

EXPENSE TESTING
HOSPITAL AND SKILLED NURSING FACILITY AUDIT PROGRAM (1999)

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EXPENSE TESTING

Regulation References: 42 CFR 413.1, 413.9, 413.20 and 413.24

- OBJECTIVES:
1. To ascertain that expenses have been properly classified and recorded and reasonably stated.
 2. To determine that all costs including indirect expense have been properly accounted for when offsets are made using costs instead of revenues.
 3. To ascertain that miscellaneous income and expenses have been handled correctly in the cost report (income offset and expenses excluded where necessary).
 4. To ascertain that costs not related to patient care are excluded from reimbursable costs.

OTHER REFERENCES:

PRM-I, §§600, 2100 and 2300

Cost Report Forms: Hospital:

HCFA 2552, Worksheet A
HCFA 2552, Worksheet A-6
HCFA 2552, Worksheet A-8
HCFA 2552, Worksheet G-1
HCFA 2552, Worksheet G-2
HCFA 2552, Worksheet G-3
HCFA 2552, Worksheet D-6

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EXPENSE ACCOUNT ANALYSIS

1. If scoped for audit because of desk review variances or other reasons, review and analyze the expense accounts to confirm that the costs were actually incurred, allowable, and for the items tested, the services rendered and properly classified in that account. Tests could include inquiry of the provider, comparison of subaccounts to determine where the material variance(s) is incurred, vouching where necessary to ensure the expense is allowable, correctly classified as capital or expense, and recorded in the appropriate account. The extent to which detailed analysis is made of specific expense accounts depends on:
 - A. Adequacy of internal control procedures regarding account classifications.
 - B. Relative materiality of the total amount charged to an account.
 - C. The need to establish the nature of the individual items charged.
 - D. The materiality of any variance between current and prior cost reporting periods.
 - E. Relative likelihood that the account or subaccount may contain nonallowable expenses.

Note: Agreements for payments in excess of \$10,000 must have an "access" clause in the purchase agreement.

RECONCILIATION OF TRIAL BALANCE OF
EXPENSES

2. If not done at desk review, reconcile supporting documentation (working trial balance) to the cost report trial balance of expenses (Worksheet A).
 - A. Reconcile the expenses shown on Worksheet A to the provider's working trial balance and financial statements. Significant differences must be explained.
 - B. Ensure that total expenses on the Statement of Patient Revenue and Operating Expenses (Worksheet G-2) are reconciled to the trial balance of expenses (Worksheet A). Significant differences must be adequately explained.
 - C. Review the composition of and the amounts entered in the cost centers on the provider's current and prior years'

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working trial balances and cost reports for evidence of cost shifting to different cost centers, and changes in cost center groupings or cost center structure.

- D. Determine if there were any reclassifications between the trial balance and the cost report. Determine if they were appropriate in accordance with Medicare policies.
- E. Review Worksheet G-1 (Fund Statement) for any activities that should receive overhead allocations but were excluded from Worksheet A because of fund accounting.
- F. Review the other expenses on the Statement of Revenues and Expenses (Worksheet G-3) and ascertain how these items are classified on the cost report and whether the classification is correct. If it is incorrect, propose an adjustment.

COST CENTER STRUCTURE

- 3. A. Review the general ledger account groupings for the current cost report to determine if some of the accounts were inappropriately grouped on Worksheet A. For example, in accordance with PRM-II, instructions for Worksheet A, if the provider separately costed two or more clinics on its books, each clinic should be separately reported on Worksheet A. Examples of other inappropriate groupings include combining operating room, recovery room, and anesthesia in one cost center; combining operating room and cardiovascular lab in one cost center; combining emergency room and ambulatory surgery or air ambulance in one cost center; etc. See also PRM-I, §§2203 and 2302.8.
- B. Determine whether the cost centers reported in the cost report are consistent with those of the prior years. If changes were made, appropriate Intermediary prospective approval should have been obtained. If changes were made to correct inappropriate groupings of departments/accounts, a prospective approval is not necessary.

DIRECT COSTING

- 4. A. Review the working trial balance to determine whether any general service costs are directly assigned to other cost centers. Such costs could include fringe benefits, medical records cost, billing cost, admitting cost, dietary cost, telephone costs, copy charge costs, etc.
- B. Review provider's general journal to determine whether

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	there has been direct costing on the books. If so, review in accordance with Step C following. C. Test to verify that the direct assignment is in accordance with PRM-I, §2307. 1. The provider must have written approval for direct assignment of cost and the method used must be consistent with the method approved. 2. All costs that can be directly allocated must be assigned as part of the provider's ongoing recordkeeping system. 3. The basis for allocation must be factual and auditable. Statistical surrogates, such as time studies, may not be used. 4. Indirect supervision, residual costs, and previously allocated overhead must be allocated through cost finding. The basis must be an appropriate measure of the benefits provided. D. If the provider elected to direct cost any general service cost center, review the cost center to ensure that all costs that should have been directly costed were and that such costs were not also allocated through stepdown on Worksheet B. Review the statistics for the relevant general service cost center(s) to verify that they are still an appropriate basis for allocating the remaining costs of the cost center on Worksheet B.		

