

HOSPITAL
INDIRECT COST RATE & PATIENT CARE PROPOSALS

**Submission/Approval of Patient Care and Indirect Cost Rate(s) Guidelines/
Documentation Requirements**

I. Guidelines

A. Submission of Proposals

1. Claims for the reimbursement of research patient care costs and indirect costs (IDC) under research grants and contracts must be supported by rates approved by the cognizant federal agency. A hospital that has not previously established research patient care or IDC rates with the Department must submit its initial research patient care and/or IDC proposal to the appropriate federal cognizant agency within 90 days from the effective date of the Federal award for reimbursement of research patient care costs and/or IDC. The hospital is required to submit a proposal(s) annually for each fiscal year for which such costs are claimed unless directed otherwise by the cognizant agency. Submission of the proposal(s) is due annually within six (6) months after the close of the hospital's fiscal year. Failure to comply with this requirement may result in the disallowance of research patient care costs and/or IDC.
2. Requests for an extension of the due date for submission of a proposal will be considered by the cognizant agency provided that such requests are submitted prior to the proposal due date.
3. If the hospital is required to submit an indirect cost proposal and/or patient care, the proposal must be prepared in accordance with the hospital regulations 45 CFR, PART 74 APPENDIX E., and both proposals (indirect cost and research patient care) must be submitted concurrently and based on the same source documentation. Although separate Negotiation Agreements will be issued for indirect costs and research patient care, both negotiations can be conducted simultaneously.

B. Types of Rates.

Patient Care and IDC rates may be established as either provisional, final, predetermined, or fixed with a carry-forward provision (s). However, predetermined IDC rates may not be used to reimburse costs under contracts, only grants. Patient Care predetermined rates may be used on either contracts or grants.

C. Negotiation of Rates

1. Upon the completion of the review of the proposal(s) submitted by the hospital, the cognizant federal agency will notify the hospital of any issues related to allowability, allocability, reasonableness or consistent treatment of cost and will negotiate the appropriate rate(s).
2. The results of the negotiation will be formalized in a "Negotiation Agreement" then signed by the appropriate cognizant official and an authorized representative of the hospital. Each agreement will include the following provisions:
 - (a) The agreed upon rate(s) and information directly related to the use of the rate (e.g., type of rates, effective period, on-site or off-site, etc.)
 - (b) General terms and conditions of the Agreement.
 - (c) Special terms and conditions of the Agreement (if any).
 - (d) Additional information (if necessary) that may be needed by the users of the Agreement.
 - (e) The equipment capitalization policy threshold in effect for the fiscal years negotiated.
3. Sub-recipient Hospitals - The primary recipient is responsible for negotiating appropriate IDC and patient care rates (see Sub-section V.C.1.) with sub-recipient and affiliate hospitals.

II. Documentation Requirements

A. Documentation

1. The rate proposal(s) will typically be based on the hospital's actual costs and charges for the most recently completed fiscal year or the fiscal year designated by the cognizant agency. However, if the hospital is aware of factors that are expected to result in significant changes to the rates for a future fiscal year during which the award is to be performed, a separate proposal based on projected costs and charges can be submitted for that year.

2. Hospitals participating in the Center for Medicare and Medicaid services (CMS) Medicare program, Title XVIII of the Social Security Act, and/or other Federal entitlement programs must use the "Hospital Cost Report for Hospitals and Hospital Health Care Complexes" (Form 2552 format or equivalent) and the related schedules for cost, cost allocation and statistics (i.e. trial balances of expenses - expenses, reclassifications and adjustments, step-down of costs, and ancillary data for cost and charge ratios). If a hospital does not participate in the Medicare program but does participate in the CMS Medicaid or Maternal and Child Health programs, the hospital is to submit the equivalent forms required under those programs which contain essentially the same information as the required Medicare forms.

B. Checklist

The hospital's proposal(s) must be accompanied by:

- (1) The independent audited financial statements;
- (2) A complete copy of the CMS Hospital Cost Report, form 2552 or equivalent, as filed with the Medicare fiscal intermediary. The financial data in the Medicare cost report forms (or equivalent) are to be used to develop the rate(s) presented in the proposal unless the hospital is a small entity and chooses to use the simplified method.
- (3) The financial data in the CMS cost report or equivalent document must be reconciled to the audited financial statements and the calculated indirect cost, fringe benefit and patient care rate proposals submitted reconciled to the CMS cost report.
- (4) The most recently completed copy of the "Notice of Final Program Reimbursement" for Medicare participating hospitals. This document is the results of the review/audit of the Medicare cost report by the fiscal intermediary or its representative; and
- (5) Where an initial indirect cost or patient care rate is being requested, copies of the document(s) listing the award amount, budget, grant/contract number and awarding agency for all awards must accompany the proposal.
- (6) Effective for fiscal year _____ the capitalization level for equipment is \$_____.

Please explain any boxes not checked on a separate sheet.

Common errors to avoid in submitting proposals:

1. A completed CMS report not submitted with proposal.
2. The expenses submitted for the cost category administrative and general expenses was not screened for unallowable/unallocable cost as specified in the hospital regulations 45 CFR, PART 74 APPENDIX E.
3. Financial statements not submitted.
4. The capitalization policy for equipment was not stated in the proposal.
5. The expense for Malpractice insurance is allowable for patient care rates ONLY.

6. The cost for interest expense is allowable, if the institution has an approved interest waiver.

7. Proposal data for patient care per diem rates should reconcile to the CMS cost report Worksheet D-1, Part II, LINE 38 and for patient care ancillary rates should be reconciled to the CMS cost report Worksheet C.