

# Cost Reporting Boot Camp

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# Objectives

## Part I:

- What you need to need to complete the cost report
- Common cost report calculations

## Part II:

- Where it is located on the cost report
- How to deal with the complicated issues

# 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?

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

# 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

# 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.

# Cost Reporting

## Information Needed to Complete the RHC Cost Report

# 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

**2011 and forward:**

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 1/1/13 – 12/31/13.
  - For new clinics in 2013, financial statements must reflect costs from the date of the clinic's certification to 12/31/13.
- 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

# 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



# 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

# 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





# 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



## 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

WORKSHEET 5 for W-2 EMPLOYEES									
Employee/Category	Gross Wages	Is this person related to the owner or management of the company?	Wages and Fringe Medical Health Insurance	Benefit - Job Life Insurance	Title Itemization Disability Insurance	Dental Insurance	Pension / 401K / IRA	Other Fringe Benefits	Employer related Payroll Taxes
<b>Physicians:</b>									
Total Physicians									
<b>Physician Assistant(s)</b>									
Total Physician Assistant									
<b>Nurse Practitioner(s)</b>									
Total Nurse Practitioner									
<b>Mental Health:</b>									
Total Mental Health									
<b>Nursing: (Please distinguish RN's from LPN's)</b>									
Total Nursing									
<b>Medical Assistants:</b>									
Total Medical Assistants									
<b>X-ray Technicians:</b>									
Total X-ray Technicians									
<b>Lab Technicians: (List only those employees who are solely lab techs)</b>									
Total Lab Technicians									
<b>All Other Office Staffing (Non-Clinical):</b>									
Total Other Office Staffing									
<b>TOTALS OF ALL JOB DESCRIPTIONS</b>									

# 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

Vaccine Ratio Calculation

WORKSHEET 6 - VACCINE INFORMATION				
CLINIC NAME _____				
F.Y.E: _____				
Vaccination	Total Vaccines Given	Medicare Vaccines Given	Cost Per Dose	
Pneumovax				
H1N1				
Seasonal Influenza				
H1N1 and Seasonal Influenza given on same day				
Have you included the Pneumo and Seasonal Influenza vaccine invoices to support the cost per dose? YES _____ NO _____				





# 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.

# Medicare Bad Debt

- Medicare Bad Debt IS:
  - Deductibles and Coinsurance amounts uncollectible from Medicare beneficiaries after reasonable collection efforts

# PSR

- 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:  
[http://www.cms.hhs.gov/psrr/downloads/Registration\\_Tips\\_Providers.pdf](http://www.cms.hhs.gov/psrr/downloads/Registration_Tips_Providers.pdf)

# PSR

- Report types 710 AND 71S
  - 710: Summary PS&R
  - 71S: Preventive Services PS&R
- Visits, charges and payment from both PS&R reports must be added together for worksheet C reporting

# PSR

- Compare PSR 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)

# Medicare Bad Debt

- Medicare Bad Debt IS NOT:
  - Uncollected deductibles and coinsurance from:
    - private pay patients, or any other non-Medicare beneficiary
    - Medicare Advantage or Medicare Part B
  - Charity, Courtesy, and Third-Party Payer Allowances
  - Uncollected amounts due from other payers
  - Disputed Medicare claims

# Criteria for Allowable Bad Debts

- Debt must be related to covered services and derived from deductible and coinsurance amounts.
- Provider must establish that reasonable collection efforts were made.
- Debt was actually uncollectible when claimed as worthless.
- Sound business judgment established that there was no likelihood of recovery at any time in the future.

# When to write off a Medicare Bad Debt

- The CFR at 42 CFR 413.89(f) requires that the uncollectible Medicare deductible and coinsurance be charged off as bad debts **in the accounting period when the bad debt is determined to be worthless.**

# When to write off a Medicare Bad Debt

- Bad debt log is for Medicare deductibles and coinsurance deemed uncollectible and **written off clinic's books** during the cost reporting period.
- It can, and most often does, contain **dates of service** prior to the current cost reporting period.
- Based on write off date, not date of service!