ADMINISTRATIVE AND GENERAL EXPENSES

- 5.. Specify individual subaccounts within this heading that are to be investigated for proper classification, reasonableness and relatedness to patient care.
Where errors are noted, and your tests are based on a sample that is not statistically valid, you should consider expanding the sample to verify that the expanded sample is representative of the population. However, if in your judgment the amount sampled is representative of the population, then you do not need to expand the sample. The audit adjustments should reflect the population and not just the errors in the original or expanded sample.
- A. Compare Administrative and General (A&G)

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subaccounts with those of the prior year, looking for any material variances and new subaccounts or activities that should be reviewed.

The following are examples of costs or subaccounts that may be included in A&G (although they may be elsewhere) and that should be reviewed, as applicable, through vouching, testing, preparing necessary analysis, etc. Refer to PRM-I, chapter or section as indicated, for proper treatment.

1. Legal and consulting (§§2100 through 2104 and 2135);
2. Organization, reorganization or start-up costs (§§2134 and 2132) (see Exhibit 6, Step 17);
3. Planning costs (§2154) (see Exhibit 6, Step 17);
4. Tax penalty (§2122);
5. Physician recruitment - all direct and indirect costs including a portion of the administrator's compensation if the administrator performs this function (§2182);
6. Dues and subscriptions (§2138);
7. Physician billings (§2110) (see Exhibit 9, Step 5);
8. Nonallowable board of directors fees (§906.3);
9. Tax planning fees (§2100 through 2104);
10. Income taxes (§§2122);
11. Franchise or business license tax (§§2122.4, 2133 and 2135.3);
12. Property tax, insurance and interest related to patient care could be reclassified to depreciation, but working capital interest does not get reclassified (§§202.1, 2122 and 2161) (see Exhibit 6, Step 9, and Exhibit 7);
13. Appraisal fees (§134.12) (see Exhibit 6, Step 22):
 - for assets not connected with provider operations
 - associated with the sale or anticipated sale of

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	a provider organization		
	- assets which were already adequately reflected in the provider's books, records or tax returns;		
14.	Life insurance premiums where the provider is the beneficiary (§2130);		
15.	Membership in social or fraternal organizations (§2138);		
16.	Telephone, television and radio (§2106) (see Exhibit 6, Step 5C);		
17.	Labor union activities (§2180);		
18.	Contributions to others (§§2100 through 2104 and 2139);		
19.	Unreasonable administrator's compensation in accordance with wage study guidelines (§904) (see Exhibit 5, Step 7E);		
20.	Unmet accrued compensation (§906.4) (see Exhibit 5, Step 7E);		
21.	Service charge imposed by lender on credit card payments for patient bills (§§202 and 2100 through 2104);		
22.	Public relations, fund raising, marketing and advertising (§2136);		
	Note: Advertising, consulting, public relations and promotion costs are usually found in subaccounts in the A&G marketing accounts. Provider surveys/studies, feasibility reports and other items of this nature should be reviewed because they may be incurred to increase the patient population, which is an activity not related to patient care, necessary, or proper.		
23.	Credit card cost (§§2100 through 2104);		
24.	Travel expenses; and		
25.	Miscellaneous expense (§§2100 through 2104).		
B.	Ensure that nonallowable costs and costs that should be capitalized have been excluded from A&G (adjusted,		

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reclassified, set up as a nonreimbursable cost center) and that appropriate treatment has been applied.

- C. From the analysis made, select a representative sample of expenditures for review. Determine if these are allowable in accordance with PRM-I, Chapter 21.

RECLASSIFICATIONS

6. Review and analyze the reclassifications scoped for audit.

Where applicable, cross-reference reclassification entries to the audit work performed on special areas of the audit (e.g., interest, pension). Do not analyze in this audit step those reclassifications that will be audited in detail in subsequent audit steps or sections.

