



# **Management Overview of RHC Cost Reporting Technical Assistance July 30, 2019**



# Agenda

- 1. Cost Report Overview**
- 2. Building Blocks – ABCs**
  - 1. Expenses**
  - 2. Visits**
  - 3. Productivity standards**
  - 4. Flu & Pnu Costs**
  - 5. P S & R**
  - 6. Bad Debts**
- 3. Questions**



# **Webinar Objective**

To provide general information on the RHC cost reporting understandable to RHC managers and providers and focused on impact, timing, and responsibilities of the RHC to prepare timely and accurate Medicare and Medicaid cost reports.

# RHC Cost Report

## OVERVIEW

# **RHC Cost Report Overview**

The purpose of the Medicare Cost Report is reconciling payments received from Medicare as compared to the allowable costs reported by the RHC. The process will result in a settling of monies owed or due to Medicare for the cost report fiscal year.

Medicaid uses a cost reporting process to establish Medicaid RHC rates and/or settle Medicaid RHC payments with the RHC. Each state is different.

# Why is a Cost Report important?

1	Medicare will not pay you if you do not file a cost report and will ask for any Medicare money paid during the year to be refunded.
2	RHC Medicare and Medicaid rates are based upon the cost report.
3	RHCs receive a cost report settlement for flu, pneu, bad debts, preventive co-pays/deductibles and rate settlements.
4	You are responsible for preparing the Cost Report accurately and in compliance with Medicare and Medicaid rules.

# Medicare RHC Cost Report Reimbursement Regulations

The screenshot shows the CMS.gov website interface. At the top, there is a navigation bar with links for Home, About CMS, Newsroom, Archive, Share, Help, and Print. Below this is the CMS.gov logo and the text "Centers for Medicare & Medicaid Services". A search bar is located to the right of the logo. Below the search bar is a navigation menu with buttons for Medicare, Medicaid/CHIP, Medicare-Medicaid Coordination, Private Insurance, Innovation Center, Regulations & Guidance, Research, Statistics, Data & Systems, and Outreach & Education. The main content area shows the breadcrumb trail: Home > Regulations and Guidance > Manuals > Paper-Based Manuals Items > Details for title: 15-1. The "Manuals" section is highlighted, and a "Return to List" link is provided. The "Details for title: 15-1" section shows the Publication # as 15-1 and the Title as "The Provider Reimbursement Manual - Part 1". Below this is a "Downloads" section with a list of 31 chapters, each with a download icon and file size. The chapters are: Chapter 1 -- Depreciation (141KB), Chapter 2 -- Interest Expense (77KB), Chapter 3 -- Bad Debts, Charity, and Courtesy Allowances (22KB), Chapter 4 -- Cost of Educational Activities (17KB), Chapter 5 -- Research Costs (11KB), Chapter 6 -- Grants, Gifts and Income From Endowments (4KB), Chapter 7 -- Value of Services of Nonpaid Workers (35KB), Chapter 8 -- Purchase Discounts and Allowances, and Refunds (56KB), Chapter 9 -- Compensation of Owners (76KB), Chapter 10 -- Cost to Related Organizations (18KB), Chapter 11 -- Allowance In Lieu Of Specific Recognition Of Other Costs - RESERVED (5KB), Chapter 12 -- Return On Equity, Capital Of Proprietary Providers - RESERVED (5KB), Chapter 13 -- Inpatient Routine Nursing Salary Cost Differential - RESERVED (8KB), Chapter 14 -- Reasonable Cost of Therapy and Other Services (480KB), Chapter 15 -- Change of Ownership (12KB), Chapter 21 -- Costs Related to Patient Care (833KB), Chapter 22 -- Determination of Cost of Services (318KB), Chapter 23 -- Adequate Cost Data and Cost Finding (188KB), Chapter 24 -- Payment to Providers (114KB), Chapter 25 -- Limitations on Coverage of Costs Under (5KB), Chapter 26 -- Lower of Cost or Charges (32KB), Chapter 27 -- ESRD Services and Supplies (128KB), Chapter 28 -- Prospective Payments (367KB), Chapter 29 -- Provider Payment Determination And Appeals (77KB), Chapter 30 -- NON-PPS Hospitals and Distinct Part Units (278KB), and Chapter 31 -- Organ Donation and Transplant Reimbursement (99KB). A link for "Help with File Formats and Plug-Ins" is also present.

<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021929.html>

# Cost Reporting Forms for Independent & Provider-based RHCs

Description	Independent	Provider-based
Cost Reporting Form	CMS-222-17	CMS-2552-10
Link to PDF of Forms	<a href="https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R1P246.pdf">https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R1P246.pdf</a>	<a href="https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3P240f.pdf">https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3P240f.pdf</a>
Software Vendors 4 vendors for RHCs and 2 for hospital cost reports	<a href="https://med.noridianmedicare.com/web/jea/audit-reimbursement/cost-reports/cms-approved-vendor-listing">https://med.noridianmedicare.com/web/jea/audit-reimbursement/cost-reports/cms-approved-vendor-listing</a>	<a href="https://med.noridianmedicare.com/web/jea/audit-reimbursement/cost-reports/cms-approved-vendor-listing">https://med.noridianmedicare.com/web/jea/audit-reimbursement/cost-reports/cms-approved-vendor-listing</a>

## Crosswalk of Forms between Provider-based & Independent RHCs

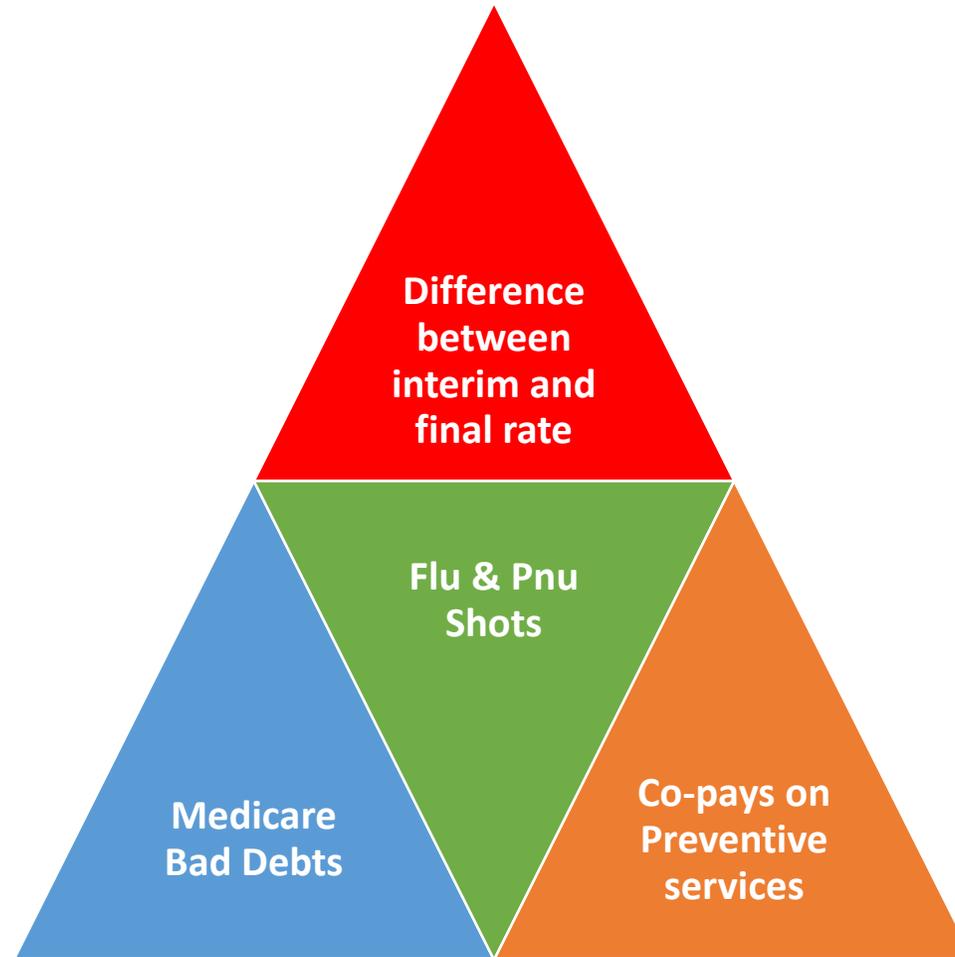
Purpose of Form	Independent	Provider-based
Provider Name, Location, CCN Number, Signature	S Parts I, II & III	<b>S-2/S-8</b>
Malpractice Information, Hours of Operation	S-1 Part I & II	<b>NA</b>
Replaces the 339 Questionnaire	S-2	<b>NA</b>
Payer Mix and mental health visits	S-3	<b>NA</b>
Expense information (Trial Balance of total expenses)	A	<b>A/M-1</b>
Reclassifications (Salaries to the proper cost center)	A-6	<b>A-6</b>
Adjustments (remove non-allowable expenses, straight-line depreciation on assets, value of services)	A-8	<b>A-8</b>
Related Party Transaction (adjust RPTs to actual cost)	A-8-1	<b>A-8-1</b>
Allocation of Overhead (Hospital or Parent)	NA	<b>B Part I, B-1</b>

