CHAPTER 23

ADEQUATE COST DATA AND COST FINDING

Section

General

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CHAPTER 23

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2300. PRINCIPLE

Providers receiving payment on the basis of reimbursable cost must provide adequate cost data based on financial and statistical records which can be verified by qualified auditors. The cost data must be based on an approved method of cost finding and on the accrual basis of accounting. However, where governmental institutions operate on a cash basis of accounting, cost data on this basis will be acceptable subject to appropriate treatment of capital expenditures.

2302. DEFINITIONS

2302.1 Accrual Basis of Accounting.--Under the accrual basis of accounting, revenue is recorded in the period when it is earned, regardless of when it is collected, and expenditures for expense and asset items are recorded in the period in which they are incurred, regardless of when they are paid. Section 2305ff sets forth special rules regarding recognition of expenses under the Medicare program relating to liquidation of liabilities.

2302.2 Cash Basis of Accounting.--Under the cash basis of accounting, revenues are recognized only when cash is received and expenditures for expense and asset items are not recorded until cash is disbursed for them.

2302.3 Governmental Institution.-A provider of services owned and operated by a Federal, State, or local governmental agency.

2302.4 Allocable Costs.--An item or group of items of cost chargeable to one or more objects, processes, or operations in accordance with cost responsibilities, benefits received, or other identifiable measure of application or consumption (also known as general service costs).

A. Directly Allocable Costs--Directly allocable costs are chargeable based on actual usage (e.g., metered electricity) rather than a statistical surrogate.

B. Indirectly Allocable Costs--Indirectly allocable costs are not chargeable based on actual usage, and thus, must be allocated on the basis of a statistical surrogate (e.g., square feet).

2302.5 Applicable Credits.--Those receipts or types of transactions which offset or reduce expense items that are allocable to cost centers as direct or indirect costs. Typical examples of such transactions are: purchase discounts, rebates, or allowances; recoveries or indemnities on losses; sales of scrap or incidental services; adjustments of overpayments or erroneous charges; and other income items which serve to reduce costs.

2302.6 Charges.--The regular rates established by the provider for services rendered beneficiaries and to other paying patients. Charges should be related consistently to the cost of the services and uniformly applied to all patients whether inpatient or outpatient.

2302.7 Cost Finding.--A determination of the cost of services by the use of informal procedures, i.e., without employing the regular processes of cost accounting on a continuous or formal basis. It is the determination of the cost of an operation by the assignment of direct costs and the allocation of indirect costs.

2302.8 Cost Center.--An organizational unit, generally a department or its subunit, having a common functional purpose for which direct and indirect costs are accumulated, allocated and apportioned. In addition, those natural expense classifications (e.g., depreciation) and nonallowable cost centers (e.g., research) specifically required by the instructions to be shown on the cost report fall under this definition. See §§2302.9 and 2302.10 for the proper classification of a cost center as general service or special service. See also §§2202.6, 2202.7, 2202.8, and 2203ff, for the proper classification of costs as either general routine, special care, or ancillary. (See also §§2302.4 and 2313.2.)

2302.9 General Service Cost Centers.--Those organizational units which are operated for the benefit of the institution as a whole. Each of these may render services to other general service areas as well as to special or patient care departments. Examples of these are: housekeeping, laundry, dietary, operation of plant and maintenance of plant. Costs incurred for these cost centers are allocated to other cost centers on the basis of services rendered.

2302.10 Special Service Cost Centers.--Commonly referred to as Ancillary Cost Centers. Such centers usually provide direct identifiable services to individual patients, and include departments such as the operating room, radiology, laboratory, etc.

2302.11 Outpatient Occasions of Service.--Each examination, consultation or treatment received by an outpatient in any service department of a hospital. Such occasions of service should be recorded by individual department and classified as to emergency room, clinics or private ambulatory.

2302.12 Private Ambulatory.--Patients referred to the provider by their private physicians to receive treatment or diagnostic tests in one or more of the ancillary cost centers (special service cost centers) and who do not receive any services in the clinic or the emergency room. Such patients are sometimes referred to as Private Referred Outpatients or Private Outpatients.

2302.13 RCCAC.--A ratio that may be expressed as follows:

- the ratio of total beneficiary charges to total charges applied to total costs on a departmental basis; or

- for cost reporting purposes, the ratio of total cost to total charges applied to total beneficiary charges on a departmental basis.

2302.14 Home Health Discipline.--One of the six visiting services covered under the Medicare home health benefit. The six services are skilled nursing, physical therapy, speech pathology, occupational therapy, medical social services, and home health aide. In cost finding for home health agencies, separate per visit costs must be developed for each of the disciplines provided.

2302.15 Home Health Visit.--A personal contact in the place of residence of a patient made for the purpose of providing a covered service by a health worker on the staff of the home health agency or by others under contract or arrangement with the home health agency; or a visit by a homebound patient on an outpatient basis to a hospital, skilled nursing facility, rehabilitation center, or outpatient department affiliated with a medical school when arrangements have been made by the home health agency for the furnishing of a covered service on an outpatient basis because it requires the use of equipment which cannot be made readily available in the home.

2302.16 Hospital-based Skilled Nursing Facility Cost Centers.--Cost centers established to accumulate the routine costs applicable to the care and treatment of those patients receiving skilled nursing services.

2302.17 Hospital- or SNF-based Home Health Agency Cost Centers.--Cost centers established to accumulate costs applicable to the care and treatment of those patients receiving home health agency services.

2304. ADEQUACY OF COST INFORMATION

Cost information as developed by the provider must be current, accurate, and in sufficient detail to support payments made for services rendered to beneficiaries. This includes all ledgers, books, records and original evidences of cost (purchase requisitions, purchase orders, vouchers, requisitions for materials, inventories, labor time cards, payrolls, bases for apportioning costs, etc.), which pertain to the determination of reasonable cost, capable of being audited.

Financial and statistical records should be maintained in a consistent manner from one period to another. However, a proper regard for consistency need not preclude a desirable change in accounting procedures, provided that full disclosure of significant change is made to the intermediary.

2304.1 Availability of Records of Providers.--A participating provider of services must make available to its intermediary its fiscal and other records for the purpose of determining its ongoing record keeping capability. The intermediary's examination of such records and documents are necessary to ascertain information pertinent to the determination of the proper amount of program payments due the provider. (See §2404ff.)

2305. LIQUIDATION OF LIABILITIES

A. General.--A short term liability must be liquidated within 1 year after the end of the cost reporting period in which the liability is incurred, subject to the exceptions specified in §§2305.1 and 2305.2. Liquidation must be made by check or other negotiable instrument, cash or legal transfer of assets such as stocks, bonds, real property, etc. Where liquidation is made by check or other negotiable instrument, these forms of payment must be redeemed through an actual transfer of the provider's assets within the time limits specified in this section. Where the liability (1) is not liquidated within the 1-year time limit, or (2) does not qualify under the exceptions specified in §§2305.1 and 2305.2, the cost incurred for the related goods and services is not allowable in the cost reporting period when the liability is incurred, but is allowable in the cost reporting period when the liquidation of the liability occurs.

B. Effective Date.--The policy for liquidation of short term liabilities as specified in §§2305-2305.2 is effective for costs incurred during cost reporting periods beginning on or after April 1, 1978. Any short term liabilities for costs that exist before this effective date must be liquidated by the end of the provider's first effective cost reporting period under this policy.

2305.1 Exception to 1-Year Time Limit.--If, within 1 year following the end of a provider's cost reporting period, the provider furnishes to the intermediary sufficient written justification (based upon documented evidence) for nonpayment of the liability, the intermediary may grant an extension for good cause. This extension must not extend beyond 3 years after the end of the cost reporting period in which the liability was incurred. Examples of valid justification, i.e., good cause, would include, but are not limited to, insufficient cash flow, or accounting error in the receipt and processing of bills for the cost of goods and services.

2305.2 Application and Exceptions.--The policy for liquidation of liabilities as specified in §2305ff applies to all costs except those described in the PRM sections listed below:

A. Section 220 - Interest paid to The Mother House or other governing body of a religious order;

B. Section 704.5 - Members of organizations having arrangements with provider;

C. Section 2146.2 - Reimbursement for costs of vacation;

D. Sections which mandate liquidation within 75 days after the end of the cost reporting period in which the liability was incurred.

E. Section 2142.1 – Qualified defined benefit pension plans, which are funded deferred compensation arrangements, shall be reported on a cash accounting basis in accordance with 42 CFR §413.100(c)(vii)(D).

2306. COST FINDING METHODS

Departments within a provider are usually divided into two types: 1) Those that produce patient care revenue (e.g., routine services, radiology), and 2) Those that do not directly generate patient care revenue but are utilized as a service by other departments (e.g., laundry and linen, dietary). The two types of departments are commonly referred to as "revenue-producing cost centers" and "nonrevenue-producing cost centers," respectively.

Although nonrevenue-producing cost centers do not directly produce patient care revenue, they contribute indirectly to patient care revenue generated by "serving" as a service to the revenue-producing centers and also to other nonrevenue-producing centers. Therefore, for the purpose of proper matching of revenue and expenses, the cost of the revenue-producing centers should include both its direct expenses and its proportionate share of the costs of each nonrevenue-producing center (indirect costs) based on the amount of services received. The process of allocating the cost of a particular nonrevenue-producing center to other nonrevenue-producing centers and revenue-producing centers is performed by utilizing a set of statistics (e.g., pounds of laundry for allocating "laundry and linen" costs, square feet for allocating "depreciation building" costs).

Every nonrevenue-producing cost center has the potential of being allocated to every other nonrevenue-producing cost center in addition to the revenue-producing cost centers. This precludes a simple allocation of the direct expense of the nonrevenue-producing cost center because the indirect costs derived from allocation of other nonrevenue-producing cost centers must be computed in determining the "full cost" (direct and indirect costs) of the nonrevenue-producing cost center being allocated. All cost finding methods employ this computation in determining the full costs of departments.