- A. For those reclassification entries that are material in nature, perform audit tests and procedures (e.g., vouch, analyze) as considered necessary in the circumstances.
- B. Determine the propriety of entries transferring costs from nonallowable cost centers to allowable cost centers.
- C. Ensure that insurance, taxes and interest related to building and equipment have been classified into the appropriate cost center for capital-related costs. If the capital-related costs of buildings or equipment are directly assigned to cost centers benefiting from the costs, the cost of insurance, taxes and interest should be similarly directly assigned. (This does **not** apply to a provider that is subject to PPS capital, where insurance and taxes are classified as "other capital-related costs" and allocated to the various capital-related cost accounts on the basis of the ratio of gross assets.)

Note: Rental expense on movable equipment must be reclassified to the appropriate capital-related cost center when depreciation on movable equipment is not charged on an actual depreciation basis by department.

- D. Ensure that cost allocation statistics relating to the cost that has been reclassified have been reclassified appropriately. See Exhibit 11, Step 6.

ADJUSTMENTS TO COST - COST AND REVENUE
OFFSETS

7. Prepare a list of miscellaneous revenue accounts listing account number, name and amount. These accounts should be taken from the trial balance and/or financial statements

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and should include miscellaneous income and changes in fund balances from all funds (not only the general fund). Reconcile the total miscellaneous income and changes to fund balances to Worksheets G-3 and G-1 and propose any necessary adjustments.

Review the previously mentioned accounts and indicate disposition of each miscellaneous revenue account.

Note: Adjustments must be made to disallow the direct and indirect costs for those cost items that have been determined to require offset (not related to patient care, recovered from outside sources, etc.). These items are coded "A" for a cost adjustment on Worksheet A-8.

If the total cost of such activity cannot be determined, the total revenue must be offset as a reduction of costs. These items are coded "B" for a revenue offset on Worksheet A-8.

- A. For cost adjustments (coded A on Worksheet A-8), review supporting documentation for all adjustments noted by scoping. Determine if the amounts are correct and are related to noncovered services, the nature of the adjustments and the consistency in the application of the basis for cost adjustments. Where the cost (including applicable indirect cost) cannot be identified, apply the total revenue received as a reduction of operating costs.
- B. For revenue adjustments (coded B on Worksheet A-8), ensure that all revenue offsets on Worksheet A-8 equal full cost or are used when cost cannot be determined. Unless specifically exempted in accordance with Medicare rules, verify that material "other income" items disclosed on the working trial balance and/or Worksheet G-3 were taken into account in determining the offsets on Worksheet A-8, such as:
 1. Purchase and quantity discounts and allowances;
 2. Rebates and refunds;
 3. Drugs and supplies sold to other than patients; and
 4. Investment income (see Exhibit 7, Step 7).

Note: Income derived from nonallowable activities must not be offset against the nonallowable cost centers prior to or during the cost finding process.

Trace these items to Worksheet A-8 and ensure that

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they were handled in accordance with Medicare principles of reimbursement.

Ensure that income from interest and finance charges or delinquent accounts receivable is offset against allowable A&G costs. Determine that related costs incurred are not removed from costs to avoid the income offset. (PRM-I, §2110.2.)

- C. Determine provider's policy with regard to charges for telephone, television, personal comfort items, private duty nurses and any luxury items. Review general ledger accounts that may be aggregated for financial statement purposes.
 1. If a separate charge is made, review daily revenue to determine that it has been properly excluded from patient care revenue.
 2. If charges are separately recorded, trace the charges to the cost or revenue offset made on Worksheet A-8.
 3. Full costs (direct and indirect) of items and services such as telephone, TV and radio located in patient accommodations and furnished solely for the personal comfort of the patient should be offset or set up as nonreimbursable cost centers (PRM-I, §2106).

INSURANCE EXPENSE

8. Perform an analysis of insurance expense.

- A. For capital-related costs:

1. For purposes of verifying the capital pass-through, ensure that property taxes and insurance expense pertaining to nonreimbursable assets (those assets that are not related to patient care) are included in provider pass-through costs, but are allocated to a nonreimbursable cost center through the stepdown process. An inventory of physical property descriptions is useful in identifying nonreimbursable activities.
2. Ensure that the liability portion of auto insurance is not included as capital-related cost.

Note: Do not duplicate work done in the Depreciation section of the audit program.

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B. For self-insurance funds:

1. Review and evaluate the reasonableness of premiums paid to self-insure which should not be in excess of the cost of available comparable commercial insurance.

Note: PRM-I, §2162.C, states that the provider should periodically obtain comparative cost data.

2. Ensure that payments made into the fund are made in accordance with the conditions in PRM-I, §§2162.ff involving trustee funds and captive insurance companies, and §§2161.ff involving provider-maintained funds in segregated accounts. Also, see §2161.B for losses claimed as cost.
3. Verify that accruals are paid within 75 days after year end for self-insurance/pooling arrangements.
4. Ensure that overfunding is not included in allowable cost.