## **RHC Cost Caps by Year**

	<b>2016</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>
<b>Medicare Cap</b>	\$81.32	\$82.30	\$83.45	\$84.70
<b>Medicare Economic Index</b>	1.10%	1.20%	1.40%	1.50%

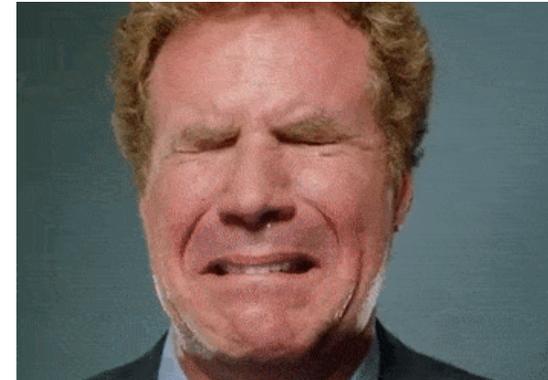
**Provider-based RHCs with less than 50 beds are not subject to the above caps.**

# What does Medicare Settle on the Cost Report?



# Cost Report Repayments to Medicare

- Many of the MACs did the following:
  - Increased the interim rate above the cap
  - Paid Interim Settlements during the year.
- This resulted in the following:
  - Much smaller settlements to RHCs
  - Some RHCs paying back monies to Medicare
  - RHC Consultants having to do a lot of explaining



# Professional Tip: Get Help

[https://www.web.narhc.org/narhc/Consultants\\_Vendors1.asp](https://www.web.narhc.org/narhc/Consultants_Vendors1.asp)

The screenshot displays the 'Consultants & Vendors' page on the NARHC website. The page features a header with the NARHC logo and navigation links. The main content area is organized into a grid of vendor profiles. Each profile includes a logo, a name, and a brief description of services. The vendors listed include:

- CDS**: A company providing various services.
- HBS**: A company providing various services.
- WIPFLI**: A company providing various services.
- inQuise**: A company providing various services.
- WIPFLI**: A company providing various services.

The footer of the page contains the NARHC logo, contact information, and social media links.

# Wisconsin Office of Rural Health - Wipfli

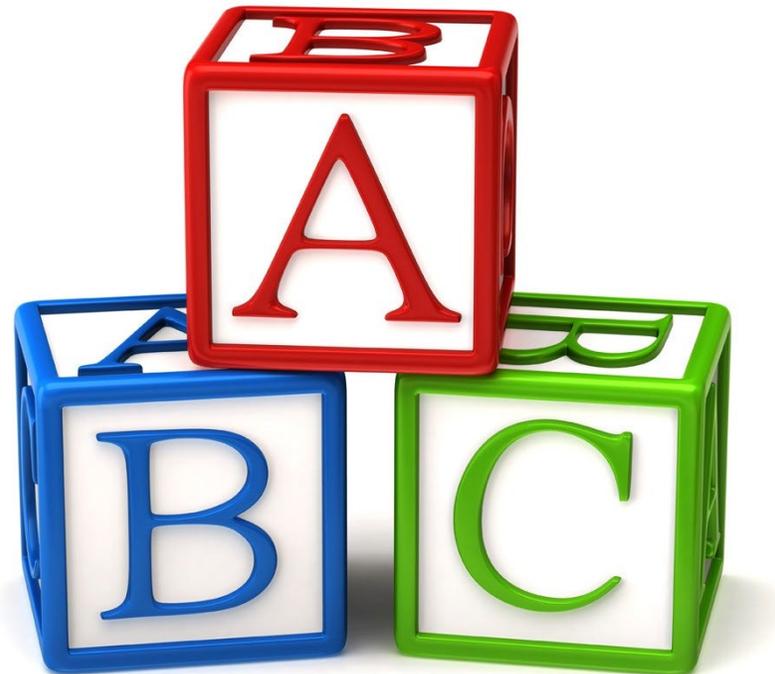
<http://worh.org/library/medicare-cost-reporting-rural-health-clinics>

The screenshot displays the Wisconsin Office of Rural Health (WORH) website. The header includes the WORH logo and navigation links: Home, Resources, Funding, Hospitals, Clinics, FMS, Workforce, Collaborations, Projects, and About Us. A search bar is also present. The main content area is titled "Medicare Cost Reporting for Rural Health Clinics" and features three video thumbnails:

- Part One: Cost Reporting for RHCs** - Medicare Cost Reporting for Rural Health Clinics Part I Cost Reporting Overview
- Part Two: Costs Defined** - Medicare Cost Reporting for Rural Health Clinics Part II RHC Costs Defined
- Part Three: Reporting RHC Visits** - Medicare Cost Reporting for Rural Health Clinics Part III Reporting RHC Visits

On the right side of the page, there is a "Sign Up" button for "Get regular digests of the Rural Reporter". Below this is a quote from an anonymous physician, loan assistance program participant: "I was ready to leave [the community where I practice] and this program was a big part of my decision to stay. I will probably work there for the rest of my career." A "Project Highlight" section for CLARITY (Web-Based Event Reporting Project) is also visible, describing a partnership with the Rural Wisconsin Health Cooperative (RWHC) to provide an opportunity for Critical Access Hospitals in Wisconsin to adopt and implement web-based event reporting.

# Building Blocks



# **What is a Medicare Cost Report?**

Form 222 or 2552 - Medicare Cost Report is required by all RHC's to be completed on an annual basis.

If covers a 12-month period of time with some exceptions: You may have up to a 13-month cost report or you may have a short period if you sell the RHC or change ownership.

# **The First Major Change in the Independent RHC cost report in 25 years**



The overall burden to RHCs is estimated at 55 hours compared to the existing burden associated with the CMS-222-92 of 50 hours.

# New Information Requirements

Independent Rural Health Clinics will have to provide new information for their annual cost report submissions this year. The Centers for Medicare and Medicaid Services (CMS) has replaced the CMS-222-92 form with the new CMS-222-17 and replaced Chapter 29 of the Provider Reimbursement manual with Chapter 46. Instructions and forms were provided by CMS in Transmittal 1 on May 18, 2018 and the new cost report forms are required for cost report submissions ending on or after September 30, 2018. Alternatively, provider-based RHCs in a hospital healthcare complex, will continue to use Form CMS-2552-10 instead. Below is a link to the new cost report forms and instructions.

<https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R1P246.pdf>

# Why Change?

The reason for the changes to the independent RHC cost report are as follows:

1. To incorporate electronic filing of the cost report using the MCRReF system. The following link has information on how MCRReF works:

<https://www.cms.gov/Medicare/Compliance-and-Audits/Part-A-Cost-Report-Audit-and-Reimbursement/MCRReF.html>

2. To eliminate unnecessary FQHC information due to the Form 224-14 used by FQHCs
3. To incorporate information previously submitted on the Form 339 Questionnaire (no longer required)

# Sources – RHC Cost Reports

<b><u>Description</u></b>	<b><u>Link</u></b>
<b>Chapter 46, RHC Instructions and Forms, May 18, 2018. (95 page PDF)</b>	<a href="https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R1P246.pdf">https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R1P246.pdf</a>
<b>Medicare Cost Report E-Filing (MCR<sub>e</sub>F) MLN Matters Number: MM10611 revised November 2, 2018</b>	<a href="https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM10611.pdf">https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM10611.pdf</a>
<b>MCR<sub>e</sub>F FAQs (5-page PDF)</b>	<a href="https://www.cms.gov/Medicare/Compliance-and-Audits/Part-A-Cost-Report-Audit-and-Reimbursement/Downloads/MCR&lt;sub&gt;e&lt;/sub&gt;F-FAQ.pdf">https://www.cms.gov/Medicare/Compliance-and-Audits/Part-A-Cost-Report-Audit-and-Reimbursement/Downloads/MCR<sub>e</sub>F-FAQ.pdf</a>

# Mandated Cost Reporting Timeframes

Description	Timeframe
Cost Report prepared by the clinic and due to Medicare	5 months year-end
Number of days the MAC has to accept the cost report	30 days
Number of days the MAC has to pay a tentative settlement	60 days
Time to final settle cost report	1 year from acceptance

Source: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/fin106c08.pdf>

# Deadlines for 12/31/2019 Fiscal Year Ends

#	Requirement	Due Date
1.	To claim Medicare Bad Debts, the bad debt must be written off by the fiscal year end (usually 12/31)	12/31/2019
2.	Liquidate accrued bonuses or payments to owners	75 days after year-end. March 16, 2020
3.	Liquidate accruals for non-owners.	One year after year-end. December 31, 2020
4.	Complete Requested Workpapers from your Cost Report Preparer	3 months after the fiscal year end in most cases
5.	Sign up with EIDM/IACS for the P S and R.	ASAP

# Gathering Information for the Cost Report

Your Cost Report Preparer will send you a checklist of information or Excel spreadsheet to submit to your cost report preparer.