One of the methods of cost finding described in §§2306 or 2310 must be used to determine the actual costs of services rendered during the provider's initial Medicare cost reporting period. (See §2312 for conditions under which a provider may change cost finding methods.) However, free-standing home health agencies must use the step-down method, and may not change methods. (See §2308.)

2306.1 Step-Down Method.--This method recognizes that services rendered by certain nonrevenue-producing departments or centers are utilized by certain other nonrevenue-producing centers, as well as by the revenue-producing centers. All costs of nonrevenue-producing centers are allocated to all centers which they serve, regardless of whether these centers produce revenue. The cost of the nonrevenue-producing center serving the greatest number of other centers is allocated first. Following the allocation of the cost of the nonrevenue-producing center, that center will be considered "closed" and no further costs are allocated to that center. This applies even though it may have received some services from a center whose cost is allocated later. Generally, when two centers render service to an equal number of centers while receiving benefits from an equal number, that center which has the greatest amount of expense should be allocated first.

2306.2 Double-Apportionment Methods.--The double-apportionment method may be used by a provider (other than a free-standing home health agency - see §2308) upon approval of the intermediary. This approval pertains to the use of the methodology, not to the use of a substitute cost report (see HCFA Pub. 15-II, §108ff) generated through a computer system.

This method also recognizes that services rendered by certain nonrevenue-producing departments or centers are utilized by certain other nonrevenue-producing centers, as well as by the revenue-producing centers. The first allocation of the costs of the nonrevenue-producing centers is made to all cost centers serviced by these centers. These centers are not "closed" after the first allocation. They remain "open" accumulating their portion of the costs of all other nonrevenue-producing centers from which service is received. The first allocation is followed by a second allocation of costs involving the allocation of all costs remaining in the nonrevenue-producing centers. The second allocation equates to the step-down method of cost allocation.

A. Double-Apportionment - Accumulative.--This method of double-apportionment cost finding allocates the direct and indirect costs of the nonrevenue-producing centers during the first allocation. The cost of the nonrevenue-producing center is allocated to all cost centers which receive service from that center (including itself if it provides service to itself) during the first allocation. The second allocation allocates the costs received during the first allocation in the same manner as the step-down cost finding method. The statistics used in the second allocation are the same as the statistics used in the first allocation except for (a) accumulated cost which is used as the recommended basis for allocating the cost of the administrative and general cost center, and (b) elimination of the statistics of the "closed" cost centers.

B. Double-Apportionment - Nonaccumulative.--This method of double-apportionment cost finding allocates only the direct cost of the nonrevenue-producing centers during the first allocation. The direct costs are allocated to all centers receiving service

(including itself if it provides service to itself) during the first allocation. The second allocation allocates the indirect costs received during the first allocation in the same manner as step-down cost finding. The statistics used in the second allocation are the same as the statistics used in the first allocation except for (a) accumulated cost which is used as the recommended basis for allocating the administrative and general cost center, and (b) the elimination of the statistics for "closed" cost centers.

2306.3 Multiple-Apportionment.--The multiple-apportionment method may be used by a provider (other than a free-standing home health agency - see §2308) upon approval of the intermediary. This approval pertains to the use of the methodology, not to the use of the substitute cost report (see HCFA Pub. 15-II, §108ff) generated through a computer system. The approval also pertains to the number of allocations when the multiple apportionment method of cost finding is selected.

This method of cost finding allocates the cost of the nonrevenue-producing centers in the same manner as the double-apportionment methods described in §2306.2, except that the number of allocations is determined by the user. For example: A user elects five allocations under multiple-apportionment method of cost finding. Allocations one through four are identical to the first allocation described in the double-apportionment methodologies in §2306.2. The fifth allocation is identical to the second allocation described in the double-apportionment methodologies.

A. Multiple-Apportionment-Accumulative.--See §2306.2A.

B. Multiple-Apportionment-Nonaccumulative.--See §2306.2B.

2307. DIRECT ASSIGNMENT OF GENERAL SERVICE COSTS

The costs of a general service cost center need to be allocated to the cost centers receiving service from that cost center. This allocation process is usually made, for Medicare cost reporting purposes, through cost finding using a statistical basis that measures the benefit received by each cost center. Alternatives to cost finding as described below may be used where appropriate after obtaining intermediary approval. The provider must make a written request to its intermediary and submit reasonable justification for approval of the change no later than 90 days prior to the beginning of the cost reporting period for which the change is to apply. The intermediary must respond in writing to the provider's request, whether approving or denying the request, prior to the beginning of the cost reporting period to which the change is to apply.

When the request is approved, the change must be applied to the cost reporting period for which the request was made, and to all subsequent cost reporting periods unless the intermediary approves a subsequent request for a change by the provider. The effective date of the change will be the beginning of the cost reporting period for which the request has been made.

A. Direct Assignment of Cost.--Direct assignment of cost is the process of assigning directly allocable costs of a general service cost center (see §2302.9) to all cost centers receiving service from that cost center based upon actual auditable usage. Hours worked by hourly wage or metered utility consumption are examples of measures of actual usage. Estimates, including a statistical surrogate such as square feet, are not acceptable. Time studies are considered statistical surrogates and, thus, may not be used

as a basis for direct assignment of costs. Indirectly allocable supervision costs, other indirectly allocable costs (hereinafter, residual costs) and costs allocated from previously allocated general service cost centers (hereinafter, overhead costs) must not be directly assigned to the using cost centers, but must be allocated through cost finding.

Note: This subsection describes direct assignment of general service costs on the provider's accounting records and is distinguished from the allocation of direct salary and wage costs as described in §2313.2E.

The direct assignment of costs must be made as part of the provider's accounting system with costs recorded in the ongoing normal accounting process. This means costs are to be recorded on a regular basis throughout the accounting period, not only as period ending adjusting entries. For example, if the costs being directly assigned are an element of payroll costs, the direct assignment should be recorded as often as all payroll costs are recorded (usually each pay period). If a provider fails to maintain the records as specified in its request and as a basis for the intermediary's approval, no direct assignment of cost is allowed for the cost reporting period and a new request must be initiated for any future direct assignment of cost.

Examples of acceptable direct assignment of cost to benefiting cost centers are salaries paid to housekeeping staff directly assigned, based on time records of housekeeping maintained throughout the cost reporting period; purchased laundry and linen costs directly assigned, based on invoices which identify the cost for each benefiting cost center; and depreciation on movable equipment physically present or used in each of the cost centers.

The following conditions must be met before Medicare will accept direct assignment for cost reporting purposes:

1. All costs within the general service cost center which can be directly allocated must be assigned to the benefiting cost centers as part of the provider's routine accounting process.

2. Any indirect supervision and residual costs remaining in the cost center together with any previously allocated overhead must be allocated through cost finding to all remaining benefiting cost centers.

3. The basis for assigning directly allocable costs of a general service cost center to the benefiting cost centers must be on a factual and auditable basis. This precludes the use of averages, estimates or statistical surrogates such as square feet. For example, the assignment of actual housekeeping salaries by each employee based on actual hours worked in the benefiting cost centers is acceptable, whereas the use of the surrogate, square feet, is inappropriate for direct assignment.

4. The basis of allocation for cost finding any indirect supervisory costs, residual costs and allocated overhead must be an appropriate measure of the benefits provided to the remaining cost centers. Any deviation from the allocation basis prescribed for cost finding must be reviewed and approved by the intermediary in advance as part of the provider's request for direct assignment of costs.

B. Direct Assignment of Costs to Provider Components.--In some cases, providers may only be able to directly assign costs of a general service cost center by subdividing existing cost centers and, in turn, allocating costs via cost finding for the benefiting cost centers within each of the specific general service cost centers.

For example, a provider may have two buildings of differing ages and depreciation related to each can be factually ascertained. Each building would become a general service cost center and the allocation to the cost centers within each would be separately accomplished using an appropriate statistical basis such as square feet. Another example could be the separate metering of utilities for each building within a health care complex: separate general service cost centers for each building would be established and utility cost would be directly assigned to the using building based on actual bills incurred during the reporting period. Statistical allocations to benefiting cost centers within each building would be required.

To accommodate additional general service cost centers, the provider must add additional columns to the allocation worksheets, or attach a supporting worksheet with similar information, to document the step-down of costs to those cost centers benefiting from the general service cost centers. Any modifications necessary to worksheets after the cost allocation must also be approved by the intermediary as part of the request for direct assignment of costs.

For determining nonallowable costs applicable to the nonpaid workers cost center, the analysis set forth at §707.2 would still be required.

Example of Component Allocation: Building Depreciation

There are two buildings housing the hospital and the SNF, built in 1950 and 1975, respectively. Annual depreciation is $100,000 for the hospital and $50,000 for the SNF. (The cost centers are not all-inclusive and are shown to illustrate the principle.)

	Hospital		SNF		Total
	Statistic (Sq. Feet)	Cost	Statistic (Sq. Feet)	Cost	Cost
Admin. & Gen.	25,000	10,000			10,000
Operation of Plant	75,000	30,000			30,000
Dietary	10,000	4,000			4,000
Radiology	20,000	8,000			8,000
Laboratory	12,500	5,000			5,000
Adult & Ped.	100,000	40,000			40,000
Special Care	7,000	2,800			2,800
SNF-Certified*			70,000	35,000	35,000
SNF-Noncertified*			30,000	15,000	15,000
Gift Shop	500	200			200
	250,000	100,000	100,000	50,000	150,000
Unit Cost Multipliers	.400		.500		

*Routine Only

Example of Component Allocation: Utilities

In addition to the facts in the prior example, the provider has established, in accordance with §§2302.8 and 2313.1, a unique cost center called "Utilities." The cost center is used to accumulate the cost of all utilities. The cost center includes electricity costs of $200,000 ($45,000 is separately metered and applies to the SNF). In addition, other utilities, not separately metered, total $400,000. Overhead allocated from other cost centers totals $100,000. There are no supervisory costs in this cost center.

