CHAPTER 32

HOME HEALTH AGENCY COST REPORT
FORM CMS-1728-94

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3200. GENERAL

The Paperwork Reduction Act of 1995 establishes the requirement that the private sector be informed as to why information is collected and what the information is used for by the government. In accordance with §1815(a), 1833(e), and 1861(v)(1)(A) of the Act, providers of service participating in the Medicare program are required to submit annual information to achieve settlement of costs for health care services rendered to Medicare beneficiaries. *In addition*, 42 CFR 413.20 requires cost reports from providers on an annual basis. *A*ll home health agencies (HHAs) must complete Form CMS-1728-94 *in accordance with cost report filing requirements contained in 42 CFR 413.24*. *The* information reported must conform to the requirements and principles set forth in the Provider Reimbursement Manual (CMS Pub. 15-1). The instructions contained in this chapter are effective for cost reporting periods ending on or after December 31, 1994.

For cost reporting periods ending on or after March 31, 2000, home health agencies (HHAs) must submit cost reports currently required under the Medicare regulations in a standardized electronic cost reporting (ECR) format. (See 42 CFR Part 413.24 (f)(4).)

NOTE: This form is not used by HHAs that are hospital-based *or SNF-based*. Instead, they use Form CMS-2552 *and Form CMS-2540, respectively*.

HHAs, as the term is used in this chapter, refers to institutions meeting the requirements of §1861(o) of the Act. Refer to *Medicare Benefit Policy Manual* (CMS Pub.) 100-02, chapter 7 and CMS Pub. 15-1 for further definition of terms.

The cost data reported must be based on the step down method of cost finding (see 42 CFR 413.24(d) (1)) and on the accrual basis of accounting. However, where governmental institutions operate on a cash basis of accounting, cost data developed on such basis of accounting are acceptable, subject to appropriate treatment of capital expenditures.

Small HHAs, as defined in 42 CFR 413.24(d), will not have to complete certain identified worksheets of Form CMS-1728-94, e.g., Worksheets A-1, A-2, and A-3.

An HHA may be considered a small HHA if:

1. The HHA received less than $35,000 in Medicare reimbursement for the immediately preceding cost reporting period, and

2. This reimbursement represented less than 50 percent of the total operating cost of the agency.

Supplemental worksheets are provided on an as needed basis depending on the needs of the HHA. Not all supplemental worksheets are needed by all HHAs. The following conditions are examples of situations for which supplemental worksheets are needed:

- Reimbursement is claimed for a HHA-based comprehensive outpatient rehabilitation facility (CORF), HHA-based rural health clinic (RHC), *HHA-based* Federally qualified health center (FQHC), or community mental health center (CMHC); or

- The HHA has physical therapy services furnished by outside suppliers.

HHAs are required to use the stepdown method of cost finding. (See CMS Pub. 15-1, §2308.) However, a*n* HHA that is considered small may use a simplified version of the stepdown method for HHA cost allocations. (See 42 CFR 413.24(d).)

In completing the worksheets, reductions in expenses must always be shown in parentheses ( ).

3201. ROUNDING STANDARDS FOR FRACTIONAL COMPUTATIONS

Throughout the Medicare cost report, required computations result in the use of fractions. The following rounding standards must be employed for such computation.

1. Round to 2 decimal places
   a. Percentages
   b. Averages
   c. Full time equivalent employees
   d. Per diems, hourly rates

2. Round to 5 decimal places
   a. Sequestration (e.g., 2.092 percent is expressed as .02092)

3. Round to 6 decimal places
   a. Ratios (e.g., unit cost multipliers, cost/charge ratios)

If a residual exists as a result of computing costs using a fraction, adjust the residual in the largest amount resulting from the computation. For example, in cost finding, a unit cost multiplier is applied to the statistics in determining costs. After rounding each computation, the sum of the allocation may be more or less than the total cost being allocated. Adjust this residual to the largest amount resulting from the allocation so that the sum of the allocated amounts equals the amount being allocated.

3202. RECOMMENDED SEQUENCE FOR COMPLETING FORM CMS-1728-94

All providers using Form CMS-1728-94 must adhere to the following sequence of completion. If worksheets are not completed because they are not applicable, do not include blank worksheets in the assembly of the cost report.

Step	Worksheet	Instructions
1	S-2	Read §3204. Complete entire worksheet.
2	*S-2-1*	*Read §3204.1 Complete entire worksheet.*
3	S-3	Read §3205. Complete *entire* worksheet.
4	A-1, A-2, A-3	Read §§3207-3209. Complete all worksheets unless you are a small HHA. (See 42 CFR 413.24 (d) and §3200.)
5	A	Read §3206. Complete columns 1 through 6, lines 1-29.
6	A-4	Read §3210. Complete, if applicable.
7	A	Read §3206. Complete columns 7 and 8, lines 1-29.

Step	Worksheet	Instructions
8	A-6	Read §3212. Complete Part A. If the answer to Part A is "Yes," complete Parts B and C.
9	A-7	Read §3213. Complete entire worksheet.
10	Supp. A-8-3	Read §3219. Complete entire worksheet, if applicable.
11	A-5	Read §321*1*. Complete entire worksheet.
12	A	Read §3206. Complete columns 9 and 10, lines 1-29.
13	B and B-1	Read §3214. Complete entire worksheets.
14	C	Read §3215. Complete entire worksheet.
15	D	Read §3216. Complete lines 1 through 27.
16	D-1	Read §3217. Complete lines 1 through 4.
17	D	Read §3216. Complete lines 1 through 31.
18	F, F-1, F-2	Read §3218. Complete all worksheets.

