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KENTUCKY MEDICAID COST REPORTING
January 2018

The State of Kentucky uses Myers and Stauffer as the auditors of RHC cost reports. Myers and Stauffer are very demanding and attempts to disallow as much cost as possible by placing strict data demands and very short time frames to obtain the documents. This is very effective in lowering your cost per visit. The best way to combat this is prepare an Evidence Binder or Comprehensive Workpaper Binder ahead of time and to accumulate the data throughout the year with proper cost centers for the cost report. We have included in this report instructions for maximizing your base year costs, examples of the documents requested by Myers and Stauffer from recent audits, and a blank cost report which includes the cost centers that should be established for accounting purposes.

This report includes data requirements, common mistakes, and depreciation regulations as well. Please review this report closely as you plan your accounting system, budgeting, and cash flow planning as you can expect to have cash issues during the base year if you want to really invest in a Medicaid rate that will benefit you for years and years to come. For example, in our table on page 3 the base year creates a loss of $80,000, but that increase of $8 per visit would generate additional Medicaid reimbursement of $400,000 over 10 years.

Healthcare Business Specialists

Specializing in RHC reimbursement

Suite 214 502 Shadow Parkway Chattanooga, TN 37421

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Base Year Cost Report Planning

Some states have special rules for establishing payment rates from Medicaid in rural health clinics. Tennessee, Kentucky, Alabama, and Arkansas all have similar rules and it is important to maximize your cost per visit during these base years.

In Kentucky, the base year is the first full year the clinic is a RHC. You will be required to act strangely in the base year to maximize your reimbursement.

First, the world will be upside down. You will want your costs high and your visits low. You do not want to have a ton of visits, otherwise it will be difficult to keep your reimbursement rate up to the highest level it could be. If there was ever a year to take that two-week dream vacation, this is the year. Also, you will want to pay yourself as much as possible. This is not the year to minimize your tax liability, by having a low salary. You want to pay yourself as much as possible.

How are you going to do this?

1. First, when you set your projected rate with Medicaid, set it for as high as you possibly can dream. A rate of $150 to $175 is not unheard of. Get as much as you possibly can, because if you worry about having to pay some back in the future (you may very well have to), you will kill your future rate because you will not have enough cash flow to establish a high reimbursement rate. If you get $75 from Medicaid and only have enough money to pay your expenses at $75 per visit, you will get a base rate of $75 and you will never get

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much more than that. If you get a projected rate of $150 and spend $135 of that amount, you will have to pay back $15 per visit, but in the future, you will receive $135 per visit or $60 more per visit than if you had taken a lower projected cost per visit.

2. Go to the bank and get a line of credit for as much as you possible can. $100,000 to $250,000 is a good starting place. The more the better. You will lose money during the base year due to the cost per visit you need to create. Here is the methodology:

   The cost report computes your cost per visit by dividing your total allowable cost by your total visits including Medicare, Medicaid, Commercial, and self-pay. If you maximize your Medicaid rate in the base year, you will lose money because the other payers will rarely reimburse you at the rate the Medicaid will pay you under the RHC program. The idea is to get your cost up during the base year and then try to lower them after the base year is over.

Base Year Cost Reporting

Description	Medicare	Medicaid	Other	Total
Payor Mix	30%	50%	20%	100%
Allowable Expenses	300,000	500,000	20,000	1,000,000
Total Visits	3,000	5,000	2,000	10,000
Cost Per Visit	$100	$100	$100	$100
Collections per Visit	$80	$100	$90	$92
Loss Per Visit	$20	0	$10	$8
Loss per Payer	($60,000)	0	($20,000)	($80,000)

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3. Pay yourself. Increase your salary to the highest amount you can pay and still pay the bills. You must pay yourself for Medicaid to allow the payments in most states. (Medicare has special rules for the value of services for sole proprietors and partners; however, Medicaid in some cases does not honor this type of reimbursement. To be safe, pay yourself)
4. Accrue a bonus to yourself to be paid within 75 days of year-end. This amount should be as much cash flow as you can justify for the 75 days after year-end. Even if you do not take a salary for the first two months of the following year. Remember, that money will not help you set your rate.
5. Pay bonuses, set up a retirement plan for your employees and fund it as an accrual. Remember owners must pay themselves for accrued expenses within 75 days of year-end, but entities other than owners (employees, consultants, etc.) you have 12 months (one year) from year-end to pay accruals.
6. If you have a related party transaction. For example, if you rent a building from yourself or a relative, reduce that payment as low as possible during the base year. Remember, this amount is non-allowable. This could cripple your rate if you pay a large rent payment as a related party and it is disallowed. You can use the actual cost as an allowable expense. You will want to lower your rent and increase your compensation to the highest amount possible.

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COST REPORT DATA REQUIREMENTS

Trial balance of expenses

- Most important document on the cost report
- Accrual based accounting (not tax)
- Assets must be capitalized
- Identify salaries by job title (MD, ARNP, PA, Admin, etc)

Labor Summary

- Salaries and hours by employee including job title
- Separately identify physician medical director comp and time vs clinic
- Expense and hours for contracted providers

Fixed Asset Schedule

- Book depreciation instead of cash
- Identify medical equipment vs office equipment

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Examples of non-allowable expenses

- Marketing/PR
- Donations
- Start-up costs (must be amortized)
- Political and lobbying activities
- Bad debts
- Other non-RHC costs – (Laboratory, Technical components, and hospital visits)

Non-operating (misc) revenue

Identify source of revenue (rent, medical records sales, etc)

Be aware of any related-party costs

Physician (or physician's family) owns RHC building and leases back to the clinic

Visits

- Only include face-to-face visit with a MD, midlevel or other qualified provider
- Do not include nurse only visits
- Do not include injection or lab only visits
- Identify site of service (clinic, nursing home, hospital, etc) Identify by month if possible

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Medicare visits – must have access to Provider Statistical and Reimbursement (PS&R) Summary

Must have active login id

Report types 710 and 71S

Productive Hours (FTE)

Do not include holiday, sick, CPE, etc

MEDICAID COST REPORT

Purpose – To determine a Medicaid Prospective Payment System (PPS) rate to be used going forward

Subject to annual MEI increases

Worksheets Similar to Medicare Cost Report

- Certification page
- Statistical and other data
- Date licensed as RHC
- Type of control
- Number of visits
- Title XIX
- Title XVIII
- All Other

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Schedule A – Expenses

- General Service Costs
- Direct Service Costs
- Other Non-Reimbursable Costs

Schedule A-1 Adjustments
Schedule A-2 Reclasses
Schedule A-3 Related Party Costs
Schedule A-4 Staffing
Costs and FTEs
Schedule A-4-1 –
Purchased Services
Schedule A-5
Depreciation
Questionnaire
Schedule A-6 – Grants, Gifts and Endowments
Schedule B – Cost Allocation

Must break out medical & nursing sq ft, lab, radiology, pharmacy, etc

Schedule C – Apportionment of Costs to Title XIX
Include Medicaid and total lab and radiology tests

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COMMON COST REPORT MISTAKES

Cash vs accrual Method

Provider compensation

Medicare and Medicaid typically uses MGMA benchmarks*

- KY is part of Southern Region
- Family Medicine (without OB)
- Physician - $229,900 and 3,894 encounters ($59.03 per encounter)
- NP - $93,213 and 2,779 encounters ($33.54 per encounter)

Expenses not liquidated

Must be paid within one year

Related party expenses not adjusted

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Appendix I

Blank Kentucky RHC Cost Report

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KENTUCKY MEDICAL ASSISTANCE PROGRAM
Primary Care Centers, Rural Health Clinics, and Federally Qualified Health Centers
Universal Cost Report

Department for Medicaid Services
275 East Main Street, 6W-C
Frankfort, KY 40621
Phone: 502-564-8196
Fax: 502-564-6917

As Submitted by Provider

Kentucky Medicaid
Universal Cost Report

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As Submitted by Provider

KENTUCKY MEDICAL ASSISTANCE PROGRAM
Primary Care Centers, Rural Health Clinics, and Federally Qualified Health Centers
Universal Cost Report

For

____

(Provider Name)

____

(Provider Number)

____

(Address)

____

(City)

____

(Phone)

____

(Fax)

____

(E-mail)

For the Period Beginning____________________

and Ending ____________________

As Submitted by Provider

CERTIFICATION BY OFFICER OR ADMINISTRATOR

Medicaid Provider No. 0
Period: From 01/00/00
To 01/00/00

I HEREBY CERTIFY that I have examined the accompanying Kentucky Medical Assistance Program Universal Cost Report for the period ended 01/00/00 and that, to the best of my knowledge and belief, they are true, correct and complete statements prepared from the books and records of 0 (Provider Name), in accordance with applicable program directives, except as noted.

(Signed) ______________________
Officer or Administrator

____
Title

____
Date

PROVIDER CONTACT AND/OR DESIGNEE

Name: ______________________

Address: ______________________

Phone: ______________________

Fax: ______________________

E-mail: ______________________

Corporate owner under name other than PCC or RHC:
(i.e., name of hospital that owns entity) ______________________

Corporate Contact: ______________________

STATISTICAL AND OTHER DATA

Medicaid Provider No 0
Period: From 01/00/00
To 01/00/00

General Information

1. Provider Name 0 Date Submitted ____

Date facility licensed as primary care center or rural health clinic ____

Name of Chief Administrative Officer ____

Title ____ Telephone Number ____

Type Of Control

2. (a) **Voluntary Non Profit**
   - ( ) Church
   - ( ) Other - (Specify) ____

   (b) **Proprietary**
   - ( ) Individual
   - ( ) Partnership
   - ( ) Corporation
   - ( ) Other - (Specify) ____

   (c) **Government**
   - ( ) State
   - ( ) County
   - ( ) City
   - ( ) Other - (Specify) ____

Name of Governing Board ____

Address ____

Name of Chairman of Governing Board ____

Statistical Data

3. Number of Visits or Encounters:

		Number	Percent
Title XIX Covered Visits	(a)		0.00%
Title XVIII Covered Visits	(b)		0.00%
All Other Visits	(c)		0.00%
Total Visits	(d)	0	0.00%

ADJUSTMENT AND RECLASSIFICATION OF OPERATING EXPENSES

Schedule A

Medicaid Provider No. ________

Period From ________

To ________

	COST CENTERS	Salaries	Other	Total	Adjustments	Reclassifica-tions	Net (1) Expenses
		1	2	3	4	5	6
	General Service Cost Centers:						
1.	Depreciation						
2.	Property & Plant Operation						
3.	Housekeeping & Maintenance						
4.	Employee Benefits						
5.	Employee Education & Training						
6.	Administration & General						
7.	Central Services & Supplies						
8.	Medical Records						
9.	Patient Transportation						
10.	Outreach						
11.	Health Education Services						
12.	Social Services						
13.	Nutritional Counseling						
14.	Family Planning Counseling						
15.	Clinical Pharmacology						
16.	Other (Specify)						
17.	Other (Specify)						
	Direct Service Cost Centers:						
18. a.	Medical & Nursing Services						
b.	Screening (EPSDT)						
c.	Home Health						
d.	Nurse Midwifery						
e.	Audiology						
f.	Other (Specify)						
g.	Other (Specify)						
19.	Laboratory						
20.	Radiology						
21.	Pharmacy						
22.	Dental Services						
23.	Optometry Services						
24.	Other (Specify)						
25.	Other (Specify)						
	Other Non-Reimbursable Cost Centers:						
26.	Research						
27.	Other (Specify)						
28.	Other (Specify)						
29.	**TOTAL EXPENSES**					-0-	

(1) Transfer amounts in Column 6 to Schedule B, Column 1.