	Electricity				Other Utilities		Overhead		
	Hospital		SNF						
	Stat. (Sq.Ft.)	Cost	Stat. (Sq.Ft.)	Cost	Stat. (Sq.Ft.)	Cost	Stat. (Cost)	Cost	Total
A&G	25,000	15,500			25,000	28,571	44,071	7,345	51,416
Operation of Plant	75,000	46,500			75,000	85,714	132,214	22,036	154,250
Dietary	10,000	6,200			10,000	11,429	17,629	2,938	20,567
Radiology	20,000	12,400			20,000	22,857	35,257	5,876	41,133
Laboratory	12,500	7,750			12,500	14,286	22,036	3,673	25,709
Adult & Ped.	100,000	62,000			100,000	114,286	176,286	29,381	205,667
Special Care	7,000	4,340			7,000	8,000	12,340	2,057	14,397
SNF-Certified *			70,000	31,500	70,000	80,000	111,500	18,583	130,083
SNF-Noncertified *			30,000	13,500	30,000	34,286	47,786	7,964	55,750
Gift Shop	500	310			500	571	881	147	1,028
	250,000	155,000	100,000	45,000	350,000	400,000	600,000	100,000	700,000
Unit Cost Multipliers	.62		.45		1.142857		.166667		

*Routine Only

2308. COST FINDING METHODS - HOME HEALTH AGENCIES

Effective for cost reporting periods beginning on or after October 1, 1980, free-standing home health agencies are required to use the stepdown method of cost finding. Provider-based home health agencies are required to use the same method of cost finding as is used by the related provider. (See HCFA Pub. 15-II, chapters 4 and 8.)

2310. MORE SOPHISTICATED METHODS

A more sophisticated method of cost finding designed to allocate cost more accurately may be used by the provider (other than a free-standing home health agency) upon approval of the intermediary. A more sophisticated method is generally dependent on computerized programs to produce the allocation results; the approval by the intermediary pertains to the cost finding methodology, not the computer system. The computer system must be reviewed and approved by HCFA before an intermediary can accept it in lieu of HCFA forms.

2310.1 Matrix.--Matrix, matrix inversion, and simultaneous equations are basically the same method of cost finding except for the use of different mathematical formulas to compute the same results. All use as a basis, a rectangular array of mathematical elements (as a coefficient of simultaneous linear equations) that can be combined to form sums and products to compute the final results. Implementation of these methodologies are usually feasible only through the use of computer systems. With the use of these methods, a nonrevenue-producing center is never "closed" until it has received all the cost from all nonrevenue-producing centers which provided service to it. The order of allocation is not important in matrix method of cost finding because the "full cost" (direct and indirect costs) is determined for each nonrevenue-producing center simultaneously before the cost is allocated to other nonrevenue-producing centers and ultimately to the revenue-producing centers.

2312. CHANGING COST FINDING METHODS

Should a provider (other than a free-standing home health agency) desire to change cost finding methods (regardless of whether the desired change is to be a more or less sophisticated method), the request to change must be made to the intermediary in writing and must be submitted to the intermediary 90 days prior to the end of the cost reporting period to which the request for change applies. See §2313 for provider and intermediary responsibilities when a request is submitted or if a cost report is filed without a prior approval.

Intermediary determination of a provider's request to change methods will be furnished to the provider in writing within 60 days and will be considered binding on the provider as of the date of the intermediary's written notice.

Where the intermediary approves the provider's request to change methods, the provider must use this method for the cost reporting period to which the request applies and for all subsequent cost reporting periods, unless the intermediary approves a subsequent request by the provider to change cost finding methods.

Effective for cost reports (other than amended cost reports) filed after May 31, 1985, a provider may change its cost finding method from the double apportionment method (see §2306.2), the multiple apportionment method (see §2306.3), or a more sophisticated method (see §2310) to the stepdown method provided for in the Medicare cost reporting forms (see §2306.1) without prior notification or approval of its fiscal intermediary by filing a cost report using the stepdown method. Having once exercised this election, the provider may not again change its method of cost finding without prior notification and approval of its fiscal intermediary, as described above.

2313. CHANGING BASES FOR ALLOCATING COST CENTERS OR ORDER IN WHICH COST CENTERS ARE ALLOCATED.

When a provider wishes to change its statistical allocation basis for a particular cost center and/or the order in which the cost centers are allocated because it believes the change will result in more appropriate and more accurate allocations, the provider must make a written request to its intermediary for approval of the change ninety (90) days prior to the end of that cost reporting period. The intermediary has sixty (60) days from receipt of the request to make a decision or the change is automatically accepted. The provider must include with the request all supporting documentation to establish that the new method is more accurate. If the provider is requesting the simplified method (hospitals only), as described in HCFA Pub. 15-II, Chapter 36, §3617, the provider must demonstrate that the maintenance of the new statistics is less costly. The change should not result in inappropriately shifting costs. Hospitals should be cognizant of this particularly to avoid violating the capital consistency rule under the hospital inpatient capital prospective payment system.

If a provider has requested a change in allocation bases, the provider must maintain both sets of statistics until an approval is granted. If the request is denied, the provider reverts back to the previously approved methodology. If the provider has failed to maintain the statistics per the previously approved methodology, the fiscal intermediary may accept the previous year's statistics, if the prior year's statistics can be reasonably related to the current year's costs. Otherwise, the incremental program costs associated with the unapproved change must be disallowed. If the provider continues to use the unapproved statistics/methodology for the subsequent year, all costs and statistics will be disallowed for those cost centers affected by the unapproved change. This requirement will apply to all cost finding methods.

The intermediary's approval of a provider's request will be furnished to the provider in writing within sixty (60) days of receipt of the request. Where the intermediary approves the provider's request, the change must be applied to the cost reporting period for which the request was made and to all subsequent cost reporting periods unless the intermediary approves a subsequent request for change by the provider. The effective date of the change will be the beginning of the cost reporting period for which the request has been made.

If the provider has elected the simplified method, as described in HCFA Pub 15-II, Chapter 36, §3617, the approval will be for a three year period. The provider can not change methods until the three year period has expired.

If a provider has submitted a cost report with a change in its allocation statistics and/or order of allocation without prior approval from its intermediary, the intermediary must reject the cost report. If the provider can prove that the change results in a more appropriate and more accurate allocation of cost, is supported by adequate auditable documentation, and meets all the other conditions of this chapter, the fiscal intermediary may accept the provider's change upon resubmission of the cost report, notwithstanding the lack of prior approval.

NOTE: If the cost report is rejected for lack of prior approval, the provider risks the assessment of interest and withholding of interim payments. The cost report may be further delayed if the intermediary rejects the resubmission because of inadequate supporting documentation. To avoid rejection of the cost report and possible interest and withholding, providers should adhere to the time frames discussed above.

2313.1 Use of Provider's Unique Cost Centers.--Based on the provider's individual accounting system, a provider may elect to use its unique cost centers in lieu of the recommended cost centers on the cost reporting forms for cost finding purposes, subject to the following provisions.

A. Each cost center must meet the definition of a cost center as expressed in §2302.8.

B. Each cost center to be established must:

1. Be separately identified in the provider's accounting system with any direct costs recorded on a regular ongoing basis throughout the accounting period, not only period ending adjusting entries;

2. For general service cost centers, be placed in the allocation sequence in an order such that the cost center serving the most other cost centers, while receiving benefits from the least number of cost centers, is allocated earliest in the sequence. (See §2306.1.); and

3. For general service cost centers, use a single statistical basis of allocation which accurately measures the amount of service rendered by that cost center to the other cost centers. (See §2307.)

C. The intermediary must be satisfied that the provider's use of its unique cost centers will result in a more accurate cost finding.

D. A written request must be submitted to the intermediary 90 days prior to the end of the cost reporting period for which it applies and must be approved by the intermediary within 60 days from the date of receipt. The intermediary's approval, which applies to both the cost centers and the proposed basis of allocation, must be furnished in writing and is binding for the initially approved and all subsequent cost reporting periods until a subsequent request is approved.

2313.2 Special Applications.--It is not possible to prescribe standard allocation rules for every situation. Such determination needs to be made by providers subject to approval by the intermediary. However, the following are some common issues which have arisen over the years.

A. Admitting.--Where the admitting department serves both inpatients and outpatients, gross charges would be an adequate basis for allocation. However, where the admitting department serves only inpatients (i.e., the provider has a separate outpatient registry), all the costs of inpatient admitting may be allocated to the general routine and special care areas on the basis of number of admissions. The cost of the outpatient registry should be allocated to only the benefiting outpatient departments on a reasonable basis.

B. Utilization Review.--Where hospital utilization review costs are identified as a separate general service cost center, and if the utilization review program serves only inpatients, these costs may be allocated to the general routine and special care cost centers, as appropriate, on a reasonable basis (e.g., number of reviews or patient days). (See §2126ff.)

C. Home Health Disciplines.--Each of the six home health disciplines (see §2302.14) must be reported as a single cost center as specified on the cost reporting forms. The creation of subcategories (or any form thereof) of any of these cost centers is not allowed.

D. Renal Dialysis.--Notwithstanding the provisions of §§2307 and 2313.1, providers furnishing renal dialysis services must retain the capability of completing the renal dialysis worksheets (e.g., Supplemental Worksheet I series for hospitals) by modality.

E. Periodic Time Studies.--Periodic time studies, in lieu of ongoing time reports, may be used to allocate direct salary and wage costs. However, the time studies used must meet the following criteria:

1. The time records to be maintained must be specified in a written plan submitted to the intermediary no later than 90 days prior to the end of the cost reporting period to which the plan is to apply. The intermediary must respond in writing to the plan within 60 days from the date of receipt of the request, whether approving, modifying, or denying the plan.

2. A minimally acceptable time study must encompass at least one full week per month of the cost reporting period.

3. Each week selected must be a full work week (Monday to Friday, Monday to Saturday, or Sunday to Saturday).

4. The weeks selected must be equally distributed among the months in the cost reporting period, e.g., for a 12 month period, 3 of the 12 weeks in the study must be the first week beginning in the month, 3 weeks the 2nd week beginning in the month, 3 weeks the 3rd, and 3 weeks the fourth.

5. No two consecutive months may use the same week for the study, e.g., if the second week beginning in April is the study week for April, the weeks selected for March and May may not be the second week beginning in those months.

