Objectives

Part I:
- What you need to complete the cost report
- Where it is located on the cost report

Part II:
- Common cost report calculations
- How to deal with the complicated issues

Why a Cost Report?
- Cost reports are due five months after FYE
- Medicare will cut off payments to the clinic for an unfiled cost report

RHC Cost Report
- Cost reports must be submitted in electronic format (ECR File) on CMS approved vendor software via CD.
- Signed Hard Copy must also be submitted with an electronic “fingerprint” matching the electronic cost report.

RHC Designation
- Provider based – owned, operated by Hospital, SNF, HHA (Schedule M)
- Independent – (Freestanding) may be MD/DO owned, privately owned or owned by other health professionals (CMS Form 222)

Why a Cost Report?
- Reconciles Medicare’s interim payment method to actual cost per visit
- Allowable RHC Costs/RHC Visits = RHC Cost Per Visit = RHC rate; not to exceed the maximum allowable reimbursement rate for current period
- Determines future reimbursement rates
- Reimburses for Pneumococcal and Influenza vaccine costs

Cost Reporting
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Promoting Access to Health Care

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Cost Reporting

Information Needed to Complete the RHC Cost Report

- Financial Statements
- Visits by type of practitioner
- Clinic hours of operation
- FTE calculations
- Total number of clinical staff hours worked during the cost report period.

Information Needed to Complete the RHC Cost Report

- Salaries by employee type
- Vaccine Information
- Related Party Transactions
- Depreciation Schedule

Information Needed to Complete the RHC Cost Report

- Medicare Bad Debt
- Laboratory Costs
- Non-RHC X-ray Costs
- PSR - obtained on-line through IACS

Information Needed to Complete the RHC Cost Report

NEW FOR 2011:
Preventative Charges for Medicare Beneficiaries

Financial Statements

- Balance Sheet
- Profit and Loss Statement
- Trial Balance
Financial Statements

- Must match cost reporting period
  - For most this will be 1/1/11 – 12/31/11.
  - For new clinics in 2011, financial statements must reflect costs from the date of the clinic’s certification to 12/31/11.
- Reasonable & Necessary

Financial Statements

- All costs from the financial statements must be reflected in columns 1 and 2 of worksheet A (independent) or M-1 (provider-based)
  - Column 1: Compensation
  - Column 2: All Other
- Expenses should be detailed enough to properly classify within cost report categories

Financial Statements

- Miscellaneous/Non-Patient Care revenue must be reviewed for possible offsets
- Non-allowable expenses must be reviewed for offset or classification in a non-reimbursable cost center

Financial Statements

RHC Visits

- Definition: Face-to-face encounter with qualified provider during which covered services are performed.
- Issues: RHCs count non-billable encounters
  * No Charges
  * Injections
  * Non-qualified providers
  * Non-covered services

RHC Visits

- Broken down by provider type (MD, PA, NP)
- Count only face-to-face encounters
- Do not include visits for hospital, non-covered services, non qualified providers or injections

Visit Summary

- Summary of all visits by insurance type and provider type
Clinic Hours of Operation

- Should reflect hours practitioners are available to see patients
- Broken between hours operating as an RHC or a Non-RHC, if applicable
- Reported on worksheet S, lines 11 & 12 (independent)
- Reported in military time format

Hours worked for FTE Calculation

- Only clinical hours should be used in the FTE calculation
- Categorize each practitioner’s work into:
  - Administrative (used to reclassify wages of provider)
  - Patient care – Clinic/Nursing Home (used to calculate the FTE input on the cost report for the provider)
  - Inpatient care hours - if inpatient work is part of the provider’s clinic compensation package (used to adjust wages of provider)

Nursing Staff Hours

- Total number of remaining clinical staff hours worked per year (for use in calculating the staff time ratio of time available for giving vaccines).
  - RN
  - LPN
  - MA

FTE Calculation

Staff of RHC

- If clinic financials do not separate salaries by provider type (Physician, PA, NP, Nurse, MA) a reclassification may be necessary.
- Fringe benefits and employer paid payroll taxes should be available to be used in other calculations such as provider administrative reclassification and lab carve out