# When to write off a Medicare Bad Debt

Two types of Medicare bad debts:

- Indigent or Medically Indigent Patients
  - No collection efforts required for Medicaid beneficiaries. Must bill Medicaid and retain remittance advice as documentation
- Patients not deemed to be indigent:
  - Collection efforts required

# Indigent Patients

- Automatic indigence determination for Medicare/Medicaid dual-eligible beneficiaries
- **Must bill** Medicaid for proof of eligibility and apply any Medicaid payments, if applicable.
- Must have a processed State Medicaid remittance advice before allowing dual eligible bad debts

# Indigent Patients

Indigent patients not eligible for Medicaid:

- Indigence must be **determined by the provider**, not by the patient (i.e., a patient's signed declaration of his inability to pay his medical bills cannot be considered proof of indigence)
- Take into account a patient's **total resources** which would include, but are not limited to, an analysis of assets (only those convertible to cash, and unnecessary for the patient's daily living), liabilities, and income and expenses

# Indigent Patients

Indigent patients not eligible for Medicaid:

- Determine that no source other than the patient would be legally responsible for the patient's medical bill; e.g., title XIX, local welfare agency and guardian and
- Patient's file should contain documentation of the method by which indigence was determined in addition to all backup information to substantiate the determination.

# Reasonable Collection Efforts

- **SAME EFFORT** applied to any bill:
  - Collection letters
  - Phone calls
  - Collection agency (if used for non-Medicare patients)

# Presumption of Noncollectibility (120 Day Rule)

- If after reasonable and customary attempts to collect a bill, the debt remains unpaid more than **120 days** from the date the first bill is mailed to the beneficiary, the debt may be deemed uncollectible.
- Any payments received from the beneficiary re-starts the 120 uncollectability timeframe

# Collection Policy

- Must be consistent among all payer types
- Must involve the issuance of a bill on or shortly after the date of service
- Should include other actions such as:
  - Subsequent billings
  - Collection Letters
  - Telephone Calls or personal contacts with this party
- Must constitute a **GENUINE**, rather than a token, collection effort.

# Collection Policy

- May involve the use of a Collection Agency in addition to or in lieu of subsequent billing by the clinic. If used:
  - Refer all uncollected patient charges of **like amount** regardless of class of patient
  - If the collection agency collects from the beneficiary, the **FULL AMOUNT** collected must be applied to the Medicare bad debt
  - Collection agency fees applicable to the collection of the debt can be recorded as an administrative expense on the clinic's financial statements

# Collection Policy

Do **NOT** include a “**MEDICARE COLLECTION POLICY**” section within your collection policy. (This will indicate different treatment/procedures for the collection of Medicare bad debts and cause your bad debts to be disallowed at audit)

# Collection Policy

Within the section of the collection policy that outlines the procedure for bad debt write off (consistent among all patient classes), include a section that explains how to complete the Medicare bad debt log:

- How to fill out the log
- Documentation maintenance
- Referral to the cost report

# Audit Documentation

## Indigent Patients

- Medicaid dual-eligible beneficiary: Medicaid remittance advice indicating payment or denial of payment.
- Indigent, not Medicaid eligible: Documentation of the method by which indigence was determined in addition to all backup information to substantiate the determination

# Audit Documentation

## Non-Indigent Patients

- Collection efforts must be documented in the patient's file
  - Copies of bills
  - Documentation of phone calls/personal contact
  - Follow up letters

# Bad Debt Log

- Patient Name
- HIC number
- Date of service
- Whether the patient has been deemed indigent and their Medicaid number if this was the method utilized to determine indigence
- Date the first bill was sent to the beneficiary
- Date the bad debt was written off
- Remittance advice date
- Deductible and coinsurance amount
- Total Medicare bad debt (reduced by recoveries)



# Worksheet S

## Statistical Data Reporting

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# 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)

# Worksheet A / Worksheet M-1

## Expense Reporting

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# 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