Schedule A-1

ADJUSTMENTS TO EXPENSES

Medicaid Provider No. 0
Period From 01/00/00
To 01/00/00

Description	(1) Basis For Adjustment	Amount (2) Increase (Decrease)	Schedule A Line # to be Increased Or Decreased
	1	2	3
1. Investment Income on Comingled Restricted and Unrestricted Funds			
2. Trade Quantity and Time discounts On Purchase			
3. Rebates and Refunds of Expense			
4. Telephone Service (Pay Stations, etc.)			
5. Parking Lot			
6. Sale of Scrap, Waste, etc.			
7. Rental of Living Quarters to Employees and Others			
8. Rental of Facility Space			
9. Sale of Medical Supplies to Other Than Patients			
10. Sale of Medical records and Abstracts			
11. Vending Machine Concessions			
12. Finance or Penalty Charges			
13. Fund Raising Expenses			
14. Grants, Gifts and Income Designated by Donor for Specific Expenses, Net of Fund Raising Expenses			
15. Reimbursement From Employees for Educational Costs			
16. Recovery of Insured Loss			
17. Depreciation			
18. Adjustment Resulting From Transactions With Related Organizations			
19. Gains and Losses on Disposals of Capital Assets			
20. Other (Specify)			
21. Other (Specify)			
22. Other (Specify)			
23. **TOTAL ADJUSTMENTS**		$ -	

(1) (A) = Costs, (B) = Revenues
(2) Transfer Amounts in Column 2 to Schedule A, Column 4

ADJUSTMENTS TO EXPENSES

Medicaid Provider No. 0
Period From 01/00/00
To 01/00/00

Description	(1) Basis For Adjustment	Amount (2) Increase (Decrease)	Schedule A Line # to be Increased Or Decreased
	1	2	3
24. **SUBTOTAL FROM PAGE 1**		$ -	
25. Other (Specify)			
26. Other (Specify)			
27. Other (Specify)			
28. Other (Specify)			
29. Other (Specify)			
30. Other (Specify)			
31. Other (Specify)			
32. Other (Specify)			
33. Other (Specify)			
34. Other (Specify)			
35. Other (Specify)			
36. Other (Specify)			
37. Other (Specify)			
38. Other (Specify)			
39. Other (Specify)			
40. Other (Specify)			
41. Other (Specify)			
42. Other (Specify)			
43. Other (Specify)			
44. Other (Specify)			
45. Other (Specify)			
46. Other (Specify)			
47. Other (Specify)			
48. Other (Specify)			
49. Other (Specify)			
50. **TOTAL ADJUSTMENTS**		$ -	

(1) (A) = Costs, (B) = Revenues
(2) Transfer Amounts in Column 2 to Schedule A, Column 4

RECLASSIFICATION OF EXPENSES

Medicaid Provider No. ____________
Period From ____________
To ____________

Explanation	Increase (1) Cost Center 1	Line No. 2	Amount 3	Decrease (1) Cost Center 4	Line No. 5	Amount 6
To Reclassify to						
1. Employee Benefits	Empl. Ben.	4.		Admin. & Gen.	6.	
2. Personnel Dept.	Empl. Ben.	4.		Emp. Educ & Trn.	5.	
3. Health Service						
4. Hospitalization Ins.						
5. Workmen's Comp.						
6. Group Ins.						
7. Social Security Taxes						
8. Unemployment Taxes						
9. Pension Plan Costs						
10.						
To Reclassify to						
11. Depreciation	Depreciation	1.		Admin. & Gen.	6.	
12. Property Ins.						
13. Property Interest						
14. Property Taxes						
15. Rent						
16.						
To Reclassify to						
17. Depreciation	Depreciation	1.		Property & Plant Op.	2.	
18.				Housekeep. & Mnt.	3.	
19.						
To Reclassify to						
20. Employee Benefits	Empl. Ben.	4.		Empl. Ed. & Trn.	5.	
21.						
To Reclassify to						
22. Admin. & General	Admin. & Gen.	6.		Cen. Sys. & Sup.	7.	
23.				Med. Recs.	8.	
24.				Pat. Trans.	9.	
25.						
26.						
27.						
To Reclassify to						
28. Outreach	Outreach	10.		Health Ed.	11.	
29.						
To Reclassify to						
30. Social Services	Soc. Serv.	12.		Nutr. Cous.	13.	
31.				Fam. Plan.	14.	
32.				Clin. Pharm.	15.	
33.						
34.						
35.						
36						
37.						
38.						
39.						
40. SUBTOTAL						

(1) Transfer Amounts in Columns 3 & 6 to Schedule A, Column 5

RECLASSIFICATION OF EXPENSES

Medicaid Provider No. ____________
Period From ____________
To ____________

	Explanation	Increase (1) Cost Center 1	Line No. 2	Amount 3	Decrease (1) Cost Center 4	Line No. 5	Amount 6
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							
13.							
14.							
15.							
16.							
17.							
18.							
19.							
20.							
21.							
22.							
23.							
24.							
25.							
26.							
27.							
28.							
29.							
30.							
31.							
32.							
33.							
34.							
35.							
36.							
37.							
38.							
39.							
40.							
41.							
42.							
43.							
44.							
45.							
46.							
47.	TOTAL						

(1) Transfer Amounts in columns 3 & 6 to Schedule A, Column 5

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS

Schedule A-3

Medicaid Provider No. ________________
Period From ________________
To ________________

A. In The Amount Of Costs To Be Reimbursed By The KMAP Program, Are Any Costs Included Which Are The Result Of Transactions With Related Parties?

_________ YES _________ NO

IF YES: Complete Parts B and C.

B. Costs Incurred And Adjustments Required As Result Of Transactions With Related Organizations:

	Amount Reported On Schedule A					
	Line No.	Cost Center	Expense Item	Amount Reported	Amount Allowable	Adjustment (4 - 5)
	1	2	3	4	5	6
1.						
2.						
3.						
4.						
5.	TOTAL					

C. Interrelationship Of Provider To Related Organizations:

	Provider			Related Organization		
	(1) Code	Name	% Ownership	Name	% Ownership	Type Of Business
	1	2	3	4	5	6
1.						
2.						
3.						
4.						

(1) Use the following codes to indicate the interrelationship of the provider with related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organizations and in provider.
B. Corporation, partnership or other organization has financial interest in provider.
C. Provider has financial interest in corporation, partnership or other organization.
D. Director, officer, administrator, or key person of provider of such person has financial interest in related organization
E. Individual is director, officer, administrator, or key person of provider and related organization.
F. Director, officer, administrator, or key person of related organization ore relative of such person has financial interest in provider.
G. Other (financial or non-financial). Specify.

Schedule A-4

SCHEDULE OF STAFFING COSTS

Medicaid Provider No. ____________
Period From ____________
To ____________

	% of Business Ownership	Number of Staff FTEs 1	Annual Hours 2	Compensation 3	Fringe Benefits 4	Payroll Taxes 5	Total Cost 6	Total Visits 7	Cost per FTE 8	Cost per Hour 9	Cost per Visit 10
Administrative Staff											
1. Chief Administrative Staff								XXXXXXX			XXXXXXX
2. Chief Financial Officer								XXXXXXX			XXXXXXX
3. Medical Director								XXXXXXX			XXXXXXX
4. Other Administrative Staff								XXXXXXX			XXXXXXX
5. Total Administrative Staff								XXXXXXX			XXXXXXX
Medical Staff											
6. Physicians											
7. Physician Assistants											
8. Nurse Practitioners											
9. Nurse Midwives											
10. Dentists								XXXXXXX			XXXXXXX
11. Licensed Practical Nurses								XXXXXXX			XXXXXXX
12. Aides								XXXXXXX			XXXXXXX
13. Registered Nurses								XXXXXXX			XXXXXXX
14. Other: Visiting Nurse								XXXXXXX			XXXXXXX
15. Total Medical Staff											
Other Staff											
16. Radiologists								XXXXXXX			XXXXXXX
17. Radiology Technicians								XXXXXXX			XXXXXXX
18. Pathologists								XXXXXXX			XXXXXXX
19. Pathology Technicians								XXXXXXX			XXXXXXX
20. Pharmacists								XXXXXXX			XXXXXXX
21. Clinical Pharmacists								XXXXXXX			XXXXXXX
22. Optometrists								XXXXXXX			XXXXXXX
23. Other: Clinical Psychologist								XXXXXXX			XXXXXXX
24. Other: Clinical Social Worker								XXXXXXX			XXXXXXX
25. Phys. Srvcs Under Agreement								XXXXXXX			XXXXXXX
26. Total Other Staff											
26. **TOTAL**											

As Submitted by Provider

SUMMARY OF PURCHASED SERVICES

Schedule A-4-1

Medicaid Provider No. ____________

Period From ____________

To ____________

	Name	Service Provided	Cost Center	Units of Service	Fee per Unit	Amount
	Administrative Services:					
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
	Medical Services:					
9.						
10.						
11.						
12.						
13.						
14.						
15.						
16.						
	Other Services:					
17.						
18.						
19.						
20.						
21.						
22.						
23.						
24.						
25.	**TOTAL**					

DEPRECIATION QUESTIONNAIRE

Schedule A-5

Medicaid Provider No. 0
Period From 01/00/00
To 01/00/00

1. Was Depreciation Included In Cost Report Calculated On A Straight Line Basis?

   ________ YES ________ NO

2. Is Depreciation Funded?

   ________ YES ________ NO

   If YES: What Basis? ________________________________

   Where Recorded? ________________________________

   Balance In Fund At End Of Period $ ________________

   Earnings Of Fund During Period $ ________________

3. Were There Any Gains Or Losses On Disposals Of Capital Assets During This Period?

   ________ YES ________ NO

   If YES: Were The Effects Of Those Gains And Losses Excluded From Expenses On Schedule

   ________ YES ________ NO

   If NO: Where Included?

   Cost Center ________ Amount $ ____________

GRANTS, GIFTS AND ENDOWMENT FUNDS

Medicaid Provider No. ____________
Period From ____________
To ____________

CHANGES IN FUND BALANCE

Source	Specified (1) Purpose	Beginning Balance 1	Received 2	Expended 3	Ending (2) Balance 4
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10. Subtotal - Restricted					
11. Subtotal - Unrestricted					
12. **TOTAL**					

DONATED ASSETS

Source	Description	Cost Basis
1.		
2.		
3.		
4.		
5.		

(1) Identify Restricted Purpose of Fund, if None, Indicated Unrestricted.
(2) Column 1 + Column 2 - Column 3.
(3) Transfer Amounts from Schedule E-1, Line F-1.

Schedule B

Medicaid Provider No. ______
Period From ______
To ______

COST ALLOCATION

Cost Center	Net (1) Expense 1	Deprecia-tion 2	Employee Benefits 3	Sub-Total 4	Admin. & General 5	Outreach 6	Social Services 7	Other ( ) 8	Other ( ) 9	Other ( ) 10	Total (2) 11
General Service Cost Centers:											
1. Depreciation											
2. Employee Benefits											
3. Administration & General											
4. Outreach											
5. Social Services											
6. Other											
7. Other											
8. Other											
Direct Service Cost Centers:											
9. Medical & Nursing Services (3)						XXXXXX	XXXXXX				
10. Laboratory						XXXXXX	XXXXXX				
11. Radiology						XXXXXX	XXXXXX				
12. Pharmacy							XXXXXX				
13. Dental Services						XXXXXX	XXXXXX				
14. Optometry Services						XXXXXX	XXXXXX				
15. Other (Specify)						XXXXXX	XXXXXX				
16. Other (Specify)						XXXXXX	XXXXXX				
17. Other						XXXXXX	XXXXXX				
Other Non-Reimbursable Cost Centers:											
18. Research						XXXXXX	XXXXXX				
19. Other (Specify)						XXXXXX	XXXXXX				
20. Other (Specify)						XXXXXX	XXXXXX				
21. Other						XXXXXX	XXXXXX				
22. **Total Expenses**											

(1) Transfer amounts to Column 1 from Schedule A, Column 6.
(2) Transfer amounts in Column 11 to Schedule C, Column 4.
(3) Transfer amounts in Column 1, Line 9, from Schedule A, Column 6, Line 18a, thru 18g.

Schedule B-1

COST ALLOCATION STATISTICS

Medicaid Provider No. ____________
Period From ____________
To ____________

Cost Center	Deprecia-tion (Sq. Ft.) 2	Employee Benefits (Gross Sal.) 3	Admin. & General (Accum. Cost) 5	Outreach (# Visits) 6	Social Services (% Assigned) 7	Other ( ) 8	Other ( ) 9	Other ( ) 10
Direct Service Cost Centers:								
9. Medical & Nursing Services				XXXXXX	XXXXXX			
10. Laboratory				XXXXXX	XXXXXX			
11. Radiology				XXXXXX	XXXXXX			
12. Pharmacy					XXXXXX			
13. Dental Services				XXXXXX	XXXXXX			
14. Optometry Services				XXXXXX	XXXXXX			
15. Other (Specify)				XXXXXX	XXXXXX			
16. Other (Specify)				XXXXXX	XXXXXX			
17. Other								
Other Non-Reimbursable Cost Centers:								
18. Research				XXXXXX	XXXXXX			
19. Other (Specify)				XXXXXX	XXXXXX			
20. Other (Specify)				XXXXXX	XXXXXX			
21. Other				XXXXXX	XXXXXX			
22. Total Statistic								
23. Cost to be Allocated (1)								
24. Unit Cost Multiplier (2)								

(1) Transfer Amounts From Schedule B, Column 1, Lines 1 thru 8.
(2) Line 23 - Line 22.