Start Early and get the information to the preparer as soon as possible.

If you do not have the checklist by your cost report year-end or shortly thereafter contact your cost report preparer.



# Medicare Cost Report Table of Contents

1. Medicare Cost Report – Form 222/2552 (ECR File)
2. Medicare Workpapers which include 3 through 9.
3. Trial Balance of expenses that ties to WKS A.
4. Workpapers to support reclassifications or adjustments.
5. How total visits were computed.
6. How Provider FTEs are computed
7. Flu and Pnu logs and invoices
8. P S and R including preventive services
9. Medicare Bad Debt listing in Excel

# All Inclusive Rate (AIR) Per Visit Calculation

Total Allowable RHC Costs minus Flu/Pnu costs

---

Total RHC Visits (Includes all payor types)

=

RHC Cost Per Visit (limited to cap if applicable)

Chapter 13, Section 80.4 The A/B MAC re-calculates the AIR by dividing the total allowable costs across all patient types (i.e., the numerator) by the number of visits (as defined in section 40) for all patient types (i.e., the denominator). If fewer than expected visits based on the productivity standards have been furnished, the A/B MAC substitutes the expected number of visits for the denominator and uses that instead of the actual number of visits.

# Allowable Costs

“Allowable costs must be reasonable and necessary and may include practitioner compensation, overhead, equipment, space, supplies, personnel, and other costs incident to the delivery of RHC services.”

- Provider Reimbursement Manual, Pub. 15

# Total Expense Source Documents (Numerator)

Provide your Expenses  
Typically one of the following:

1. Financial Statements
2. Trial balance
3. Tax return

ABC Company

Table: Cash Flow

For Period Cash Flow	FY 2000	FY 2001	FY 2004
<b>Year Received</b>			
Cash from Operations			
Cash Receipts	\$111,000	\$91,000	\$1,000,000
Customer Cash from Operations	\$111,000	\$91,000	\$1,000,000
<b>Additional Cash Received</b>			
Notes Payable Issued	\$0	\$0	\$0
Notes Current Borrowing	\$0	\$0	\$0
Notes Other Long Term Obligations	\$0	\$0	\$0
Notes Long Term Assets	\$0	\$0	\$0
Notes of Other Current Assets	\$0	\$0	\$0
Notes of Long Term Assets	\$0	\$0	\$0
Notes from Other Sources	\$0	\$0	\$0
Customer Cash Received	\$111,000	\$91,000	\$1,000,000
<b>Payments Made</b>			
Expenses from Operations			
Cash Payments	\$200,000	\$414,000	\$400,000
Bill Payments	\$200,000	\$414,000	\$400,000
Supplier Payments	\$200,000	\$414,000	\$400,000
<b>Additional Cash Spent</b>			
Notes Payable Issued	\$0	\$0	\$0
Principal Repayment of Current Borrowing	\$0	\$0	\$0
Other Current Obligations	\$0	\$0	\$0
Long Term Liability/Physical Equipment	\$200,000	\$414,000	\$400,000
Purchase Other Current Assets	\$200,000	\$414,000	\$400,000
Purchase Long Term Assets	\$0	\$0	\$0
Supplier Payments	\$0	\$0	\$0
Customer Cash Spent	\$200,000	\$414,000	\$400,000
<b>Net Cash Flow</b>			
Net Cash Flow	\$200,000	\$111,000	\$200,000
Cash Balance	\$200,000	\$111,000	\$200,000

# Source Documents for Cost Report Expenses

- **For provider-based RHCs**
  - Departmental summary reports
  - Internally prepared financial statements (Trial Balance)
  - Hospital cost report data
- **For independent RHCs**
  - Financial statements prepared by outside accountants
  - Internally prepared financial statements (Quickbooks)
  - Tax returns

# Worksheet A Form 222-17 for Independent RHCs

05-18

FORM CMS-222-17

4690 (Cont.)

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

# Worksheet A Form 222-17 for Independent RHCs

4690 (Cont.)

FORM CMS-222-17

05-18

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES				CCN:	PERIOD: FROM: _____ TO: _____	WORKSHEET A	
COST CENTER	SALARIES 1	OTHER 2	TOTAL (col. 1 + col. 2) 3	RECLASSIFI- CATIONS 4	RECLASSIFIED TRIAL BALANCE (col. 3 ± col. 4) 5	ADJUSTMENTS 6	NET EXPENSES FOR ALLOCATION (col. 5 ± col. 6) 7
<b>FACILITY OVERHEAD-ADMINISTRATIVE COSTS</b>							
60 6000 Office Salaries							60
61 6100 Depreciation-Office Equipment							61
62 6200 Office Supplies							62
63 6300 Legal							63
64 6400 Accounting							64
65 6500 Insurance							65
66 6600 Telephone							66
67 6700 Fringe Benefits And Payroll Taxes							67
68 6800 Other (specify)							68
73 Subtotal-Administrative Cost (sum of lines 60 through 68)							73
74 Total Overhead (sum of lines 59 and 73)							74
<b>COST OTHER THAN RHC SERVICES</b>							
75 7500 Pharmacy							75
76 7600 Dental							76
77 7700 Optometry							77
78 7800 Non-allowable GME Pass Through Costs							78
79 7900 Telehealth							79
80 8000 Chronic Care Management							80
81 8100 Other (specify)							81
86 Subtotal-Cost Other Than RHC (sum of lines 75 through 81)							86
<b>NON-REIMBURSABLE COSTS</b>							
87 8700							87
88 8800							88
89 8900							89
90 Subtotal Non-Reimbursable Costs (sum of lines 87 through 89)							90
100 TOTAL COSTS (sum of lines 39, 74, 86, and 90)							100

# Provider-Based RHCs Cost Report Forms – M-1

10-12 ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/ FEDERALLY QUALIFIED HEALTH CENTER COSTS		FORM CMS-2552-10				4090 (Cont.)	
		PROVIDER CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET M-1			
Check applicable box: <input type="checkbox"/> RHC <input type="checkbox"/> FQHC		COMPONENT CCN: _____					
	COMPEN- SATION 1	OTHER COSTS 2	TOTAL (col. 1 + col. 2) 3	RECLASS- IFICATIONS 4	RECLASSIFIED TRIAL BALANCE (col. 3 + col. 4) 5	ADJUSTMENTS 6	NET EXPENSES FOR ALLOCATION (col. 5 + col. 6) 7
<b>FACILITY HEALTH CARE STAFF COSTS</b>							
1	Physician						1
2	Physician Assistant						2
3	Nurse Practitioner						3
4	Visiting Nurse						4
5	Other Nurse						5
6	Clinical Psychologist						6
7	Clinical Social Worker						7
8	Laboratory Technician						8
9	Other Facility Health Care Staff Costs						9
10	Subtotal (sum of lines 1-9)						10
<b>COSTS UNDER AGREEMENT</b>							
11	Physician Services Under Agreement						11
12	Physician Supervision Under Agreement						12
13	Other Costs Under Agreement						13
14	Subtotal (sum of lines 11-13)						14
<b>OTHER HEALTH CARE COSTS</b>							
15	Medical Supplies						15
16	Transportation (Health Care Staff)						16
17	Depreciation-Medical Equipment						17
18	Professional Liability Insurance						18
19	Other Health Care Costs						19
20	Allowable GME Costs						20
21	Subtotal (sum of lines 15-20)						21
22	Total Cost of Health Care Services (sum of lines 10, 14, and 21)						22
<b>COSTS OTHER THAN RHC/FQHC SERVICES</b>							
23	Pharmacy						23
24	Dental						24
25	Optometry						25
26	All other nonreimbursable costs						26
27	Nonallowable GME costs						27
28	Total Nonreimbursable Costs (sum of lines 23-27)						28
<b>FACILITY OVERHEAD</b>							
29	Facility Costs						29
30	Administrative Costs						30
31	Total Facility Overhead (sum of lines 29 and 30)						31
32	Total facility costs (sum of lines 22, 28 and 31)						32

The net expenses for cost allocation on Worksheet A for the RHC/FQHC cost center line must equal the total facility costs in column 7, line 32 of this worksheet.

FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4066)

Rev. 3

40-659

# Worksheet B-1 Provider-based RHC Cost Statistics

Provider-based RHCs receive an allocation of parent overhead from the hospital. The provider-based RHC must maintain statistics to support the allocation of overhead. Such statistics may include:

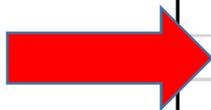
1. Square Footage
2. Time Studies
3. Gross Salaries
4. Accumulated Costs
5. Pounds of Laundry

4090 (Cont.)		FORM CMS-2552-10				10-12	
COST ALLOCATION - STATISTICAL BASIS		PROVIDER CCN:		PERIOD: FROM _____ TO _____		WORKSHEET B-1	
COST CENTER DESCRIPTIONS	CAPITAL RELATED COST		EMPLOYEE BENEFITS (GROSS SALARIES)	RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUM COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)
	BLDGS. & FIXTURES (SQUARE FEET)	MOVABLE EQUIPMENT (DOLLAR VALUE)					
	1	2	4	5A	5	6	7
<b>ANCILLARY SERVICE COST CENTERS</b>							
50 Operating Room							50
51 Recovery Room							51
52 Labor Room and Delivery Room							52
53 Anesthesiology							53
54 Radiology-Diagnostic							54
55 Radiology-Therapeutic							55
56 Radioisotope							56
57 Computed Tomography (CT) Scan							57
58 Magnetic Resonance Imaging (MRI)							58
59 Cardiac Catheterization							59
60 Laboratory							60
61 PBP Clinical Laboratory Services-Program Only							61
62 Whole Blood & Packed Red Blood Cells							62
63 Blood Storage, Processing, & Trans.							63
64 Intravenous Therapy							64
65 Respiratory Therapy							65
66 Physical Therapy							66
67 Occupational Therapy							67
68 Speech Pathology							68
69 Electrocardiology							69
70 Electroencephalography							70
71 Medical Supplies Charged to Patients							71
72 Implantable Devices Charged to Patients							72
73 Drugs Charged to Patients							73
74 Renal Dialysis							74
75 ASC (Non-Distinct Part)							75
76 Other Ancillary (specify)							76
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88 Rural Health Clinic (RHC)							88
89 Federally Qualified Health Center (FQHC)							89
90 Clinic							90
91 Emergency							91
92 Observation Beds							92
93 Other Outpatient Service (specify)							93

# Using Benchmark Data

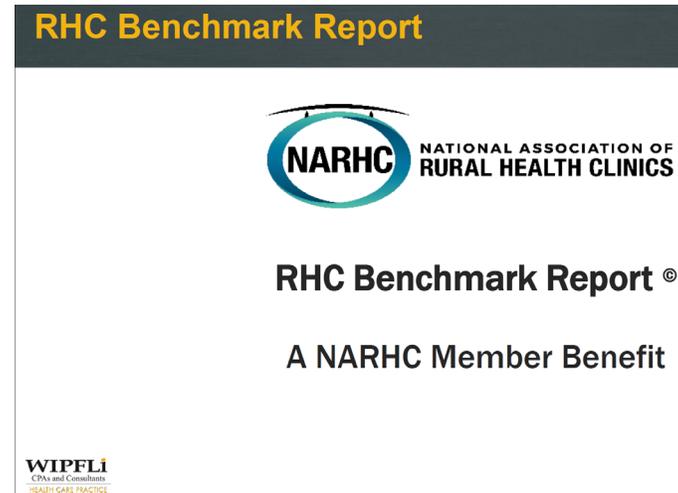
*What elements of cost are causing the variance: provider, support staff, overhead, parent allocation?*

Category/Indicator	2018				
	RHC		Mean		
	Values		MI	Midwest	Nation
Number of Facilities	1		61	383	837
<b>Clinic Cost per Encounter:</b>					
Total Health Care Staff	130.04	↓	79.09	98.42	92.91
Total Direct Costs of Medical Services	146.41	→	123.21	129.20	117.97
Allowable GME Overhead	0.00		0.00	0.00	0.00
Clinic Overhead	59.88	↓	27.57	22.73	24.09
Parent Provider Overhead Allocated	122.44	↓	81.28	81.91	78.20
Allowable Overhead (Clinic and Parent)	182.32	↓	108.34	104.07	101.54
Allowable Overhead Ratio (Clinic and Parent)	100%	→	100%	99%	99%
Total Allowable Cost per Actual Encounter	328.74	↓	230.60	233.00	218.67
Total Allowable Cost per Adjusted Encounter	328.74	↑	221.89	222.99	208.51



# Professional Tip: Benchmark your Cost Report

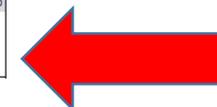
<https://www.wipfli.com/healthcare>



<https://www.ruralhealthinfo.org/assets/762-2349/slides-121415.pdf>



Category/Indicator	2015			2016			2017		
	Mean			Mean			Mean		
	TN	Southern	Nation	TN	Southern	Nation	TN	Southern	Nation
<b>Number of Facilities</b>	62	708	1,242	71	672	1,154	74	628	1,056
<b>Encounters per FTE:</b>									
Physicians	5,209	4,970	4,729	5,167	4,941	4,651	4,577	4,725	4,577
Physician Assistants	3,435	3,677	3,639	3,574	3,834	3,740	2,967	3,911	3,738
Nurse Practitioners	3,215	3,487	3,327	3,267	3,497	3,332	3,242	3,469	3,286
Visiting Nurses	0	119	375	0	200	525	595	538	815
Clinical Psychologist/Social Worker	980	1,658	1,876	1,620	1,356	1,478	1,140	1,643	1,746
Midlevel Staffing Ratio	80%	55%	54%	80%	57%	57%	81%	59%	58%
Midlevel Visit Ratio	72%	46%	46%	72%	49%	49%	74%	52%	51%
<b>Cost per Encounter:</b>									
Physician	56.84	55.83	59.10	63.93	58.88	62.04	69.22	62.80	64.96
Physician Assistant	36.38	33.84	33.82	31.04	31.25	33.06	36.05	31.91	34.63
Nurse Practitioner	32.81	32.05	34.37	34.54	33.23	35.19	34.45	34.21	37.09
Visiting Nurse	#DIV/0!	313.49	97.39	0.00	263.49	103.50	117.07	111.29	69.26
Clinical Psychologist/Social Worker	165.53	89.32	52.67	96.58	92.61	69.71	53.73	72.72	55.53
Total Health Care Staff Cost	11.47	12.51	14.19	10.78	12.78	14.74	11.17	13.34	15.23
<b>Cost per FTE:</b>									
Physician	264,333	266,709	269,434	306,012	279,334	276,635	292,911	290,846	288,698
Physician Assistant	124,961	124,427	123,069	110,934	119,809	123,661	106,947	124,798	129,446
Nurse Practitioner	105,480	111,750	114,345	112,868	116,211	117,254	111,682	118,694	121,874
Visiting Nurse	28,001	37,413	36,524	0	52,791	54,352	69,655	59,818	56,466
Clinical Psychologist/Social Worker	162,220	148,073	98,810	156,460	125,626	103,017	61,251	119,484	96,944
Total Healthcare Staff Costs per Provider FTE	42,539	52,546	57,439	40,642	53,339	58,968	39,858	54,220	59,977
<b>Clinic Cost per Encounter:</b>									
Total Health Care Staff	51.69	57.24	61.57	53.60	58.35	62.87	55.26	61.28	65.82
Total Direct Costs of Medical Services	63.14	67.38	72.52	66.27	68.57	74.17	69.76	71.36	76.99
Facility Cost	13.89	9.59	10.19	11.96	9.69	11.10	12.23	9.70	11.17
Clinic Overhead	58.49	47.41	54.20	55.36	48.54	58.44	57.95	48.90	59.63
Allowable Overhead	54.16	43.97	47.63	50.77	44.96	49.02	54.90	45.65	50.02
Allowable Overhead Ratio	93%	93%	88%	92%	93%	84%	95%	93%	84%
Total Allowable Cost per Actual Encounter	117.30	111.02	119.97	117.04	113.51	123.18	124.66	116.60	126.77
Total Allowable Cost per Adjusted Encounter	113.26	108.92	116.96	113.58	111.25	119.82	119.42	114.12	123.30
Cost of Vaccines and Administration per Adjusted Encounter (Reimbursed Separately)	(2.65)	(2.62)	(3.47)	(2.73)	(2.89)	(3.99)	(2.01)	(3.24)	(4.13)
Payment Rate per Adjusted Encounter	110.61	106.30	113.49	110.85	108.36	115.83	117.41	110.88	119.17
<b>Total Encounters</b>	469,666	8,501,938	15,452,512	558,284	8,198,077	14,340,172	592,558	7,780,195	13,469,393
<b>Total Medicare Encounters</b>	75,336	2,029,889	3,634,757	83,802	1,846,994	3,210,685	92,153	1,648,929	2,895,111
<b>Medicare Percent of Visits</b>	16%	24%	24%	15%	23%	22%	16%	21%	21%
<b>Injection Cost:</b>									
Cost per Pneumococcal Injection	220.94	173.43	188.83	282.22	201.14	229.88	274.63	245.80	270.32
Cost per Influenza Injection	44.09	48.89	49.13	43.52	48.15	51.14	54.66	68.29	66.41