Step	Worksheet	Instructions
	CMHC	
19	Supp. CM-1, Pt I	Read §3225.1. Complete column 0, lines 1-12.
20	Supp. CM-1, Pt III	Read §3225.3. Fully complete.
21	Supp. CM-1, Pt I	Read §3225.3. Complete columns 1-6, lines 1-12.
22	Supp. CM-1, Pt II	Read §3225.2. Fully complete.
23	Supp. CM-1, Pt I	Read §3225.3. Fully complete.
24	Supp. CM-2	Read §3226. Complete entire worksheet.
25	Supp. CM-3	Read §3227. Complete lines 1-24
26	Supp. CM-4	Read §3228. Complete lines 1-7.
27	Supp. CM-3	Read §3227. Complete lines 25-28

Step	Worksheet	Instructions
	RHC/FQHC	
28	S-4	Read §3233. Complete entire worksheet.
29	RF-1	Read §3234. Complete entire worksheet.
30	RF-2	Read §3235. Complete entire worksheet.
31	RF-4	Read §3237. Complete entire worksheet.
32	RF-5	Read §3238. Complete entire worksheet.
33	RF-3	Read §3236. Complete entire worksheet.
	HOSPICE	
34	S-5	Read §3239. Complete entire worksheet.
35	K-1, K-2, K-3	Read §§3241-3243. Complete all worksheets.
36	K	Read §3240. Complete entire worksheet.
37	K-4, Parts I and II	Read §3244. Complete entire worksheets.
38	K-5, Parts I - III	Read §§3245-3245.3. Complete entire worksheets.
39	K-6	Read §3246. Complete entire worksheet.

Step	Worksheet	Instructions
	HOSPICE	
Step	*Worksheet*	*Instructions*
40	*O-1, O-2, O-3, O-4*	*Read §3248. Complete all worksheets.*
41	*O*	*Read §3247 Complete entire worksheet.*
42	*O-5*	*Read §.3249 Complete entire worksheet.*
43	*O-6, Parts I and II*	*Read §3250 Complete entire worksheets.*
44	*O-7*	*Read §3251 Complete entire worksheet.*
45	*O-8*	*Read §3252 Complete entire worksheet.*
46	S	Read §3203. Complete Part II entirely. Then complete Part I.

3203. WORKSHEET S - HOME HEALTH AGENCY COST REPORT

The *contractor* indicates in the appropriate box whether this is the initial cost report (first cost report filed for the *provider*), final report due to termination, or if this is a reopening. If it is a reopening, indicate the number of times the cost report has been reopened.

3203.1 Part I - Certification by Officer or Administrator of Provider(s). -- This certification is read, prepared, and signed after the cost report has been completed in its entirety. The cost report is not accepted by the *contractor* unless it contains an original signature.

3203.2 Part II - Settlement Summary.--Enter the balance due to or from for each component of the complex. Transfer the settlement amounts as follows:

- Home health agency from Worksheet D, Part II, line 29 (Part A from column 1 and Part B from column 2).
- HHA-based CORF from Worksheet J-3, line 24.
- HHA-based CMHC from Worksheet CM-3, line 26.
- HHA-based RHC or FQHC from Worksheet RF-3, line 26. Specify the provider type.

3204. WORKSHEET S-2 - HOME HEALTH AGENCY COMPLEX IDENTIFICATION DATA

The information required on this worksheet is needed to properly identify the provider.

Line 1.--Enter the street address and P.O. Box (if applicable) of the HHA.

Line 1.01.--Enter the city, state, and zip code of the HHA.

Lines 2 through 6.--On the appropriate lines and columns indicated, enter the *component* name, *CMS certification* number *(CCN)*, and certification date of the HHA and its various components, if any.

Line 2.--This is an institution which meets the requirements of §§1861(o) and 1891 of the Act and participates in the Medicare program.

Line 3.--This is a distinct part CORF that has been issued a CORF *CCN* and meets the requirements of §1861(cc) of the Act. If you have more than one HHA-based CORF, subscript this line and report the required information for each CORF.

Line 3.50.--This is a distinct part Hospice that has been issued a Hospice *CCN* and meets the requirements of §1861(dd) of the Act. If you have more than one HHA-based Hospice, subscript this line and report the required information for each Hospice.

Line 4.--This is a distinct part CMHC that has been issued a CMHC *CCN* and meets the requirements of §1861(ff) of the Act. If you have more than one HHA-based CMHC, subscript this line and report the required information for each CMHC.

Line 5.--This is a distinct part RHC that has been issued a RHC *CCN* and meets the requirements of §1861(aa) of the Act. If you have more than one HHA-based RHC, subscript this line and report the required information for each RHC.

Line 6.--This is a distinct part FQHC that has been issued a FQHC *CCN* and meets the requirements of §1861(aa) of the Act. If you have more than one HHA-based FQHC, subscript this line and report the required information for each FQHC. *Only the primary FQHC is identified on this line when filing a consolidated cost report. Effective for cost reporting periods beginning on or after October 1, 2014, HHA-based FQHCs will no longer complete this line and will be required to complete the form CMS-224-14.*

Line 7.--Enter the inclusive dates covered by this cost report. In accordance with 42 CFR 413.24(f), you are required to submit periodic reports of your operations which generally cover a consecutive 12 month period of your operations. (See CMS Pub. 15-2, §§102.1-102.3 for situations where you may file a short period cost report.)

Cost reports are due on or before the last day of the fifth month following the close of the period covered by the report. A 30 day extension of the due date may be granted by the contractor only when a provider's operations are significantly adversely affected due to extraordinary circumstances over which the provider has no control. (See 42 CFR 413.24 (f) (2) (ii).)

When you voluntarily or involuntarily cease to participate in the health insurance program or experience a change of ownership, a cost report is due no later than 150 days following the effective date of the termination of your agreement or change of ownership. There are no provisions for an extension of the cost report due date for termination or change of ownership.

Line 8.--Enter the type of ownership or auspices under which the *HHA* is conducted.