MANAGEMENT CONTRACTS

- 9.. Where costs of management contract fees are included in the allowable costs, perform the following audit steps.

A. Review the management contract for the following:

1. Extent of management duties.
2. Basis for management fees.

Determine that the provider maintains documentation of services rendered and the status of the accomplishment of the stated goals and objectives. This would include some or all of the following depending upon the scope and type of contract:

- a. Copy of the contract and any amendments.
- b. Periodic progress reports prepared by the management company.
- c. Board minutes (including minutes of committee meetings) or other documentation addressing the continued effectiveness of

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	management company services. d. Any other documentation such as visit or contact reports, evaluations, cost/benefit analysis, etc. 3. Reasonableness of the management fee. Note: Depending on the type of contract, consider the management fee cost per bed, cost per patient day, etc., for reasonableness. Is the management fee reasonable when total costs of the managed provider are compared to those of comparable nonmanaged providers? In some cases (for example, where there were no competitive bids and no reasonable explanation given by the provider for not having competitive bids), it might be appropriate to review a detailed listing of the services by component, with a justification of the fee by component. This approach is referred to as the componentized analysis, where the services provided are grouped into like categories for comparison with marketplace prices for similar services. Where appropriate, the following components should be reviewed: a. Provider Development Services b. Administrative Consulting Services - on-site staff, off-site support, specialist visits, other tangible services, other intangible services and standby services. c. Departmental Consulting Services d. Data Processing/Systems Services e. Other Considerations such as the relationship of current period services to current period fees. Where management fees are found to be unreasonable, propose an audit adjustment. B. Determine the relationship between the provider and the management firm and if it is through ownership or control (application of exception rule and arms-length transaction).		

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	1. Determine to what extent, if any, the board of directors of the provider retains control over operation of the facility. 2. Determine the provisions for termination of the contract. Can either party terminate upon given notice? 3. Determine if there are any members or relatives of members of the management company on the board of directors of the provider or in policy positions with the provider. 4. Determine if there are any other factors or situations that would indicate a related organization situation. C. Ascertain compliance/adherence of the management firm to the provisions of the management contract.		

EXCLUDED UNITS

10. Under PPS, excluded units of a provider are reimbursed on the basis of cost. Excluded unit status is granted to certain units meeting the qualification described in 42 CFR 412.22 through 412.32 and PRM-I §2803ff.

Determine whether the provider is shifting costs to cost reimbursed excluded units either through inappropriate direct costing on its accounting records or through the use of inappropriate cost allocation statistics.

As part of the cost report audit, review the following for excluded units:

- A. Confirm that the unit meets the qualifications to continue as an excluded unit (PRM-I, §2803.61). Ensure that the permanent file contains the tie-in notice (Form HCFA-2007) and that the number of certified beds agrees with that claimed in the cost report.
- B. Ensure that excluded units are identified as separate cost centers on the cost report.
- C. Analyze the direct costs of the excluded unit to determine their allowability and proper classification.
- D. Ensure the target rate used to calculate the excluded unit's reimbursement is correct.

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E.	Ensure that beds assigned to the unit are physically separate from other beds. Excluded unit beds should not be commingled with beds not included in the unit.		
F.	If not previously performed, review statistics for cost allocations and ensure that the provider's accounting system in which the unit is located properly allocates costs and maintains statistical data adequate to support the allocations.		
G.	If not done in another section of the audit program, review the provider's reconciliation of Medicare statistics (patient days, discharges, charges, deductibles, coinsurance and payments) for the excluded unit. Also, review total patient days for the excluded unit. Ensure that Medicare discharges for the excluded unit are not included as PPS discharges.		
H.	If not done in another section of the audit program, ensure that interim bills are not counted as discharges on the cost report.		
I.	Ensure that the number of beds or the size of the excluded unit did not increase during the cost reporting period; see 42 CFR 412.25(b), which requires that beds in an excluded unit may only change at the beginning of a cost reporting period.		
	Note: If beds have increased during the period, patients occupying new beds must be billed under PPS.		

ORGAN ACQUISITION COST

11. The cost incurred for organ acquisition for certified transplant hospitals is a pass-through cost for providers reimbursed under PPS. Medicare will only reimburse the provider for Medicare transplants. For providers other than certified transplant hospitals, reimbursement for organ acquisition cost is through the sale of excised organs to other hospitals or organ procurement organizations (OPOs). Medicare does not directly reimburse these providers for the cost of organ acquisition.