# **New Cost Centers – Independent RHCs**

The new Form CMS-222-17 expands the number of cost centers and add specific cost centers for costs such as:

- a. Pneumococcal vaccines (CR 30) Must be entered here or you will not get paid.**
- b. Influenza vaccines (CR 31) Same Here.**
- c. Telehealth (CR 79)**
- d. Chronic Care Management (CR 80)**

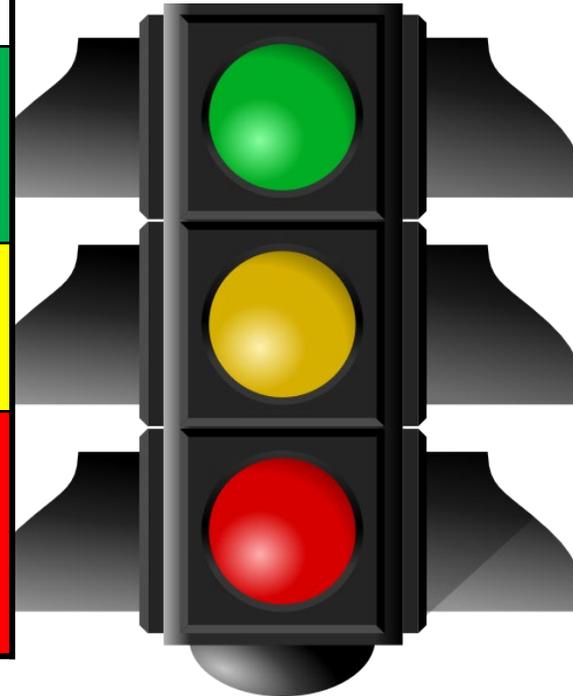
# Form 222–17 Cost Center Conversion Cheat sheet

## [Cost Report Conversion from Form 222-92 to Form 222-17 Trial Balance Cheat Sheet](#)

Cost Report Trial Balance Coding for Cost Centers		
Account Type	Form 222-92 (Old)	Form 222-17 (New)
Health Care Staff: Physician	1	1
Health Care Staff: Physician Assistant	2	2
Health Care Staff: Nurse Practitioner	3	3
Health Care Staff: Certified Nurse Midwife		4
Health Care Staff: Visiting Nurse	4	5 (RN) and 6 (LPN)
Health Care Staff: Other Nurse	5	10
Health Care Staff: Clinical Psychologist	6	7
Health Care Staff: Social Worker	7	8
Health Care Staff: Laboratory Technician	8	9
Health Care Staff: Transcription	9	10.01
Health Care Staff: Contract Labor	10	10.02
Costs Under Agreement: Physician Services	13	15
Costs Under Agreement: Physician Supervision	14	16
Other Health Care: Medical Supplies	17	25
Other Health Care: Transportation	18	26
Other Health Care: Depreciation (Medical Equipment)	19	27
Other Health Care: Professional Liability Insurance	20	28
Other Health Care: Allowable GME	20.50	29
Other Health Care: Pneumococcal Vaccine & Med Supplies		30
Other Health Care: Influenza Vaccine & Med Supplies		31
Other Health Care: Other Health Care Costs (Specify)	21	
Other Health Care: CME, Dues, Licenses, Subscriptions	22	32
Other Health Care: Electronic Health Records	23	32.01
Other Health Care: Small Equipment		32.02
Facility Overhead: Rent	26	40
Facility Overhead: Insurance	27	41
Facility Overhead: Interest	28	42
Facility Overhead: Utilities	29	43
Facility Overhead: Depreciation (Building & Fixtures)	30	44
Facility Overhead: Depreciation (Equipment)	31	45
Facility Overhead: Housekeeping & Maintenance	32	46
Facility Overhead: Property Tax	33	47
Facility Overhead: Other Overhead Facility Costs (Specify)	34	
Facility Overhead: Other Overhead Facility Costs (Specify)	35	
Facility Overhead: Other Overhead Facility Costs (Specify)	36	
Facility Overhead (Administrative): Office Salaries	38	60
Facility Overhead (Administrative): Depreciation (Office Equipment)	39	61
Facility Overhead (Administrative): Office Supplies	40	62
Facility Overhead (Administrative): Legal	41	63
Facility Overhead (Administrative): Accounting	42	64
Facility Overhead (Administrative): Insurance	43	65
Facility Overhead (Administrative): Telephone	44	66
Facility Overhead (Administrative): Fringe Benefits & Payroll Taxes	45	67
Facility Overhead (Administrative): Billing Service	46	68
Facility Overhead (Administrative): Miscellaneous	47	68.01
Facility Overhead (Administrative): Non-Allowable Costs	48	68.02
Facility Overhead (Administrative): Corporate Administrative Allocation		68.03
Costs Other than RHC: Pharmacy	51	75
Costs Other than RHC: Dental	52	76
Costs Other than RHC: Optometry	53	77
Costs Other than RHC: Non-Allowable GME Pass Through Costs	53.50	78
Costs Other than RHC: EPSDT/Physicals	54	81
Costs Other than RHC: Hospital	55	81.01
Costs Other than RHC: Chronic Care Management	55.50	80
Costs Other than RHC: Telehealth	55.60	79
Costs Other than RHC: Private Practice	56	81.02
Costs Other than RHC: Laboratory		81.03
Costs Other than RHC: Radiology		81.04

# RHC Cost Report can be divided in 3 sections

CR Description- WKS A	CR Line
Healthcare Staff Costs	1-39
Facility Overhead	40-74
Non-RHC and Non-Reimbursable	75-100



# Healthcare Costs – CR Lines 1-39

COST CENTER			SALARIES	OTHER
			1	2
<b>FACILITY HEALTH CARE STAFF COSTS</b>				
1	0100	Physician		
2	0200	Physician Assistant		
3	0300	Nurse Practitioner		
4	0400	Certified Nurse Midwife		
5	0500	Registered Nurse		
6	0600	Licensed Practical Nurse		
7	0700	Clinical Psychologist		
8	0800	Clinical Social Worker		
9	0900	Laboratory Technician		
10	1000	Other (specify)		
14		Subtotal-Facility Health Care Staff Costs (sum of lines 1 through 10)		
<b>COSTS UNDER AGREEMENT</b>				
15	1500	Physician Services Under Agreement		
16	1600	Physician Supervision Under Agreement		
17		Subtotal Under Agreement (sum of lines 15 and 16)		
<b>OTHER HEALTH CARE COSTS</b>				
25	2500	Medical Supplies		
26	2600	Transportation (Health Care Staff)		
27	2700	Depreciation-Medical Equipment		
28	2800	Malpractice Premiums		
29	2900	Allowable GME Costs		
30	3000	Pneumococcal Vaccines & Med Supplies		
31	3100	Influenza Vaccines & Med Supplies		
32	3200	Other (specify)		
38		Subtotal-Other Health Care Costs (sum of lines 25 through 32)		
39		Total Cost of Services (Other Than Overhead And Other RHC Services) (sum of lines 14, 17, and 38)		