1 = voluntary non-profit, church
2 = voluntary non-profit, other
3 = proprietary, sole proprietor
4 = proprietary, partnership
5 = proprietary, corporation
6 = private non-profit
7 = governmental & private combined
8 = governmental, federal
9 = governmental, state
10 = governmental, city
11 = governmental, city-county
12 = governmental, county
13 = governmental, health district

- Combined Governmental and Private.--This is an HHA administered jointly by a private organization and a governmental agency, supported by tax funds, public funds, earnings, and contributions, which provides nursing and therapeutic services.

- Governmental Agency.--This is an HHA administered by a state, county, city, or other local unit of government and having as a major responsibility prevention of disease and community education. It must offer nursing care of the sick in their homes.

- Voluntary Non-Profit.--This is an HHA which is governed by a community-based board of directors and is usually financed by earnings and contributions. The primary function is the care of the sick in their homes. Some voluntary agencies are operated under church auspices.

- Private Not-for-Profit.--This is an HHA that is a privately developed and governed non-profit organization which provides care of the sick in the home. This agency must qualify as a tax exempt organization under title 26 USC 5018 of the Internal Revenue Code.

- Proprietary Organization.--This is an HHA that is owned and operated by non-governmental interests and is not a non-profit organization.

Line 9.--Indicate whether this is a low or no Medicare utilization cost report. Enter an “L” for low Medicare utilization or “N” for no Medicare utilization. If “L” is selected you must meet your contractor’s criteria for filing a low Medicare utilization cost report. (See 42 CFR 413.24 (h).)

Lines 10 through 12.--Enter on the appropriate lines the amount of depreciation claimed under each method of depreciation used by the HHA during the cost reporting period.

Line 13.--Enter the sum of lines 10 through 12. This amount must equal the amount of depreciation included in costs on Worksheet A.

Line 14.--Were there any disposals of capital assets during the cost reporting period? Enter "Y" for yes or "N" for no.

Line 15.--Was accelerated depreciation claimed on any asset in the current or any prior cost reporting period? Enter "Y" for yes or "N" for no.

Line 16.--Was accelerated depreciation claimed on assets acquired on or after August 1, 1970? (See CMS Pub. 15-1, Chapter 1.) Enter "Y" for yes or "N" for no.

Line 17.--If depreciation is funded, enter the fund balance at the end of the cost reporting period.

Line 18.--Did the provider cease to participate in the Medicare program at the end of the period to which this cost report applies? (See CMS Pub. 15-1, chapter 1.) Enter "Y" for yes or "N" for no.

Line 19.--Was there a substantial decrease in the health insurance proportion of allowable costs from prior cost reporting periods? (See CMS Pub. 15-1, chapter 1.) Enter "Y" for yes or "N" for no.

Line 20.--Does the provider qualify as a small HHA (as explained in 42 CFR 413.24 (d))? Enter "Y" for yes or "N" for no.

Line 21.--Does the HHA qualify as a nominal charge provider (as explained in 42 CFR 409.3)? Enter "Y" for yes or "N" for no.

Line 22.--Does the HHA contract with outside suppliers for physical therapy services? (See CMS Pub. 15-1, chapter 14.) Enter "Y" for yes or "N" for no.

Line 22.01.--Does the HHA contract with outside suppliers for occupational therapy services? Enter "Y" for yes or "N" for no.

Line 22.02.--Does the HHA contract with outside suppliers for speech therapy services? Enter "Y" for yes or "N" for no.

Lines 23 through 25.--If the facility is a non-public provider that qualifies for an exemption from the application of the lower of cost or charges (as explained in 42 CFR 413.13(f)) indicate the component and services that qualify for this exemption with a "Y".

Line 26.--If the HHA componentized (or fragmented) its administrative and general *(A&G)* service costs, enter 1 for option one and 2 for option two. Do not respond if A&G services are not fragmented. (See §3214 for an explanation of the A&G componentization options.)

Line 27.01-27.03.--Enter the amount of malpractice insurance premiums, paid losses and/or self insurance premiums, respectively.

Line 28.--If malpractice premiums are reported in other than the A&G cost center, enter Y (yes) or N (no). If yes, submit a supporting schedule listing the cost centers and amounts contained therein.

Line 29-29.03.--If this provider is part of a chain organization, enter "Y" for yes and enter the home office name, home office number, address of the home office, and contractor name and identifying number of the contractor who receives the home office cost statement; otherwise, enter "N" for no. 32-12 Rev.

3204.1. WORKSHEET S-2-1 - HOME HEALTH AGENCY REIMBURSEMENT QUESTIONNAIRE

This worksheet collects organizational, financial and statistical information previously reported on Form CMS-339. Where instructions for this worksheet direct the HHA to submit documentation/information, mail or otherwise transmit the requested documentation to the contractor with submission of the electronic cost report (ECR). The contractor has the right under §§1815(a) and 1883(e) of the Act to request any missing documentation.

NOTE: The responses on all lines are "yes" or "no" unless otherwise indicated. When the instructions require documentation, indicate on the documentation the Worksheet S-2-1 line number the documentation supports.

Line 1.--Indicate whether the HHA has changed ownership immediately prior to the beginning of the cost reporting period. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the date the change of ownership occurred in column 2. Also, submit the name and address of the new owner and a copy of the sales agreement with the cost report.

Line 2.--Indicate whether the HHA has terminated participation in the Medicare program. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the date of termination in column 2, and "V" for voluntary or "I" for involuntary in column 3.

Line 3.--Indicate whether the HHA is involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the HHA or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", submit a list of the individuals, the organizations involved, and a description of the transactions with the cost report.

