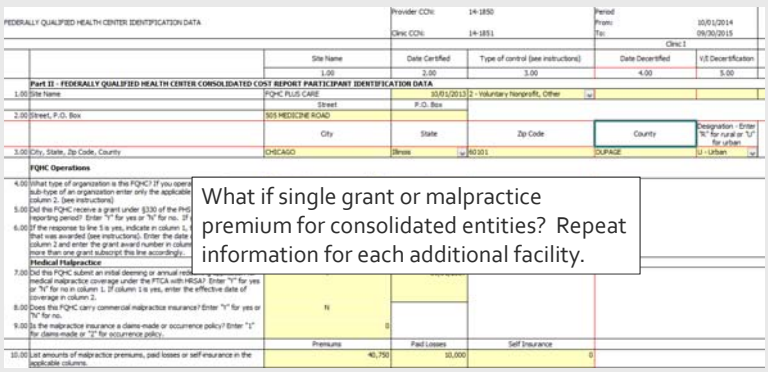
FORM CMS 224-14 WORKSHEET S-1, PART II

- Separate S-1, Part II for each consolidated facility identified on S-1, Part I, subscripts of line 14



FEDERALLY QUALIFIED HEALTH CENTER IDENTIFICATION DATA

Provider CCN: 14-1850 Clinic CCN: 14-1851 Period From: 10/01/2014 To: 09/30/2015 Clinic 1

		Site Name	Date Certified	Type of control (see instructions)	Date Decertified	V,E Decertification
		1.00	2.00	3.00	4.00	5.00
	Part II - FEDERALLY QUALIFIED HEALTH CENTER CONSOLIDATED COST REPORT PARTICIPANT IDENTIFICATION DATA					
1.00	Site Name	FQHC PLUS CARE	10/01/2013	2 - Voluntary Nonprofit, Other		
	Street		P.O. Box			
2.00	Street, P.O. Box	505 MEDICINE ROAD				
	City		State	Zip Code	County	Designation - Enter "R" for rural or "U" for urban
3.00	City, State, Zip Code, County	CHICAGO	Illinois	60101	DUPAGE	U - Urban
	FQHC Operations					
4.00	What type of organization is this FQHC? If you opera sub-type of an organization enter only the applicable column 2. (see instructions)					
5.00	Did this FQHC receive a grant under §330 of the PHS reporting period? Enter "Y" for yes or "N" for no. If					
6.00	If the response to line 5 is yes, indicate in column 1, that was awarded (see instructions). Enter the date column 2 and enter the grant award number in colum more than one grant subscript this line accordingly.					
	Medical Malpractice					
7.00	Did this FQHC submit an initial deeming or annual red medical malpractice coverage under the FTCA 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.					
8.00	Does this FQHC carry commercial malpractice insurance? Enter "Y" for yes or "N" for no.	N				
9.00	Is the malpractice insurance a claims-made or occurrence policy? Enter "1" for claims-made or "2" for occurrence policy.	0				
		Premiums	Paid Losses	Self Insurance		
10.00	List amounts of malpractice premiums, paid losses or self-insurance in the applicable columns.	40,750	10,000	0		

What if single grant or malpractice premium for consolidated entities? Repeat information for each additional facility.

8o

FORM CMS 224-14 WORKSHEET A SERIES

- Only the following cost centers can be subscripted.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-224-14
TABLE 5 - COST CENTER CODING

TABLE 5 - NONSTANDARD COST CENTER DESCRIPTIONS AND CODES

	CODE	USE
GENERAL SERVICE COST CENTERS		
Other General Service (specify)	1200	(20)
OTHER FQHC SERVICES		
Other (specify)	6800	(20)
NONREIMBURSABLE COST CENTERS		
Other Nonreimbursable (specify)	7900	(20)

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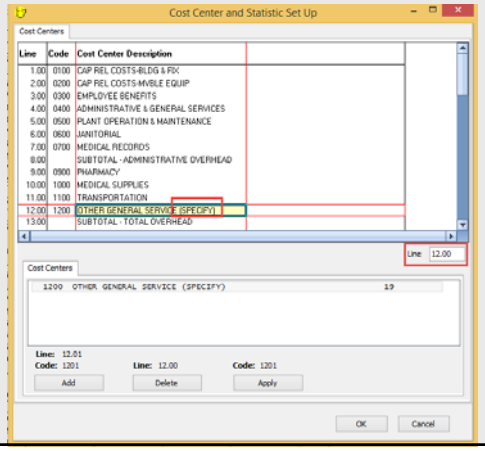
FORM CMS 224-14 WORKSHEET A SERIES

- Descriptions can (must) be changed and 19 subscripts available.



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FORM CMS 224-14 WORKSHEET B

CALCULATION OF FEDERALLY QUALIFIED HEALTH CENTER COSTS

		From Wkst. A, col. 7, line:	Direct Cost by Practitioner from Wkst. A	Total Medical & Mental Health Visits by Practitioner	Other Direct Care Costs (see instructions)	General Service Cost (see instructions)	Total Costs by Practitioner	Average Cost Per Visit by Practitioner
			1.00	2.00	3.00	4.00	5.00	6.00
1.00			485,228	25,659	170,015	250,703	905,946	35.31
2.00			0	0	0	0	0	0.00
3.00			188,348	2,600	17,228	78,655	284,231	109.32
4.00			191,401	7,834	51,908	93,092	336,401	42.94
5.00			135,528	7,968	52,796	72,055	260,379	32.68
6.00			101,612	3,747	24,828	48,377	174,817	46.66
7.00			47,388	3,085	20,441	25,952	93,781	30.40
8.00			62,035	1,900	12,589	28,552	103,176	54.30
9.00	CLINICAL SOCIAL WORKER	31.00	116,074	4,400	29,154	55,566	200,794	45.64
10.00	REG DIETICIAN/CERT DSMT/MNT EDUCATOR	33.00	35,133	800	5,301	15,470	55,904	69.88
11.00	TOTALS		1,362,747	57,993	384,260	668,422	2,415,429	
12.00	UNIT COST MULTIPLIER				6.625972	0.382610		
13.00	TOTAL COST PER VISIT							41.65
	PART II - CALCULATION OF ALLOWABLE							
			Total Cost (from Wkst. A col. 7, line 47)	Total I & R Visits	Title XVIII I & R Visits	Ratio of Title XVIII Visits to Total Visits	Allowable Title XVIII Direct GME Costs	

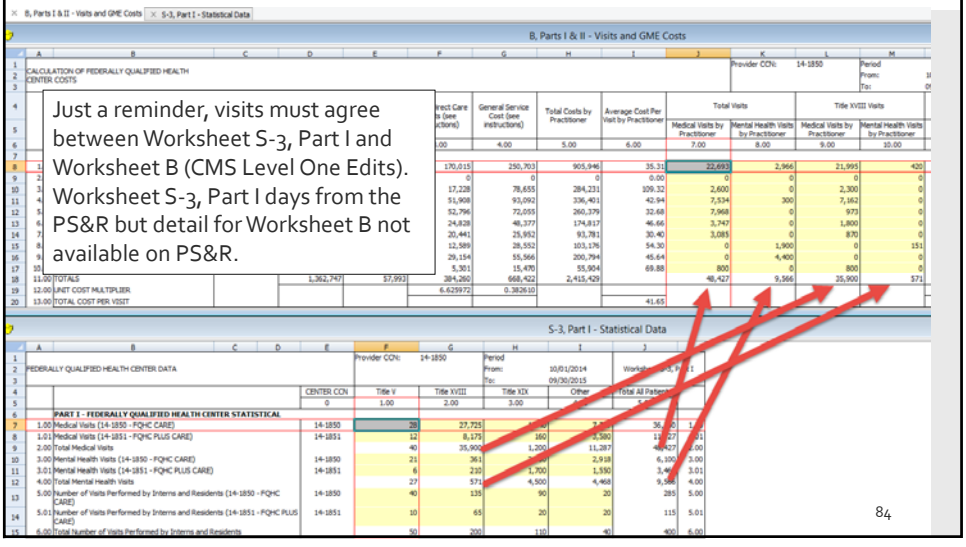
Accumulated cost type allocation of Other direct and General Service cost centers.