# Facility Overhead CR Lines 40-74

FACILITY OVERHEAD-FACILITY COST		
40	4000	Rent
41	4100	Insurance
42	4200	Interest On Mortgage Or Loans
43	4300	Utilities
44	4400	Depreciation-Buildings And Fixtures
45	4500	Depreciation-Movable Equipment
46	4600	Housekeeping And Maintenance
47	4700	Property Tax
48	4800	Other (specify)
59		Subtotal-Facility Costs (sum of lines 40 through 48)
FACILITY OVERHEAD-ADMINISTRATIVE COSTS		
60	6000	Office Salaries
61	6100	Depreciation-Office Equipment
62	6200	Office Supplies
63	6300	Legal
64	6400	Accounting
65	6500	Insurance
66	6600	Telephone
67	6700	Fringe Benefits And Payroll Taxes
68	6800	Other (specify)
73		Subtotal-Administrative Cost (sum of lines 60 through 68)
74		Total Overhead (sum of lines 59 and 73)

# Non-allowable Expenses CR 75-100

COST OTHER THAN RHC SERVICES		
75	7500	Pharmacy
76	7600	Dental
77	7700	Optometry
78	7800	Non-allowable GME Pass Through Costs
79	7900	Telehealth
80	8000	Chronic Care Management
81	8100	Other (specify)
86		Subtotal-Cost Other Than RHC (sum of lines 75 through 81)
NON-REIMBURSABLE COSTS		
87	8700	
88	8800	
89	8900	
90		Subtotal Non-Reimbursable Costs (sum of lines 87 through 89)
100		TOTAL COSTS (sum of lines 39, 74, 86, and 90)

# Separate General Ledger accounts for **Non-allowable Expenses**

Certain **Non-RHC expenses** need separate accounting or general ledger accounts.

- A. Laboratory supplies/reagents/licenses
- B. Radiology supplies/ film/ licenses
- C. EKGs tracing supplies or Part B technical component costs.
- D. Any service billed to Part B and there is a supply cost.
- E. Chronic Care Management
- F. Tele-Health

# Why are Visits so Important?

Visits are important because  
They are the denominator in  
The cost per visit calculation.

Do not count 99211 visits,  
Injections, lab procedures,  
hospital visits, non-rhc visits



## Definition of an RHC Visit per Section 40 of Chapter 13 of the Medicare Benefits Policy Manual

An RHC visit is a **medically-necessary** medical or mental health visit, or a qualified preventive health visit. The visit must be a **face-to-face (one-on-one) encounter** between the patient and a physician, NP, PA, CNM, CP, or a CSW during which time one or more RHC services are rendered. A Transitional Care Management (TCM) service can also be an RHC visit. Services furnished must be **within the practitioner's state scope of practice, and only services that require the skill level of the RHC or practitioner are considered RHC visits.**

# Total Visit Counts

2	<u>PROVIDE AT LEAST ONE OF THE FOLLOWING (A. OR B.) TO DETERMINE THE TOTAL PATIENT VISITS OR ENCOUNTERS AND NEED ONE OF THE FOLLOWING.</u>
a.	<b>CPT Frequency report by Provider from your computer system.</b>
b.	Written or manual visit count with physician, physician assistant, and nurse practitioner visits provided.

# Additional Information Required for Independent RHCs Only

To capture additional information from the RHC such as:

- a. Malpractice premiums, paid losses, and self-insurance
- b. Medical visits, mental health visits, and visits by interns and residents
- c. Visits by payor mix (Worksheet S-3)
  - a. i. Title V- CHIP
  - b. ii. Title XVIII – Medicare
  - c. iii. Title XIX – Medicaid
  - d. iv. Other – Commercial, self-pay, etc.

# Additional Visit Information for Independent RHCs Only

## TAB 2

### Worksheet S-3 – Total Visits by Payor Mix

Please provide the RHC Total Visits as follows. If the clinic does not provide mental health visits or visits by interns and residents, you do not have to complete this form.

#	Description	CHIP	Medicare	Medicaid	Other	Total
1	Medical Visits					
2	Total Medical Visits					
3	Mental Health Visits					
4	Total Mental Health Visits					
5	Number of Visits Performed by Interns and Residents					
6	Total Number of Visits Performed by Interns and Residents					
7	Total Visits					

# Health Care Provider FTEs

Cost report requires separation of provider visits, time, (and cost):

Physician  
Physician Assistant  
Nurse Practitioner  
Visiting Nurse  
Clinical Psychologist  
Clinical Social Worker



**The Provider FTE calculation is important  
For Productivity Calculations  
(based up a 2,080 Hour work year)**

<b>Provider</b>	<b>Visits</b>
<b>Physician</b>	<b>4,200</b>
<b>Physician Assistant</b>	<b>2,100</b>
<b>Nurse Practitioner</b>	<b>2,100</b>

# Time Studies for Provider FTEs

Rural Health Clinic Physician Time Study									
Physician Name: _____					Date: _____				
Physician Signature: _____									
To complete, place an "X" in the appropriate box for each 15-minute increment to identify the activities performed.									
		Part A - Provider Component					RHC Component		
		Supervision	Committee Work	Administration of Department	Quality Control	Emergency Room Availability	Patient Services	Documentation	
0:00	0:15								
0:15	0:30								
0:30	0:45								
0:45	1:00								
1:00	1:15								
1:15	1:30								
1:30	1:45								
1:45	2:00								
2:00	2:15								

# Influenza and Pneumococcal

4	<u>PROVIDE ALL OF THE FOLLOWING</u> INFORMATION TO CLAIM INFLUENZA AND PNEUMOCOCCAL REIMBURSEMENT ON THE COST REPORT.
a.	Medicare logs with patient name & HIC number and date of service for pneumococcal and influenza patients.
b.	A count, listing, or log on non-Medicare patients in order for us to determine total flu shots provided.
c.	Invoices supporting influenza and pneumococcal purchases during the year. This will help us to determine the cost of the supply cost.

# Influenza and Pnemococcal Shot Logs

<b>Patient Name</b>	<b>HIC Number</b>	<b>Date of Service</b>
John Smith	411992345A	12/31/2013
Steve Jones	234123903A	12/31/2013
Ashley Taylor	903214934A	12/31/2013

Medicare Influenza and Medicare Pnemococcal shots should be maintained on separate logs. Pnumo pays around \$270 per shot and influenza is \$66 or so.

# EIDM Access – P S and R

Start here first. This takes the longest and is the most confusing.



# PS & R Reports

The screenshot shows a CMS website page with a navigation bar at the top containing links for Medicare, Medicaid/CHIP, Medicare-Medicaid Coordination, Private Insurance, Innovation Center, Regulations & Guidance, Research, Statistics, Data & Systems, and Outreach & Education. The main content area is titled "Provider Statistical & Reimbursement Report" and includes a sidebar with links for "Provider Community" and "MAC Community". The main text describes the PS&R System, its redesign, and provides information on how to generate reports and access the system. It also includes sections for "Downloads" and "Related Links".

Home > Research, Statistics, Data and Systems > Provider Statistical & Reimbursement Report > Provider Statistical & Reimbursement Report

## Provider Statistical & Reimbursement Report

[Provider Community](#)  
[MAC Community](#)

### Provider Statistical & Reimbursement Report

#### Provider Statistical and Reimbursement (PS&R) System

The Provider and Statistical Reimbursement (PS&R) System is a key tool for institutional healthcare providers, Medicare Administrative Contractors (MACs) and CMS. The system accumulates statistical and reimbursement data applicable to the processed and finalized Medicare Part A claims. This data is summarized in various reports, which are used by providers to prepare Medicare cost reports, and by MACs during the audit and settlement process.

The CMS has redesigned the PS&R system and the new system (PS&R Redesign) is a web-based, centralized system, housed at CMS. The previous PS&R (Legacy PS&R) is housed at each MAC. The PS&R Redesign shall be utilized to file and settle all cost reports with fiscal years ending January 31, 2009 and later. All cost reports with fiscal years ending prior to January 31, 2009 will continue to be filed and settled using data from the Legacy PS&R. The PS&R Redesign will only contain the data needed to file January 31, 2009 cost reports, and later. All data needed prior to that period must continue to be requested from the MAC.