6. The time study must be contemporaneous with the costs to be allocated. Thus, a time study conducted in the current cost reporting year may not be used to allocate the costs of prior or subsequent cost reporting years.

7. The time study must be provider specific. Thus, chain organizations may not use a time study from one provider to allocate the costs of another provider or a time study of a sample group of providers to allocate the costs of all providers within the chain.

The intermediary may require the use of different, or additional, weeks in the study in its response to the provider's request for approval and may prospectively require changes in the provider's request as applied to subsequent cost reporting periods.

23l4. LIMITATION OF ALLOCATION OF INDIRECT COSTS WHERE ANCILLARY SERVICES ARE FURNISHED UNDER ARRANGEMENTS

A. "No Overhead Allocation" Method.--

l. Where a provider furnishes ancillary services to Medicare patients under arrangements with others, the provider must pay the supplier and request reimbursement from the Medicare program. Where a provider simply arranges for such services for non-Medicare patients, and does not pay the non-Medicare portion of such services, its books will reflect only the cost of the Medicare portion. Therefore, allocation of indirect costs to a cost center which includes only the cost of the Medicare portion would result in excessive assignment of indirect costs to the program. Since services were also arranged for non-Medicare patients, part of the overhead costs should be allocated to that group.

Consequently, in the foregoing situation, no indirect costs may be allocated to the Medicare portion. Instead, the total indirect costs will be allocated to all other departments so that each of these departments will absorb proportionately those indirect costs which otherwise would have been allocated to the arranged for services. In this way, Medicare will share in such indirect costs in the proportion that it shares in the costs of all other services furnished directly by the provider.

The overhead elimination is accomplished by removing from the statistical bases used for allocation (square feet, hours, etc.) the statistics for the cost center that includes Medicare-only services purchased under arrangements. The cost of Medicare services should then be separately apportioned. This cost should not be apportioned with other ancillary cost centers if the Combination Method of cost finding is used since such a procedure would result in the apportionment of Medicare cost to non-Medicare patients. In addition, if a provider incurs other direct costs for all patients, e.g., paramedics or aides who assist a physical therapist in performing physical therapy services, such costs should be reclassified from the ancillary cost center and allocated as part of administrative and general expenses.

2. There may be situations where Medicaid or other third-party payers will pay a supplier directly for services rendered to their beneficiaries while Medicare and other groups of patients receive such services under arrangements through the provider. In these cases, since the provider is not recording all of the costs of services rendered to all patients, the "no overhead allocation" method stated in l. above should be applied.

B. "Grossing Up" Method.--If the intermediary determines that a provider is able to "gross up" the costs and charges for services to non-Medicare patients so that both charges and costs are recorded as if the provider had provided such services directly, then indirect costs may be applied to the ancillary department.

"Grossing up" of costs means applying to the non-Medicare patient services the same schedule of charges used by the servicing entity to bill the provider for Medicare patient services. Costs so determined should be added to the costs of services of Medicare patients. "Grossing up" of charges means applying the provider's standard charge structure to the non-Medicare patient services. If the provider does not have a charge structure, the charge structure used by the servicing entity may be used to apportion costs if it provides for similar charges for similar services to both Medicare and non-Medicare patients. Charges so determined should be added to charges for services to Medicare patients and used to apportion costs in accordance with the apportionment method the provider is required to use under the program.

Where a provider uses the "grossing-up" technique, direct costs related to the services of paramedics, aides, etc., should not be reclassified from the ancillary cost center.

In order to use the "grossing-up" technique, the provider must receive the intermediary's written approval within 90 days after the beginning of the cost reporting period in which the "grossing-up" technique will be used. Once this technique has been approved, the provider may not change to the "no overhead allocation" method stated above, unless it receives intermediary approval within 90 days after the beginning of the cost reporting period in which the change will take place.

2320. COST FINDING SCHEDULES

The cost data submitted must be based on the accrual basis of accounting which is recognized as the most accurate basis for determining costs. Particular attention should be given to accruals in the first reporting period, particularly if the first reporting period is a short period. All accruals of a significant nature must be recorded on the provider records at year end to preclude inequity of cost allocation. Those providers who maintain their records on a cash basis may record such accruals as worksheet adjustments. Significant costs to be represented by accruals include, but are not limited to, employee vacation pay, bonuses, and professional fees. Governmental institutions that operate on a cash basis of accounting may submit cost data on that basis subject to appropriate treatment of capital expenditures. Cents are omitted in the preparation of all worksheets and schedules except when inclusion is required to properly reflect average per diem cost, average cost per visit, average cost per hour, etc. Percentages should be carried two places to the right of the

decimal point except where different instructions for percentages are specified in home health agency cost forms. Bases other than those recommended for any of the schedules may be used with the intermediary's approval, provided such bases will produce more accurate results. In lieu of the forms provided, the provider may wish to use its own worksheets and schedules. These are acceptable if the information and data are presented in a manner comparable to the required forms and are approved by the intermediary. Cost reports are due on or before the last day of the third month following the close of the accounting period.

2328. DISTRIBUTION OF GENERAL SERVICE COSTS TO NONALLOWABLE COST AREAS

Nonallowable cost centers to which general service costs apply should be entered on the cost allocation worksheets after all General Service Cost Centers. General service costs would then be distributed to the nonallowable cost centers in the routine stepdown process. Revenue derived from nonallowable activities must not be offset against the nonallowable cost centers prior to or during the cost finding process. In the event there are more nonallowable cost centers than the cost allocation worksheets can presently accommodate, then supplemental worksheets should be prepared. When the stepdown process is complete, only allowable costs should be carried forward to the cost apportionment worksheets.

The Adjustments to Expenses worksheet (e.g., Worksheet A-8 for hospitals) will continue to be used for expense recoveries (rebates, refunds, etc.); adjustments based on the income received; nonallowable costs to which general service costs are not applicable, except that for patient telephones an Adjustments to Expenses worksheet adjustment only on the basis of cost (not revenue received) can be used even though general service costs are applicable; and the amount applicable to Part B for hospital-based physicians (unless the contract includes a proportionate share of general service costs). These items will still be carried forward to the trial balance of expenses worksheet.

The following illustrates how certain types of nonreimbursable costs and adjustments should be handled:

A. Research.--A separate cost center should be established and the cost, determined on an accrual basis, should be carried forward to the cost allocation worksheets so that a proportionate share of general service costs may be distributed to it.

B. Sale of Scrap, Waste, Etc.--The income from these items should be used as a reduction of the applicable expense before these expenses receive their share of indirect expenses. If the applicable expense cannot be determined, for expediency the "Operation of Plant" account can be used.

C. Rebates and Recovery of Expense.--The amount of the rebates or recovery should be used to reduce the applicable expense before these expenses receive their proportionate share of indirect expenses.

D. Gift, Flower and Coffee Shops.--Where cost centers are maintained for these functions (see §§2105.2 and 2145 concerning coffee shops), the cost should be carried forward for cost finding and receive an allocable share of general service costs. After the allocation is made, the total cost of these functions must be excluded in determining reimbursable costs. In this case, income will not be used to reduce costs. Where the costs (direct and allowable share of general service costs) attributable to any nonallowable cost area are so insignificant as to not warrant establishment of a nonreimbursable cost center, these costs may be adjusted on the Adjustments to Expenses worksheet of the cost reporting forms. However, where cost centers are not maintained for these functions, the income derived from them must be used to reduce total hospital costs. For expediency, the cost in the "Operation of Plant" account can be reduced.

E. Amount Applicable to Part B for Hospital-Based Physicians.--Since this amount is generally based upon the direct salary and fringe benefits of the physicians, no general service costs would normally apply and the adjustment would be made on the Adjustments to Expenses worksheet. If, however, the contractual agreement with hospital-based physicians requires the physicians to reimburse the hospital for costs incurred by the hospital related to physician services, these costs should bear an appropriate portion of general service costs.

F. Services Furnished as Payment-In-Kind Under Reserved Bed Agreements.--Under the terms of a reserved bed agreement, a provider may agree to compensate another facility for reserving beds by offering free or discounted services rather than by making cash payment. (See §2105.3.) When this occurs, the provider making payment must make an adjustment to remove the cost of furnishing the free or discounted services from its allowable costs. This is accomplished by (1) "grossing-up" the appropriate department charges as described in §2314 B., if the services are billable or (2) if the services are not billable, by either establishing a nonallowable cost center, as described above, or making appropriate adjustments on the Adjustments to Expenses worksheet to remove direct as well as indirect costs associated with the cost of the services provided.

G. Home-Delivered Meals.--The acquisition cost of meals in a home-delivered meals program may be excluded from the statistical basis used to allocate A&G cost. In the case of meals prepared by the provider, the cost of raw food is excluded. In the case of the purchase of prepared meals, the cost of the meals is excluded. The amount of cost excluded must be based on auditable records of actual cost. Neither estimates nor statistics are acceptable. All other direct costs (salaries, fringe benefits, transportation and contract services) will receive overhead cost through the required step-down process. This treatment of direct cost is limited to the costs of home-delivered meals programs only.

H. Home Health Agency-Based Hospice.--The cost of inpatient care provided under contract for an HHA-based hospice may be excluded from the statistical basis used to allocate A&G cost. The amount of cost excluded must be based on auditable records of the actual cost to the HHA for care provided to hospice patients under an arms-length contract with a non-related provider of inpatient care. All other hospice costs will receive overhead cost from the parent HHA through the required step-down process.

This treatment of direct cost is limited to the determination of the costs of HHA-based hospice programs only.

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2336. SEPARATE COST ENTITIES IN AN INSTITUTIONAL COMPLEX

A. General.--There are a number of institutions which, although operating as a single administrative entity, offer several clearly different types of service; e.g., short-term acute, long-term medical, rehabilitation, skilled nursing, home health, hospice, long-term psychiatric or long-term tuberculosis.