Staff Wages Worksheet
Vaccine Information

Seasonal Influenza and Pneumovax

- Total vaccines given of each to ALL insurance types
- Total Medicare vaccines given of each (Medicare log must accompany cost report)
- Cost of vaccines (include invoices if possible)
- Total clinical hours worked (from FTE worksheet)

Vaccine Worksheet

Influenza Log

Pneumo Log

Related Party Transactions

- Most common related party transaction is related party building ownership (e.g. building is owned by the doctors which also own the clinic – clinic pays ‘rent’ to docs)
- Medicare will only allow ‘cost of ownership’ of the related party
- Cost is adjusted to actual expense incurred by the related party

Related Party Transactions

- Related party building ownership cost items for reporting
  - Mortgage Interest
  - Property Taxes
  - Building Depreciation
  - Property Insurance
  - Repairs & Maintenance paid by building owners
  - Lawn Service, etc. – if not already in clinic expenses
Depreciation Schedule

- Date Asset Purchased
- Description of Asset
- Cost of Asset

Medicare Bad Debt

- Medicare bad debt form must accompany cost report of total bad debt being claimed.
- Medicare bad debt is claimed on the cost report based on the fiscal year in which the bad debt was written off, not date of service.

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Lab/X-ray/EKG Allocations

- Staff performing lab, X-ray, EKG duties
- Allocate % of time for non-RHC carve out for staff performing non-RHC lab/X-ray/EKG duties vs. RHC duties
- Time studies of staff to support the allocated carve out

Lab Allocation Worksheet

<table>
<thead>
<tr>
<th>Date</th>
<th>Service</th>
<th>Time Spent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

X-ray Allocation Worksheet

<table>
<thead>
<tr>
<th>Date</th>
<th>Service</th>
<th>Time Spent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Health Services Associates, Inc.
A copy of your PS&R (Provider Statistical and Reimbursement System report) will need to be obtained by the clinic electronically from IACS (Identity Management and Authentication System).

This link provides detail instructions for IACS registration:

Compare PS&R total to your Medicare visit count. Is this accurate? If not, determine why:
- Were incidental services included in the visit count?
- Were dual-eligible counted twice?
- Did more than one visit get counted on one day (surgical procedure/office visit)?

Statistics on Worksheet S – Independent/S-8 Provider Based

- Facility Name
- Entity Status
- Hours of Operation
- If combined cost report for multiple locations, worksheet S, Part III
- If filing a ‘No Utilization’, “N” for line 13 (independent)

Cost Report Categories

Cost Report has three main cost classifications:
- Healthcare Costs
- Facility Overhead
- Non-RHC/Non-Allowable
Cost Report Categories

Healthcare Costs
- Compensation for providers, nurses and other healthcare staff
- Compensation for physician supervision
- Cost of services and supplies incident to services of physicians (including drugs & biologicals incident to RHC service)
- Cost related to the maintenance of licenses and insurance for medical professionals

Allowable Cost of Compensation – Health Care Staff
- Salaries & Wages
- Payroll Taxes
- Health & Life Insurance
- Pension Contributions
- Paid vacation or leave, including holidays and sick leave
- Educational courses
- Unrecovered cost of medical services rendered to employees

Physicians Services Under Agreement
- Supervisory services of non-owner, non-employee physician
- Medical services by non-owner, non-employee physician at clinic (can be cost or fee-for-service)
- Medical services by non-owner, non-employee physician at location other than clinic (can be cost or fee-for-service)

Other Health Care Costs
- Malpractice and other insurance (Premium can not exceed amount of aggregate coverage)
- Depreciation
- Transportation of Health Center Personal Overhead Costs:
  - Facility
  - Administration

Facility Overhead

Facility Overhead – Facility Cost
- Rent
- Insurance
- Interest on Mortgage or Loans
- Utilities
- Other building expenses

Facility Overhead – Administrative
- Office Salaries
- Office Supplies
- Legal/Accounting
- Contract Labor
- Other Administrative Costs
Non-RHC Costs

- Lab, X-ray, EKG
- Items and services not covered under program (e.g. dental, physical, etc.)