Note – information included on this webpage applies to the PS&R Redesign only. Any information pertaining to the Legacy PS&R will continue to be found in the Medicare Financial Management Manual (CMS Pub. 100-06) Chapter 9, and providers will continue to contact their MAC for more information.

There are numerous reports that may be generated from the PS&R, but they are primarily grouped into two categories, Provider Summary Reports and Payment Reconciliation Reports. Provider Summary Reports contain accumulated data that can be used for cost reporting and data analysis, summarized by specific criteria. The Payment Reconciliation Reports (also known as Detail Reports) contain detailed, claim specific data that supports the Provider Summary reports.

Users may generate their own Provider Summary reports using the PS&R Redesign user interface screens. The reports are available to be printed or downloaded using various methods. The Payment Reconciliation reports may be requested by the provider using the user interface screens, but due to the sensitive data they contain, the reports must be authorized and transmitted to the provider by their MAC.

Prior to accessing the PS&R system, users will first need to register for a user ID and password in CMS' Enterprise Identity Management system (EIDM). EIDM is the CMS identification and authentication system used to access CMS web-based applications. EIDM allows users to obtain one ID and password needed to access multiple web-based systems, one of which is the PS&R system. Links to the EIDM user guides and other helpful EIDM information are located on this page.

#### Downloads

[Frequently Asked Questions \[PDF, 795KB\]](#)

#### Related Links

[EIDM](#)  
[EIDM Registration and Login](#)  
[EIDM Support - External User Services](#)

<https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/PSRR/index.html>

# EIDM: Change Password FAQ

**Q: How do I change my SPOT/EIDM password, and how often do I need to change it?**

**A: You must log in to the [EIDM portal](#) once every 60 days to change your password.**  
You **may** change your **Password** as well as **personal information** associated with your Enterprise Identity Management (EIDM) account through the **My Profile** menu on the EIDM website.

## Change Password

1. Navigate to CMS' EIDM portal: <https://portal.cms.gov>

Important: Keep a written record of the log-in and Passwords in the RHC Policy and Procedure Manual at all times since the EIDM Security Officials may change. You will need to access the system to print the P S and R and you will need to change the password every 60 days.

**Important – Ask for Preventive Charge Report**  
**Report Type: 710 and 71S (Summary) not Detailed**

Ask for the P S and R report that has preventive charges on it.

It is a separate report from the P S and R.

It is important to enter these charges as this is where you get your co-pays paid.

# P S & R Reports – 710 Visits, Charges, Deductibles, Payments

## PROVIDER STATISTICAL AND REIMBURSEMENT SYSTEM

Program ID: REDESIGN  
 Paid Dates: 08/01/07 THRU 01/03/19  
 Report Run Date: 01/03/19  
 Provider FYE: 12/31  
 Provider Number: ██████████

PROVIDER SUMMARY REPORT  
 CLINIC - RURAL HEALTH

Page: 1  
 Report #: OD44203  
 Report Type: 710 ←

SERVICES FOR PERIOD	SERVICES FOR PERIOD	SERVICES FOR PERIOD	SERVICES FOR PERIOD
01/01/18 - 12/31/18	No Data Requested	No Data Requested	No Data Requested

### STATISTIC SECTION

CLAIMS 2,633

### CHARGE SECTION

REV CODE	DESCRIPTION	UNITS	CHARGES	UNITS	CHARGES	UNITS	CHARGES	UNITS	CHARGES
0521	RURAL/CLINIC	2,452	\$322,876.00						
0524	RHC/FQHC PT A SNF	2	\$640.00						
0525	RHC/FQHC SNF	184	\$31,988.00						
<b>TOTAL COVERED CHARGES</b>		<b>2,638</b>	<b>\$355,504.00</b>						

*Handwritten notes: WKSC Line 10, WKSC Line 17*

### REIMBURSEMENT SECTION

GROSS REIMBURSEMENT	\$246,255.01				
LESS					
CASH DEDUCTIBLE	\$10,898.13				
BLOOD DEDUCTIBLE	\$0.00				
COINSURANCE	\$64,653.10				
NET MSP PAYMENTS	\$0.00				
PRE-SEQUESTRATION DEMO REDUCTION	\$0.00				
SEQUESTRATION	\$3,488.28	\$0.00	\$0.00	\$0.00	\$0.00
POST-SEQUESTRATION DEMO REDUCTION	\$0.00				
REBILLING ADJUSTMENT	\$0.00				
<b>NET REIMBURSEMENT</b>	<b>\$167,215.50</b>				

*Handwritten notes: WKSC Line 15, C-1 Line 1*

# P S & R Reports – 71S Preventive Visits, Charges, Payments

## PROVIDER STATISTICAL AND REIMBURSEMENT SYSTEM

Program ID: REDESIGN  
 Paid Dates: 08/01/07 THRU 01/03/19  
 Report Run Date: 01/03/19  
 Provider FYE: 12/31  
 Provider Number: 448966 Mid-South Convenient Care

PROVIDER SUMMARY REPORT  
 CLINIC - RURAL HEALTH - PREVENTIVE SERVICES

Page: 1  
 Report #: OD44203  
 Report Type: 71S



SERVICES FOR PERIOD	SERVICES FOR PERIOD	SERVICES FOR PERIOD	SERVICES FOR PERIOD
01/01/18 - 12/31/18	No Data Requested	No Data Requested	No Data Requested

### STATISTIC SECTION

CLAIMS 1,079

### CHARGE SECTION

REV CODE	DESCRIPTION	UNITS	CHARGES	UNITS	CHARGES	UNITS	CHARGES	UNITS	CHARGES
0521	RURAL/CLINIC	920	\$98,656.00						
<b>TOTAL COVERED CHARGES</b>		920	\$98,656.00						

*Handwritten notes:*  
 WKS C Line 10  
 WKS C Line 15 &  
 WKS C Line 18

### REIMBURSEMENT SECTION

GROSS REIMBURSEMENT	\$76,774.00		
LESS			
CASH DEDUCTIBLE	\$0.00		
BLOOD DEDUCTIBLE	\$0.00		
COINSURANCE	\$0.00		
NET MSP PAYMENTS	\$0.00		
PRE-SEQUESTRATION DEMO REDUCTION	\$0.00		
SEQUESTRATION	\$1,533.06	\$0.00	\$0.00
POST-SEQUESTRATION DEMO REDUCTION	\$0.00		
REBILLING ADJUSTMENT	\$0.00		
<b>NET REIMBURSEMENT</b>	<b>\$75,240.94</b>		

*Handwritten note:* C-1 Line 1

### ADDITIONAL INFORMATION SECTION

CLAIM INTEREST PAYMENTS \$0.20

# P S & R Reports – 71S Preventive Visits, Charges, Payments

## PROVIDER STATISTICAL AND REIMBURSEMENT SYSTEM

Program ID: REDESIGN  
 Paid Dates: 08/01/07 THRU 01/03/19  
 Report Run Date: 01/03/19  
 Provider FYE: 12/31  
 Provider Number: 448966 Mid-South Convenient Care

PROVIDER SUMMARY REPORT  
 CLINIC - RURAL HEALTH - PREVENTIVE SERVICES

Page: 1  
 Report #: OD44203  
 Report Type: 71S



SERVICES FOR PERIOD	SERVICES FOR PERIOD	SERVICES FOR PERIOD	SERVICES FOR PERIOD
01/01/18 - 12/31/18	No Data Requested	No Data Requested	No Data Requested

### STATISTIC SECTION

CLAIMS 1,079

### CHARGE SECTION

REV CODE	DESCRIPTION	UNITS	CHARGES	UNITS	CHARGES	UNITS	CHARGES	UNITS	CHARGES
0521	RURAL/CLINIC	920	\$98,656.00						
<b>TOTAL COVERED CHARGES</b>		920	\$98,656.00						

*Handwritten notes:*  
 WKS C Line 15 & Line 10  
 WKS C Line 18

### REIMBURSEMENT SECTION

GROSS REIMBURSEMENT	\$76,774.00				
LESS					
CASH DEDUCTIBLE	\$0.00				
BLOOD DEDUCTIBLE	\$0.00				
COINSURANCE	\$0.00				
NET MSP PAYMENTS	\$0.00				
PRE-SEQUESTRATION DEMO REDUCTION	\$0.00				
SEQUESTRATION	\$1,533.06	\$0.00	\$0.00	\$0.00	\$0.00
POST-SEQUESTRATION DEMO REDUCTION	\$0.00				
REBILLING ADJUSTMENT	\$0.00				
<b>NET REIMBURSEMENT</b>	<b>\$75,240.94</b>				

*Handwritten note:* C-1 Line 1

### ADDITIONAL INFORMATION SECTION

CLAIM INTEREST PAYMENTS \$0.20

# Interim Payments to be reported on the Cost Report

111 BLY 100307 | OLY GMBIA, SC 29202-3907 | PALMETTOGBA COMPANY | ISO 9001

WIB INC JURISDICTION J  
 Account Georgia and Tennessee



October 9, 2018

[Redacted]

Subject: YEAR END RATE REVIEW FOR FYE: December 31, 2018 FCR: [Redacted] CCN: [Redacted] NPI: [Redacted]

Dear [Redacted]

We have recently completed your Year End rate review for the year ending December 31, 2018. These reviews were based on previous audit history for your facility, the provider statistical and reimbursement report and the December 31, 2017 as-filed cost report.