Where the cost of services rendered for each type of service differs or where there are significant differences in the operating costs of the various facilities, to treat the institution as one entity for cost reimbursement purposes would mean an underpayment or overpayment for services rendered to beneficiaries. The average cost of a patient day in one part of the complex may differ from another part, but treatment of the complex as one unit for cost reimbursement purposes will result in averaging the costs of the various components. Under these circumstances, a high utilization by Medicare patients in the more costly area would result in an underpayment to the institution, while a high utilization in the lower cost areas would result in an overpayment.

In order to insure equitable treatment for those institutions furnishing different types of services separate entities for cost reimbursement must be established in, and subprovider identification numbers issued to, those institutions that meet the criteria described in §§ 2336.l and 2336.2. These separate entities must, if they seek to be considered a part of the main provider for purposes of Medicare certification and reimbursement, meet the applicable criteria.

2336.l Patient Service Criteria for Establishing Cost Entities in an Institutional Complex.--The following criteria pertaining to patient services will be evaluated by the State agency.

A. Types of Service.--Separate cost entities can only be established for components providing clearly different services; e.g., short-term acute, long-term medical, long-term psychiatric, or long-term tuberculosis. Those services generally provided by short-term acute hospitals (intensive care, self care, and similar services) may not be established as separate cost facilities, nor may the customary separate clinical departments of a short-term hospital (pediatrics, obstetrics, etc.) be set up as separate cost entities.

The definition of long-term and short-term entities will be in conformity with the definition in the AHA Guide Issue (August l, l969): "Long term--over 50 percent of all patients admitted have a stay of 30 days or more. Short term--over 50 percent of all patients have a stay of less than 30 days."

B. Admission and Discharge Procedures.--Separate admission and discharge records must be maintained for each unit. When a patient is moved from one cost entity to another cost entity, the patient's record must be closed and sent to medical records, and a new medical chart prepared upon admission to the receiving cost entity.

C. Physical Arrangement.--The components to be separately costed must be in separate buildings; or, if not separated, the physical arrangement must be equivalent to separate buildings in the location of the nursing stations, the call system hook-ups, and the arrangement of equipment, walks, doors, etc.

Each unit must have enough beds to permit economical and effective operation as a separate unit and all beds comprising a unit must be contiguous (not scattered through various floors, wings, or buildings), except swing beds.

D. Nursing Staff Organization.--The nursing or patient care staffs assigned to a separate cost entity must service exclusively in that cost entity during a shift. Also, there must be a charge nurse or other supervisor of patient care to supervise each shift for each separate cost entity exclusively.

E. Licensure and Accreditation.--If State law provides for separate licensing of facilities of the kind represented by a unit to be separately costed, the unit must be so licensed

F. Utilization Review Plan.--The institution's utilization review plan must reflect the proper standards for each type of care offered.

2336.2 Accounting Criteria for Establishing Cost Entities in an Institutional Complex.--The following criteria pertaining to the cost-finding capability of each institutional complex will be evaluated by the fiscal intermediary.

A. The process of cost finding in an institutional complex is one of allocating the cost of the entire institution to the different entities. In effect, each entity will be treated as a cost center.

B. The accounting system must provide for the proper allocation to the various cost entities those revenues and costs that are attributable to facilities or services that are shared by them including those entities providing noncovered care. Adequate statistical data must be developed and maintained currently to corroborate the basis of allocation. One of the required statistics must be the number of square feet used by each component both before and after the effective date of the change to an institutional complex.

2336.3 Cost Report Requirements of an Institutional Complex.-- The following cost reporting requirements apply:

A. The institution will be required to file one cost report covering the period from the beginning of its reporting period to its regular year-end reporting time. Where the effective date of the change does not coincide with the beginning of the cost reporting year, the provider will use the weighted average method to determine the total square feet used by each component during the year. The number of square feet used by each component, as determined by the use of this method, will be used as a basis to allocate those expenses that are required to be allocated on the basis of square feet. This method will be used only for a year in which a change in certification occurs.

EXAMPLE:

Facts:

Total square feet in hospital	l00,000 sq. ft.
Certified as short-term acute care hospital	9 months
Certified as short-term acute care hospital and long-term care unit	3 months

Acute care unit - 75,000 sq. ft.
Long-term care unit - 25,000 sq. ft.

Computation of total square feet used by each unit:

Acute care unit - 9 months x l00,000 sq. ft. =	900,000	
Acute care unit - 3 months x 75,000 sq. ft. =	225,000	
	l,l25,000 =	93.75%
Long-term care - 3 months x 25, 000 sq. ft. unit	75,000 -	6.25%
	l,200,000	l00.00%

Acute care unit - 93.75% x l00,000 sq. ft. =	93,750 sq. ft.
Long-term care - 6.25 x l00,000 sq. ft. =	6,250 sq. ft.
unit	l00,000 sq. ft.

B. The cost report must include each entity as a separate cost center (see § 2336.2A).

C. Worksheet A, trial balance of expenses, and Worksheet B, cost-finding schedule, of the cost report must show total cost for the entire institutional complex. Separate cost centers must be listed on Worksheet B for each subprovider number and any noncovered area. Worksheet B-l, statistical basis for cost-finding, must show the statistical apportionment basis for each area listed on Worksheet B. Separate calculations of reimbursement settlement and statistics must be submitted by each cost entity.

D. The cost report and supplemental schedules for all components within an institutional complex must be submitted simultaneously and must cover the same cost reporting period.

E. All components included in the cost report must use the same method of cost apportionment and must establish the same charges for like services (see §2203).

F. All components within an institutional complex must be serviced by the same fiscal intermediary for purposes of audit and settlement.

G. Each component within an institutional complex that offers patient care services that are covered under the program should be considered, within the limitations imposed by this section, to be a provider for reimbursement purposes. Such reimbursement functions as the establishment of interim rates, limitation of reasonable costs, application of lower of costs or charges, and similar matters will be governed by regulations and policies that apply to all hospital cost reports.

H. An institutional complex must file the profit and loss and the balance sheet section of the cost report to reflect the entire hospital.

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2337. EFFECTIVE DATE OF CHANGE IN BED SIZE AND/OR BED DESIGNATION(S) OF PARTICIPATING SKILLED NURSING FACILITY AND/OR NURSING FACILITY

Under §1866 of the Social Security Act (the Act), the Secretary has the authority to enter into an agreement with an institution or an institutional complex to provide covered services to our beneficiaries. The provider agreement requires compliance with the requirements the Secretary deems necessary for participation in the Medicare or Medicaid program. See §1866(b)(2) and §1902 (a)(27) of the Act. On the effective date of the provider agreement, the institution or institutional complex is deemed to have met the requirements for participation based upon a survey of the institution or institutional complex as it was configured (i.e., bed size/bed location configuration) on the date(s) of the survey. HCFA's authority to regulate bed size changes in a SNF or a NF is based on the authority to ensure compliance with the provider agreement under §1866 of the Act and to further ensure that the configuration that has been approved for the institution or institutional complex does not so drastically change from that of the original certified configuration so as to endanger resident health and safety or otherwise change in a material fashion the identity of the entity that HCFA originally certified for program participation.

An institution or institutional complex may choose to participate in the Medicare and/or Medicaid programs either in its entirety, or a portion thereof, but not both. If only a portion of an institution or institutional complex actually participates in either program it is classified as a distinct part and must meet the criteria found in §2337.1. For example, an institution has 4 wings that consist of 25 beds each. Three contiguous wings that contain 75 beds are dually participating (i.e., participating in Medicare and Medicaid). The fourth wing is only certified to participate in Medicare. It consists of 25 beds. Therefore, in this instance the institution is fully participating for purposes of Medicare (i.e., 100 beds) and is participating as a distinct part (i.e., 75 beds) for purposes of Medicaid. The policies on bed size changes and changes in designated bed locations that are included in this section apply, regardless of whether an institution is fully participating (i.e., all beds within the institution or institutional complex are certified to participate in the Medicare and/or Medicaid program) or participating as or with a distinct part.

A SNF may be:

- An entire institution for skilled nursing or rehabilitative care, such as a nursing home; or

- A distinct part of an institution such as, a hospital, personal care home, assisted living facility, board and care home, domiciliary care facility, rest home, continuing care retirement community or nursing home.

An institution that is primarily for the care and treatment of mental diseases cannot be a SNF.

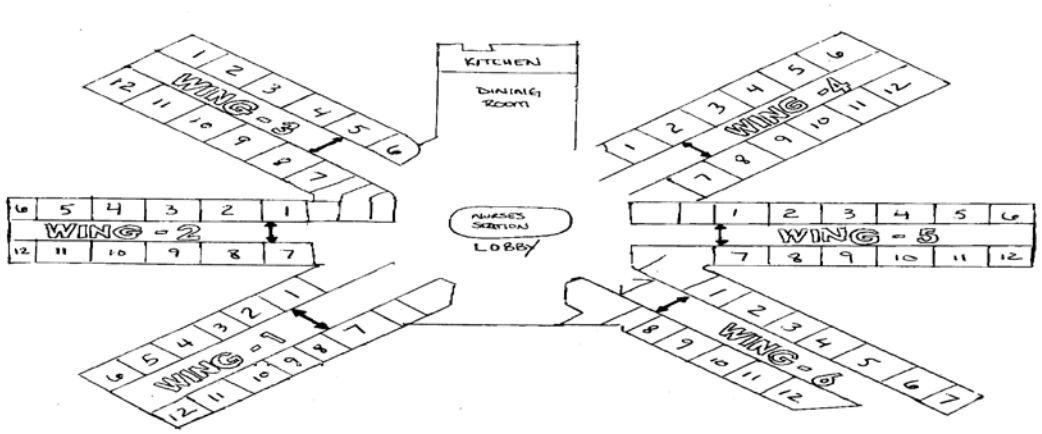

EXHIBIT I
FLOOR PLAN OF A NURSING FACILITY

2337.1 Requirements for Distinct Part Certification.--If the institution or institutional complex is participating as a distinct part SNF and/or NF, for a change to be approved the requested change in bed size must conform with the requirements to be classified as a distinct part. The term "distinct part" refers to a portion of an institution or institutional complex (e.g., a nursing home or a hospital) that is certified to provide SNF and/or NF services. A distinct part must be physically distinguishable from the larger institution and fiscally separate for cost reporting purposes. An institution or institutional complex can only be certified with one distinct part SNF and/or one distinct part NF. A hospital-based SNF is by definition a distinct part. Multiple certifications within the same institution or institutional complex are strictly prohibited. The distinct part must consist of all beds within the designated area. The distinct part can be a wing, separate building, a floor, a hallway, or one side of a corridor. The beds in the certified distinct part area must be physically separate from (that is, not commingled with) the beds of the institution or institutional complex in which it is located. However, the distinct part need not be confined to a single location within the institution or institutional complex's physical plant. It may, for example, consist of several floors or wards in a single building or floors or wards which are located throughout several different buildings within the institutional complex. In each case, however, all residents of the distinct part would have to be located in units that are physically separate from those units housing other patients of the institution or institutional complex. Where an institution or institutional complex owns and operates a SNF and/or a NF distinct part, that SNF and/or NF distinct part is a single distinct part even if it is operated at various locations throughout the institution or institutional complex. The aggregate of the SNF and/or NF locations represents a single distinct part subprovider, not multiple subproviders, and must be assigned a single provider number. Exhibit I, above, is an illustration of a floor plan of a nursing facility followed below by examples which meet the requirements for a distinct part, as well as examples that do not meet the requirements for a distinct part.