No allocation basis changes accommodated.

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

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

FORM CMS 224-14 WORKSHEET B



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MEDICARE COST REPORT UPDATE

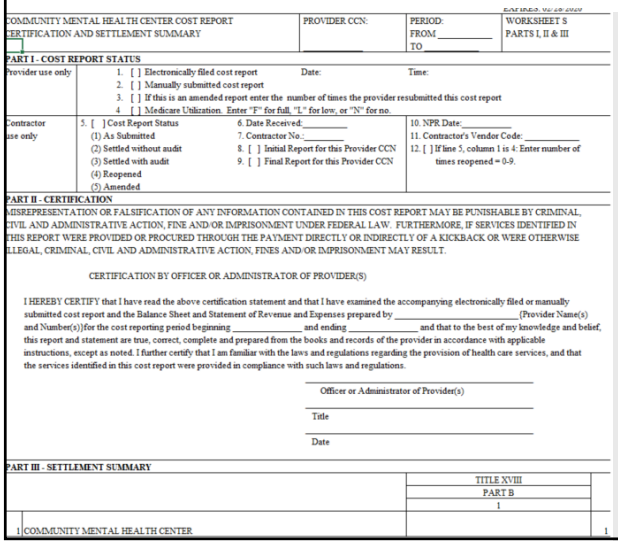
- Agenda
  - Regulation Changes Impacting Cost Reporting
  - Recent Cost Reporting Changes
    - Hospital
    - Provider-based Hospice and FQHC changes
    - Skilled Nursing facility
    - Home Health Agency
    - Federally Qualified Health Center
    - CMHC
    - Rural Health Clinic

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



COMMUNITY MENTAL HEALTH CENTER COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	PROVIDER CCN:	PERIOD: FROM _____ TO _____	WORKSHEET S PARTS I, II & III

PART I - COST REPORT STATUS

Provider use only

1. [ ] Electronically filed cost report Date: Time:
2. [ ] Manually submitted cost report
3. [ ] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [ ] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

Contractor use only

5. [ ] Cost Report Status
(1) As Submitted
(2) Settled without audit
(3) Settled with audit
(4) Reopened
(5) Amended

6. Date Received: _____
7. Contractor No.: _____
8. [ ] Initial Report for this Provider CCN
9. [ ] Final Report for this Provider CCN

10. NPR Date: _____
11. Contractor's Vendor Code: _____
12. [ ] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by _____ (Provider Name(s) and Number(s)) for the cost reporting period beginning _____ and ending _____ and that to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

Officer or Administrator of Provider(s)

Title

Date

PART III - SETTLEMENT SUMMARY

		TITLE XVIII PART B 1	
1	COMMUNITY MENTAL HEALTH CENTER		1

- 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

4590 (Cont.) FORM CMS-2088-17 DRAFT

COST REPORT IDENTIFICATION DATA	PROVIDER CCN:	PERIOD: FROM _____ TO _____	WORKSHEET S-1 PARTS I & II

PART I - IDENTIFICATION DATA

Community Mental Health Center Address:

	1	Provider CCN 2	CBSA 3	Date Certified 4	Type of control (see instructions) 5	
1	CMHC Name:					1
2	Street:	P.O. Box:				2
3	City:	State:	ZIP Code:	County:		3
4	Cost Reporting Period (mm/dd/yyyy) From:	To:				4
5	Is this CMHC part of a chain organization as defined in §2150 of CMS Pub. 15-1 that claims home office costs in a Home Office Cost Statement? Enter "Y" for yes or "N" for no in column 1. If yes, enter the chain organization's information below.					5
6	Name of Chain Organization:					6
7	Street:	P.O. Box:		Home Office CCN:		7
8	City:	State:	Zip Code:			8
Medical Malpractice						
9	Is this CMHC legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.					9
10	If line 9 is "Y", is the malpractice insurance a claims-made or occurrence policy? Enter "1" for claims-made or "2" for occurrence policy.					10
			Premiums	Paid Losses	Self Insurance	
11	Enter total malpractice premiums in column 1, total paid losses in column 2, and total self insurance in column 3					11
12	Are malpractice premiums and/or paid losses reported in other than the Administrative and General cost center? Enter "Y" for yes or "N" for no. (see instructions)					12

- 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 II - STATISTICAL DATA

	REIMBURSABLE COST CENTERS	Wkst. A	VISITS Medicare Patients 1	VISITS Other Patients 2	VISITS Total 3	PATIENT DAYS Medicare 4	PATIENT DAYS Other 5	PATIENT DAYS Total 6	
1	Drugs & Biologicals	23							1
2	Occupational Therapy	24							2
3	Behavioral Health Treatment/Services	25							3
4	Individual Therapy	26							4
5	Group Therapy	27							5
6	Activity Therapy	28							6
7	Family Therapy	29							7
8	Psychiatric Testing	30							8
9	Education Training	31							9
10	Other (specify)	32							10
11	TOTAL (sum of lines 1 through 10)								11
12	Unduplicated Census								12

	REIMBURSABLE COST CENTERS	Wkst. A	FTE ON PAYROLL Staff Therapists 7	Physicians 8	Social Workers 9	Others 10	
1	Drugs & Biologicals	23					1
2	Occupational Therapy	24					2
3	Behavioral Health Treatment/Services	25					3
4	Individual Therapy	26					4
5	Group Therapy	27					5
6	Activity Therapy	28					6
7	Family Therapy	29					7
8	Psychiatric Testing	30					8
9	Education Training	31					9
10	Other (specify)	32					10
11	TOTAL (sum of lines 1 through 10)						11
12	Unduplicated Census						12

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

DRAFT FORM 2088-17 WORKSHEET S-2

DRAFT FORM CMS-2088-17 4590 (Cont.)

COST REPORT REIMBURSEMENT QUESTIONNAIRE | PROVIDER CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET S-2

		Y/N 1	DATE 2	Y/N 3	
	PROVIDER ORGANIZATION AND OPERATION				
1	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, enter the date (mm/dd/yyyy) of the change in column 2. (see instructions)				1
2	Has the provider terminated participation in the Medicare Program? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the termination date (mm/dd/yyyy); and, enter in column 3, "V" for voluntary or "I" for involuntary.				2
3	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that were related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? Enter "Y" for yes or "N" for no in column 1. (see instructions)				3