As required by law, President Obama issued a sequestration order on March 1, 2013 requiring across-the-board reductions in Federal spending. In general, Medicare FFS claims with dates-of-service or dates-of-discharge on or after April 1, 2013, will incur a 2 percent reduction in Medicare payments. Therefore, to prevent making overpayments, interim and pass-through payments related to the Medicare cost report will be reduced by 2 percent. Beginning April 1, 2013 the 2 percent reduction will be applied to Periodic Interim Payments (PIP), Critical Access Hospital (CAH) and Cancer Hospital interim payments, and pass-through payments for Graduate Medical Education, Organ Acquisition, and Medicare Bad Debts.

The results of these reviews are as follows:

Provider	Type of Review	New Rate \$/Per Diem	New Biweekly	Effective Date	Lump Sum
[Redacted]	RHC I	96.38		1/1/2018	\$36,798
TOTAL:					\$36,798

*WKS C-1 Line 3*

The net result of these reviews is a lump sum underpayment of \$36,798. This amount will be issued on or before October 19, 2018. Enclosed are the computations and payment schedule(s) for your reviews.

If you have any questions please call me at (803) 763-1392 or e-mail me at [brenda.williams@palmettogba.com](mailto:brenda.williams@palmettogba.com).

Sincerely,  
*Brenda Williams*

Brenda Williams  
 Accountant II, Provider Reimbursement  
 Provider Reimbursement

# Medicare Bad Debt Reimbursement is 65% of the uncollected of Medicare Co-pays and Deductibles



<https://www.alabamapublichealth.gov/ruralhealth/assets/webinar.medicarebaddebt.12.10.13.pdf>

# Medicare Bad Debt Summary

A provider's bad debts resulting from Medicare *deductible and coinsurance* amounts that are uncollectible from Medicare beneficiaries are considered in the program's calculation of reimbursement to the provider if they meet the criteria specified in 42 CFR 413.89.

Per 42 CFR 413.89(e), a bad debt must meet the following criteria to be allowable:

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

<https://med.noridianmedicare.com/web/jea/audit-reimbursement/audit/bad-debt>

# Medicare-Medicaid Crossover

## Bad Debt Classification

Providers claiming Medicare bad debt must meet 42 CFR 413.89 and all requirements from Chapter 3 of the Provider Reimbursement Manual (<https://go.usa.gov/xEuwD>). Correctly classify unpaid deductible and coinsurance amounts for Medicare-Medicaid crossover claims in your accounting records. For bad debt amounts:

- Do not write off to a contractual allowance account
- Charge to an expense account for uncollectible accounts (bad debt)

**Effective for cost reporting periods beginning on or after October 1, 2019, providers must comply with these longstanding Medicare bad debt requirements.**

# Medicare Bad Debt Summary

1. Medicare coinsurance 20% of charges.
2. Medicare deductible of \$185.00 in 2019.
3. Billed to the Part A MAC.
4. Nothing else is allowed.
5. Must try to collect for 120 days from first bill.
6. Must treat everyone the same.
7. Do not have to turn over to collection agency.
8. Must be written off in the fiscal year of the cost report.
9. Collection efforts must cease.

# Medicare Bad Debt Listing – Write off

Medicare Bad Debts must be written off by the end of the fiscal year to be claimed on the cost report.

Collection efforts must cease.



## **A Medicare Bad Debt must meet the following Criteria:**

1. The debt must be related to a covered service and derived from the Deductible and Coinsurance amounts.
  - A. No Fee for Service. IE. Hospital, Technical Components.
  - B. No Medicare Advantage plans.
2. The provider must be able to establish that reasonable collection efforts were made.
  - A. At least 120 days of first bill.
  - B. First Bill as least within 45 to 60 days of service.
  - C. Four documented collection efforts made.
3. The debt was actually uncollectible when claimed as worthless.
4. Sound business judgment indicated there was little likelihood of recovery in the future.

# **Capturing the information for Bad Debt**

1. Use an Excel Spreadsheet
2. Keep Regular and Crossover Bad Debt in separate spreadsheets
3. Provide Medicare with the spreadsheet.
4. Start early. Start NOW.
5. Provide it to the Preparer ASAP.



# **Crossover or Dual Eligible Bad Debt**

- If Medicaid does not pay the complete coinsurance or deductible; a RHC can include this difference as an allowable bad debt on the cost report and Medicare will reimburse you for this bad debt. Keep up with in a separate file.

# Bad Debt – Excel Spreadsheets

<b><u>Description</u></b>	<b><u>Link</u></b>
<b>Bad Debt Policy for Medicare Cost Report and Policy and Procedure Manuals</b>	<a href="https://www.dropbox.com/s/0xjrovohy5q6532/2016%20Sample%20Bad%20Debt%20Policy%20for%20Rural%20Health%20Clinics.pdf?dl=0">https://www.dropbox.com/s/0xjrovohy5q6532/2016%20Sample%20Bad%20Debt%20Policy%20for%20Rural%20Health%20Clinics.pdf?dl=0</a>
<b>Medicare Bad Debt Log in Excel</b>	<a href="https://www.dropbox.com/s/1o6zh90uxhxmzd/2016%20Medicare%20Bad%20Debt%20Excel%20Spreadsheet%20for%20Medicare%20Only%20in%20September%202016.xls?dl=0">https://www.dropbox.com/s/1o6zh90uxhxmzd/2016%20Medicare%20Bad%20Debt%20Excel%20Spreadsheet%20for%20Medicare%20Only%20in%20September%202016.xls?dl=0</a>
<b>Medicare/Medicaid Crossover Bad Debt Log in Excel</b>	<a href="https://www.dropbox.com/s/auf8w5dsu49q1v5/2016%20Medicare%20Bad%20Debt%20Excel%20Spreadsheet%20for%20Medicare%20and%20Medicaid%20Crossovers%20in%20September%202016.xls?dl=0">https://www.dropbox.com/s/auf8w5dsu49q1v5/2016%20Medicare%20Bad%20Debt%20Excel%20Spreadsheet%20for%20Medicare%20and%20Medicaid%20Crossovers%20in%20September%202016.xls?dl=0</a>

# Electronic Filing of Cost Reports



# Electronic Filing of RHC Cost Reports

Currently 50,000 cost reports claiming \$200 billion of Medicare funds are filed annually to 12 different MACs

Effective July 2, 2018 Cost Reports may be filed by the following methods:

1. Via mail or express delivery services
2. Via MCRReF portal in the EDIM system

**Electronic filing is not Required**

# Electronic Filing Details

MCRReF – a new application allows you to electronically transmit (e-File) your Medicare Cost Report

- Available as of 5/1/2018
- Usage is optional. Mail and hand-delivery remain filing options.
- Accessible by your EIDM (Enterprise Identity Management System) PS&R Security Official (SO) and Backup Security Official (BSO)
- Your MAC will have access to e-Filed cost report materials

# MCREf (M-Cref) Detailed Overview

System Login: <https://mcref.cms.gov>

- Access is controlled by EIDM
- Restricted to EIDM PS&R SO / BSO
- Existing PS&R SOs / BSOs already have access
- Any organization without access to PS&R must register a PS&R SO with EIDM.

## **MCRReF Authorized Cost Report Filer**

CMS has created within EIDM a dedicated MCRReF role that the EIDM Security Official of your organization or Backup Security Official could delegate out to a particular person that they want for cost report filing. And the SO or BSO will be able to approve that role. And it's called the **MCRReF authorized cost report filer** role.

# Contact Information

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[www.ruralhealthclinic.com](http://www.ruralhealthclinic.com)

# Contact Information

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# Questions, Comments, Thank You