As Submitted by Provider

Schedule C

APPORTIONMENT OF DEPARTMENTAL COSTS TO TITLE XIX

Medicaid Provider No. ____________

FYE: ____________

	Cost Centers	Units Of Service	Number Of Units of Service: Title XIX	Number Of Units of Service: Total	Title XIX Utilization	Total Departmental Cost	Title XIX Departmental Cost
			1	2	3	4	5
1.	Medical And Nursing Services	Visits					
2.	Laboratory	Procedures					
3.	Radiology	Procedures					
4.	Pharmacy	Prescriptions					
5.	Dental Services	Visits					
6.	Optometry Services	Visits					
7.	Other (Specify)						
8.	Other (Specify)						
9.	Other						
10.	**TOTAL**						

Schedule E-1

SUMMARY STATEMENT OF REVENUES AND EXPENSES

Medicaid Provider No. ____________
Period: From ____________
To ____________

A. **Patient Revenues**

1. Title XIX	$ -		
2. Other (Specify)			
3. Total Patient Revenues		$ -	

B. **Bad Debts and Allowances**

1. Allowance for Bad Debts			
2. Other (Specify)			
3. Total Allowances and Bad Debts		$ -	

C. **Net Patient Revenues**			$ -
D. **Less - Total Operating Expenses**			$ -
E. **Net Income From Service to Patients**			$ -

F. **Other Revenues**

1. Contributions, donations, etc.,			
--Restricted			
--Unrestricted			
2. Interest Income			
--Restricted			
--Unrestricted			
3. Rental Income			
4. Other Investment Income			
5. Revenue From Coffee Shop/Canteen, Vending Machines			
6. Parking Lot			
7. Other (Specify)			
8. Total Other Revenues		$ -	

G. **Other Expenses**

1. Other (Specify)	$ -		
2. Total Other Expenses		$ -	

H. **Total Other Revenues and Expenses**			$ -
I. **Net Income (Loss) For the Period**			$ -

Schedule E-2

STATEMENT OF CHANGES IN FUND BALANCE

Medicaid Provider No. ____________

Period: From ____________

To ____________

Fund Balance as of ______________________________ ____________

Additions

______________________________ ____________

______________________________ ____________

______________________________ ____________ ____________

Total Additions

Deductions

______________________________ $ -

______________________________ ____________

______________________________ ____________

Total Deductions $ -

Fund Balance as of ____________

BALANCE SHEET
(Current Period)

Medicaid Provider No. ____________________ FYE: ____________

ASSETS

A. **CURRENT ASSETS**

1. Cash on Hand and in Bank		$ -
2. Short-Term Investments		
3. Accounts Receivable	$ -	
4. Notes Receivable		
5. Less: Allowance for Uncollectible Accounts and Notes Receivable		
6. Inventories		
7. Prepaid Expenses		
8. Other Current Assets (Specify)		

9. TOTAL CURRENT ASSETS $ -

B. **PROPERTY, PLANT AND EQUIPMENT**

	COST	ACCUM DEPR.	BOOK VALUE
1. Land	$ -		$ -
2. Buildings		$ -	
3. Leasehold Imp.			
4. Movable Equipment			
5. Motor Vehicles			
6. Other Fixed Assets (Specify)			

7. TOTAL PROPERTY, PLANT AND EQUIPMENT $ -

C. **OTHER ASSETS (if any)**

1. Deposits	$ -
2. Long-Term Investments	
3. Special Funds	
4. Other (Specify) ____________	

5. TOTAL OTHER ASSETS $ -

TOTAL ASSETS $ -

BALANCE SHEET
(Current Period)

Medicaid Provider No. ______________________ FYE: ____________

LIABILITIES

A. CURRENT LIABILITIES

1.	Accounts Payable	$ -	
2.	Mortgages Payable within one year		
3.	Notes and Loans Payable one year		
4.	Salaries and Wages Payable		
5.	Payroll Taxes Payable		
6.	Accrued Taxes		
7.	Deferred Income		
8.	Other Current Liabilities (Specify) ____________		
	____________		
9.	TOTAL CURRENT LIABILITIES		$ -

B. LONG-TERM LIABILITIES

1.	Mortgages Payable Over one year	$ -		
2.	Notes Payable Over one year			
3.	Unsecured Loans			
4.	Other Long-term Liabilities (Specify) ____________			
	____________			
5.	TOTAL LONG-TERM LIABILITIES		$ -	
				$ -

FUND BALANCE

1.	Unrestricted	$ -	
2.	Restricted (Specify)____________		
	____________		
3.	Other ____________		
	TOTAL FUND BALANCE		$ -

TOTAL LIABILITIES AND FUND BALANCE $ -

BALANCE SHEET
(Prior Period)

Medicaid Provider No. ______________________ FYE: __________

ASSETS

A. CURRENT ASSETS

1. Cash on Hand and in Bank		______
2. Short-Term Investments		______
3. Accounts Receivable	______	
4. Notes Receivable	______	
5. Less: Allowance for Uncollectible Accounts and Notes Receivable	______	______
6. Inventories		______
7. Prepaid Expenses		______
8. Other Current Assets (Specify)		
______		______
______		______
9. TOTAL CURRENT ASSETS		$ -

B. PROPERTY, PLANT AND EQUIPMENT

	COST	ACCUM DEPR.	BOOK VALUE	
1. Land	______		______	
2. Buildings	______	______	______	
3. Leasehold Imp.	______	______	______	
4. Movable Equipment	______	______	______	
5. Motor Vehicles	______	______	______	
6. Other Fixed Assets (Specify)	______	______	______	
______	______	______	______	
______	______	______	______	
7. TOTAL PROPERTY, PLANT AND EQUIPMENT				$ -

C. OTHER ASSETS (if any)

1. Deposits	______	
2. Long-Term Investments	______	
3. Special Funds	______	
4. Other (Specify) ______	______	
______	______	
5. TOTAL OTHER ASSETS		$ -

TOTAL ASSETS $ -

BALANCE SHEET
(Prior Period)

Medicaid Provider No. ____________________ FYE: ____________

LIABILITIES

A. **CURRENT LIABILITIES**

1.	Accounts Payable	______	
2.	Mortgages Payable within one year	______	
3.	Notes and Loans Payable one year	______	
4.	Salaries and Wages Payable	______	
5.	Payroll Taxes Payable	______	
6.	Accrued Taxes	______	
7.	Deferred Income	______	
8.	Other Current Liabilities (Specify) ______	______	
	______	______	
9.	TOTAL CURRENT LIABILITIES		$ -

B. **LONG-TERM LIABILITIES**

1.	Mortgages Payable Over one year	$ -		
2.	Notes Payable Over one year	______		
3.	Unsecured Loans	______		
4.	Other Long-term Liabilities (Specify) ______	______		
	______	______		
5.	TOTAL LONG-TERM LIABILITIES		$ -	
				$ -

FUND BALANCE

1.	Unrestricted	______	
2.	Restricted (Specify) ______	______	
	______	______	
3.	Other ______	______	
	TOTAL FUND BALANCE		$ -

TOTAL LIABILITIES AND FUND BALANCE $ -

Appendix II

Myers & Stauffer Requests for Additional Information

Healthcare Business Specialists
Specializing in RHC reimbursement
Suite 214 502 Shadow Parkway Chattanooga, TN 37421
Email: marklynnrhc@gmail.com
Website: www.ruralhealthclinic.com
Telephone: (423) 243-6185

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

CERTIFIED MAIL

Dear [redacted]:

We have received the documentation you submitted on September 29, 2017. After reviewing your submission, we find that additional documentation is needed.

In accordance with 907 KAR 1:055 Section 4(3), we are requesting that certain items be sent to us within thirty (30) calendar days for initial assessment and preliminary review to determine if any additional supporting documentation is needed. All requested items must be received **in their entirety** prior to the deadline or the response will be considered incomplete and appropriate sanctions will be applied. If information is not received within thirty (30) days, the Department for Medicaid Services shall reimburse your facility based on the Medicaid physician fee schedule applied to physician services pursuant to 907 KAR 3:010 until a final rate has been established.

Please do not send Myers and Stauffer LC any Protected Health Information (PHI) unless specifically requested. As required by law and only when requested, send only the minimum amount necessary. We request that any email, including all attachments, and/or fax should be transmitted securely in a file that is both encrypted and password protected. You may also send information containing PHI on an encrypted password-protected CD or DVD by U.S. mail or other secure mail carrier. As a contractor to the State, Myers and Stauffer must comply with various state and federal laws, including the Health Insurance Portability and Accountability Act (HIPAA) to prevent inappropriate use and/or disclosure. We appreciate your assistance in safeguarding protected data.

All items may be e-mailed to crdoco@mslc.com or a hard copy sent to:

RHC/FQHC Unit
Myers and Stauffer LC
150 Flynn Avenue, Suite 200
Frankfort, KY 40601

Should you have any questions regarding this project, please contact me at 502.695.6870 or 888.749.5799.

Sincerely,

Suzy Erfani
Staff Accountant

SE/ryc

Enclosure(s)

cc: David Dennis, Administrative Branch Manager, Department for Medicaid Services
George Hosfield, Department for Medicaid Services

Please forward the following items to Myers and Stauffer LC for preliminary review of your fiscal year ending April 30, 2017, cost report:

- Please provide a signed copy of the attached cost checklist.
- Please provide a depreciation schedule to support depreciation expense of $59,969.
- Please provide a signed copy of the attached "Certification by Officer or Administrator" from the as-submitted cost report.
- Please provide a copy of the facility's floorplan, labeled with the use of each room and square footage.
- According to Schedule C of the cost report, Title XIX Utilization is approximately 93%, please explain the reason for the facility having this proportion of Medicaid patients. Note 1
- According to the trial balance, there are **Legal & Accounting** fees of **$8,640.60**. Please provide an explanation of the nature and purpose of these fees, along with copies of the applicable invoices.
- Please provide backup documentation along with an explanation of the destination and purpose of the **Travel & Entertainment** expenses in the amount of **$3,944.82**. Note 2
- Please provide backup for the following cost report adjustments: Note 3
  - **Non-Allowable Expenses- $22,282.00**
- Please provide invoice support for the following expenses:
  - **Advertising:** Note 4
    - **02/02/2017 Tri State Outdoor- $950.00**
    - **02/23/2017 Bottom Sign Company- $1,315.00**
    - **05/17/2016 Pine Mountain Shopper- $195.00**
    - **10/19/2016 Berry- $99.00**
    - **04/19/2017 KVA Inc.- Movie Ad- $350.00**
  - **Repairs & Maintenance:**
    - **02/23/2017 Robert Carlson- $3,600.00**
    - **02/28/2017 M&B Complete Lawn Care- $1,245.00**
    - **04/25/2017 Ricky Browning- $1250.00**
    - **04/25/2017 M Lambert- $1,000.00**

- **Operating Supplies:**
  - **02/07/2017 McKesson- $4,098.10**
  - **02/28/2017 Ebsco Industries- $5,000.00**
  - **04/30/2017 Credit Card Sheet- $7,850.00**
  - **03/07/2017 Eclinical Works- $1,197.10**
  - **02/09/2017 JohnCo- $2,537.64**
- **Office Supplies:**
  - **05/02/2016 Stapes Credit Plan- $1,503.23**
  - **04/30/2017 Credit Card Sheet- $3,386.89**
  - **04/30/2017 Credit Card Sheet- $15,092.37**
  - **01/19/2017 Office of Inspector General- $500.00**
- **Meals:**
  - **11/21/2016 Cash-Food- $58.55**
  - **04/30/2017 Credit Card Summary- $412.98**
  - **04/30/2017 Credit Card Sheet- $1,575.28**
- **Telephone:**
  - **05/02/2016 Windstream- $490.72**
  - **07/01/2016 AT&T- $318.53**

- The working trial balance contains an expense for **Car Leases** in the amount of **$9,488.96**. Please describe the business use of these vehicles along with any mileage logs available. Additionally, please provide a copy of the lease agreement or invoice support.

Note 5

- The working trial balance contains an expense for **Bank Charges** in the amount of **$1,350.00**. Please describe the nature and purpose of these expenses.

  - **01/31/2017 MTOT Disc- $78.09**
  - **04/30/2017 I PMT Essemthfee- $29.99**
  - **11/30/2016 Service Charge- $10.00**

- Please provide a description of the relationship of the facility with KMSF, UK Chandler Hospital, and UL Healthcare.

- Please explain the purpose of advertising expenses.

Note 6

- Does the owner perform any other functions for the clinic (admin, etc.)? Please provide time and salary allocations for all functions.

- On the submitted cost report there is a reclassification for laboratory salaries and square footage for laboratory is provided, however there are no

allocations for laboratory expenses. Please answer the following questions regarding the clinic's laboratory:

- What types of labs are performed by the clinic?
- Are there any labs which are sent out for analysis?
- If so, does the outside laboratory bill Medicaid?
- Please provide an allocation for laboratory expenses.
- How many lab procedures were performed at the facility?