***NOTE**: A related party transaction occurs when services, facilities, or supplies are furnished to the provider by organizations related to the provider through common ownership or control. (See Pub. 15-1, chapter 10 and 42 CFR 413.17.)*

Line 4.--Indicate in column 1 whether the financial statements were prepared by a certified public accountant; enter "Y" for yes or "N" for no. If column 1 is yes, indicate the type of financial statements in column 2 by entering "A" for audited, "C" for compiled, or "R" for reviewed. Submit a complete copy of the financial statements (i.e., the independent public accountant's opinion, the statements themselves, and the footnotes) with the cost report. If the financial statements are not available for submission with the cost report enter the date they will be available in column 3.

If column 1 is no, submit a copy of the internally prepared financial statements, and written statements of significant accounting policy and procedure changes affecting Medicare reimbursement which occurred during the cost reporting period. You may submit the changed accounting or administrative procedures manual in lieu of written statements.

Line 5.--Indicate whether the total expenses and total revenues reported on the cost report differ from those on the filed financial statements. Enter "Y" for yes or "N" for no in column 1. If you answer "Y" in column 1, submit reconciliation with the cost report.

Line 6.--Indicate whether you are seeking reimbursement for bad debts resulting from Medicare deductible and/or coinsurance amounts which are uncollectible from Medicare beneficiaries. (See 42 CFR 413.89(e) and CMS Pub. 15-1, chapter 3, §§306 - 324 for the criteria for an allowable bad debt.) Enter "Y" for yes or "N" for no in column 1. If you answer "Y" in column 1, submit a completed Exhibit 1 or internal schedule duplicating the documentation requested on Exhibit 1 to support the bad debts claimed.

Exhibit 1 displayed at the end of this section requires the following documentation:

Columns 1, 2, 3, 4.--Patient Names, Health Insurance Claim (HIC) Number, and Dates of Service (From - To)--The documentation required for these columns is derived from the beneficiary's bill. Furnish the patient's name, HIC number and dates of service that correlate to the filed bad debt. (See CMS Pub. 15-1, chapter 3, §314 and 42 CFR 413.89.)

Columns 5 & 6.--Indigency/Welfare Recipient--If the patient included in column 1 has been deemed indigent, place a check in column 5. If the patient in column 1 has a valid Medicaid number, include this number in column 6. See the criteria in CMS Pub. 15-1, chapter 3, §§312 and 322 and 42 CFR 413.89 for guidance on the billing requirements for indigent and welfare recipients.

Columns 7 & 8.--Date First Bill Sent to Beneficiary & Date Collection Efforts Ceased--This information should be obtained from the HHA's files and should correlate with the beneficiary name, HIC number, and dates of service shown in columns 1, 2, 3 and 4 of this exhibit. The date in column 8 represents the date that the unpaid account is deemed worthless, whereby all collection efforts, both internal and by an outside entity, ceased and there is no likelihood of recovery of the unpaid account. (See CFR 413.89(f), and CMS Pub. 15-1, chapter 3, §§308, 310, and 314.)

Column 9.--Medicare Remittance Advice Dates--Enter in this column the remittance advice dates that correlate with the beneficiary name, HIC number, and dates of service shown in columns 1, 2, 3 and 4 of this exhibit.

Columns 10 & 11.--Deductibles & Coinsurance--Record in these columns the beneficiary's unpaid deductible and coinsurance amounts that relate to covered services.

Column 12.--Total Medicare Bad Debts--Calculate the total bad debts by summing up the amounts on all lines of columns 10 and 11. This "total" must agree with the bad debts claimed on the cost report. Attach additional supporting schedules, if necessary, for bad debt recoveries.

Line 7.--Indicate whether your bad debt collection policy changed during the cost reporting period. Enter "Y" for yes or "N" for no in column 1. If you answer "Y" in column 1, submit a copy of the revised policy with the cost report.

Line 8.--Indicate whether patient coinsurance amounts were waived. Enter "Y" for yes or "N" for no in column 1. If you answer "Y" in column 1, ensure that they are not included on the bad debt listings (i.e., Exhibit 1 or your internal schedules) submitted with the cost report.

Line 9.--Indicate whether the cost report was prepared using the Provider Statistical & Reimbursement (PS&R) Report only. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" enter the paid through date of the PS&R in column 2. Also, submit a crosswalk between revenue codes and charges found on the PS&R to the cost center groupings on the cost report. This crosswalk will reflect a cost center to revenue code match only.

Line 10.--Indicate whether the cost report was prepared using the PS&R for totals and provider records for allocation. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" enter the paid through date of the PS&R used to prepare this cost report in column 2. Also, submit a detailed crosswalk between revenue codes, departments and charges on the PS&R to the cost center groupings on the cost report. This crosswalk must show dollars by cost center and include which revenue codes were allocated to each cost center. The total revenue on the cost report must match the total charges on the PS&R (as appropriately adjusted for unpaid claims, etc.) to use this method. Supporting work papers must accompany this crosswalk to provide sufficient documentation as to the accuracy of the provider records. If the contractor does not find the documentation sufficient, the PS&R will be used in its entirety.

Line 11.--If you entered "Y" on either line 9 or 10, indicate whether adjustments were made to the PS&R data for additional claims that have been billed but not included on the PS&R used to file this cost report. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", include a schedule which supports any claims not included on the PS&R. This schedule should include totals consistent with the breakdowns on the PS&R, and should reflect claims that are unprocessed or unpaid as of the cut-off date of the PS&R used to file the cost report.

Line 12.--If you entered "Y" on either line 9 or 10, column 1, indicate whether adjustments were made to the PS&R data for corrections of other PS&R information. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", submit a detailed explanation and documentation which provides an audit trail from the PS&R to the cost report.

Line 13.--If you entered "Y" on either line 9 or 10, column 1, indicate whether other adjustments were made to the PS&R data. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", include a description of the other adjustments and documentation which provides an audit trail from the PS&R to the cost report.