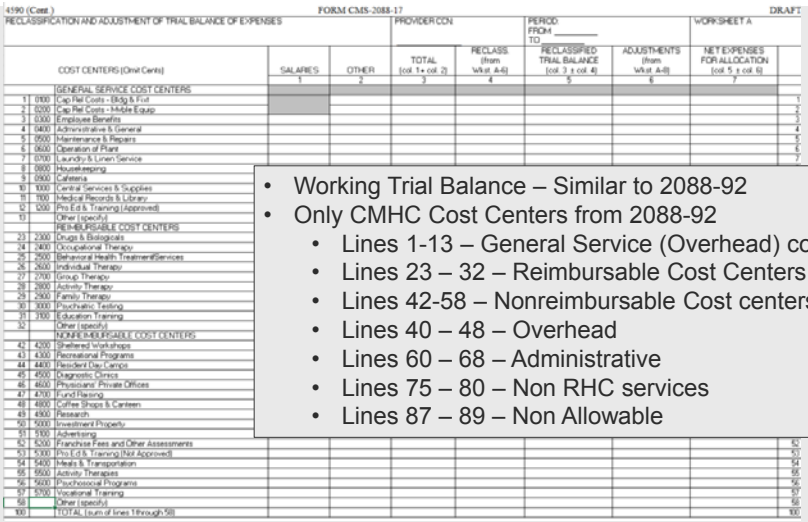
		Y/N 1	AGR 2	DATE 3	
	FINANCIAL DATA AND REPORTS				
4	Column 1: Were the financial statements prepared by a Certified Public Accountant? Enter "Y" for yes or "N" for no. Column 2: If yes, enter in column 2: "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy of financial statements or enter date available (mm/dd/yyyy) in column 3. (see instructions). If no, see instructions.				4
5	Are the cost report total expenses and total revenues different from those on the filed financial statements? Enter "Y" for yes or "N" for no in column 1. If yes, submit reconciliation.				5

		Y/N
	BAD DEBTS	
6	Is the provider seeking reimbursement for bad debts? Enter "Y" for yes or "N" for no. If yes, see instructions.	6
7	If line 6 is yes, did the provider's bad debt collection policy change during the cost reporting period? Enter "Y" for yes or "N" for no. If yes, submit a copy.	7
8	If line 6 is yes, were patient deductibles and/or co-payments waived? Enter "Y" for yes or "N" for no. If yes, see instructions.	8

		Y/N 1	DATE 2	
	PS&R REPORT DATA			
9	Was the cost report prepared using the PS&R report only? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the paid-through date (mm/dd/yyyy) of the PS&R report used to prepare the cost report. (see instructions.)			9
10	Was the cost report prepared using the PS&R report for totals and the provider's records for allocation? Enter "Y" for yes or "N" in column 1. If yes, enter in column 2 the paid-through date (mm/dd/yyyy) of the PS&R report used to prepare the cost report.			10
11	If line 9 or 10 is yes, were adjustments made to PS&R report data for additional claims that have been billed but are not included in the PS&R report used to file the cost report? Enter "Y" for yes or "N" for no. If yes, see instructions.			11
12	If line 9 or 10 is yes, were adjustments made to PS&R report data for corrections of other PS&R report information? Enter "Y" for yes or "N" for no. If yes, see instructions.			12
13	If line 9 or 10 is yes, were adjustments made to PS&R report data for Other? Enter "Y" for yes or "N" for no. If yes, describe the other adjustments:			13
14	Was the cost report prepared only using the provider's records? Enter "Y" for yes or "N" for no.			14

- Worksheet S-2
  - Replaces Form 339

DRAFT FORM 2088-17 WORKSHEET A


4590 (Cont.) FORM CMS-2088-17 DRAFT

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES | PROVIDER CCN | PERIOD: FROM TO | WORKSHEET A

		COST CENTERS (Omit Cents)	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASS. (from Wkst. A-6)	RECLASSIFIED TRIAL BALANCE (col. 3 + col. 4)	ADJUSTMENTS (from Wkst. A-8)	NET EXPENSES FOR ALLOCATION (col. 5 + col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	0100	Cap Rel Costs - Bldg & Fixt								1
2	0200	Cap Rel Costs - Mobile Equip								2
3	0300	Employee Benefits								3
4	0400	Administrative & General								4
5	0500	Maintenance & Repairs								5
6	0600	Operation of Plant								6
7	0700	Laundry & Linen Service								7
8	0800	Housekeeping								8
9	0900	Cafeteria								9
10	1000	Central Services & Supplies								10
11	1100	Medical Records & Library								11
12	1200	Pro Ed & Training (Approved)								12
13		Other (specify)								13
		REIMBURSABLE COST CENTERS								
23	2300	Drugs & Biologicals								23
24	2400	Occupational Therapy								24
25	2500	Behavioral Health Treatment/Services								25
26	2600	Individual Therapy								26
27	2700	Group Therapy								27
28	2800	Activity Therapy								28
29	2900	Family Therapy								29
30	3000	Psychiatric Testing								30
31	3100	Education Training								31
32		Other (specify)								32
		NONREIMBURSABLE COST CENTERS								
42	4200	Sheltered Workshops								42
43	4300	Recreational Programs								43
44	4400	Resident Day Camps								44
45	4500	Diagnostic Clinics								45
46	4600	Physicians' Private Offices								46
47	4700	Fund Raising								47
48	4800	Coffee Shops & Canteen								48
49	4900	Research								49
50	5000	Investment Property								50
51	5100	Advertising								51
52	5200	Franchise Fees and Other Assessments								52
53	5300	Pro Ed & Training (Not Approved)								53
54	5400	Meals & Transportation								54
55	5500	Activity Therapies								55
56	5600	Psychosocial Programs								56
57	5700	Vocational Training								57
58		Other (specify)								58
100		TOTAL (sum of lines 1 through 58)								100

- 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

4690 (Cont.) FORM CMS-222-17 DRAFT

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | CCN: _____ | PERIOD: FROM: _____ TO: _____ | WORKSHEET A-8-1

PART I - COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount included in Wkst. A, col. 5	Net Adjustments (col. 4 minus col. 5) *	
	1			4	5	6	
1							1
2							2
3							3
4							4
5	TOTALS						5

- 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

* The amounts
Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which have not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

PART II - INTERRELATIONSHIP TO RELATED ORGANIZATIONS AND/OR HOME OFFICE

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires the

DRAFT FORM 2088-17 WORKSHEET A-8-2

4590 (Cont.) FORM CMS-2088-17 DRAFT

PROVIDER-BASED PHYSICIANS ADJUSTMENTS | PROVIDER CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET A-8-2

	Wkst. A Line #	Cost Center/ Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
100	TOTAL									100

- RCE adjustment applied to physician salaries for provider services

	Wkst. A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
100	TOTAL									100

DRAFT FORM 2088-17 WORKSHEET B/B-1

DRAFT FORM CMS-2088-17 4590 (Cont

COST ALLOCATION GENERAL SERVICE COSTS | PROVIDER CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET B

	COST CENTERS	Net Expenses (from Wkst. A, Col.7)	Capital Related: Buildings & Fixtures	Capital Related: Movable Equipment	Employee Benefits	Subtotal (cols. 0-3)	Administrative & General	Maintenance & Repairs	Operation of Plant	
		0	1	2	3	3A	4	5	6	
	GENERAL SERVICE COST CENTERS									
1	Cap Rel Costs - Bldg & Fixt									1
2	Cap Rel Costs - Mvble Equip									2
3	Employee Benefits									3
4	Administrative and General									4
5	Maintenance and Repairs									5
6	Operation of Plant									6
7	Laundry and Linen Service									7
8	Housekeeping									8
9	Cafeteria									9
10	Central Services and Supplies									10
11	Medical Records and Library									11
12	Pro Ed & Training (Approved)(1)									12
13	Other (specify)									13
	REIMBURSABLE COST CENTERS									
23	Drugs & Biologicals									23
24	Occupational Therapy									24
25	Behavioral Health Treatment Services									25
26	Individual Therapy									26
27	Group Therapy									27
28	Activity Therapy									28
29	Family Therapy									29
30	Psychiatric Testing									30
31	Education Training									31
32	Other (specify)									32
	NONREIMBURSABLE COST CENTERS									