Note: Medicare now pays for the acquisitions of kidney, heart, liver and lung organs. Separate Worksheets D-6 are completed for each type of organ. Separate Medicare certifications for each type of organ are required.

As part of the cost report audit and settlement, review the following for the hospital cost report, and Worksheet D-6:

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CERTIFIED ORGAN TRANSPLANT PROVIDERS

A. For a provider with organ transplant certification:

1. Ensure that the provider has received the necessary certification for the period under audit.
2. Determine how the provider accumulated the organ acquisition days and charges.
3. Test the accumulation of the organ acquisition days and charges reported on Worksheet D-6, Parts I and II, if applicable, by:
 - a. Verifying the mathematical accuracy of the accumulations,
 - b. Tracing a sample of the patients to their medical records to determine that the purpose of the stay was to donate the organ(s), and
 - c. Testing, for the sample selected, the days and charges related to the patient's donation of the organ to the medical records.
4. Test that the charges and days related to organ donors for excising organs are excluded from Medicare charges and Medicare days as shown on Worksheet S-3 and Worksheet D, all parts. These charges and days, however, should be included in total charges and days for cost reporting purposes.
5. Test the organ costs included in the acquisition cost center on the hospital cost report and Worksheet D-6,, to determine:
 - a. That the direct costs relate to the appropriate organ acquisition, and
 - b. Overhead associated with the organ acquisition is properly allocated.
6. Ensure that costs, revenues and statistics are accurate by implementing the following:
 - a. When direct organ acquisition costs are reported in Part III, ensure there are corresponding statistics in Part IV of Worksheet D-6, lines for organs purchased, and vice versa.

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- b. When revenues for organs sold are reported in Part III of Worksheet D-6, ensure there are corresponding statistics in Part IV of Worksheet D-6, lines for organs sold, and vice versa.
- c. Ensure that partial payments for organs made by a primary payer other than Medicare were offset on Worksheet D-6, in accordance with the cost reporting instructions.
- d. Review the accounts receivable to verify the accuracy for both total and Medicare usable organs reported on Worksheet D-6, in accordance with the cost reporting instructions.

Where the data in Steps 6a through 6d does not agree, require the provider to reconcile the difference and amend the data accordingly.

7. Ensure that the revenue for organs sold as shown on Worksheet D-6, Part III, line 58, is properly deducted from the total organ acquisition cost and charges columns on line 53 of Worksheet D-6, Part III, to determine net organ acquisition cost and charges.

If possible, calculate the average revenue per organ sold and compare it to other Certified Transplant Centers (CTCs) for reasonableness.

Note: Kidneys sent to military hospitals (without a reciprocal sharing agreement with the OPO prior to March 3, 1988); sent to VA hospitals; sent outside the United States; or transplanted into non-Medicare beneficiaries on or after March 8, 1989; and kidneys that were totally paid for by primary insurance other than Medicare, are not to be reported as Medicare usable kidneys.

OTHER PROVIDERS PERFORMING ORGAN
EXCISIONS

- B. Ensure that all costs associated with the acquisition of organs are treated as nonreimbursable if the provider is not a certified transplant center. For hospitals incurring costs related to organ transplants that are not certified, Worksheet D-6 is not completed. A reclassification of costs from the Organ Acquisition cost center to a non-reimbursable cost center is not necessary. If there

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is an entry on Worksheet A:

1. Test that the direct cost of organ acquisition has been correctly included in the organ acquisition cost center (Worksheet B), so that overhead expenses are properly allocated to the cost center. The cost center does not flow to settlement since these costs are not reimbursable.
2. Test that the charges and days for excision of organs are excluded from Medicare charges and days, but are included in total charges and days.

EXCEPTIONAL COSTS FOR TERMINATED PROVIDERS

12. Ensure that Medicare costs are adjusted to include the following unusual items:
 - A. Administrative costs incurred after a provider terminates participation in the Medicare program and that are included in the final cost report as provided for in PRM-I, §2176.
 - B. Cost related to unemployment, lump sum pension plan and severance pay resulting from cessation of operations and termination of program participation.

AMBULANCE COSTS

13. Test that provider has claimed costs in accordance with the Balanced Budget Act of 1997 (BBA-97).
 - A. Check if provider if claiming ambulance costs.
 - B. If "yes", check that line 56, Worksheet S-2, Form HCFA-2552, contains a "Y" and an amount.
 - C. Verify that the amount agrees with the limit furnished by the fiscal intermediary responsible for its preparation. Adjust, if necessary.
 - D. Check that the amount on line 27, Worksheet S-3, Part 1, Form HCFA-2552, agrees with the number of trips indicated on the PS&R Report. Adjust, if necessary.