Line 14.--Indicate whether the cost report was prepared using HHA records only. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", submit detailed documentation of the system used to support the data reported on the cost report. If detail documentation was previously supplied, submit only necessary updated documentation with the cost report.

The minimum requirements are:

- *Internal records supporting program utilization statistics, charges, prevailing rates and payment information broken into each Medicare bill type in a manner consistent with the PS&R report.*
- *A reconciliation of remittance totals to the provider's internal records.*
- *The name of the system used and system maintainer (vendor or HHA). If the HHA maintained the system, include date of last software update.*

NOTE: Additional information may be supplied such as narrative documentation, internal flow charts, or outside vendor informational material to further describe and validate the reliability of your system.

Line 15.--Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.

Line 16.--Enter the employer/company name of the cost report preparer.

Line 17.--Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.

EXHIBIT 1

LISTING OF MEDICARE BAD DEBTS AND APPROPRIATE SUPPORTING DATA

HHA Name _____
HHA CCN _____
FYE _____

Prepared By _____
Date Prepared _____

Patient Name	*HIC. No.*	*Dates of Service*		*Indigency / Welfare Recipient (Check if applicable)*		*Date First Bill Sent to Beneficiary*	*Date Collection Efforts Ceased*	*Medicare Remittance Advice Dates*	*Deductible**	*Co-Insurance**	*Total Medicare Bad Debts*
		From	*To*	*Yes*	*Medicaid Number*						
1	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*	*11*	*12*

**These amounts must not be claimed unless the HHA or HHA-based entity bills for these services with the intention of payment. See instructions for columns 5 and 6 - Indigency/Welfare Recipient, for possible exception.*

This page is reserved for future use.

3205. WORKSHEET S-3 - HOME HEALTH AGENCY STATISTICAL DATA

In accordance with 42 CFR 413.20(a), 42 CFR 413.24(a), and 42 CFR 413.24(c), you are required to maintain statistical records for proper determination of costs payable under the Medicare program. The statistics required on this worksheet pertain to a *HHA*. The data to be maintained, depending on the services provided by the agency, includes the number of program visits, total number of agency visits, number of program home health aide hours, total agency home health aide hours, program unduplicated census count and total unduplicated census count, program patient count, and total agency patient count. In addition, FTE data are required by employee staff, contracted staff, and total staff.

HHA Visits.--A visit is an episode of personal contact with the beneficiary by staff of the HHA or others under arrangements with the HHA for the purpose of providing Medicare-type services. A Medicare-type service is a service which satisfies the definition of a home health service in CMS Pub. *100-02, chapter 7, §§40 and 50, CMS Pub. 100-04, chapter 10*, and 42 CFR 409.40. In preparing the cost report, recognize only the costs associated with Medicare-type like-kind visits in reimbursable cost centers. Medicare like-kind visits generally fall under the definition of Medicare visits as described in 42 CFR 409.45 (b) through (g). In counting like-kind visits, it is critical that non-Medicare visits are of the same type as those that would be covered by Medicare. This insures that costs of services are comparable across insurers and that providers are reimbursed equitably for home health services provided. A visit is initiated with the delivery of Medicare-type home health service and ends at the conclusion of delivery of Medicare-type home health services. (See 42 CFR 409.48(c).) Use lines 1 through 7 to identify the number of service visits and corresponding number of patients. The patient count in columns 2, 4, and 6 includes each individual who received each type of service. The sum of the patient count in columns 2 and 4 may not equal the amount in column 6 for each line. Also, the total of all of the lines may not equal line 10, unduplicated census count, since many patients receive more than one type of service. Beneficiaries who experience multiple spells of illnesses (multiple visits and/or multiple discharges and admissions) within a cost reporting period must be counted only once in the unduplicated census count.

Part I - Statistical Data.--

Columns 1 and 2.--Enter data pertaining to Title XVIII patients only. Enter in column 1 the Title XVIII visits for each discipline for services rendered through September 30, 2000 for reporting periods which overlap October 1, 2000. For reporting periods which begin on or after October 1, 2000 enter in column 1 all visits rendered during the entire cost reporting period. Enter in column 2 the patient count applicable to the Title XVIII visits in column 1 for each line description. See CMS *Pub. 100-02, chapter 7, §70.2* for patient count determination. Enter the sum of lines 1 through 7 in column 1 on line 8 (total visits). The sum of lines 1 through 7 in column 2 do not equal the unduplicated census count on line 10 because a beneficiary could be receiving more than one type of service.

Columns 3 and 4.--Enter data pertaining to all other patients for the entire reporting period. Enter in column 3 the count of all the agency visits except Title XVIII visits for each discipline. Enter in column 4 the total agency patient count, except Title XVIII, applicable to the agency visits entered in column 3. Enter the sum of lines 1 through 7 in column 3 on line 8 (total visits). The sum of lines 1 through 7 in column 4 may not equal the unduplicated census count on line 10 because a patient could be receiving more than one type of service.

Columns 5 and 6.--The amounts entered in column 5 are the sum of columns 1 and 3 for each discipline for cost reporting periods ending on or before September 30, 2000. For reporting periods which overlap October 1, 2000, enter in column 5 the total visits rendered during the entire reporting period. For reporting periods which overlap October 1, 2000, the amounts entered in column 5 may not equal the sum of columns 1 and 3 for each discipline. For reporting periods beginning on or after October 1, 2000, column 5 will again equal the sum of columns 1 and 3. The amounts entered in column 6 may not be the sum of columns 2 and 4 for each discipline. The unduplicated census count

on line 10, column 6, may not necessarily equal the sum of the unduplicated census count, line 10, columns 2 and 4.

For example, if a patient receives both covered services and noncovered services, he or she is counted once as Title XVIII (for covered services), once as other (for noncovered services), and only once as total.

Lines 1 through 6.--These lines identify the type of home health services rendered to patients. The entries reflect the number of visits furnished and the number of patients receiving a particular type of service.