1. Meet Distinct Part Certification.--An institution or institutional complex can any **one** of the following examples discussed in the context of Exhibit I above, that meets the requirements for distinct part certification.

o All rooms numbered 1 through 12 in wing 1 and all rooms numbered 1 through 12 in wing 2 constitute a distinct part. This option is approvable because it constitutes all beds in each wing.

o All rooms numbered 1 through 12 in wing 5. This option is approvable because it includes all beds in the wing.

o Room numbers 1 through 6 in wing 4 constitute a distinct part. This option is approvable because it includes all beds that constitute a single side of the corridor.

o Room numbers 7 through 12 in wing 2 and all rooms 1 through 12 in wing 1 constitute a distinct part. This option is approvable because it includes all beds in wing 1 and all beds that constitute a single side of the corridor in wing 2.

2. Do Not Meet Distinct Part Certification.--Neither of the options discussed below, in the context of Exhibit I above, meet the requirements for distinct part certification.

o Room numbers 1 through 12 in wing 1 and rooms 3,4, and 5 in wing 6 do not constitute a distinct part. This option is not approvable because of the inclusion of the three rooms in wing six.

o Room number 2 in wing 1, room numbers 5 and 7 in wing 6, and room numbers 4,5,6, 10, 11, and 12 in wing 4. This option is not approvable because the distinct part area must be physically separate from (that is, not commingled with) the beds of the institution or institutional complex in which it is located.

2337.2 Changes in Bed Size of Participating SNF and/or NF.--When an institution or institutional complex not previously certified as or with a SNF or NF establishes a SNF or NF, it must be initially certified and periodically recertified. If an institution or institutional complex has an existing SNF or NF agreement, it may elect to change the number of beds that are certified to participate in the Medicare or Medicaid program up to two times per cost reporting year in accordance with the requirements set out below. Where a change in the size of a SNF also impacts the size of a NF, or vice versa this represents one change for the SNF and one change for the NF. An institution or institutional complex may only change the bed size of its SNF and/or its NF once on the first day of the beginning of its cost reporting year and again on the first day of a single cost reporting quarter within that same cost reporting year in order to effect one of the following combinations:

o An increase in its bed size on the first day of the beginning of its cost reporting year and an increase in its bed size on the first day of a single cost reporting quarter that falls within the same cost reporting year, or;

o An increase in its bed size on the first day of the beginning of its cost reporting year and a decrease in its bed size on the first day of a single cost reporting quarter that falls within the same cost reporting year, or;

o A decrease in its bed size on the first day of the beginning of its cost reporting year and an increase in its bed size on the first day of a single cost reporting quarter that falls within the same cost reporting year.

At no time can the RO or the SA approve two decreases in the bed size of an institution within the same cost reporting year.

The institution or institutional complex may submit only ONE change in bed size at a time. Furthermore, an institution cannot request a change in its bed size just because it undergoes a change of ownership (CHOW) or because it has been approved to change its cost reporting year. In either of these circumstances, it is still bound by the filing requirements found in §2337.3.

A request for a change in the number of certified beds cannot be approved on a retroactive basis. All changes are made on a prospective basis only in accordance with the effective date indicated above. The institution requesting a change in bed size must submit a written request to the RO or SA (as appropriate) in conformance with the requirements found in §2337.3. An institution or institutional complex can not self-designate the effective date of a change in bed size.

2337.3 General Request Filing Requirements.--An institution or institutional complex seeking a change in the number of Medicare or Medicaid certified beds must:

1. Submit a written request to the RO or SA (as appropriate) for the change 45 days before

o The first day of its cost reporting year to effect a change on the first day of its cost reporting year or;

o The first day of a single cost reporting quarter within the same cost reporting year at which time it seeks to change its bed size to effect a change on the first day of the designated cost reporting quarter.

2. Submit floor plans identifying all areas of the institution or institutional complex with the current certified bed configuration and the proposed certified bed configuration in order for the RO or SA to determine that the proposed change is in fact, in conformance with the rules for full participation or distinct part certification, whichever applies.

3. Include a reference to the cost reporting year of the institution or institutional complex. If there has been a change in the cost reporting year originally selected by the institution or institutional complex, submit a copy of the letter submitted to the fiscal intermediary (for Medicare) and the fiscal intermediary's response to the request. Absent such a change, the institution or institutional complex must adhere to the cost reporting year selected at its initial certification.

The RO or the SA will review the request and notify the institution in writing of its determination regarding the request, including the effective date of the change in bed size and the bed locations, prior to the start of the cost reporting year or the cost reporting quarter, whichever applies.

2337.4 Exceptions--There are certain situations (described below) which we believe warrant an exception to the above policy. Therefore, even if the institution or institutional complex has been approved for a change in bed size in accordance with the policies articulated above, the institution or institutional complex may be granted a change in bed size on the basis of one of these situations. To request a change in bed size based on one of these situations, the institution or institutional complex must file a written request with the RO or the SA (as appropriate) 45 days before the first day of its next cost reporting quarter, at which time the request will be effective if approved, along with floor plans identifying all areas of the institution or institutional complex with the current certified bed configuration and the proposed certified bed configuration. An exception may be granted based only on one of the following situations:

A. Life Safety Code (LSC) Requirements.--An exception may be granted if the request is to reduce the size of the SNF or NF to avoid being out of compliance with LSC requirements (e.g., sprinkler installation). The proposed bed configuration must be separated from the rest of the institution or institutional complex by a 2-hour fire wall, so that there is no danger of the fire spreading there from other parts not meeting safety requirements. In this case, the proposed reduction in the size of the SNF or NF may be established with an effective date that is requested by the institution or institutional complex, but not earlier than the date that the separation can be documented. A full survey by the fire authority must be performed if the reason for the request is to limit noncompliance with LSC requirements.

B. Elimination of Distinct Part.--An exception may be granted if an institution or institutional complex concludes that it wants to become fully participating (i.e., all beds within the institution or institutional complex are certified to participate in the Medicare and/or Medicaid program). If the institution or institutional complex decides to become fully certified to participate in the Medicare and/or Medicaid program, **it cannot return** to distinct part certification until, at the earliest, the beginning of its next cost reporting year.

C. Enlargement Through Construction, Purchase or Lease of Additional Space.--An exception may be granted if the institution or institutional complex requests to increase the size of its SNF or NF to include space acquired through new construction, purchase or lease (e.g., constructing a new wing, purchasing an adjacent building or leasing a floor in a hospital).

2337.5 Change in Designated Bed Location(s).--An institution or institutional complex may request to change its designated bed locations, as long as there is no change in the number of beds certified to participate in the Medicare and/or Medicaid program, by submitting a written request to the SA or the RO 30 days in advance of such a change. In addition, the institution or institutional complex must submit floor plans identifying all areas of the institution or institutional complex with the current certified bed configuration and the proposed certified bed configuration in order for the RO or SA to determine that the proposed change is in fact, in conformance with the rules for full certification or distinct part certification, whichever applies. The institution or institutional complex must adhere to the notification requirements found in 42 CFR 483.10(b)(11)(ii)(A) and the residents rights requirements found in 42 CFR 483.10(o). The request must be approved by the RO or SA before the institution or institutional complex makes the change. No changes are made on a retroactive basis.

2337.6 Cost Report Requirement After Change in Bed Size and/or Change in Designated Bed Location(s).--Where an institution or institutional complex receives approval for a change in bed size and/or a change in its designated bed locations, it will be required to file one cost report covering the period from the beginning of its reporting period to its regular year-end reporting time. Where an institution or institutional complex changes its bed size or its designated bed location(s) during its cost reporting year, adequate statistical data must be maintained to corroborate the basis for allocation of costs. One of the required statistics must be the number of square feet used by the certified area and nonparticipating area both before and after the effective date of the change in bed size and/or the effective date of the change in designated bed location(s). The SNF will use the weighted average method to determine the total square feet used by the certified area and the nonparticipating area during the year. The number of square feet used by the certified area and the nonparticipating area, as determined by this method, will be used as a basis to allocate those expenses that are required to be allocated on the basis of square feet. This method will be used only for a year in which a change in bed size and/or a change in designated bed location(s) occurs.

EXAMPLES:

A. Facts:

Total square feet in facility 100,000 sq. ft.
Wholly certified SNF 6 months
Distinct-part SNF 6 months
Certified area - 50,000 sq. ft.
Nonparticipating area - 50,000 sq. ft.

Computation of total square feet used by each area:

Certified area - 6 months x 100,000 sq. ft.	=	600,000
Certified area - 6 months x 50,000 sq. ft.	=	300,000
		900,000 = 75%
Nonparticipating-6 months x 50,000 sq. ft. area	=	300,000 = 25%
		1,200,000 100%

Certified area - 75% x 100,000 sq. ft.	=	75,000 sq. ft.
Nonparticipating - 25% x 100,000 sq. ft. area	=	25,000 sq. ft.
		100,000 sq. ft.