- Similar to 2088-92
- CMHC Cost Centers Only

DRAFT FORM 2088-17 WORKSHEET C

DRAFT | FORM CMS-2088-17 | 4590

APPORTIONMENT OF PATIENT SERVICE COSTS | PROVIDER CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET C

	REIMBURSABLE COST CENTERS	From Wkst. B, col. 14, Reimbursable Costs (1)	Total Charges (2)	Ratio of Cost to Charges (col. 1 ÷ col. 2) (3)	Medicare Charges (4)	Medicare Cost (col. 3 × col. 4) (5)	
23	Drugs & Biologicals						23
24	Occupational Therapy						24
25	Behavioral Health Treatment/Services						25
26	Individual Therapy						26
27	Group Therapy						27
28	Activity Therapy						28
29	Family Therapy						29
30	Psychiatric Testing						30
31	Education Training						31
32	Other (specify)						32
50	TOTAL (Lines 23 through 32)						50

- Simplified
- No A/B lines

DRAFT FORM 2088-17 WORKSHEET D

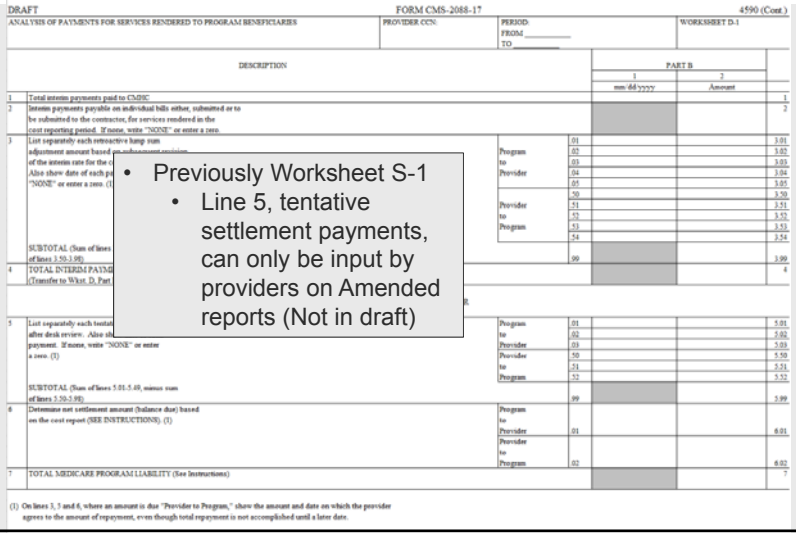
4590 (Cont.) | FORM CMS-2088-17 | DRAFT

CALCULATION OF REIMBURSEMENT SETTLEMENT | PROVIDER CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET D

	DESCRIPTION		
1	Gross APC/PPS payments		1
2	Outlier payments		2
3	Outlier reconciliation amount (transfer from line 54)		3
4	Gross reimbursement (sum of lines 1 through 3)		4
5	Primary payer payments		5
6	Deductibles billed to program patients (do not include coinsurance)		6
7	Coinsurance billed to program patients (see instructions)		7
8	Subtotal (line 4 minus lines 5, 6, and 7)		8
9	Reimbursable bad debts (see instructions)		9
10	Adjusted reimbursable bad debts		10
11	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		11
12	Subtotal (line 8 plus line 10)		12
13	Other adjustments (specify) (see instructions)		13
14	Amount due prior to the sequestration adjustment (line 12 plus line 13)		14
15	Sequestration adjustment (see instructions)		15
16	Amount due after sequestration adjustment (see instructions)		16
17	Interim payments		17
18	Tentative settlement (For contractor use only)		18
19	Balance due provider/program (line 16 minus lines 17 and 18) (indicate overpayment in brackets)		19
20	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		20
	TO BE COMPLETED BY CONTRACTOR		
50	Original outlier amount (see instructions)		50
51	Outlier reconciliation adjustment amount (see instructions)		51
52	The rate used to calculate the Time Value of Money		52
53	Time Value of Money (see instructions)		53
54	Total (sum of lines 51 and 53)		54

- Similar to 2088-92
- Simplified
  - No “TOPs”
  - No LCC
  - Lines 50 – 54 added for outlier reconciliation

DRAFT FORM 2088-17 WORKSHEET D-1



DRAFT FORM CMS-2088-17 4590 (Cont.)

ANALYSIS OF PAYMENTS FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES | PROVIDER CCN: | PERIOD: FROM _____ TO _____ | WORKSHEET D-1

	DESCRIPTION		PART B 1 mm/dd/yyyy	PART B 2 Amount	
1	Total interim payments paid to CMHC				1
2	Interim payments payable on individual bills either, submitted or to be submitted to the contractor, for services rendered in the cost reporting period. If none, write "NONE" or enter a zero.				2
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the c... Also show date of each pa... "NONE" or enter a zero. (1)	Program to Provider	01		3.01
			02		3.02
			03		3.03
			04		3.04
			05		3.05
		Provider to Program	50		3.50
			51		3.51
			52		3.52
			53		3.53
			54		3.54
	SUBTOTAL (Sum of lines ... of lines 3.50-3.98)		99		3.99
4	TOTAL INTERIM PAYM... (Transfer to Wkst. D, Part ...				4
5	List separately each tentat... after desk review. Also sh... payment. If none, write "NONE" or enter a zero. (1)	Program to Provider	01		5.01
			02		5.02
			03		5.03
		Provider to Program	50		5.50
			51		5.51
			52		5.52
	SUBTOTAL (Sum of lines 5.01-5.49, minus sum of lines 3.50-3.98)		99		5.99
6	Determine net settlement amount (balance due) based on the cost report (SEE INSTRUCTIONS). (1)	Program to Provider	01		6.01
		Provider to Program	02		6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (See Instructions)				7

(1) On lines 3, 5 and 6, where an amount is due "Provider to Program," show the amount and date on which the provider agrees to the amount of repayment, even though total repayment is not accomplished until a later date.

- Previously Worksheet S-1
  - Line 5, tentative settlement payments, can only be input by providers on Amended reports (Not in draft)

DRAFT FORM 2088-17 WORKSHEET F

DRAFT FORM CMS-2088-17 4590 (Cont.)

STATEMENT OF REVENUES AND EXPENSES | PROVIDER CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET F

1	Total patient revenue			1
2	Less: Allowance and discounts on patients' accounts			2
3	Net patient revenues (line 1 minus line 2)			3
4	Less: Total operating expenses (per Worksheet A, column 3, line 100)			4
5	Net income from service to patients (line 3 minus line 4)			5
	OTHER INCOME			
6	Grants, gifts, and income designated by donor for specific expenses			6
7	Payments received from specialists			7
8	Investment income on unrestricted funds			8
9	Trade, quantity, time and other discounts on purchases			9
10	Rebates and refunds of expenses			10
11	Income from laundry and linen service			11
12	Income from cafeteria - employees, guests, etc.			12
13	Sale of medical supplies to other than patients			13
14	Sale of workshop products or services			14
15	Coffee shops and canteen			15
16	Vending machines			16
17	Rental of building or office space to others			17
18	Sale of scrap, waste, etc.			18
19	Sale of medical records and abstracts			19
20	Other (Specify)			20
21	Total other income (sum of lines 6 through 20)			21
22	Total (line 5 plus line 21)			22
	OTHER EXPENSES			
23	Fund raising			23
24	Gift, coffee shops, and canteen			24
25	Investment property			25
26	Other (specify)			26
27	Total other expenses (sum of lines 23 through 26)			27
28	Net income (or loss) for the period (line 22 minus line 27)			28