Line 7.--Enter in columns 3 and 5 the total of all other visits. Enter in columns 4 and 6 the patient count applicable to visits furnished by the agency but which are not reimbursable by Title XVIII.

Line 8.--Enter the sum of lines 1 through 7 for all columns as appropriate.

Line 9.--Enter the number of hours applicable to home health aide services.

Line 10, 10.01 and 10.02.--Enter on line 10 in the appropriate column the unduplicated count of all patients receiving home visits or other care provided by employees of the agency or under contracted services for the entire the reporting period. Enter on line 10.01 in the appropriate column the unduplicated count of all patients receiving home visits or other care provided prior to October 1, 2000 by employees of the agency or under contracted services during the reporting period. Enter on line 10.02 in the appropriate column the unduplicated count of all patients receiving home visits or other care provided on or after October 1, 2000 by employees of the agency or under contracted services during the reporting period. Beneficiaries who receive services before and after October 1, 2000 must be included in both unduplicated census counts before and after October 1, 2000. The sum of lines 10.01 and 10.02 may not necessarily equal line 10. For cost reporting periods beginning on or after October 1, 2000, do not subscript line 10 as all unduplicated census count data is entered on line 10. Count each individual only once. However, because a patient may be covered under more than one health insurance program, the total census count may not equal the sum of the Title XVIII and all other census counts. For purposes of calculating the unduplicated census count, if a beneficiary has received health care in more than one MSA, you must prorate the unduplicated census count based on the ratio of visits provided in an MSA to the total visits furnished to the beneficiary so as to not exceed a total of (1). For example, if an HHA furnishes 100 visits to an individual beneficiary in one MSA during the cost reporting period and the same individual received a total of 400 visits (the other 300 visits were furnished in other MSAs during the cost reporting period), the reporting HHA would count the beneficiary as a .25 (100 divided by 400) in the unduplicated census count for Medicare patients for the cost reporting period. Round the result to two decimal places, e.g., .2543 is rounded to .25. **A provider is also to query the beneficiary to determine if he or she has received health care from another provider during the year, i.e., Maryland versus Florida for beneficiaries with seasonal residence**.

Part II - Employment Data (Full Time Equivalent).--

Lines 11 through 27--Lines 11 through 27 provide statistical data related to the human resources of the HHA. The human resources statistics are required for each of the job categories specified in lines 11 through 25. Enter any additional categories needed on lines 26 and 27.

Enter the number of hours in your normal work week.

Report in column 1 the full time equivalent (FTE) employees on the HHA's payroll. These are staff for which an IRS Form W-2 is used.

Report in column 2 the FTE contracted and consultant staff of the HHA. Compute staff FTEs for column 1 as follows. Total all hours for which employees worked and divide by 2080 hours.

Round to two decimal places, e.g., .04447 is rounded to .04. Compute contract FTEs for column 2 as follows. Add all hours for which contracted and consultant staff worked and divide by 2080 hours.

If employees are paid for unused vacation, unused sick leave, etc., exclude these paid hours from the numerator in the calculations.

Part III - Metropolitan Statistical Area (MSA) or Core Based Statistical Area (CBSA) Code Data.--

Line 28.--Enter the total number of MSAs and/or CBSAs where Medicare covered services were provided during the cost reporting period. MSA codes identify the geographic area at which Medicare covered service are furnished while CBSA codes are five character numeric codes that also identify the geographic area at which Medicare covered service are furnished. Obtain these codes from your *contractor*. The number of identified MSAs/CBSAs must be between 1 and 30.

Line 29.--List all MSA/CBSA and/or Non-MSA/Non-CBSA codes where Medicare covered home health services was provided. Enter one MSA/CBSA code on each line as necessary. If additional lines are needed, continue subscripting with lines 29.01, 29.02 et cetera, as necessary entering one MSA/CBSA code on each subscripted line. Obtain these codes from your *contractor*. Non-MSA (rural) codes are assembled by placing the digits "99" in front of the two digit State code, e.g., for the state of Maryland the rural MSA code is 9921. For HHA services rendered on or after January 1, 2006, enter the 5 digit CBSA code and Non-CBSA (rural). Non-CBSA codes are assembled by placing the digits "999" in front of the two digit State code, e.g., for the state of Maryland the Non-CBSA code is 99921. This line may only be subscripted through line 29.29.

Part IV - PPS Activity Data - Applicable for Services Rendered on or After October 1, 2000.--

In accordance with 42 CFR §413.20 and §1895 of the Social Security Act, home health agencies are mandated to transition from a cost based reimbursement system to a prospective payment system (PPS) effective for home health services rendered on or after October 1, 2000.

The statistics required on this worksheet pertain to home health services furnished on or after October 1, 2000. Depending on the services provided by the HHA the data to be maintained for each episode of care payment category for each covered discipline include aggregate program visits, corresponding aggregate program charges, total visits, total charges, total episodes and total outlier episodes, and total non-routine medical supply charges.

All data captured in Part IV of this worksheet must be associated only with episodes of care which terminate during the current fiscal year for payment purposes. Similarly, when an episode of care is initiated in one fiscal year and concludes in the subsequent fiscal year, all data required in Part IV of this worksheet associated with that episode will appear in the fiscal year on the PS&R in which the episode of care terminates.

HHA Visits.--See the second paragraph of this section for the definition of an HHA visit.

Episode of Care.--Under home health PPS the 60 day episode is the basic unit of payment where the episode payment is specific to one individual beneficiary. Beneficiaries are covered for an unlimited number of non-overlapping episodes. The duration of a full length episode will be 60 days. An episode begins with the start of care date and must end by the 60th day from the start of care.

Less than a full Episode of Care.--

When 4 or fewer visits are provided by the HHA in a 60 day episode period, the result is a low utilization payment adjustment (LUPA). In this instance the HHA will be reimbursed based on a standardized per visit payment.