- Schedule C indicates total **Medical and Nursing Services** visits as **4,670**, please provide a breakdown of these visits for each individual provider.

- Please provide us with the number of hours worked by each medical provider during the cost report period.

- Salaries on Schedule A are **$462,769** which tie to salaries on Schedule A-4, Schedule of Staffing Costs, however, salaries on the supporting documentation are **$485,699**. Please explain or provide documentation for this variance.

Note 7

- Please provide copies of contracts or lease agreements for any contractual agreement greater than **$10,000.**

- Please attach documentation supporting the specific specialties of the physicians and APRN's employed by your facility.

- Please provide detail on the medical director position (name, FTE's, annual hours, verification of licensure, medical specialty, and salary).

- Please answer the following questions related to vaccinations. Please segregate vaccine expenses related to children from those related to adults, in the Expense Amount Column.
  - **For children,** please review the attached table and disclose your expenses related to only the vaccinations listed. Please provide the trial balance account/cost report line they are associated with on the Universal Cost Report.
  - **For adults,** please disclose the amount of **all** vaccinations for adults, as well as the trial balance account in which these expenses are included. Please separately identify adult flu vaccinations.

0
7

CPT Code	Vaccine	Expense Amount	Trial Balance Account/ Cost Report Line
90460	IM Admin 1st/Only Component		
90461	IM Admin Each Addl Component		
90471	Immunization Admin		
90472	Immunization Admin Each Add		
90473	Immune Admin Oral/Nasal		
90474	Immune Admin Oral/Nasal Addl		
90620	Menb Pr w/OMV Vaccine		
90621	Menb RLP Vaccine		
90630	Vaccine for Influenza for Injection into Skin		
90632	HEP A-Vaccine Adult IM		
90633	Hep A Vacc Ped/Adol (2 dose)		
90634	Hep A Vacc Ped/Adol (3 dose)		
90636	Hep A/Hep B Vacc Adult IM		
90644	Meningoccl HIB Vac 4 Dose IM		
90645	Hemophilus Influenza B Vaccine (HIB), HBOC Conjugate (4 dose schedule)		
90646	HIB BOOSTER HIGH RISK CHILD		
90647	HIB Vaccine, Prp-Omp, IM (3 dose)		
90648	HIB Vaccine, Prp-T, IM (4 Dose)		
90649	HPV Vaccine, Types 6, 11, 16, 18 (Quadrivalent		
90650	Vaccine for Human Papilloma Virus (3 Dose schedule) Injection into muscle		
90651	Vaccine for Human Papilloma Virus (3 Dose schedule) Injection into muscle		
90654	Flu vaccine No Preserv ID		
90655	FLU-No Preserv 6-35 M		
90656	Flu Vaccine No Preserv 3 >		
90657	Flu Vaccine, 3 Yrs, IM		
90658	Flu (Fluvirin) 3yrs>, Im		
90660	Flu Vaccine, Nasal		
90661	Flu vacc cell cult Prsv Free		
90662	Flu Vacc Prsv Free Inc Antig		
90669	Pneumococcal Vacc, Ped <5 (PNU 7)		
90670	Pneumococcal Vacc, Ped <5 (PNU 13)		

0
7

CPT Code	Vaccine	Expense Amount	Trial Balance Account/ Cost Report Line
90672	Flu Vaccine 4 Valent Nasal		
90673	Flu Vacc Riv3 No Preserv		
90680	Rotavirus Vacc 3 Dose, Oral		
90681	Rotavirus Vacc 2 Dose Oral		
90685	Flu Vac No Prsv 4 Val 6-35 M		
90686	Flu Vac No Prsv 4 VAL 3 Yrs+		
90688	Flu Vac 4 Val 3 Yrs Plus IM		
90696	Kinrix Dtap-Ipv Vaccine 4-6 yr IM		
90698	Pentacel Dtap-Hib-Ip Vacine, IM		
90700	Dtap vaccine, <7 Yrs, IM		
90702	DT Vaccine, <7 Yrs, Im		
90703	Tetanus Vaccine, IM		
90707	MMR Vaccine, Sc		
90710	MMR-V Vaccine, Sc		
90713	Poliovirus, Ipv, Sc/Im		
90714	TD Vaccine No Prsrv 7/> IM		
90715	TDaP Vaccine >7 Im		
90716	VAR Chicken Pox Vaccine, Sc		
90720	Diphtheria, Tetanus Toxoids, and Whole Cell Pertussis Vaccine and		
90721	Diphtheria, Tetanus Toxoids, and Acellular Pertussis Vaccine and Hemop		
90723	DTAP-HepB-Ipv Vacine , Im		
90725	Cholera Vaccine for Injectable Use		
90732	Pneumococcal Vaccine		
90733	Meningococcal Vaccine, SC		
90734	Meningococcal Vaccine, IM		
90736	Zoster Vacc, SC		
90740	HEPB Vacc Ill Pat 3 Dose IM		
90743	HEP B Vacc, Adol, 2 Dose, IM		
90744	HEP B-PF Ped/Adol 3 dose Im		
90746	HEP B Vacc Adult 3 Dose IM		

Provider Name: ______
Provider Number: ____
Cost Report Period: ____

FEDERALLY QUALIFED HEALTH CARE/RURAL HEALTH CLINIC COST CHECKLIST

Do you have any of the following costs reported in your cost report for the time period indicated above? If yes, enter the amount and cost report line number.

	Yes/No	Amount	Line
a. Research costs	No		
b. Corporate reorganization costs	No		
c. Start-up costs	No		
d. Political and lobbying activities	No		
e. Social and fraternal organizational costs	No		
f. Labor union activities	No		
g. Public relations, fund raising, marketing, and advertising.	No		
h. Contributions	No		
i. Volunteer expense	No		
j. Lab Referrals	No		
k. Legal Fees	No		
l. Independent Contractor Physicians	No		

Provider Name: ____
Provider Number: __
Cost Report Period: ____________________

FEDERALLY QUALIFIED HEALTH CARE /RURAL HEALTH CLINIC COST CHECKLIST (CONTINUED)

Do you have any of the following cost reported in your cost report? If yes, enter the amount and cost report line number.

	Yes/No	Amount	Line
m. Physicians providing services at this clinic and also at a private practice?	No		
n. Bad Debt Expense	No		
o. Expenses related to shared resources with any of your affiliates	No		
p. Cost report prepared based on accrual or cash basis	Accrual (List accrual or cash)		

I hereby certify that I have examined the questions listed above and that, to the best of my knowledge and belief, they are true and correct based on the books and records of the provider listed above.

____
Name

____
Date

MYERS AND STAUFFER LC

CERTIFIED PUBLIC ACCOUNTANTS

DELIVERED VIA EMAIL

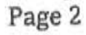
We have received the documentation you submitted on November 30, 2017. After reviewing your submission, we find that additional documentation is needed.

In accordance with 907 KAR 1:055 Section 4(3), we are requesting that certain items be sent to us within thirty (30) calendar days for initial assessment and preliminary review to determine if any additional supporting documentation is needed. All requested items must be received **in their entirety** prior to the deadline or the response will be considered incomplete and appropriate sanctions will be applied. If information is not received within thirty (30) days, the Department for Medicaid Services shall reimburse your facility based on the Medicaid physician fee schedule applied to physician services pursuant to 907 KAR 3:010 until a final rate has been established.

Please do not send Myers and Stauffer LC any Protected Health Information (PHI) unless specifically requested. As required by law and only when requested, send only the minimum amount necessary. We request that any email, including all attachments, and/or fax should be transmitted securely in a file that is both encrypted and password protected. You may also send information containing PHI on an encrypted password-protected CD or DVD by U.S. mail or other secure mail carrier. As a contractor to the State, Myers and Stauffer must comply with various state and federal laws, including the Health Insurance Portability and Accountability Act (HIPAA) to prevent inappropriate use and/or disclosure. We appreciate your assistance in safeguarding protected data.

All items may be e-mailed to crdoco@mslc.com or a hard copy sent to:

RHC/FQHC Unit
Myers and Stauffer LC
150 Flynn Avenue, Suite 200
Frankfort, KY 40601



Should you have any questions regarding this project, please contact me at 502.695.6870 or 888.749.5799.

Sincerely,

Tiffany Buchanan
Staff Accountant

TEB/ryc

Enclosure(s)

cc: David Dennis, Administrative Branch Manager, Department for Medicaid Services
George Hosfield, Department for Medicaid Services

Please provide the following items to Myers and Stauffer LC for preliminary review of your fiscal year ending December 31, 2014, cost report:

- Please provide a depreciation schedule that traces back to the trial balance depreciation item of **$13,036.**

- The Trial Balance contains **Legal & Accounting** fees in the amount of **$26,059.80**. Please provide account detail, as well as an explanation of the nature and purpose of this expense.

- The Trial Balance contains **Travel and Auto Expense** in the amount of **$12,769.57.** Please provide account detail and a narrative of the business purpose of these expenses. Additionally, please answer the following questions:
    - What is the percentage of personal use of these vehicles?
    - What was the purpose and destination for any of the travel expenses?

- Employee Bonus Payments of **$3,350.00** were included on the trial balance. Please answer the following questions regarding bonus payments:
    - How were the bonuses determined and what was the basis of the bonus (i.e. profit, productivity)
    - Were the bonuses given to all employees?
    - When were the bonuses paid?

Note 1

- Salaries on Schedule A are **$675,412** which tie to salaries on the trial balance, however, salaries on the payroll summary, are **$395,327**. Please explain or provide documentation for this variance.

Note 1

- Please provide detail on the medical director position (name, FTE's, annual hours, verification of licensure, medical specialty, and salary).

- Does the owner perform any other functions for the clinic (admin, etc.)? Please provide time and salary allocations for all functions.

- Please provide a copy of the following contracts, or lease agreements, as well as any contractual agreement greater than **$10,000**, including compensation agreements.
    - Building rental agreement
    - Office cleaning contract
    - Contract labor

- Schedule C indicates total **Medical and Nursing Services** visits of **7,160** and Title XIX visits of **5,777**. Please provide detailed documentation for the number of visits by physician by payor.

- Please provide backup documentation for the following expenses:
  - **Education & Training - $24,240.54**
  - **Equipment Lease - $17,514.60**
  - **Security - $8,307.04**
  - **Property Tax - $14,361.71**
  - **Computer Networking - $9,272.48**
  - **Rent - $45,553.69**
  - **Repairs & Maintenance - $18,426.83**
  - **Supplies - $93,633.60**
  - **Telephone Expense - $9,157.96**

- The submitted supporting documentation indicates that salaries were redistributed from medical to administrative for Tarek Husain, Dorrita Mullins, Eyad Albaree, and Ayman Albaree. Please provide support for making these adjustments.

- Please provide copies of the canceled checks payable to [illegible] totaling $30,000 and [illegible] totaling $25,000, for which adjustments were made to add these expenses to the cost report.

- Please provide support for the following adjustments made on Schedule A-1, invoices or canceled check copies are preferred. Additionally, please explain why these expenses were not reported on the facility's trial balance.
  - To Record Depreciation on Medical Equipment - $5,714
  - To Record Depreciation on X-Ray Machine - $2,500
  - To Record Legal Fees - $15,000
  - To Record Depreciation on Security Equipment - $1,113
  - To Record Depreciation on Improvements - $834
  - To Record Employee Benefits - $16,500
  - To Record Minor Movable Equipment - $4,500
  - To Record Minor Movable Construction Project - $6,750
  - To Record Office Supplies - $4,850

- Please answer the following questions related to vaccinations. Please segregate vaccine expenses related to children from those related to adults, in the Expense Amount Column.
    - **For children**, please review the attached table and disclose your expenses related to only the vaccinations listed. Please provide the trial balance account/cost report line they are associated with on the Universal Cost Report.
    - **For adults,** please disclose the amount of **all** vaccinations for adults, as well as the trial balance account in which these expenses are included. Please separately identify adult flu vaccinations.