- Similar to 2088-92
- Was Worksheet G

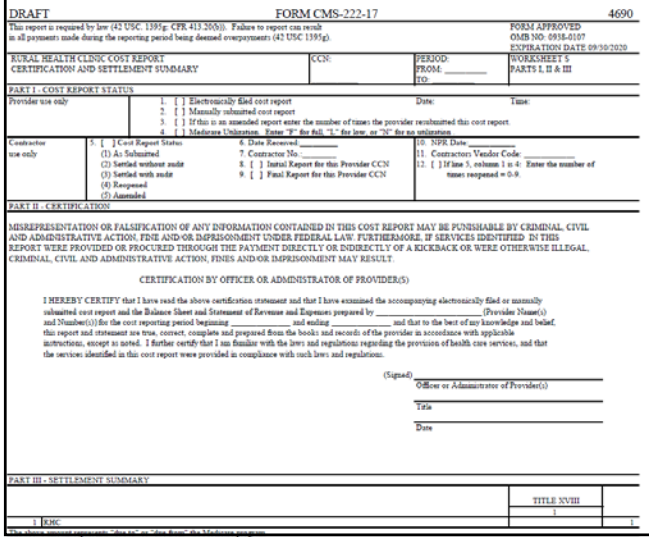
MEDICARE COST REPORT UPDATE

- 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

DRAFT FORM 222-17 WORKSHEET S



DRAFT — FORM CMS-222-17 — 4690

This report is required by law (42 USC 1395g; CFR 413.20(b)). Failure to report can result in all payments made during the reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO: 0938-0107
EXPIRATION DATE 09/30/2020

RURAL HEALTH CLINIC COST REPORT
CERTIFICATION AND SETTLEMENT SUMMARY

CCN: | PERIOD: FROM: _____ TO: | WORKSHEET S PARTS I, II & III

PART I - COST REPORT STATUS

Provider use only

1. [ ] Electronically filed cost report
2. [ ] Manually submitted cost report
3. [ ] If this is an amended report enter the number of times the provider resubmitted this cost report.
4. [ ] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no utilization.

Date: Time:

Contractor use only

5. [ ] Cost Report Status:
(1) As Submitted
(2) Settled without audit
(3) Settled with audit
(4) Reopened
(5) Amended

6. Date Received: _____
7. Contractor No.: _____
8. [ ] Initial Report for this Provider CCN
9. [ ] Final Report for this Provider CCN

10. NPR Date: _____
11. Contractor's Vendor Code: _____
12. [ ] If line 5, column 1 is 4: Enter the number of times reopened = 0-9.

PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by _____ (Provider Name(s) and Number(s)) for the cost reporting period beginning _____ and ending _____ and that to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Signed) _____
Officer or Administrator of Provider(s)

Title

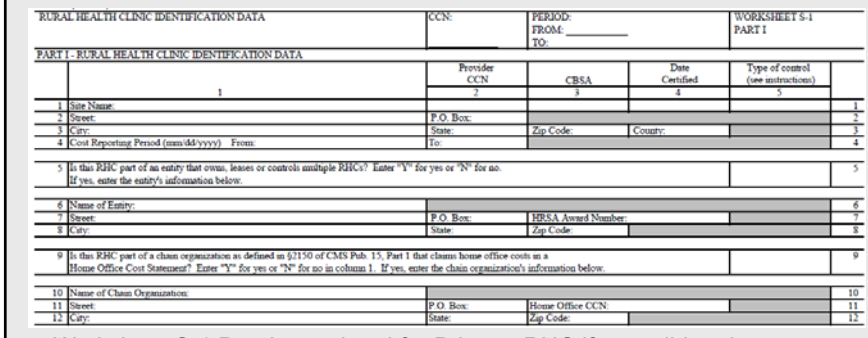
Date

PART III - SETTLEMENT SUMMARY

		TITLE XVIII	
		1	
1	RHC		1

- 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

DRAFT FORM 222-17 WORKSHEET S-1, PART I



RURAL HEALTH CLINIC IDENTIFICATION DATA | CCN: | PERIOD: FROM: _____ TO: | WORKSHEET S-1 PART I

PART I - RURAL HEALTH CLINIC IDENTIFICATION DATA

	1	Provider CCN 2	CBSA 3	Date Certified 4	Type of control (see instructions) 5	
1	Site Name:					1
2	Street:	P.O. Box:				2
3	City:	State:	Zip Code:	County:		3
4	Cost Reporting Period (mm/dd/yyyy) From:	To:				4
5	Is this RHC part of an entity that owns, leases or controls multiple RHCs? Enter "Y" for yes or "N" for no. If yes, enter the entity's information below.					5
6	Name of Entity:					6
7	Street:	P.O. Box:	HRSA Award Number:			7
8	City:	State:	Zip Code:			8
9	Is this RHC part of a chain organization as defined in §2150 of CMS Pub. 15, Part 1 that claims home office costs on a Home Office Cost Statement? Enter "Y" for yes or "N" for no in column 1. If yes, enter the chain organization's information below.					9
10	Name of Chain Organization:					10
11	Street:	P.O. Box:	Home Office CCN:			11
12	City:	State:	Zip Code:			12

- 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

DRAFT FORM 222-17 WORKSHEET S-1, PART I

	Consolidated Cost Report	Y/N	Date Requested	Date Approved	Number of RHCs	
		1	2	3	4	
13	Is this RHC filing a consolidated cost report per CMS Pub. 100-02, chapter 13, §80.2? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, complete columns 2 through 4, and line 14, beginning with subscripted line 14.01. If column 1 is no, leave line 14 blank. (see instructions)					13

	Site Name	CCN	CBSA	Date Requested	Date Approved	
	1	2	3	4	5	
14	List of Consolidated Providers					14
14.01						14.01

- 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

DRAFT FORM 222-17 WORKSHEET S-1, PART I

Medical Malpractice					
15	Does this RHC carry commercial malpractice insurance? Enter "Y" for yes or "N" for no.				15
16	If line 15 is yes, is the malpractice insurance a claims-made or occurrence policy? Enter "1" for claims-made or "2" for occurrence policy.				16
		Premiums	Paid Losses	Self Insurance	
17	List amounts of malpractice premiums, paid losses or self-insurance in the applicable columns.				17
18	Are malpractice premiums, paid losses or self-insurance reported in a cost center other than the Malpractice Premiums cost center? Enter "Y" for yes or "N" for no. (see instructions)				18
Miscellaneous					
19	Is this RHC and/or any consolidated RHCs involved in training residents in an approved GME program in accordance with 42 CFR 405.2468(f)? Enter "Y" for yes or "N" for no. (see instructions)				19
20	Have you received an approval for an exception to the productivity standard?				20
21	Does the facility operate as other than a RHC? Enter "Y" for yes or "N" for no.				21
22	If line 21 is "Y", specify type of operation. (i.e. physicians office, independent laboratory, etc.)				22
23	Identify days and hours by listing the time the facility operates as a RHC next to the applicable day.				23

		Hours of Operation		
		From	To	
	Days	1	2	
23.01	Sunday			23.01
23.02	Monday			23.02
23.03	Tuesday			23.03
23.04	Wednesday			23.04
23.05	Thursday			23.05
23.06	Friday			23.06
23.07	Saturday			23.07
24	Identify days and hours by listing the time the facility operates as other than a RHC next to the applicable day.			24

		Hours of Operation		
		From	To	
	Days	1	2	
24.01	Sunday			24.01
24.02	Monday			24.02

Lines 15 – 18, Malpractice Information
Lines 19 – 23, Approved I&R training
Lines 23 and 24 Hours of Operation

DRAFT FORM 222-17 WORKSHEET S-1, PART I

		Y/N	Demonstration Type	
		1	2	
25	Did this facility participate in any payment demonstration during this cost reporting period? Enter "Y" for yes or "N" for no. If column 1 is yes, enter the type of demonstration in column 2.			25
26	Are there any costs included in Worksheet A that resulted from transactions with related organizations as defined in CMS Pub. 15-1, chapter 10? If yes, complete A-8-1.			26

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-1, PART II

DRAFT FORM CMS-222-17 4690 (Cont.)