B. Facts:

Total Square feet in facility 100,000 sq. ft.
Distinct-part SNF 9 months
Certified area - 50,000 sq. ft.
Nonparticipating area - 50,000 sq. ft.
Distinct-part SNF
Certified area - 25,000 sq. ft.
Nonparticipating area - 75,000 sq. ft.

Computation of total square feet used by each area:

Certified area - 9 months x 50,000 sq. ft.	=	450,000
Certified area - 3 months x 25,000 sq. ft.	=	75,000
		525,000 = 43.75%

Nonparticipating area - 9 months x 50,000 sq. ft.	=	450,000
Nonparticipating area - 3 months x 75,000 sq. ft.	=	225,000
		675,000 = 56.25%
		1,200,000 100.00%

Certified area - 43.75% x 100,000 sq. ft.	=	43,750 sq. ft.
Nonparticipating area - 56.25% x 100,000 sq. ft.	=	56,250 sq. ft.
		100,000 sq. ft.

2338. ALLOCATION OF INTEREST AND OTHER EXPENSES RELATED TO ASSETS

A. Interest Expense.--Interest expenses incurred on funds borrowed to purchase buildings, fixtures, capital improvements, and movable equipment must be distributed among the assets the loan covers to permit the expense to be allocated properly on the same statistical bases as the asset-related depreciation expenses. This distribution is usually accomplished by a reclassification to the trial balance accounts. Specific schedules are included in the cost report for this reclassification. Providers must use the cost centers for allocating interest expense, e.g., Building and & Fixtures, Movable Equipment etc., as contained in the cost report forms, subject to any changes permitted within the criteria set out in § 23l3.

EXAMPLE:

Assets Purchased	Purchase Cost	Statistical Bases Used for Allocation of Depreciation
Buildings Fixtures	$240,000	Square feet or area = 30,000
Movable Equipment	$ 60,000	Dollar value of equipment

Borrowed $270,000 for buildings, fixtures, capital improvements and movable equipment at l0 percent annual interest. Thus, annual interest in the loan is equal to $27,000.

	Ration of Each Value to Total Value	Annual Interest Expense (l)	Annual Allocation
Buildings & Fixtures	$240,000 / $300,000 x $270,000 x l0% =	$2l,600	$2l,600 ÷ 30,000 sq. ft. = $.72 per sq. ft. of area by department*
Movable Equip't	$ 60,000 / $300,000 x $270,000 x l0% =	5,400	$5,400 ÷ $60,000 = unit value of $.09 per dollar of investment in movable equipment by department*
Total Interest Expense		$27,000	

*Where the purchase represents additional capital expenditures, the unit value must be determined by using the combination interest expense applicable to both the new assets and the old assets. Also, total square feet or total dollar value of old and new assets would be used in the computation even if there is no interest expense applicable to old assets. Where the provider allocates depreciation of movable equipment using square feet as a basis, the unit value must be computed using total square feet of the facility.

Where different statistical bases are used for allocating depreciation on the various types of fixed assets covered by a single loan, the ratio of the historical cost of the respective assets to the historical cost of the total assets purchased with the borrowed money should be used for determining the amount of interest expense (for example, mortgages, etc.) to be allocated with each category of asset as illustrated on the preceding page. Where the historical cost is not known, the estimated fair market value of the assets at acquisition date should be used.

EXAMPLE:

Assets Purchased	Estimated Fair Market Value	Ratio of Each Value to Total Value
Buildings & Fixtures	$l25,000	$l25,000 ÷ $l60,000 = 78.l25%
Movable Equipment	35,000	$ 35,000 ÷ $l60,000 = 2l.875%
Total	$l60,000	l00,00%

Borrowed $l50,000 at 6 percent annual interest to purchase various assets, thus annual interest expense is $9,000.

Annual Interest Expense and Allocation

Buildings &	$9,000 x 78.125% = $7,03l.25	Allocate on the different statistical bases used for on allocating depreciation on the various types of fixed assets.
Movable Equipment	$9,000 x 2l.875% = $l,968.75	
Allowable Interest Expense	$9,000.00*	

* All interest expenses originating from the purchase of provider assets, even though a portion is attributable to the purchase of assets not related to patient care, is allocated to the appropriate reimbursable as well as nonreimbursable cost centers using authorized bases.

B. Other Expenses Related to Assets.--Other expenses related to the depreciable assets which must be allocated on the same statistical bases of the asset-related depreciation expenses of allocation are:

l. personal property taxes for fixtures and movable equipment;

2. real property taxes for land, buildings, and capital improvements;

3. fire and casualty insurance coverage applicable to buildings, fixtures, movable equipment, and capital improvements; and

4. rent for buildings, fixtures, and movable equipment.

Rent expense pertaining to movable equipment which has been charges directly on the provider's books to the appropriate cost center(s) must be reclassified to the Depreciation-Movable Equipment cost center unless the provider has properly identified and charged all depreciation on movable equipment directly to the appropriate cost centers.

C. Interest expense incurred on funds borrowed for operating expenses must be allocated with administrative and general expenses. (See Chapter 2.)

2340. ALLOCATING NURSING SERVICE COSTS IN NURSING HOMES WITH DISTINCT-PART SKILLED NURSING FACILITY (FORMERLY EXTENDED CARE FACILITY)--GENERAL

One of the prerequisites for an institution to have a portion of its facility participate as an SNF (formerly ECF) is that it must have the record keeping capability to insure that it can adequately furnish the financial and statistical data required to separately determine costs applicable to the portion of the facility participating as an SNF and to other parts of the facility. The provider must be able to satisfy the intermediary that the system employed for recording and accumulated the number of hours of nursing services is capable of audit and equitably allocates the nursing service costs for Medicare reimbursement purposes. Nursing service costs refer only to gross salaries and wages of nursing and related personnel, such as registered nurses, LPN's, aides, etc.

2340.l Methods of Allocating Nursing Service Costs for Cost Reporting Periods Starting After l972.--For cost reporting periods starting after l972, a nursing home that has only a portion of the facility certified as a distinct-part SNF shall allocate nursing service costs for Medicare reimbursement purposes under one of the following methods:

A. Actual Time Basis.--Under the actual time method, the number of hours of nursing service is the basis for allocation of nursing service costs to the distinct part of the facility participating as an SNF and to other parts of the facility. Various systems may be employed for recording and accumulated the hours of nursing services, e.g., payroll records, assignment schedules, etc. The preferred system is the use of time recorded which separately indicate the actual time spent in providing nursing care in the part of the facility certified as an SNF and in other parts of the facility. Regardless of the system or method used, the result should be an equitable allocation of the nursing service costs between the distinct and other parts of the facility based on records or notations made at the time the services were rendered.

Where a provider is located in a State having minimum State licensure requirements for nursing care, it is presumed that the provider allocated at least the minimum nursing time required in the noncertified parts of the facility. In those situations where the provider's records indicate that nursing time allocated to the noncertified parts of the facility is less than the minimum time required, an adjustment to the provider's cost report is necessary to decrease the nursing service cost allocated to the distinct-part SNF and to increase the nursing service cost allocated to the noncertified part so as to meet at least the minimum State licensure requirements. Where it becomes necessary to decrease nursing service costs allocated to the distinct-part SNF, appropriate on the basis of total accumulated costs which include nursing service costs.

B. Average Cost Per Diem Basis.--Under this method, the number of patient days is the basis for allocation of nursing service costs between the distinct part of the facility participating as an SNF and other parts of the facility. Total nursing service costs for the entire facility are divided by the total patient days for the entire facility to arrive at an average nursing service cost per diem. This average nursing service cost per diem is then multiplied by the number of patient days in the distinct-part SNF to determine the nursing service costs that may be allocated to the distinct-part SNF.

Under the following circumstances, it is necessary to allocate nursing service costs based on an average cost per diem basis:

l. The adjustments mentioned in subsection A above would result in less than minimum State licensure requirements for nursing services in the certified portion of the facility; or

2. The intermediary determines that adequate time records have not been maintained to support an equitable allocation of nursing costs; or

3. The intermediary determines that the allocation of nursing time results in an inequitable allocation of nursing service costs to the distinct-part SNF.

Where the intermediary requires the use of the average per diem method, the provider is not permitted to retroactively use estimates to allocate nursing costs under the actual time basis method described in subsection A above.

Where a provider is able to furnish sufficient documentation to satisfy the intermediary that the patient population in the noncertified part of the facility includes and substantial number of domiciliary patients requiring little or no nursing care, the intermediary may grant an exception to the average cost per diem method and apportion costs on the basis of the facts in that case.

2342. ALLOCATING STANDBY COSTS IN A DISTINCT-PART PROVIDER HAVING A SUBSTANTIAL DIFFERENCE IN OCCUPANCY RATES BETWEEN THE CERTIFIED PORTION AND THE NONCERTIFIED PORTION

Where the unoccupied beds in a partially certified institution are concentrated in the certified portion, the standby costs attributable to the unoccupied beds (e.g., depreciation, operation of plant, etc.) would not be allocated equitably under existing cost finding methods. This section indicates the manner in which costs attributable to a provider's unoccupied beds are allocated under such circumstances so that the burden of these costs is proportionally shared by all patients in the institution. This section is applicable to all cost reporting periods beginning after September 30, l973. Cross refer to § 24l5.

2342.l General Rule.--Where the average occupancy rate of a certified portion of an institution is substantially less than the average occupancy rate in the noncertified portion, the routine costs attributable to the unoccupied beds of the institution allocated on the basis of space (see subparagraph B) are reallocated using the following basis:

Total Patient Days in the Certified Portion / Total Patient Days in the Entire Institution	x	Costs of Unoccupied Beds	=	Costs of Unoccupied Beds Allocable to Certified Portion

Only costs allocated to the inpatient areas on the basis of space are adjusted since other costs are allocated in a manner related to the actual usage of services in the institution--e.g., hours of services, meals served, etc.