CPT Code	Vaccine	Expense Amount	Trial Balance Account/ Cost Report Line
90460	IM Admin 1st/Only Component		
90461	IM Admin Each Addl Component		
90471	Immunization Admin		
90472	Immunization Admin Each Add		
90473	Immune Admin Oral/Nasal		
90474	Immune Admin Oral/Nasal Addl		
90620	Menb Pr w/OMV Vaccine		
90621	Menb RLP Vaccine		
90630	Vaccine for Influenza for Injection into Skin		
90632	HEP A-Vaccine Adult IM		
90633	Hep A Vacc Ped/Adol (2 dose)		
90634	Hep A Vacc Ped/Adol (3 dose)		
90636	Hep A/Hep B Vacc Adult IM		
90644	Meningoccl HIB Vac 4 Dose IM		
90645	Hemophilus Influenza B Vaccine (HIB), HBOC Conjugate (4 dose schedule)		
90646	HIB BOOSTER HIGH RISK CHILD		
90647	HIB Vaccine, Prp-Omp, IM (3 dose)		
90648	HIB Vaccine, Prp-T, IM (4 Dose)		
90649	HPV Vaccine, Types 6, 11, 16, 18 (Quadrivalent		
90650	Vaccine for Human Papilloma Virus (3 Dose schedule) Injection into muscle		
90651	Vaccine for Human Papilloma Virus (3 Dose schedule) Injection into muscle		
90654	Flu vaccine No Preserv ID		
90655	FLU-No Preserv 6-35 M		
90656	Flu Vaccine No Preserv 3 & >		
90657	Flu Vaccine, 3 Yrs, IM		
90658	Flu (Fluvirin) 3yrs>, Im		
90660	Flu Vaccine, Nasal		
90661	Flu vacc cell cult Prsv Free		
90662	Flu Vacc Prsv Free Inc Antig		
90669	Pneumococcal Vacc, Ped <5 (PNU 7)		
90670	Pneumococcal Vacc, Ped <5 (PNU 13)		
90672	Flu Vaccine 4 Valent Nasal		
90673	Flu Vacc Riv3 No Preserv		

CPT Code	Vaccine	Expense Amount	Trial Balance Account/ Cost Report Line
90680	Rotavirus Vacc 3 Dose, Oral		
90681	Rotavirus Vacc 2 Dose Oral		
90685	Flu Vac No Prsv 4 Val 6-35 M		
90686	Flu Vac No Prsv 4 VAL 3 Yrs+		
90688	Flu Vac 4 Val 3 Yrs Plus IM		
90696	Kinrix Dtap-Ipv Vaccine 4-6 yr IM		
90698	Pentacel Dtap-Hib-Ip Vacine, IM		
90700	Dtap vaccine, <7 Yrs, IM		
90702	DT Vaccine, <7 Yrs, Im		
90703	Tetanus Vaccine, IM		
90707	MMR Vaccine, Sc		
90710	MMR-V Vaccine, Sc		
90713	Poliovirus, Ipv, Sc/Im		
90714	TD Vaccine No Prsrv 7/> IM		
90715	TDaP Vaccine >7 Im		
90716	VAR Chicken Pox Vaccine, Sc		
90720	Diphtheria, Tetanus Toxoids, and Whole Cell Pertussis Vaccine and		
90721	Diphtheria, Tetanus Toxoids, and Acellular Pertussis Vaccine and Hemop		
90723	DTAP-HepB-Ipv Vacine , Im		
90725	Cholera Vaccine for Injectable Use		
90732	Pneumococcal Vaccine		
90733	Meningococcal Vaccine, SC		
90734	Meningococcal Vaccine, IM		
90736	Zoster Vacc, SC		
90740	HEPB Vacc Ill Pat 3 Dose IM		
90743	HEP B Vacc, Adol, 2 Dose, IM		
90744	HEP B-PF Ped/Adol 3 dose Im		
90746	HEP B Vacc Adult 3 Dose IM		
90747	HEP B Vacc Ill Pat 4 Dose IM		
90748	HEP B/HIB Vaccine, Im		

Appendix III

Depreciation Regulations

Healthcare Business Specialists
Specializing in RHC reimbursement
Suite 214 502 Shadow Parkway Chattanooga, TN 37421
Email: marklynnrhc@gmail.com
Website: www.ruralhealthclinic.com
Telephone: (423) 243-6185

RuralHealthClinic.com
Experienced Knowledge

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Telephone: (423) 243-6185

Medicare

Provider Reimbursement Manual - Part 1

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 433 | **Date: November 16, 2007**

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
Chapter 1 TOC	1-1 – 1-1.3 (4 pp.)	1-1 - 1-1.3a (5 pp.)
	-	1-1 – IM-86-1 (1 p.)
104 – 104.1	1-1.4 – 1-2 (2 pp.)	1-1.4 –1-2 (2pp.)
104.10 (Cont.) – 104.14 (Cont.)	1-2.5 – 1-2.8 (4 pp.)	1-2.5 –1-2.8 (4 pp.)
104.24 - 106	1.3.2 - 1.4 (2 pp.)	1.3.2 - 1.4 (2 pp.)
114 – 114.2	1-5.2 – 1-5.5 (4 pp.)	1-5.2 – 1-5.5 (4 pp.)
132.4 – 132.4 (Cont.)	1-13.12 – 1-13.15 (4 pp.)	1-13.12 – 1-13.15 (4 pp.)
134.3 (Cont.) – 134.4	1-17 – 1-18 (2 pp.)	1-17 – 1-18 (2 pp.)
136.10 – 136.11	1-31 – 1-32 (2 pp.)	1-31 – 1-32 (2 pp.)

NEW/REVISED MATERIAL--*EFFECTIVE DATE: N/A*

This transmittal updates Chapter 1, Depreciation to reflect a revised Table of Contents without page numbers; correction of typos; and the replacement of Fiscal Intermediary with Contractor. See below for explanation regarding significant revisions, and deletions of obsolete material.

TOC, IM-86-1 is deleted because it is obsolete, per Transmittal 8, chapter 1 of 15-2, July 1988.

Section 104.6, Land (Non-Depreciable), deletes "and return on equity capital under §§202.1 and 203 capital under §§1202.1 and 1218.12 (if applicable)." **Federal Register** §413.157 eliminated the allowance for a return on equity capital for outpatient services furnished on or after January 1, 1988; Chapter 12 will be made obsolete shortly.

DISCLAIMER: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged

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100. GENERAL

The principles of reimbursement for provider costs provide that payment for services should include depreciation on all depreciable type assets that are used to provide covered services to beneficiaries. This includes assets that may have been fully (or partially) depreciated on the books of the provider but are in use at the time the provider enters the program. The useful lives of such assets are considered not to have ended and depreciation calculated on a revised extended useful life is allowable. Likewise, a depreciation allowance is permitted on assets that are used in a normal standby or emergency capacity.

The three methods of prorating the cost of depreciable assets are: straight line, declining balance, and sum of the years' digits. For assets acquired after July 1970, however, the use of an accelerated method of depreciation is limited to a declining balance method not to exceed 150 percent of the straight-line rate under the criteria stated in §116C. The depreciation method used under the Medicare program for an asset need not correspond to the method used by a provider for non-Medicare purposes.

102. PRINCIPLES

An appropriate allowance for depreciation on buildings and equipment is an allowable cost. The depreciation must be: (a) identifiable and recorded in the provider's accounting records; (b) based on the historical cost of the asset as defined in §104.10 or, in the case of donated assets, the lesser of the fair market value or the net book value at the time of donation (see §114.2); and (c) prorated over the estimated useful life of the asset using an allowable method of depreciation as described in §116.

Depreciation on assets being used by a provider at the time it enters into the title XVIII program is allowed. This applies even though such assets may be fully or partially depreciated on the provider's books.

For all assets acquired before 1966, the provider, at its option, may choose an allowance for depreciation based on a percentage of operating costs. The operating costs to be used are the lower of the provider's 1965 operating costs or the provider's current year's allowable costs. The percent to be applied is 5 percent starting with the year 1966-67, with such percentage being uniformly reduced by one-half percent each succeeding year. The allowance based on operating costs is in addition to a regular depreciation on assets acquired after 1965. However, when the optional allowance is selected, the combined amount of such allowance on pre-1966 assets and the straight-line depreciation on assets acquired or rented after 1965 may not exceed 6 percent of the provider's allowable cost for the current year.

Depreciation is allowed on assets financed with Hill-Burton or other Federal or public funds.

104. DEFINITIONS

Depreciation is that amount which represents a portion of the depreciable asset's cost or other basis which is allocable to a period of operation. The amount of depreciation is determined by the provider's method of depreciation accounting.

The American Institute of Certified Public Accountants defines depreciation as a process of cost allocation:

"Depreciation accounting is a system of accounting which aims to distribute the cost or other basic value of tangible capital assets, less salvage (if any), over the estimated useful life of the unit (which may be a group of assets) in a systematic and rational manner. It is a process of allocation, not of

valuation. Depreciation for the year is the portion of the total charge under such a system that is allocated to the year."

104.1 Depreciable Assets.--Assets that a provider has an economic interest in through ownership (regardless of the manner in which they were acquired) are subject to depreciation. Generally, depreciation is allowable on the assets described below when required in the regular course of providing patient care. Assets which a provider is using under a regular lease arrangement would not be subject to depreciation by the provider. (See §110 on lease-purchase and sale-lease-back agreements.)

In general, assets subject to depreciation are described in the AHA Chart of Accounts for Hospitals, M-58, 15M-8/66-183305, and for the most part are also subject to depreciation for Medicare purposes. However, see the treatment of minor equipment as described below.

104.2 Buildings.--Building includes, in a restrictive sense, the basic structure or shell and additions thereto. The remainder is identified as building equipment.

104.3 Building Equipment.--Building equipment includes attachments to buildings, such as wiring, electrical fixtures, plumbing, elevators, heating system, air conditioning system, etc. The general characteristics of this equipment are: (a) affixed to the building, and not subject to transfer; and (b) a fairly long life, but shorter than the life of the building to which affixed. Since the useful lives of such equipment are shorter than those of the buildings, the equipment may be separated from building cost and depreciated over this shorter useful life.

104.4 Major Moveable Equipment.--The general characteristics of this equipment are: (a) a relatively fixed location in the building; (b) capable of being moved as distinguished from building equipment; (c) a unit cost sufficient to justify ledger control; (d) sufficient size and identity to make control feasible by means of identification tags; and (e) a minimum life of approximately three years. Major moveable equipment includes such items as accounting machines, beds, wheelchairs, desks, vehicles, x-ray machines, etc.

104.5 Minor Equipment.--The general characteristics of this equipment are: (a) in general, no fixed location and subject to use by various departments of the provider's facility; (b) comparatively small in size and unit cost; (c) subject to inventory control; (d) fairly large quantity in use; and, (e) generally, a useful life of approximately 3 years or less. Minor equipment includes such items as waste baskets, bed pans, syringes, catheters, silverware, mops, buckets, etc.

104.6 Land (Non-Depreciable).--Land (non-depreciable) includes the land owned and used in provider operations. Included in the cost of land are the costs of such items as off-site sewer and water lines, public utility charges necessary to service the land, governmental assessments for street paving and sewers, the cost of permanent roadways and grading of a non-depreciable nature, the cost of curbs and sidewalks whose replacement is not the responsibility of the provider, and other land expenditures of a non-depreciable nature. Although land used in the provision of patient care activities is a capital asset, the cost of which is neither depreciable nor amortizable under any circumstances, the historical cost limitations described in §104.10 apply to the valuation of land for purposes of determining allowable interest expense under §§202.1 and 203.

E. For Depreciable Assets Acquired By All Providers On or After December 1, 1997. -- The historical cost of the asset to the acquirer will be the historical cost less depreciation allowed to the owner of record as of August 5, 1997 (or if an asset did not exist as of August 5, 1997, the first owner of record after August 5, 1997). The asset moves from the hands of the seller to the hands of the buyer at the *assets* net book value defined in §104.23. For purposes of this section, the following apply:

1. An asset that was not in existence as of August 5, 1997 includes an asset that physically existed but was not owned by a provider participating in the Medicare program as of that date.

2. The historical cost to the owner of record is subject to the limitation on historical costs described in section B through D of this section, and is reduced by any depreciation taken by the owner of record. The limitation on historical cost is also applied to the purchase of land, which is a capital asset that is neither depreciable nor amortizable under any circumstances. (See §200 ff for application of the limitation to the cost of land for purposes of determining the allowable interest expense.)

3. Historical cost to the owner of record includes the costs of betterments or improvements that extend the estimated useful life, increase the productivity, or significantly improve the safety of an asset. (See §108.2.)

4. For assets acquired prior to a provider's entrance into the Medicare program, the historical cost to the owner of record is the historical cost when acquired, rather than when the provider entered the program.

5. For assets subject to the optional depreciation allowance as described in §413.139, the historical cost to the owner of record is the historical cost established for those assets when the provider changed to actual depreciation as described in §124. If the provider did not change to actual depreciation, as described in §126, for optional allowance assets, the historical cost to the owner of record is based on the provider's recorded historical cost of the asset when acquired. If the provider has no historical cost records for optional allowance assets, the historical cost to the owner of record is established by appraisal.