RURAL HEALTH CLINIC IDENTIFICATION DATA | CCN: _____ CENTER CCN: _____ | PERIOD: FROM: _____ TO: _____ | WORKSHEET S-1 PART II

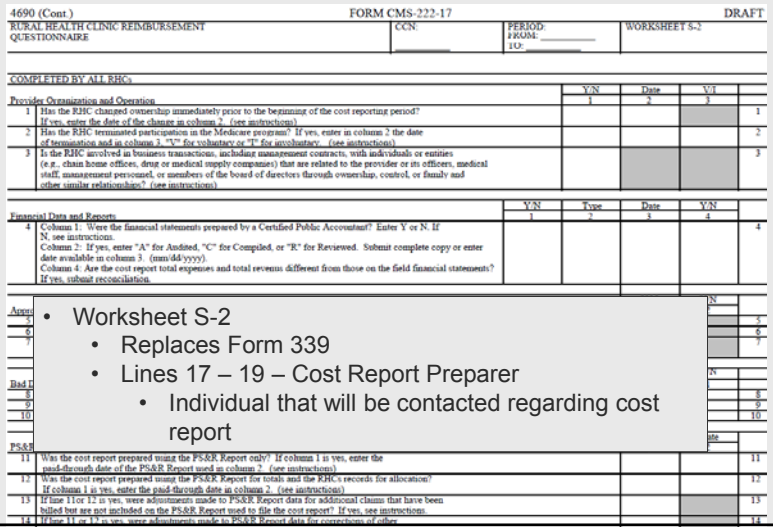
PART I - RURAL HEALTH CLINIC CONSOLIDATED COST REPORT IDENTIFICATION DATA

	1	Date Certified 2	Type of control (see instructions) 3	Date Decertified 4	V/I Decertification 5	Date of CHOW 6	
1	Site Name:						1
2	Street:	P.O. Box:					2
3	City:	State:	Zip Code:	County:			3
Medical Malpractice							
4	Does this RHC carry commercial malpractice insurance? Enter "Y" for yes or "N" for no.						4
5	If line 4 is yes, is the malpractice insurance a claims-made or occurrence policy? Enter "1" for claims-made or "2" for occurrence policy.						5
				Premiums	Paid Losses	Self Insurance	
6	List amounts of malpractice premiums, paid losses or self-insurance in the applicable columns.						6
Miscellaneous							
7	Does the facilit						7
8	If line 7 is "Y"						8
9	Identify days a						9
	Days					Operation To 2	
9.01	Sunday						9.01
9.02	Monday						9.02
9.03	Tuesday						9.03
9.04	Wednesday						9.04
9.05	Thursday						9.05
9.06	Friday						9.06
9.07	Saturday						9.07
10	Identify days a						10
	Days					Operation To 2	
10.01	Sunday						10.01
10.02	Monday						10.02
10.03	Tuesday						10.03
10.04	Wednesday						10.04
10.05	Thursday						10.05
10.06	Friday						10.06
10.07	Saturday						10.07

FORM CMS-222-17 (DATE) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4604.2)

- Part II completed for each additional consolidated entity
  - No Part II completed for main facility
- Line 1
  - Column 1 - Date Certified
  - Column 4 – Date Decertified
  - Column 5 – (V)oluntary or (I)nvoluntary
  - Column 6 – Date of CHOW
- Lines 7-10.07 – Malpractice information and hours.
  - If 1 malpractice premium for full entity repeat information

DRAFT FORM 222-17 WORKSHEET S-2



4690 (Cont.) FORM CMS-222-17 DRAFT

RURAL HEALTH CLINIC REIMBURSEMENT QUESTIONNAIRE | CCN: | PERIOD: FROM: TO: | WORKSHEET S-2

COMPLETED BY ALL RHCs

	Provider Organization and Operation	Y/N 1	Date 2	V,T 3	
1	Has the RHC changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)				1
2	Has the RHC terminated participation in the Medicare program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary. (see instructions)				2
3	Is the RHC involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)				3

	Financial Data and Reports	Y/N 1	Type 2	Date 3	Y/N 4	
4	Column 1: Were the financial statements prepared by a Certified Public Accountant? Enter Y or N. If N, see instructions. Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (mm/dd/yyyy). Column 4: Are the cost report total expenses and total revenue different from those on the field financial statements? If yes, submit reconciliation.					4

- 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

DRAFT FORM CMS-222-17 4690 (Cont.)

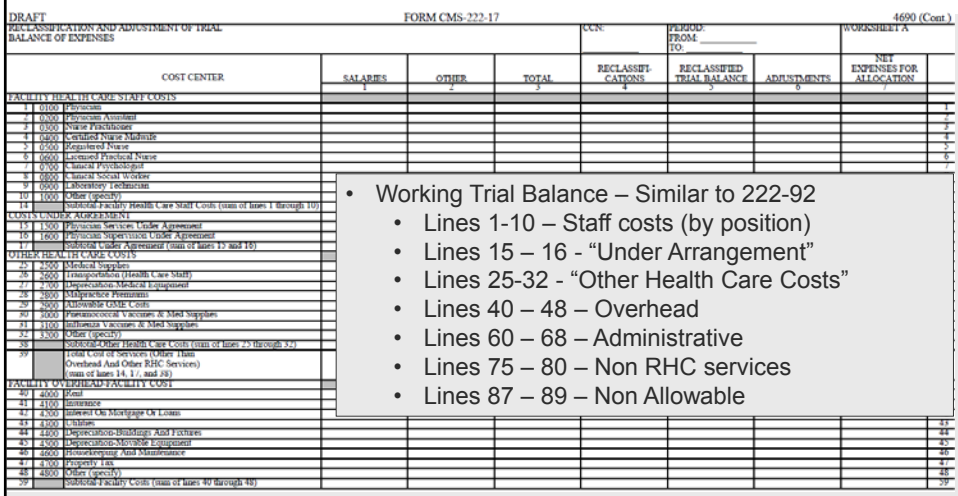
RURAL HEALTH CLINIC DATA | CCN: | PERIOD: FROM: TO: | WORKSHEET S-3

RURAL HEALTH CLINIC STATISTICAL DATA

		CENTER CCN 0	Title V 1	Title XVIII 2	Title XIX 3	Other 4	Total All Patients 5	
1	Medical Visits							1
2	Total Medical Visits							2
3	Mental Health Visits							3
4	Total Mental Health Visits							4
5	Number of Visits Performed by Interns and Residents							5
6	Total Number of Visits Performed by Interns and Residents							6
7	Total Visits (sum of lines 2 and 4)							7