Non-RHC Costs

- Lab, X-ray, EKG
- Billed to Part B by independent RHCs
- Billed through hospital and included in hospital costs for provider-based RHCs

Non-allowable Costs

- Entertainment
- Gifts
- Charitable Contributions
- Automobile Expense – where not related to patient care
- Personal expenses paid out of clinic funds

Other Costs

- Membership Costs:
  - Generally
  - Professional, technical or business related organization allowable
  - Social & Fraternal not allowable
  - Research costs not allowable
  - Translation services costs allowable

Other Costs

- Advertising Costs:
  - Staff recruitment advertising allowable
  - Yellow pages advertising allowable
  - Advertising to increase patients not allowable
  - Fund-raising advertising, not allowable

- Taxes:
  - Taxes levied by state and local governments are allowable if exemption not available
  - Fines and penalties not allowable

Prudent Buyer Principle

- The Prudent & Cost Conscious Buyer:
  - Refuses to pay more than going price for an item or service.
  - Seeks to economize by minimizing cost.
Worksheet A-1 / A-2 - Independent

Adjustments to Cost

Worksheet A-1: Used to reclassify costs to appropriate cost centers
Worksheet A-2: Used to include additional or exclude non-allowable costs

Worksheet B / Worksheet M-2

Visit Reporting

Visits are reported by type of clinician
- Physician
- Physician Assistant
- Nurse Practitioner
All clinicians working on a regular basis should be included in visits subject to the productivity standard
Physician Services Under Agreement – for the occasional ‘fill in’ (locum tenens)

FTE Calculation

How are FTEs calculated?
- FTE is based upon how many hours the practitioner is available to provide patient care
- FTE is calculated by practitioner type (Physician, PA, NP)

Medicare Productivity Standard

Productivity Standard applied in aggregate
Total visits (all providers subject to the FTE calculation) is compared to total minimum productivity standard.
A productive midlevel with visits in excess of their productivity standard can be used to offset a physician shortfall.
**Medicare Productivity Standard**

- 4,200 visits per employed or independent contractor physician FTE
- 2,100 visits per midlevel FTE
- Aggregated for application of minimum productivity standard
- Physician Services under agreement not subject to productivity standards – limited application (cannot work on a regular basis)

**Worksheet B-1 / Worksheet M-4**

**Vaccine Reporting**

**Worksheet C / Worksheet M-3**

**Settlement Data**
Settlement Data

Data is pulled from the clinic’s PS&R

- Medicare visits
- Deductibles
- Total Medicare charges (new in 2011)
- Medicare preventative charges (new in 2011)

Worksheet A-2-1/A-8-1

Related Party Transactions

Most common related party transaction is related party building ownership (e.g. building is owned by the doctors which also own the clinic – clinic pays ‘rent’ to docs)

Cost must be reduced to the ‘cost of ownership’ of the related party

Cost is adjusted to actual expense incurred by the related party

Other Topics

Promoting Access to Health Care
Depreciation

An appropriate allowance for depreciation on buildings and equipment used in provision of patient care is allowable cost.

Depreciation must be:
- Identifiable and recorded in accounting records
- Based on historical cost of asset or fair market value of donated assets
- Prorated over the estimated useful of asset

With few exceptions – straight line method of depreciation only method acceptable
- Depreciation on assets purchased with federal funds an allowable cost
- Depreciation on donated assets allowable
- Fully depreciated assets still in use can have a revised life assigned

Interest Expense

Necessary and proper interest on current and capital indebtedness is an allowable cost.

Definitions:
- Interest – cost incurred for use of borrowed funds. Can be on current or capital indebtedness.
- Necessary – incurred on a loan made to satisfy a financial need of provider. Loans which result in excess funds are not necessary. Incurred on a loan made for a purpose reasonably related to patient care.

Grants & Gifts

Unrestricted grants and gifts not deducted from operating costs.
- Post October 1983 – restricted grants also not deducted from operating costs.
- Donated supplies and space not allowable cost (except if center is unit of state or local government).
- Grants made to cover all or portion of specific costs or groups of costs for a stated period of time are seed – money grants – not deducted from operating costs.

Revenue Maximization Strategies

- Annually update fee schedule
- Coinsurance reimbursement
- Minimize non-reimbursable costs
  - Reduce overhead attributable to non-reimbursable costs
- Carve-out hours
- Medicare Advantage paying RHC rate?

Include all allowable costs
- Accrued vacation and sick pay.
- Depreciation - * donated assets
  - fully-depreciated assets

Properly record and count encounters
- If you cannot bill for it – do not count it!
Questions?