6. The historical cost of an asset acquired by hospitals and SNFs on or after July 18, 1984 and by all providers on or after December 1, 1997 may not include costs attributable to the negotiation or settlement of the sale or purchase (by acquisition, merger, or consolidation) of any capital asset for which any payment was previously made under the Medicare program. The costs to be excluded include, but are not limited to, appraisal costs (except those incurred at the request of the intermediary under §132.A.1), legal fees, accounting and administrative costs, travel costs, and the costs of feasibility studies. If payment was made for even one cost of this type, all costs of this type must be excluded from the historical cost and are not otherwise allowable.

NOTE: The change in §1861(v)(1)(O) of the Act as amended by §4404 of the Balanced Budget Act (Pub. L. 105-33) has no effect on the recovery of accelerated depreciation as described in §136.

EXAMPLE 1: An SNF was constructed in 1990 for $25 million by Walter and certified for Medicare participation. It was sold in 1995 for $30 million to Ed. Because of the limitations in C. above, the allowable acquisition cost to Ed is $25 million. Ed sells the SNF in 1998 for $30 million to Zelda. Zelda financed the transaction with $5 M in cash and $25 M in bonds. The limitation on the selling price is determined as follows:

Historical Cost to Ed	$25 million
Salvage Value	$ 1 million
Estimated useful life	32 years
Depreciation	
$25 M - $1 M = $24 M	
$24 M) 32 =	$750,000 per year
Depreciation claimed	$2, 250,000
Net Book Value on Ed's books	$22,750,000

There will be no gain or loss on the transaction to Ed. The historical cost to Zelda is $22,750,000. Zelda's allowable interest expense will be limited to the interest on $22,750,000, less the $5,000,000 paid in cash, or $17,750,000.

EXAMPLE 2: In 1995 Mary buys an SNF for $55 million from Peter who has owned and operated it under the Medicare program since it was built in 1990. The SNF cost $50 million to build and its net book value on Pete's books is $45 million. The allowable acquisition cost to Mary is $50 million. Mary continues to operate it as a Medicare provider and depreciates it at $1,250,000 a year.

In 1998 Mary converts it to a noncertified nursing home. At that time her net book value is $46,250,000. She operates it as such until 1999. She sells it to Paul at the end of 1999 for $55 million. Her net book value at the date of sale is $45 million. Paul has it certified for Medicare participation in 2000. Paul's basis is $45 million, less depreciation taken since his date of purchase.

EXAMPLE 3: In 1990, Sam builds a hospital at the cost of $14 million. He operates it as a nonparticipating hospital until 1998. At that time he sells it for $18 million to Melvin. Melvin makes improvements totaling $3 million and the hospital is certified for Medicare participation in 1999. In 2001 he sells the hospital to Hal for $30 million. The net book value on Melvin's books is $18.4 million. There is no gain or loss on the sale. The historical cost to Hal is $18.4 million.

EXAMPLE 4: Michael buys a SNF in 1983 for $20 million. He operates it as a Medicare certified facility until 1999, at which time he sells it to Warren for $6 million. The net book value at the date of sale is $9 million. There is no gain or loss on the sale. The historical cost to Warren is $9 million.

104.11 Historical Cost - Trade-Ins.--When an asset is acquired by trading-in an asset that was depreciated under the program, the cost of the new asset is the sum of the undepreciated cost (or fair market value if no cost is assigned) of the asset traded-in and any cash or other assets transferred or to be transferred to acquire the new asset. However, if the asset disposed of was acquired by the provider before its participation in the Medicare program and the sum of the undepreciated cost and the cash or other assets transferred or to be transferred exceeds the list price or fair market value of the new asset, the historical cost of the new asset is limited to the lower of its list price or fair market value.

For assets having no historical or appraisal values assigned, the cost basis is the fair market value at the date of disposal of the old asset plus the sum paid but not to exceed the lower of the list price or fair market value of the new asset.

104.12 Appraisals.--For Medicare purposes, the term "appraisal" refers primarily to the process of establishing or reconstructing the historical cost, fair market value or current reproduction cost of an asset. It includes a systematic, analytic determination and the recording and analyzing of property facts, rights, investments, and values based on a personal inspection and inventory of the property. *(See §134 ff.)*

A. Appraisal Date.--The date selected for establishing the value of fixed assets is called the appraisal date. For example, if December 31, 1967, was established as the appraisal date and the actual physical inventory of fixed assets was taken in February 1968, any additions or dispositions of fixed assets between December 1967 and February 1968 must be taken into account in the appraisal values.

B. Appraised Book Value.--The book value of an asset at the appraisal date is its appraised cost as of the date of acquisition less accumulated depreciation computed on any approved basis up to the appraisal date.

C. Appraisal Expert.--An appraisal expert means an individual or a firm that is experience and specialized in multi-purpose appraisal of plant assets involving the establishing or reconstructing of the historical cost, fair market value, or current reproduction cost of such assets; employs a specially trained and well supervised staff with a complete range of appraisal and cost construction techniques; is experienced in appraisals of plant assets used by providers; and demonstrates a knowledge and understanding of the regulations involving reimbursement principles, particularly those pertinent to depreciation.

104.13 Lease-Purchase Assets.--If a lease is a virtual purchase as described in §110.B and the lessee becomes the owner of the leased asset, the historical cost of the asset is the sum of the deferred charge (the difference between the amount of the rent paid and the amount of rent allowed as rental expense) and any additional payments made to acquire the assets, subject to the limitation on revaluation of assets. (See §110.B.2.)

104.14 Purchase of Facility as Ongoing Operation.--

A. The historical cost of assets when an ongoing facility is purchased through a bona fide sale is determined as follows:

1. For depreciable assets acquired after July 1, 1966, and prior to August 1970, the sale price or portion thereof attributable to the asset must not exceed the fair market value of the asset at the time of the sale.

2. For depreciable assets acquired after July 1970 and in the case of hospitals and SNFs, before July 18, 1984, the historical cost must not exceed the lowest of (1) the acquisition cost of the asset to the new owner, (2) the current reproduction cost adjusted for straight-line depreciation over the life of the asset to the time of the purchase, or (3) the fair market value at the time of the purchase. (See §104.15.)

3. For depreciable assets acquired by hospitals or SNFs on or after July 18, 1984, and not subject to an enforceable agreement, the limitations on historical cost specified in §104.10.C are applicable.

4. For depreciable assets acquired by all providers on or after December 1, 1997, the limitations on historical cost specified in §104.10.E are applicable.

B. For changes of ownership on or after December 1, 1997, no gain or loss is recognized on the sale. For changes of ownership before December 1, 1997, the basis for determining the gain or loss to the seller when the facility was being operated under the program at the time of sale is the sales price.

For assets acquired prior to July 1970, the sale price used by the seller in computing gain or loss for the final cost report must agree with the historical cost used by the new provider in computing depreciation.

For an asset acquired after July 1970, the basis for computing gain or loss to the seller is the sales price without regard to any limitation on the basis for depreciation to the buyer as described in §104.10. (See example 5 in §104.10.C.)

The gain or loss on the sale of each depreciable asset must be determined by allocating the lump sum sale price among all the assets sold (including land, goodwill, and any assets not related to patient care), in accordance with the fair market value of each asset as it was used by the provider at the time of sale. If the buyer and seller cannot agree on an allocation of the sale price, or if they do agree but there is insufficient documentation of the current fair market value of each asset, the intermediary for the selling provider must require an appraisal by an independent appraisal expert to establish the fair market value of each asset and must make an allocation of the sale price in accordance with the appraisal. (See §134 ff.) In any case, the sale price must be allocated among all the assets sold, even when, for example, some of the assets will be disposed of shortly after the sale.

C. If a purchaser cannot demonstrate that the sale was bona fide, the seller's net book value must be used by the purchaser as the basis for depreciation of the asset. In such a case, the purchaser must record the historical cost and accumulated depreciation of the seller recognized under the program, and these are considered as incurred by the purchaser for program purposes, such as application of §§132 ff. (See §1011.4 if related organizations are involved.)

104.15 Fair Market Value.--Fair market value is the price that the asset would bring by bona fide bargaining between well-informed and unrelated buyers and sellers at the date of acquisition. Usually the fair market is the price at which bona fide sales have been consummated for assets of like type, quality, and quantity in a particular market at the time of acquisition.

104.16 Donated Assets.--An asset is considered donated when the provider acquires the asset without making any payment for it in the form of cash, property, or services. When the provider makes any such payment in acquiring the asset, if the payment is less than the fair market value, then

104.19 Salvage Value - Depreciable Assets.--Salvage value is the estimated amount expected to be realized upon the sale or other disposition of the depreciable asset when it is no longer useful to the provider. The amount is ordinarily estimated at the time of acquisition and, except for the declining balance method, is deducted from the cost of the depreciable property to arrive at the basis for depreciation. For example, an asset is purchased for $17,000 with an expected salvage value of $2,000. The basis for depreciation becomes $15,000 (i.e., $17,000 less $2,000) for computing the depreciation.

Thus, if a provider disposes of its assets when they are in good operating condition, the salvage value is higher than it might be if the provider used the assets until their inherent life had been substantially exhausted. Virtually all assets have a salvage value substantial enough to be included in calculating depreciation, and only in the rare instance is salvage value so negligible that it may be ignored.

For assets acquired on or after December 1, 1997, and subject to the historical cost limitation in 104.10E and 104.14A.4, salvage value need not be taken.

104.20 Scrapping.--Scrapping is the physical removal from the provider's premises of tangible personal property which is no longer useful for its intended purpose and is only salable for its scrap or junk value.

104.21 Abandonment.--Abandonment means the permanent retirement of an asset for any future purpose, not merely the provider's ceasing to use the asset for patient care purposes. To claim an abandonment under the program, the provider must have relinquished all rights, title, claim, and possession of the asset with the intention of never reclaiming it or resuming its ownership, possession, or enjoyment.

104.22 Demolition.--The deliberate destruction of a building or other asset resulting in the complete loss of economic value (other than the scrap value) of the asset.

104.23 Net Book Value.--The net book value of the asset is defined as the historical cost under the program less the depreciation recognized under the program.

104.24 Bona Fide Sale.--A bona fide sale contemplates an arm’s length transaction between a willing and well informed buyer and seller, neither being under coercion, for reasonable consideration. An arm’s-length transaction is a transaction negotiated by unrelated parties, each acting in its own self interest.

106. METHODS FOR WRITING OFF COST OF MINOR EQUIPMENT

Except where prohibited by §108, a provider may treat the cost of the minor equipment needed to operate its facility in any one of the following methods:

(a) The original investment in this equipment is not amortized or depreciated. Any replacements to the base stock are charged to operating expenses. The investment in the base inventory of equipment is adjusted when there is a significant change in the inventory size. For example:

Provider Fiscal Year - July 1 to June 30

Provider Entered Program - July 1, 1966

Original Cost of Minor Equipment in Use at July 1, 1966 - $15,000

Purchases During FY July 1, 1966, to June 30, 1967 ------ $10,000

Minor Equipment Inventory Value at June 30, 1967 ------- $20,000
(Determined for this example to be a significant change in inventory size)

Charges to operating expense in FY ended June 30, 1967, are $5,000. (Purchases of $10,000 less increase in inventory value of $5,000)

(b) The net book value of such items at the time the provider enters the program may be written off ratably over 3 years; that is, one third of the net book value is written off each year. Net book value is the historical cost less previous write-off. The previous write-off should have been computed on the basis of not more than a 3-year life and in equal amounts. A full one-third write-off should have been made in the year of acquisition. If the computation had been based on longer life or a different rate, or both, or if the equipment has been previously written off directly through charges to operating expense, the net book value at the time the provider enters the program is amortized applying a 3-year basis. Thus, any asset over 3 years old, although still in use, is not included. Under this method, any new purchases are also written off ratably over a 3-year period. For example:

Provider Fiscal Year - January 1 to December 31

Provider Entered Program - January 1, 1967

Purchase Date	Acquisition Cost of Minor Equipment in Use on 1/1/67		Recomputed Write-Off To 1/1/67		Net Book Value As Of 1/1/67
1965	$9,000	minus	$6,000	equals	$3,000
1966	6,750	minus	2,250	equals	4,500
				Total	$7,500

Write-Off allowed on above equipment:
1967 - $2,500
1968 - $2,500
1969 - $2,500

facility" in *§1819(j)* of the Act, the full circumstances under which it proposes to provide services to beneficiaries on a reasonable cost basis must be reviewed and weighted by the regional office to assure compliance with the Act. Preferably, this is done before an agreement is entered into. However, the certification ordinarily can only be made based upon the on-going operation in order to assure compliance.