- 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

DRAFT FORM 222-17 WORKSHEET A



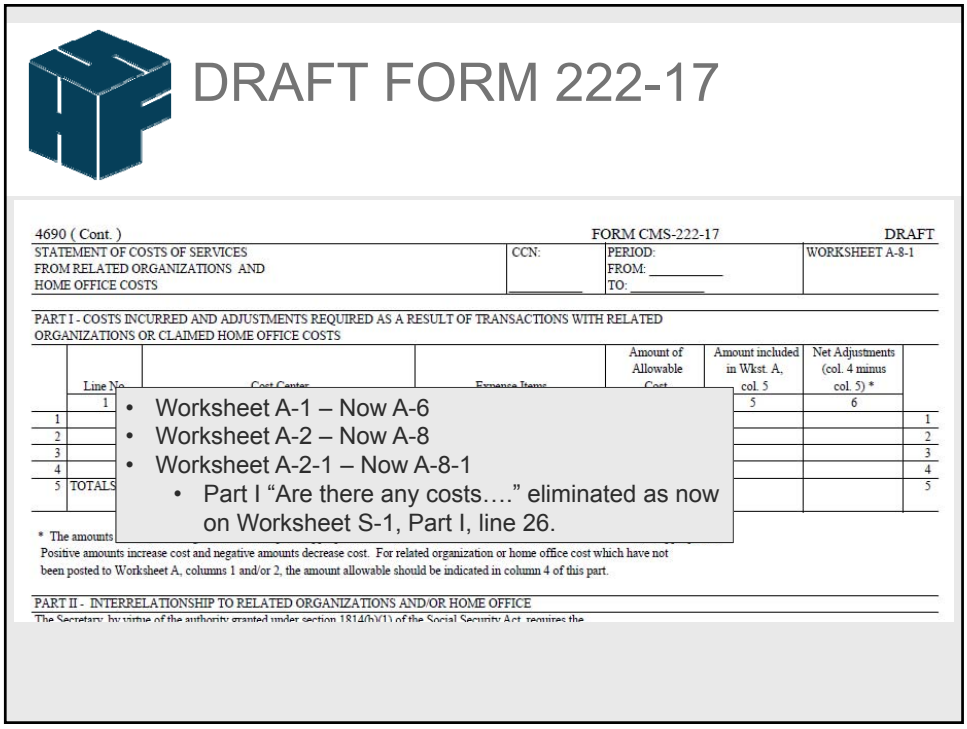
DRAFT — FORM CMS-222-17 — 4690 (Cont.)

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES | CCN: | PERIOD: FROM: TO: | WORKSHEET A

		COST CENTER	SALARIES 1	OTHER 2	TOTAL 3	RECLASSIFICATIONS 4	RECLASSIFIED TRIAL BALANCE 5	ADJUSTMENTS 6	NET EXPENSES FOR ALLOCATION 7	
FACILITY HEALTH CARE STAFF COSTS										
1	0100	Physician								1
2	0200	Physician Assistant								2
3	0300	Nurse Practitioner								3
4	0400	Certified Nurse Midwife								4
5	0500	Registered Nurse								5
6	0600	Licensed Practical Nurse								6
7	0700	Clinical Psychologist								7
8	0800	Clinical Social Worker								8
9	0900	Laboratory Technician								9
10	1000	Other (specify)								10
14		Subtotal-Facility Health Care Staff Costs (sum of lines 1 through 10)								14
COSTS UNDER AGREEMENT										
15	1500	Physician Services Under Agreement								15
16	1600	Physician Supervision Under Agreement								16
17		Subtotal Under Agreement (sum of lines 15 and 16)								17
OTHER HEALTH CARE COSTS										
25	2500	Medical Supplies								25
26	2600	Transportation (Health Care Staff)								26
27	2700	Depreciation-Medical Equipment								27
28	2800	Malpractice Premiums								28
29	2900	Allowable OME Costs								29
30	3000	Pneumococcal Vaccines & Med Supplies								30
31	3100	Influenza Vaccines & Med Supplies								31
32	3200	Other (specify)								32
38		Subtotal-Other Health Care Costs (sum of lines 25 through 32)								38
39		Total Cost of Services (Other Than Overhead And Other RHC Services) (sum of lines 14, 17, and 38)								39
FACILITY OVERHEAD-FACILITY COST										
40	4000	Rent								40
41	4100	Insurance								41
42	4200	Interest On Mortgage Or Loans								42
43	4300	Utilities								43
44	4400	Depreciation-Buildings And Fixtures								44
45	4500	Depreciation-Movable Equipment								45
46	4600	Housekeeping And Maintenance								46
47	4700	Property Tax								47
48	4800	Other (specify)								48
59		Subtotal-Facility Costs (sum of lines 40 through 48)								59

- 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

DRAFT FORM 222-17



4690 (Cont.) — FORM CMS-222-17 — DRAFT

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | CCN: | PERIOD: FROM: TO: | WORKSHEET A-8-1

PART I - COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount included in Wkst. A, col. 5	Net Adjustments (col. 4 minus col. 5) *	
	1			4	5	6	
1							1
2							2
3							3
4							4
5	TOTALS						5

* The amounts
Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which have not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

PART II - INTERRELATIONSHIP TO RELATED ORGANIZATIONS AND/OR HOME OFFICE

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires the

- 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.

DRAFT FORM 222-17 WORKSHEET B, PART I

DRAFT — FORM CMS-222-17 — 4690 (Cont.)

VISITS AND OVERHEAD COST FOR RHC SERVICES | CCN: | PERIOD: FROM: _____ TO: _____ | WORKSHEET B PARTS I & II

PART I - VISITS AND PRODUCTIVITY

	Positions	Number of FTE Personnel (1)	Total Visits 2	Productivity Standard (1) 3	Minimum Visits (col. 1 x col. 3) 4	Greater of Col. 2 or Col. 4 5	
1	Physicians			4200			1
2	Physician Assistants			2100			2
3	Nurse Practitioner			2100			3
4	Certified Nurse Midwife			2100			
5	Subtotal (sum of lines 1 through 4)						5
6	Registered Nurse						6
7	Licensed Practical Nurse						6
8	Clinical Psychologist						8
9	Clinical Social Worker						9
10	Total Staff						10
11	Physician Services Under Agreement						11

(1) Productivity standards established by CMS are: 4200 visits for each physician and 2100 visits for each nonphysician practitioner. If an exception to the productivity standard has been granted (Wkst. S-1, Part I, line 20, equals "Y"), input in col. 3, lines 1 through 4, the productivity standards derived by the contractor.

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

DRAFT FORM 222-17 WORKSHEET B, PART II

- Similar to 222-92

PART II - DETERMINATION OF TOTAL ALLOWABLE COST APPLICABLE TO RHC SERVICES

		Amount	
12	Cost of RHC services - excluding overhead and allowable GME costs (Worksheet A, column 7, line 39, minus Worksheet A, column 7, line 29)		12
13	Cost of other than RHC - excluding overhead (Worksheet A, column 7, sum of lines 86 and 90)		13
14	Cost of all services - excluding overhead - (sum of lines 12 and 13)		14
15	Ratio of RHC (line 12 divided by line 14)		15
16	Total overhead - (Worksheet A, column 7, line 74)		16
17	Overhead applicable to RHC services (line 15 times line 16) (see instructions)		17
18	Total allowable cost of RHC services (sum of lines 12 and 17)		18

DRAFT FORM 222-17 WORKSHEET B-1

4690 (Cont.) FORM CMS-222-17 DRAFT

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST	CCN:	PERIOD: FROM: TO:	WORKSHEET B-1

		PNEUMOCOCCAL 1	INFLUENZA 2	
1	Health care staff cost (from Worksheet A, column 7, line 14)			1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time			2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 multiplied by line 2)			3
4	Vaccines and related medical supplies cost (from Worksheet A, column 7, lines 30 and 31, respectively)			4
5	Direct cost of pneumococcal and influenza vaccine (sum of lines 3 and 4)			5
6	Total direct cost of the facility (from Worksheet A, column 7, line 39)			6
7	Total facility overhead (from Worksheet A, column 7, line 74)			7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)			8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 multiplied by line 8)			9
10	Total pneumococcal and influenza vaccine cost and administration (sum of lines 5 and 9)			10
11	Total number of pneumococcal and influenza vaccine injections (from provider records)			11
12	Cost per pneumococcal and influenza vaccine injection (line 10 divided by line 11)			12
13	Number of pneumococcal and influenza vaccine injections administered to Medicare beneficiaries			13
14	Medicare cost of pneumococcal and influenza vaccine and administration (line 12 multiplied by line 13)			14
15	Total cost of pneumococcal and influenza vaccine and administration (sum of columns 1 and 2, line 10) Transfer to Worksheet C, Part I, line 2			15
16	Total Medicare cost of pneumococcal and influenza vaccine and administration (sum of columns 1 and 2, line 14) Transfer to Worksheet C, Part II, line 23			16