A. Substantial Difference in Occupancy Rates.--For this purpose, a difference of 25 percentage points or more in the occupancy rates in any Medicare cost reporting period is considered substantial. Thus, if the occupancy rate is 75 percent or more in the noncertified portion, the procedure described in this section is applicable.

B. Costs Allocated on Basis of Space.--All costs actually allocated or required to be allocated to the inpatient areas on the basis of space under the cost-finding requirements are included in the computation.

2342.2 Exception.--The procedure described in § 2342.l is not followed where the certified portion:

A. has in its inpatient area staffing separate from that of the inpatient areas in the remainder of the institution, and also

B. furnishes a level of care that is not substantially equivalent to that furnished in the noncertified portion of the institution. (For this purpose, the level of care furnished by the noncertified portion

is considered substantially equivalent to the level of care furnished by a skilled nursing home if that portion meets at least the requirement that it is primarily engaged in providing skilled nursing care and related services to inpatients who require medical or nursing care, or rehabilitation services for injured, disabled, or sick persons). The information as to the level of care in both portions of a skilled nursing facility (SNF) is contained in the Directory of Medical Facilities issued by the Social Security Administration and made available to fiscal intermediaries under the program.

2342.3 Example.--The following simplified example demonstrates the effect of the procedure described in § 2342.l and the adjustment required.

A l00-bed skilled nursing home has 50 beds certified as SNF beds for Medicare purposes. Occupancy in the noncertified portion was 80 percent (l4,600 patient days out of l8,250 bed days) and the occupancy rate in the certified distinct part was 30 percent (5,475 patient days of l8,250 bed days).

Assume the space (square feet) applicable to the 50-SNF beds representing 55 percent of the accommodation areas and the space applicable to the 50 noncertified beds represented 45 percent of the accommodation areas. Routine costs allocated to accommodation areas on the basis of space, as described in § 2342.lB, amounted to $200,000. This method of allocation would result in the Medicare program absorbing a disproportionate amount of standby costs in the accommodation areas attributable to the unoccupied beds of the institution. However, the reallocation of costs as described in § 2342.l is determined as follows:

A. Actual Costs Allocated to Distinct Part, Per Cost Report:
55% x $200,000 = $ll0,000

B. Actual Costs Allocated to Noncertified Part, Per Cost Report:
45% x $200,000 = $90,000

C. Actual Space Allocated Costs Attributable to Certified Occupied Beds:

$$\frac{\text{Total Patient Days in the Certified Portion}}{\text{Bed Days Available in the Certified Portion}} \times \$ll0{,}000 =$$

$$\frac{5{,}475}{l8{,}250} \times \$ll0{,}000 = 30\% \times \$ll0{,}000 = \$33{,}000$$

D. Actual Space Allocated Costs Attributable to Noncertified Occupied Beds:

$$\frac{\text{Total Patient Days in the Noncertified Portion}}{\text{Bed Days Available in the Noncertified Portion}} \times \$90{,}000 =$$

$\frac{14,600}{18,250}$ x $90,000 = 80% x $90,000 = $72,000

E. Standby Costs Attributable to Total Unoccupied Beds:

$200,000 - (C + D) = $200,000 - ($33,000 + $72,000) = $95,000

F. Standby Costs Attributable to Unoccupied Beds Allocated to the Certified Portion:

$\frac{\text{Total Patient Days in the Certified Portion}}{\text{Total Patient Days in the Entire Institution}}$ x Standby Costs Attributable to Unoccupied Beds

$\frac{2,475}{20,075}$ x $95,000 = $25,909

Thus, the total depreciation, maintenance, etc., costs allocable to the certified portion accommodation areas should be $58,909 (C + F), rather than $110,000 (A). The $58,909 would then be used in the cost finding process in the accumulation of allowable costs for the certified portion.

Although this adjustment does not affect allowable costs for the entire facility, it does affect the allowable costs and the Medicare reimbursable portion thereof the certified portion of the facility. Thus, the adjustment to Medicare reimbursable costs will affect the apportionment of the return on equity capital to Medicare.

2344. RESTRICTIVE ADMISSION POLICIES

The program will not absorb any costs attributable to unoccupied beds where the provider has a restrictive admission policy. This section is to be applied to all cost reporting periods beginning after September 30, 1973.

2344.1 General.--Where a participating hospital or skilled nursing facility (or a distinct-part provider) has a restrictive admission policy, the effect of which is to artificially increase Medicare reimbursement, the Medicare program will not absorb any share of the cost of unoccupied beds of the institution allocated on the basis of space. Indications of restrictive admission policies could be:

A. Where virtually only Medicare or only Medicare/Medicaid beneficiaries (where Medicaid pays on the basis of costs) are admitted to the hospital or skilled nursing facility (or a distinct-part provider). Private-paying patients requiring an SNF level of care are denied admission (or in a distinct-part provider, such private-paying patients are admitted to the noncertified area).

B. Where Medicare beneficiaries still requiring an SNF level of care are discharged (or transferred to a noncertified area) when their benefits under the program are exhausted.

C. Where admission is restricted to the patients of an individual physician or small group of physicians who are considered related to the provider under the principles of Chapter l0, Cost to Related Organizations, and where other physicians are not allowed admission privileges.

2344.2 Procedure for Determining Cost to be Paid by Program Where Provider Has a Restrictive Admission Policy.--The following examples illustrate the methods to be used in determining cost recognized by the program where the provider has a restrictive admission policy.

Example l: A l00-bed fully certified SNF has a policy of only admitting Medicare eligible beneficiaries as patients. Occupancy was 80 percent and costs allocated on the basis of space amounted to $200,000. Although the facility is utilized l00 percent by Medicare beneficiaries, the program would pay only $l60,000 (80 percent x $200,000) of the costs allocated on the basis of space. The other $40,000 attributable to unoccupied beds would not be absorbed by the program, due to the provider's restrictive admission policy. This is true even though the provider's occupancy rate may be equal to or higher than the rates of similar facilities having no such restrictions.

Example 2: A l00-bed skilled nursing home has 50 of its beds certified as a distinct-part SNF for Medicare purposes. It is the policy of the home to admit only Medicare and Medicaid beneficiaries to the distinct part. Medicaid pays on the basis of cost in the State in which the facility is located. Medicare beneficiaries whose benefits are exhausted yet require SNF care are placed in the noncertified portion. Occupancy in the distinct part was 70 percent. Since the space applicable to each portion of the institution was equal, space costs amounting to $200,000 were allocated equally between the certified and noncertified portions of the institution. Since the provider has a restrictive admission policy, the program will include only $70,000 as an allowable cost for the distinct part, computed as follows:

Occupancy Rate in Certified Portion x Space Costs Allocated = To Certified Portion

70% x $l00,000 = $70,000

The $70,000 would then be used in the cost finding process in the accumulation of allowable costs for the certified portion.

2344.3 Costs Allocated on Basis of Space.--All costs actually allocated, or required to be allocated to the inpatient areas on the basis of space under the cost-finding requirements are included in the computation.

A.2304, Adequacy of Cost Information--As a result of certain provisions within the "Tax Equity and Fiscal Responsibility Act of 1982" (P.L. 97-248), hospitals and/or skilled nursing facilities will be required to submit, as part of their Medicare cost report, information not previously required. The following items must be considered in maintaining the information needed to formulate proper Medicare reimbursement. The information required must be capable of verification through audit as required by 42 CFR 405.453(a).

A. This provision applies only to hospitals that are exempt from taxes under §501(c)(3) of the Internal Revenue Code of 1954 and which were subject to F.I.C.A. taxes as of August 15, 1982, and which are not subject to F.I.C.A. taxes for part or all of a cost reporting period beginning on or after October 1, 1982, and before October 1, 1985. In accordance with §1886(b)(6) of the Social Security Act (as enacted by §101 (Payment for Inpatient Hospital Services) of P.L. 97-248) for purposes of making the target amount comparison under §1886(b)(1) of the Act, an adjustment of the operating costs of inpatient hospital services will be made where a hospital, as of August 15, 1982, was subject to F.I.C.A. taxes and which is not subject to such taxes for part or all of a cost reporting period beginning on or after October 1, 1982. A reduction will be made to such F.I.C.A. taxes that would have been paid (but not below zero) by the amount of costs which the hospital demonstrates were incurred in the period for pensions, health and other fringe benefits for employees (and former employees and family members) comparable to, and in lieu of, benefits provided under F.I.C.A. Affected hospitals will have to determine:

1. The amount of F.I.C.A. tax that would have been payable for the cost reporting period.

2. The amount of costs incurred in the period for pensions, health and other fringe benefits for employees (and former employees and family members) comparable to, and in lieu of, the benefits provided under titles II and XVIII of the Social Security Act.

B. This provision applies only to hospitals and skilled nursing facilities that have both private rooms and semi-private rooms. In accordance with §111 (Elimination of Private Room Subsidy) of P.L. 97-248, the estimated amount by which the costs incurred by a hospital or skilled nursing facility for nonmedically necessary private accommodations for Medicare beneficiaries exceeds the costs which would have been incurred by such hospital or facility for semi-private accommodations is not allowable. In order to determine proper Medicare reimbursement, the following data must be maintained by the hospital or skilled nursing facility and reported when filing the Medicare cost report for cost reporting periods beginning on or after October 1, 1982.

1. Total charges applicable to inpatient general routine private accommodations.

2. Total charges applicable to inpatient general routine semi-private accommodations.

3. Total inpatient general routine charges (including charges for private, semi-private and other inpatient general routine accommodations).

4. Total inpatient days applicable to inpatient general routine private accommodations.

5. Total inpatient days applicable to inpatient general routine semi-private accommodations.

6. Medically necessary inpatient general routine days applicable to private accommodations for Medicare beneficiaries.

Hospitals with separately certified subproviders or skilled nursing facilities must maintain these data separately for each separately certified component.

Skilled nursing facilities with separately certified distinct parts must maintain these data only for the portion of the facility that is Medicare certified.

Hospitals participating in the Medicare program as swing bed hospitals should exclude from the private room subsidy computation routine charges, days and costs applicable to skilled nursing facility type services and intermediate care facility type services.