113.2 Reimbursement.--When an entire facility or a skilled nursing care distinct-part has been leased by a provider under an arrangement whereby the lessor operates and furnishes essential services, and the lessee requires payments to the lessor that are not representative of the actual cost of the facilities or services furnished by the lessor, the program does not recognize such payments for reimbursement purposes. The program reimburses the lessee only on the basis of the lessor's reasonable costs of furnishing the services. Generally speaking, this involves two cost finding processes - one for the lessor, which requires a determination of cost attributable to the leased distinct-part of the entire facility, if applicable; and one for the lessee's actual operation. The lessor's costs are determined under the Medicare reimbursement principles except that there are no provisions for (1) owner's compensation, or (2) return on equity capital. However, these times are appropriately recognized in the cost finding procedure for the lessee. In addition, any costs for duplicate identifiable services between the lessor and lessee must be eliminated from the lessor's cost.

114. BASIS FOR DEPRECIATION

A. New Assets.--The basis for depreciation of new assets under the straight-line (see §116.1) and the sum-of-the-years' digits (see §116.2) methods is the historical cost of the asset less its salvage value. For the historical cost of donated assets, see §104.16. Section 116B explains the conditions under which the sum-of-the-years' digits method may be used.

Under the declining balance method (see §116.3), the basis for depreciation is the historical cost only. Sections 116B and C explain the applicability and limitation of the use of the declining balance method.

B. Assets Partially or Fully Depreciated on Provider's Books When Provider Enters Program.--For assets that are fully or partially depreciated on the provider's books when the provider enters the program, the basis for depreciation under the straight-line (see §116.1) and the sum-of-the-years' digits (see §116.2) methods is the adjusted historical cost, as defined below, less the salvage value. Section 116B explains the conditions under which the sum-of-the-years' digits method may be used.

Under the declining balance method (see §116.3), the basis for depreciation is the adjusted historical cost only. Sections 116B and C explain the applicability and limitation of use of the declining balance method.

The adjusted historical cost of an asset that is in use when the provider enters the program is its historical cost reduced by the depreciation accumulated up to the date of entrance into the program. Accumulated depreciation for this purpose may be determined on a straight-line basis (regardless of the depreciation method used or in use by the provider) and based on an estimate of the asset's useful life, taking into account past and current information.

When a provider enters the program, it has an opportunity to revise the useful life of its assets taking into account past and current information, subject

to the approval of the intermediary. For example, if an asset currently in use has been fully depreciated on the provider's books, it would be evident that the asset's useful life has not ended. Consequently, a new estimate of the asset's useful life, based on current information, may be made.

When the useful life of an asset is revised, the adjusted historical cost is based on the historical cost reduced by the revised accumulated depreciation based on the new estimate of the asset's useful life. The revised depreciation may be determined on a straight-line basis regardless of the depreciation method used or in use by the provider. The amount of depreciation on the provider's books is not *to be* considered in the determination.

The following illustrates how the basis for depreciation is determined for used assets when a provider enters the program and revises the useful life of an asset.

FACTS

The provider entered the program on July 1, 1993	
Asset acquired on July 1, 1987.	
Original estimated useful life is 8 years.	
Historical cost of the asset	$1,500,000
Estimated salvage value	$100,000
Accumulated depreciation on the provider's books, using the straight line method of depreciation	$1,050,000

When the provider entered the program, it reevaluated the useful life of the asset and estimated that its useful life was 12 years from the date of acquisition. The intermediary approved the change. The basis for depreciation under the program is determined as follows:

Step 1. Determine adjusted historical cost:

Historical cost	$1,500,000
Less estimated salvage value	100,000
Basis for computing revised accumulated deprecation	$1,400,000
Revised accumulated depreciation (6/12 x $1,400,000)	$700,000
Adjusted historical cost:	
Historical cost	$1,500,000
Less revised accumulated depreciation	700,000
Adjusted historical cost	$800,000

Step 2. Determine basis for depreciation under the program:

Using the straight-line method:	
Adjusted historical cost	$800,000
Less estimated salvage value	100,000
Basis for depreciation	$700,000

NOTE: The method of determining the accumulated depreciation and the adjusted historical cost for depreciation under the program is the same, regardless of the method of depreciation previously used by the provider.

114.1 Transfer of Governmental Facilities.--

A. Intergovernmental Transfer of Facilities.--When assets are transferred from one governmental entity to another under appropriate legal authority, the basis for depreciation is determined as follows.

1. Bona Fide Sale.--The basis for depreciation in a bona fide sale is the historical cost subject to the following limitations.

a. For assets acquired by other than hospitals or SNFs after 1970 and before December 1, 1997, or for assets acquired by hospitals or SNFs after 1970 and before July 18, 1984, the historical cost incurred by the present owner in acquiring the asset under a bona fide sale must not exceed the lower of:

(1) The current reproduction cost adjusted for straight-line depreciation over the life of the asset to the time of the purchase; or

(2) Fair market value at the time of the purchase.

b. For assets acquired by hospitals or SNFs on or after July 18, 1984 (see §104.10.C) and before December 1, 1997, the historical cost cannot exceed the lower of:

(1) The allowable acquisition cost, for Medicare purposes, of the asset to the owner of record as of July 18, 1984 (or in the case of an asset not in existence as of July 18, 1984, the first owner of record of the asset after that date);

(2) The acquisition cost of the asset to the new owner; or

(3) The fair market value of the asset on the date of acquisition.

c. For assets acquired by all providers on or after December 1, 1997, the allowable acquisition cost to the acquirer will be the historical cost less depreciation allowed to the owner of record as of August 5, 1997. (See §104.10.E.)

2. Donation.--An asset is considered donated when a governmental entity acquires the asset without assuming the functions for which the transferor used the asset or without making any payment for it in the form of cash, property, or services. To determine the basis for depreciation of a donated asset, see §114.2.

3. If neither items 1 or 2 above applies, i.e., the transfer was solely to facilitate administration or to reallocate jurisdictional responsibility, or the transfer constituted a taking over in whole or in part of the function of one governmental entity by another governmental entity, the basis for depreciation is:

a. For an asset on which the transferor has claimed depreciation under the Medicare program, the transferor's basis under the Medicare program prior to the transfer. The method of depreciation used by the transferee may be the same as that used by the transferor, or the transferee may change the method. (Beginning August l, 1970, a provider may only change from an accelerated method or optional method to the straight-line method. See §120.)

b. For an asset on which the transferor has not claimed depreciation under the Medicare program, the cost incurred by the transferor in acquiring the asset (not to exceed the basis that would have been recognized had the transferor participated in Medicare program) less depreciation calculated on the straight-line basis over the life of the asset to the time of transfer.

B. Transfer of State Hospital to Nonprofit Corporation Without Monetary Consideration.--If a State transfers a hospital to a nonprofit corporation without monetary consideration on or after July 18, 1984, the depreciable basis of the assets to the new owner is the net book value of the assets as recorded on the State's books at the time of the transfer. For the purpose of this section, monetary consideration includes cash, new debt, and assumed debt.

114.2 Assets Donated to Provider.--Where an asset is donated to a provider as described in §104.16, the basis for depreciation is determined as follows.

1. Assets Not Used or Depreciated Under Medicare Program.--If an asset has never been used or depreciated under the Medicare program and is donated to a provider, the basis for the purpose of calculating depreciation and equity capital (if applicable) is the fair market value of the asset (see §104.15) at the time of donation.

2. Assets Used or Depreciated Under Medicare Program--If an asset has been used or depreciated under the Medicare program and is donated to a provider or when a provider acquires such assets through estate or intestate distribution, e.g., a widow inherits a skilled nursing facility upon the death of her husband and becomes the owner of a newly certified provider, the basis for the purpose of calculating depreciation and equity capital (if applicable) is *the lesser of:*

a. The fair market value at the time of donation; or

b. The net book value in the hands of the owner last participating in the Medicare program.

For donated assets, the basis for depreciation is determined as of the date of donation or the date of death, whichever is applicable. See §104.23 for determining net book value and §104.16 for determining fair market value of donated assets.

When the provider's records do not contain the fair market value of the donated assets as of the date of donation, an appraisal of such fair market value by a recognized appraisal expert is acceptable for depreciation and owner's equity capital purposes.

The provider furnishes its intermediary with information identifying the appraisal expert and type and method of appraisal to be used. The intermediary determines whether the contemplated appraisal is acceptable. *(See §134ff.)*

Allocation of Net Depreciation Adjustment to Each Reporting Period Under the Program.--

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year Ending	Actual Depreciation Taken	Recomputed Depreciation	Excess Depreciation (2) - (3)	Gain on Sale	Net Depreciation Adjustment (4) + (5)
6/30/69	$ 20,000	$ 10,500	$ 9,500	$ 700	$ 10,200
6/30/70	19,000	10,500	8,500	700	9,200
6/30/71	18,000	10,500	7,500	700	8,200
6/30/72	17,000	10,500	6,500	700	7,200
6/30/73	16,000	10,500	5,500	700	6,200
Total	$ 90,000	$ 52,500	$ 37,500	$ 3,500	$ 41,000

D. Allocation Where the Provider is Subject to Capital PPS for Some Reporting Periods Under the Program.--After a hospital becomes subject to the capital PPS, the allocation of the net depreciation adjustment to each reporting period before and after the effective date of capital PPS must be in accordance with §2807.8.

132.4 Methods Available for Determination of Adjustment to Reimbursable Cost.--

A. Paragraph A of §132.3 describes the conditions under which a provider reflects the total net depreciation adjustment as an adjustment of depreciation in the year of disposal. Where these conditions are not met, a provider must first allocate the net depreciation adjustment to periods under the program in accordance with the provisions of paragraph B or C of §132.3. After the net depreciation for each reporting period under the program is determined:

1. The provider will compute the adjustment to reimbursable cost based upon the ratio of the program's share of reimbursable cost to total cost (see paragraph B).

2. On request of the provider, the intermediary may grant permission for the provider to compute the adjustment to reimbursable cost under the method described in paragraph C, if the provider can show that the direct costs of ancillary services furnished under arrangements in any cost reporting period, subject to recovery, are 10 percent or more of the direct costs of all ancillary services furnished.

3. Any provider may at its option compute the adjustment to reimbursable cost by recalculating, for each reporting period, all the necessary cost reporting schedules applicable to each reporting period covered by the depreciation adjustments. Schedules recomputed in accordance with this option must be submitted with the cost report for the cost reporting period in which the gain(s) or loss(es) giving rise to the depreciation adjustments took place.

The same method of computation must be used for all periods affected by the net depreciation adjustments that occur in the current reporting period.

B. Adjustment to Reimbursable Cost Based Upon the Ratio of the Program's Share of Reimbursable Cost to Total Cost.--The adjustment to reimbursable cost is computed by applying the ratio of Medicare reimbursable cost to total allowable cost for each period to the allowable portion of the net depreciation adjustment for that period. The Medicare reimbursable cost and total allowable cost includes inpatient services, nursing salary differential, outpatient and other Part B services, services provided by interns and residents not under an approved training program and ancillary services - Part B. Also, these amounts are gross allowable costs before deductibles and coinsurance billed to HI beneficiaries, return on equity capital, and the charge differential between semiprivate accommodations and less than semiprivate accommodations.

For each period under the program, that portion of the net depreciation adjustment which is applicable to nonallowable cost centers is excluded from the computation. The nonallowable portion is determined by multiplying the net depreciation adjustment for the period by the ratio of depreciation of nonallowable departments to the total depreciation claimed by the provider. See example in C below. To determine the effect on the Part B Trust Fund, the total adjustment to HI reimbursable cost for each period is multiplied by the ratio of Part B reimbursable cost to total reimbursable cost for each of the same periods. The difference between the adjustment to Part B Trust Fund will be the adjustment to Part A Trust Fund. The two examples below include no nonallowable cost centers.

Facts Applicable to Both Examples Below

Cost Report Period Ending	Total Allowable Cost	HI Allowable Cost	Percent HI Cost to Total Allowable Costs
6/30/69	$640,000	$320,000	50
6/30/70	$630,000	$252,000	40
6/30/71	$600,000	$120,000	20
6/30/72	$580,000	$104,000	18
6/30/73	$570,000	$ 85,500	15

Net Depreciation Adjustment Computed in §132.3B

Cost Report Period Ending	Percent HI Allowable Cost to Total Allowable Cost	Net Depreciation Adjustment	Adjustment to HI Reimbursable Cost
6/30/69	50	$ 9,020	$ 4,510
6/30/70	40	$ 8,610	$ 3,444
6/30/71	20	$ 8,200	$ 1,640
6/30/72	18	$ 7,790	$ 1,402
6/30/73	15	$ 7,380	$ 1,107
		$ 41,000	$ 12,103*

Net Depreciation Adjustments Computed in §132.3C

Cost Report Period Ending	Percent HI Allowable Cost to Total Allowable Cost	Net Depreciation Adjustment	Adjustment to HI Reimbursable Cost
6/30/69	50	$ 10,200	$ 5,100
6/30/70	40	$ 9,200	$ 3,680
6/30/71	20	$ 8,200	$ 1,640
6/30/72	18	$ 7,200	$ 1,296
6/30/73	15	$ 6,200	$ 930
		$ 41,000	$ 12,646*

* This net adjustment is applied as a decrease to the extent of the HI reimbursable cost in the current cost reporting period and any excess not applied is treated as an overpayment to be recovered from the provider.