An episode may end before the 60th day in the case of a beneficiary elected transfer, or a discharge and readmission to the same HHA (including for an intervening inpatient stay). This type of situation results in a partial episode payment (PEP) adjustment.

When a beneficiary experiences a significant change in condition (SCIC) and subsequently, but within the same 60 day episode, elects to transfer to another provider, a SCIC within a PEP occurs. Effective for episodes of care ending on or after January 1, 2008, do not complete column 5 for SCIC within PEP episodes.

A significant change in condition (SCIC) adjustment occurs when a beneficiary experiences a significant change in condition, either improving or deteriorating, during the 60 day episode that was not envisioned in the original plan of care. The SCIC adjustment reflects the proportional payment adjustment for the time both prior and after the beneficiary experienced the significant change in condition during the 60 day episode. Effective for episodes of care ending on or after January 1, 2008, do not complete column 6 for SCIC-only episodes.

Use lines 30 through 41 to identify the number of visits and the corresponding visit charges for each discipline for each episode payment category. Lines 42 and 44 identify the total number of visits and the total corresponding charges, respectively, for each episode payment category. Line 45 identifies the total number of episodes completed for each episode payment category. Line 46 identifies the total number of outlier episodes completed for each episode payment category. Outlier episodes do not apply to 1) Full Episodes without Outliers and 2) LUPA Episodes. Line 47 identifies the total medical supply charges incurred for each episode payment category. Column 7 displays the sum total of data for columns 1 through 6. The statistics and data required on this worksheet are obtained from the provider statistical and reimbursement (PS&R) report and only pertain to services rendered on or after October 1, 2000.

Columns 1 through 6.--Enter data pertaining to Title XVIII patients only for services furnished on or after October 1, 2000. Enter, as applicable, in the appropriate columns 1 through 6, lines 30 through 41, the number of aggregate program visits furnished in each episode of care payment category for each covered discipline and the corresponding aggregate program visit charges imposed for each covered discipline for each episode of care payment category. The visit counts and corresponding charge data are mutually exclusive for all episode of care payment categories. For example, visit counts and the corresponding charges that appear in column 4 (PEP only Episodes) do not include any visit counts and corresponding charges that appear in column 5 (SCIC within a PEP) and vice versa. This is true for all episode of care payment categories in columns 1 through 6.

Line 42.--Enter in columns 1 through 6 for each episode of care payment category, respectively, the sum total of visits from lines 30, 32, 34, 36, 38 and 40.

Line 43. -- Enter in columns 1 through 6 for each episode of care payment category, respectively, the sum total of other charges for all other unspecified services reimbursed under PPS.

Line 44.--Enter in columns 1 through 6 for each episode of care payment category, respectively, the sum total of visit charges from lines 31, 33, 35, 37, 39, 41 and 43.

NOTE: The standard episodes entered on line 9 and outlier episodes entered on line 46 are mutually exclusive.

Line 45.--Enter in columns 1 and 3 through 6 for each episode of care payment category, respectively, the total number of episodes of standard episodes of care rendered and concluded in the provider's fiscal year.

Line 46.--Enter in columns 2 and 4 through 6 for each episode of care payment category identified, respectively, the total number of outlier episodes of care rendered and concluded in the provider's fiscal year. Outlier episodes do not apply to columns 1 and 3 (Full Episodes without Outliers and LUPA Episodes, respectively).

Line 47. -- Enter in columns 1 through 6 for each episode of care payment category, respectively, the total non-routine medical supply charges for services rendered and concluded in the provider's fiscal year.

Column 7. -- Enter on lines 30 through 47, respectively, the sum total of amounts from columns 1 through 6.

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3206. WORKSHEET A - RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

Worksheet A provides for recording the trial balance of expense accounts from your accounting books and records. It also provides for the necessary reclassifications and adjustments to certain accounts prior to the cost finding calculations. Also include on Worksheets A, A-1, A-2, and A-3 all expenses incurred for only those visits completed in the current reporting period when the episode of care overlaps the cost report year end. For cost reporting periods beginning on or after October 1, 2000, do not complete Worksheets A-1, A-2 and A-3. Enter directly on Worksheet A the total expenses for Salaries and Wages (column 1), Employee Benefits (column 2) and Contracted/Purchased Services (column 4) in the appropriate cost center.

The cost centers on this worksheet are listed in a manner which facilitates the transfer of the various cost center data to the cost finding worksheets. Each of the cost centers listed does not apply to all providers using these forms. Therefore, use those cost centers applicable to your type of HHA.

Under certain conditions, a provider may elect to use different cost centers for allocation purposes. These conditions are stated in CMS Pub. 15-*1*, §2313.

Standard (i.e., preprinted) CMS line numbers and cost center descriptions cannot be changed. If a provider needs to use additional or different cost center descriptions, it may do so by adding additional lines to the cost report. Added cost centers must be appropriately coded. Identify the added line as a numeric subscript of the immediately preceding line. That is, if two lines are added between lines *2* and *3*, identify them as lines *2*.01 and *2*.02. If additional lines are added for general services cost centers, corresponding columns must be added to Worksheets B and B-1 for cost finding.

NOTE: Cost centers appearing on Worksheet A, *l*ines 6 *through* 11 may not be subscripted beyond those which are preprinted. (See CMS Pub. 15-*1*, §2313.2c)

Submit the working trial balance of the facility with the cost report. A working trial balance is a listing of the balances of the accounts in the general ledger to which adjustments are appended in supplementary columns and is used as a basic summary for financial statements.