# 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

# Overhead Costs

## 2 Categories of Overhead Costs:

- Facility
- Administration

# Facility Overhead

## Facility Overhead – Facility Cost

- Rent
- Insurance
- Interest on Mortgage or Loans
- Utilities
- Other building expenses

# Facility Overhead

## Facility Overhead – Administrative

- Office Salaries
- Office Supplies
- Legal/Accounting
- Contract Labor
- Other Administrative Costs

# Non-RHC 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

# 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



# Adjustments

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

# Lab/X-ray/EKG Allocations Worksheet A-1

Lab, X-ray, EKG

- Billed to Part B by independent RHCs
- Billed through hospital and included in hospital costs for provider-based RHCs

# Lab/X-ray/EKG Allocations Worksheet A-1

- 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

# Healthcare Wages Allocations Worksheet A-1

- Cost report calculations require wages to be classified by practitioner type/healthcare worker qualifications
- Most clinics do not have separate accounts on their financials for each type of healthcare provider/employee
- A reclassification is often required to ensure proper classification of healthcare staff wages

# Administrative Allocations Worksheet A-1

- If a practitioner also performs administrative duties for the clinic, a portion of their compensation should be reflected in the Office Salaries cost center
- A reclassification may be required
- Calculate administrative reclassification based on ratio of administrative time

**MAINTAIN TIME STUDIES**

# Non-allowable Costs – Wksht A-2

- 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

# Worksheet B / Worksheet M-2

## Visit Reporting

# Visits

- Visits are reported by type of clinician
  - Physician
  - Physician Assistant
  - Nurse Practitioner
- All clinician's 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

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# Vaccine Cost

- Clinic must maintain logs of Influenza and Pneumococcal vaccines administered
- Invoices for the cost of Influenza and Pneumococcal vaccine should be submitted with the cost report
- Submit vaccine logs electronically if possible

# Vaccine Ratios

- Ten minutes is the accepted time per vaccine administration
- Total Vaccines x 10 minutes/60 minutes = 'total vaccine administration hours'
- Divide 'total vaccine administration hours' by total clinical hours worked for **Staff Time Ratio**



# Worksheet C / Worksheet M-3

## Settlement Data

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# Settlement Data

Data is pulled from the clinic's PS&R

- Medicare visits
- Deductibles
- Total Medicare charges
- Medicare preventative charges

# Settlement Data

Data is pulled from the clinic's PS&R

- Coinsurance – info only
- Medicare payments – be sure to include MSP payments
- Bad Debts – Total
- Bad Debt – Dual Eligible

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

## Related Party Transactions

# 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

# Related Party Transactions

<b>Clinic Name:</b>	ABC Family Practice			
<b>F.Y.E.:</b>	12/31/2011			
<b>A-2-1 Related Party Transaction</b>				
	<b>Column 4 A-2-1</b>			<b>Column 5 A-2-1</b>
	Manually fill in these three columns only			
	<b>Worksheet A</b>	<b>Allowable Cost</b>	<b>Allowable Cost</b>	<b>Total</b>
	<b>Cost Report</b>	<b>included in Worksheet A</b>	<b>not included in Worksheet A</b>	<b>Allowable Cost</b>
<b><u>Related Building Expenses</u></b>	<b><u>Trial Balance</u></b>	<b><u>Trial Balance</u></b>	<b><u>Trial Balance</u></b>	<b><u>Column 5</u></b>
Depreciation	\$ -	\$ -	\$ 15,935	\$ 15,935
Interest	0	0	37,203	37,203
Insurance	4,407	4,407	0	4,407
Property Taxes	9,908	9,908	0	9,908
Repairs and Maintenance	1,222	1,222	456	1,678
Building Rent	<u>115,200</u>	<u>0</u>	<u>0</u>	<u>0</u>
<b>Total Building Expenses</b>	<b><u>\$130,737</u></b>	<b><u>\$15,537</u></b>	<b><u>\$53,594</u></b>	<b><u>\$69,131</u></b>

# Other Topics

# 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

# Depreciation

- 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?

# Revenue Maximization Strategies

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?