NOTE: Proprietary providers subject to recapture of accelerated depreciation can determine the effect that the net depreciation adjustment has on the computation of equity capital in accordance with the instructions contained under §136.10 ff. There is no similar prior year adjustment to equity capital for gains and losses on disposal of assets.

C. Apportionment of Net Depreciation Adjustment Based on Routine and Ancillary Utilization.--If the provider can demonstrate to the satisfaction of the intermediary that the method of recovery in B above would be inequitable, and can show that the direct costs of ancillary services furnished under arrangement are 10 percent or more of the direct costs of all ancillary services in any cost reporting period subject to the net depreciation adjustment, the intermediary may grant permission for the provider to compute the recovery under the following method.

Step 1 - The net depreciation adjustment for each period is first allocated to outpatient services, ancillary services (by ancillary departments where the Departmental Method was used), and nonallowable cost centers, on the basis of the ratio of depreciation (direct expense to the department) claimed for each of these cost centers to the total depreciation claimed by the provider. The residual net depreciation adjustment not allocated to these centers is then allocated to each routine service cost center on the basis of the ratio of depreciation claimed for each routine cost center to total depreciation claimed for all routine cost centers.

Step 2 - The adjustment to HI reimbursable cost for the net depreciation adjustment allocated to each cost center is determined based on the ratio of HI utilization to total utilization in the cost center, and utilizing the same basis for apportionment used in the provider's cost report, i.e., days and/or charges.

Schedule A demonstrates the process used to determine the adjustment to HI reimbursable cost based on a net depreciation adjustment in the amount of $25,920 for the period ending 12/31/67.

SCHEDULE A Period ending 12/31/67	(1) Depr. per Cost Rpt	(2) % of Cost Ctr Depr. to Tot Depr	(3) Allocation of Net Depr. Adjustment .(Col. 2 X line 1)	(4) Percent HI Program Charges to Total Charges (Per Cost Report Settlement Sheet)	(5) HI Adj. (4 X 3)
1. Net Depr. Adj.			$25,920		
2. Total Depr. per Cost Report $74,139					
3. Depart. Method Ancillaries Cost-Drugs Sold Physical Therapy					
4. Comb. Method Total Ancillaries	$ 1,335	1.8%	$ 467	42.3%	$ 198
5. Nonallow. Cost Centers Beauty Shop	297	0.4%	104	0	
6. Net Depr. Adj. Subtotal			$ 571		

Routine Services		% of Routine Cost Center Depr. to Tot. Routine Depr.	Allocation of Routine Services (Col 2 x line 10 below)	% HI Utiliz. of Rout. Ser. (Per CR)	
7. Noncert. Routine Cost Center	$23,283	39.7%	$10,064	0	
8. Certified Routine Cost Center	35,365	60.3%	15,285	24.7%	3,775
9. Tot. Routine Depr. Cert. & Uncert. $58,648		100.0%			
10. Net Depr. Adj. App. to Routine (line 1 - line 6)			$25,349		
11. HI Adjustment					$3,973
12. Allowance (See §132.3c)					79
13. Net Adjustment To HI Reimbursable Cost					$4,052

tax purposes but still in use. Medicare will recognize for depreciation purposes an appropriate adjustment to the income tax valuation in the case of such assets where the correctness of the adjustment can be documented. The allowed valuation would be the cost of such assets as of the dates of acquisition less depreciation based on the expired portion of their useful lives as they may be revised for Medicare purposes.

Where minor equipment (§104.5) is concerned, the Medicare program recognizes that the inventory costs of such equipment may not truly reflect the cost of equipment purchased and in use by the provider. Differences in the capitalization policies of providers and their desire to limit property record controls over certain classes of small assets cause variations in the recorded costs of assets generally considered depreciable. Medicare then will recognize an appropriate adjustment to the inventory costs of these assets used by the provider for income tax purposes to acknowledge the additional assets included and will permit the depreciation or amortization of the remaining cost over the remaining useful lives of the assets.

However, where all other depreciable assets are concerned, such as buildings, building equipment, major movable equipment, land improvements, and leasehold improvements, Medicare will not recognize a historical cost of such assets in excess of the historical cost used for Federal income tax purposes. Providers should be able to support this historical cost by reference to original documents such as contracts, vouchers, checks, and other evidence. If the provider does not have such original documentation constituting primary evidence of the historical cost of assets, the intermediary will consider the provider's Federal income tax returns as secondary evidence to be used in establishing or verifying the historical cost of the assets. Further, it is possible that because of the effects of other provisions of the regulations, such as "Cost to Related Organizations," the historical cost under Medicare might be less than that allowed and used for Federal income tax purposes.

Under the regulations, providers may change the useful lives of assets where this can be justified and appropriately adjust the accumulated depreciation applicable to the historical cost of the assets involved. The effect of such adjustments is to change the undepreciated amount of the historical cost for Medicare purposes. The regulations do not permit providers to increase the historical cost basis of their assets to recognize elements of costs or expenditures which were not capitalized but were considered as expense items. For example, if a provider determined that a physical modification of the building was a repair and thus an item of expense not capitalized and uses the historical cost so determined for Federal income tax purposes, the provider may not change the historical cost basis to include that expenditure previously determined a repair and capitalize it; i.e., increase the historical cost basis of the building for Medicare purposes. As another example, if a provider builds a facility and in establishing the historical cost of the building determines that materials and labor used were not part of the historical cost of the building and charges the cost of such materials and labor into expenses for Federal income tax purposes, the provider may not then include such expenditures in the historical cost of the building for Medicare purposes.

These guidelines are to be applied retroactively as well as prospectively. Where an intermediary has approved an appraisal resulting in the establishment of asset costs in excess of the cost basis used for Federal income tax purposes, or where a proprietary provider has increased the historical cost basis of its assets to an amount in excess of the historical cost basis used for Federal income tax purposes by reference to supporting documentation, the intermediary will require a redetermination of historical costs. Costs in excess of the cost basis used for Federal income tax purposes will not be recognized under Medicare. Further, for cost reporting periods beginning on or after January 1, 1970, the intermediary will also require a redetermination of allowable costs for the reporting period covered to reflect the effects of the adjustment in the historical cost basis of the assets. For cost reporting periods beginning before January 1, 1970, however, no redetermination of such allowable costs need be made for the reporting periods covered. Accumulated depreciation applicable to the depreciable assets under the program will include the full amount allowed during those periods in which an increased historical cost basis was used. The net book value so established shall be used for computations of equity capital and determinations of gain or loss on the sale of assets and for any other reimbursement purposes under Medicare.

134.4 Fixed Assets Included in Appraised Values.--Fixed asset values established by an appraisal must include all provider-owned plant assets used in patient care or in the overall operation and administration of the institution. Fixed assets used in research and other nonallowable cost areas or functions should be included so that depreciation is reflected in those departmental costs to provide a proper basis for allocating administrative and general expense. Fixed assets of a related organization not used by a provider in rendering patient care, assets acquired in anticipation of expansion, and assets held for investment and not used in the plant operation should not be included as a part of the appraised values.

Generally accepted accounting principles relating to improvements or betterments must be followed in determining the asset valuation established by the appraisal. Repair or maintenance of a nature that restores an asset to its original condition but does not extend its useful life is not a betterment or improvement but an expense of that period.

134.5 Pricing Sources.--

A. Prime or Basic Source.--The pricing of assets to establish historical costs will be based on such actual supporting documents as vendor invoices and construction contractor completion statements. In the absence of invoices such other records as revenue stamps, board minutes, contracts of purchase and deeds recorded with the county's Recorder of Deeds may be used.

B. Other Sources and Techniques.--Other methods, such as manufacturer's catalogs, libraries of material prices, or techniques involving reverse trending and price indexes may be used to establish acquisition costs and acquisition dates. Such methods may be used only when actual supporting documents are not available. When these sources and techniques are used, consideration must be given to *manufacturers* and quantity discounts. The values arrived at should closely approximate the actual historical cost of an asset at the date of acquisition.

136.7 Allowance in Lieu of Specific Recognition of Other Costs and Return on equity Capital.--The recovery of the amount paid in excess of straight-line depreciation has an effect on the allowance in lieu of specific recognition of other costs--reimbursable for services provided through June 30, 1969 (see §136.10), and the return on equity capital (see §136.11).

136.8 Basis of Assets Following Recovery of Amounts Paid in Excess of Straight-Line Depreciation.--A recovery of the amount paid in excess of straight-line depreciation due to a decrease in health insurance utilization results in an increase in the book value of those assets for which accelerated depreciation had been claimed. This increase in book value is equal to the depreciation claimed by the provider in excess of straight-line depreciation. The depreciable basis of these assets, therefore, is increased beginning with the reporting period following the recovery period, to the extent of the depreciation recovered in excess of straight-line depreciation allowed to the provider.

After a recovery of depreciation in excess of straight-line depreciation, a provider may continue to use the same method of accelerated depreciation. Allowable depreciation after the recover period is based upon the adjusted book value of the asset and is allocated over the remaining life of the asset.

136.10 Effect of Recovery of Amounts Paid in excess of Straight-Line Depreciation on the Allowance in Lieu of Specific Recognition of Other Costs.-For each cost reporting period where depreciation paid in excess of straight-line depreciation has been recovered under *§136ff,* the provider's allowable cost for each of those periods is decreased by that amount. Therefore, the provider's allowance in lieu of specific recognition of other costs (applicable to services provided through June 30, 1969) is adjusted.

The amount recovered as a result of this adjustment is computed by applying the appropriate rate for the allowance in lieu of specific recognition of other costs (12 percent for proprietary providers or 2 percent for non-profit providers) to the HI adjustment for recovery of excess depreciation.

For cost reporting periods beginning before July 1, 1969, and ending after June 30, 1969, the full allowance should be calculated and the sum so obtained shall be apportioned to that part of the period before July 1, 1969, by applying to that sum a fraction consisting of a numerator which is the number of months before July 1969 and a denominator which is the number of months in the cost reporting period. Thus, if a provider's 12-month reporting year ended December 31, 1969, the allowance recovered would be 6/12 x the allowance that would have been paid for the full 12-month period.

136.11 Computation of Increase in Equity Capital.--For proprietary institutions, the adjustment of accelerated depreciation to straight-line depreciation for a cost reporting period results in an increase in the provider's equity capital for each period in which accelerated depreciation is adjusted to straight-line depreciation is equal to the increase in the book value of the asset(s) as a result of the adjustment, less the additional reimbursement received by the provider as a result of claiming accelerated depreciation and the allowance in lieu of specific recognition of other costs. Also, the payments of the return on equity capital resulting from the conversion of accelerated depreciation to straight-line, increase the equity capital for subsequent cost reporting periods. (See example in §136.15A.)

136.13 Computation of Average Equity Capital Due to Adjustment From Accelerated Depreciation to Straight-Line Depreciation.--Section 136.11 explains the computation of the increase in equity capital due to the adjustment of accelerated depreciation to straight-line depreciation. Reimbursement to providers for the allowance of a reasonable return on equity capital, however, is based on the average equity capital during each reporting period. This section illustrates the computation of the estimated average equity capital as a result of the adjustment to straight-line depreciation.

The average equity capital for the earliest period for which recovery is made is one-half of the increase in equity capital for the period under the provisions of §136.11. The average equity capital for each period following the earliest period is one-half of the increase in equity capital for each prior period. This computation of average equity capital is illustrated in §136.15A.

For a reporting period during which the provider had previously had a zero equity balance at the end of an month, the average equity capital adjustment for the period id decreased by the percentage that the number of months in the period showing a zero balance bears to the total months in the period. (See illustration in §136.15B.)

(As an alternative to the procedures described in this section, a provider whose return on equity capital is adjusted may compute the adjustment to average equity capital for each cost period affected under the month-by-month calculation. *described in §1220.)*

136.14 Computation of Return on Equity Capital.--The return on equity capital for each period is computed by applying the rate of return and the ration that the program's share of allowable health insurance cost bears to total costs to the increase in average equity capital. This computation is illustrated in the example in §136.15A.