- Similar to 222-92

DRAFT FORM 222-17 WORKSHEET C, PART I

4690 (Cont.) FORM CMS-222-17 DRAFT

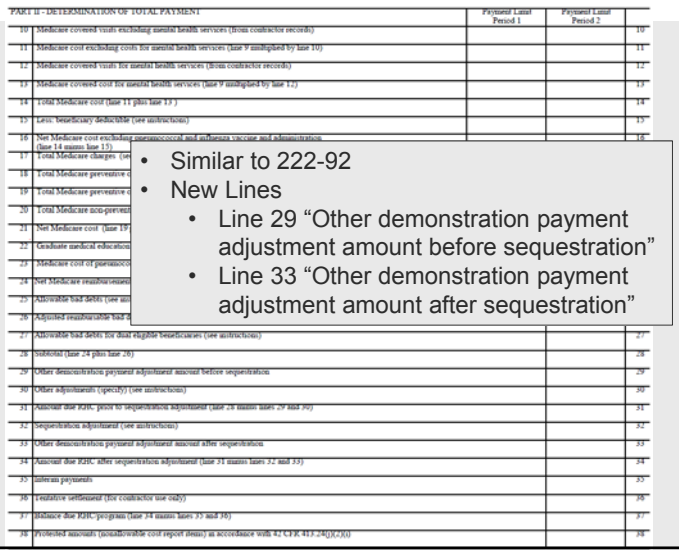
DETERMINATION OF MEDICARE PAYMENT	CCN:	PERIOD: FROM: TO:	WORKSHEET C PARTS I & II

PART I- DETERMINATION OF RATE FOR RHC SERVICES		AMOUNT	
1	Total allowable costs (Worksheet B, Part II, line 18)		1
2	Cost of pneumococcal and influenza vaccine and administration (from Worksheet B-1, line 15)		2
3	Total allowable cost excluding pneumococcal and influenza vaccine (line 1 minus line 2)		3
4	Greater of minimum visits or actual visits by health care staff		4
5	Physicians visits under agreements (from Worksheet B, Part I		5
6	Total adjusted visits (line 4 plus line 5)		6
7	Adjusted cost per visit (line 3 divided by line 6)		7

		Calculation of Limit (1)		
		Payment Limit Period 1	Payment Limit Period 2	
8	Maximum rate per visit (see instructions)			8
9	Rate for Medicare covered visits (lessor of line 7 or line 8)			9

- 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

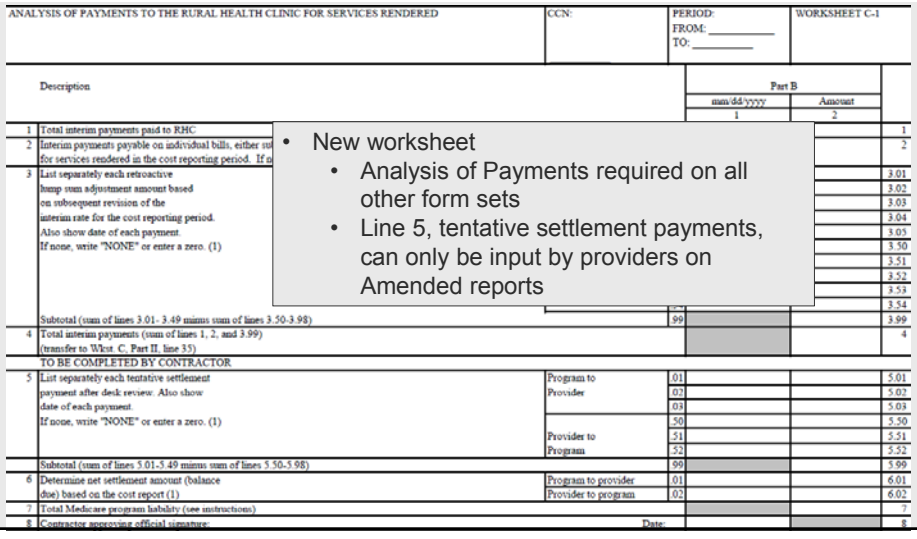


PART II - DETERMINATION OF TOTAL PAYMENT

		Payment Limit Period 1	Payment Limit Period 2	
10	Medicare covered visits excluding mental health services (from contractor records)			10
11	Medicare cost excluding costs for mental health services (line 9 multiplied by line 10)			11
12	Medicare covered visits for mental health services (from contractor records)			12
13	Medicare covered cost for mental health services (line 9 multiplied by line 12)			13
14	Total Medicare cost (line 11 plus line 13)			14
15	Less: beneficiary deductible (see instructions)			15
16	Net Medicare cost excluding pneumococcal and influenza vaccine and administration (line 14 minus line 15)			16
17	Total Medicare charges (se			17
18	Total Medicare preventive c			18
19	Total Medicare preventive c			19
20	Total Medicare non-prevent			20
21	Net Medicare cost (line 19			21
22	Graduate medical education			22
23	Medicare cost of pneumoco			23
24	Net Medicare reimbursem			24
25	Allowable bad debts (see in			25
26	Adjusted reimbursable bad d			26
27	Allowable bad debts for dual eligible beneficiaries (see instructions)			27
28	Subtotal (line 24 plus line 26)			28
29	Other demonstration payment adjustment amount before sequestration			29
30	Other adjustments (specify) (see instructions)			30
31	Amount due RHC prior to sequestration adjustment (line 28 minus lines 29 and 30)			31
32	Sequestration adjustment (see instructions)			32
33	Other demonstration payment adjustment amount after sequestration			33
34	Amount due RHC after sequestration adjustment (line 31 minus lines 32 and 33)			34
35	Interim payments			35
36	Tentative settlement (for contractor use only)			36
37	Balance due RHC/program (line 34 minus lines 35 and 36)			37
38	Protested amounts (nonallowable cost report items) in accordance with 42 CFR 413.24(f)(1)(ii)			38

- 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



ANALYSIS OF PAYMENTS TO THE RURAL HEALTH CLINIC FOR SERVICES RENDERED | CCN: | PERIOD: FROM: _____ TO: _____ | WORKSHEET C-1

	Description		Part B mm/dd/yyyy 1	Part B Amount 2	
1	Total interim payments paid to RHC				1
2	Interim payments payable on individual bills, either su for services rendered in the cost reporting period. If a				2
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.01
					3.02
					3.03
					3.04
					3.05
					3.50
					3.51
					3.52
					3.53
					3.54
	Subtotal (sum of lines 3.01- 3.49 minus sum of lines 3.50-3.98)	99			3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. C, Part II, line 35)				4
	TO BE COMPLETED BY CONTRACTOR				
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	Program to Provider 01			5.01
		02			5.02
		03			5.03
		50			5.50
		Provider to Program 51			5.51
		52			5.52
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	99			5.99
6	Determine net settlement amount (balance due) based on the cost report (1)	Program to provider 01			6.01
		Provider to program 02			6.02
7	Total Medicare program liability (see instructions)				7
8	Contractor approving official signature. Date:				8

- 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

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