Cost center coding is a methodology for standardizing the meaning of cost center labels as used by health care providers on the Medicare cost reports. The Form CMS 1728-94 provides for preprinted cost center descriptions on Worksheet A. In addition, a space is provided for a cost center code. The preprinted cost center labels are automatically coded by CMS approved cost reporting software. These cost center descriptions are hereafter referred to as the standard cost centers. One additional cost center description with general meaning has been identified. This additional description will hereafter be referred to as a nonstandard label with an "Other..." designation to provide for situations where no match in meaning to the standard cost centers can be found. Refer to Worksheet A, line 23.

The use of this coding methodology allows providers to continue to use labels for cost centers that have meaning within the individual institution. The four digit cost center codes that are associated with each provider label in their electronic file provide standardized meaning for data analysis. The preparer is required to compare any added or changed label to the descriptions offered on the standard or nonstandard cost center tables. A description of cost center coding and the table of cost center codes are in *§3295*, Table 5 of the electronic reporting specifications.

If the cost elements of a cost center are separately maintained on your books, you must maintain a reconciliation of the costs per the accounting books and records to those on this worksheet. The reconciliation is subject to review by the *contractor*.

Column 1.--Obtain the expenses listed from Worksheet A-1. The sum of column 1 must equal Worksheet A-1, column 9, line 29. *For cost reporting periods beginning on or after October 1, 2000, do not complete Worksheet A-1. Enter the total expenses for Salaries and Wages in the appropriate cost center*

Column 2.--Obtain the expenses listed from Worksheet A-2. The sum of column 2 must equal Worksheet A-2, column 9, line 29. *For cost reporting periods beginning on or after October 1, 2000, do not complete Worksheet A-2. Enter the total expenses for Employee Benefits in the appropriate cost center*

Column 3.--If the transportation costs, i.e., owning or renting vehicles, public transportation expenses, or payments to employees for driving their private vehicles can be directly identified to a particular cost center, enter those costs in the appropriate cost center. If these costs are not identifiable to a particular cost center, enter them on line 4.

Column 4.--Obtain the expenses listed in this column from Worksheet A-3. The sum of column 4 must equal Worksheet A-3, column 9, line 29. *For cost reporting periods beginning on or after October 1, 2000, do not complete Worksheet A-3. Enter the total expenses for Contracted/Purchased Services in the appropriate cost center.*

Column 5.--Enter on the applicable lines in column 5 all agency costs which have not been reported in columns 1 through 4.

Column 6.--Add the amounts in columns 1 through 5 for each cost center and enter the totals in column 6.

Column 7.--Enter any reclassifications among the cost center expenses in column 6 which are needed to effect proper cost allocation.

Worksheet A-4 reflects the reclassifications affecting the cost center expenses. This worksheet need not be completed by all providers, but is completed only to the extent reclassifications are needed and appropriate in the particular *provider's* circumstances. Show reductions to expenses in parentheses ( ).

The net total of the entries in column 7 must equal zero on line 29.

Column 8.--Adjust the amounts entered in column 6 by the amounts entered in column 7 (increase or decrease) and extend the net balances to column 8. The total of column 8 must equal the total of column 6 on line 29.

Column 9.--Enter on the appropriate lines the amounts of any adjustments to expenses indicated on Worksheet A-5, column 2. The amount on Worksheet A, column 9, line 29 must equal the amount on Worksheet A-5, column 2, line 21.

Column 10.--Adjust the amounts in column 8 by the amounts in column 9 (increase or decrease) and extend the net balances to column 10.

Transfer the amounts in column 10, lines 1 through 29, to the corresponding lines on Worksheet B, column 0.

Line Descriptions

Lines 1 and 2.--These cost centers include depreciation, leases and rentals for the use of facilities and/or equipment, interest incurred in acquiring land or depreciable assets used for patient care, insurance on depreciable assets used for patient care, and taxes on land or depreciable assets used for patient care.

Line 3.--Enter the direct expenses incurred in the operation and maintenance of the plant and equipment, maintaining general cleanliness and sanitation of the plant, and protecting employees, visitors, and agency property.

Line 4.--Enter all of the cost of transportation except those costs previously directly assigned in column 3. This cost is allocated during the cost finding process.

Line 5.--Use this cost center to record the expenses of several costs which benefit the entire facility. Examples include fiscal services, legal services, accounting, data processing, taxes, and malpractice costs. *If the option to componentize A&G costs into more than one cost center is elected, eliminate line 5. Componentized A&G lines must begin with subscripted line 5.01 and continue in sequential order (e.g., 5.01 A&G shared costs).*

Line 6.--Skilled nursing care is a service that must be provided by or under the supervision of a registered nurse. The complexity of the service, as well as the condition of the patient, are factors to be considered when determining whether skilled nursing services are required. Additionally, the skilled nursing services must be required under the plan of treatment.

Line 7.--Enter the direct costs of physical therapy services by or under the direction of a registered physical therapist as prescribed by a physician. The therapist provides evaluation, treatment planning, instruction, and consultation.

Line 8.--These services include (1) teaching of compensatory techniques to permit an individual with a physical impairment or limitation to engage in daily activities; (2) evaluation of an individual's level of independent functioning; (3) selection and teaching of task-oriented therapeutic activities to restore sensory-integrative function; and (4) assessment of an individual's vocational potential, except when the assessment is related solely to vocational rehabilitation.

Line 9.--These are services for the diagnosis and treatment of speech and language disorders that create difficulties in communication.

Line 10.--These services include (1) assessment of the social and emotional factors related to the individual's illness, need for care, response to treatment, and adjustment to care furnished by the facility; (2) casework services to assist in resolving social or emotional problems that may have an adverse effect on the beneficiary's ability to respond to treatment; and (3) assessment of the relationship of the individual's medical and nursing requirements to his or her home situation, financial resources, and the community resources available upon discharge from facility care.

Line 11.--Enter the cost of home health aide services. The primary function of a home health aide is the personal care of a patient. The services of a home health aide are given under the supervision of a registered professional nurse and, if appropriate, a physical, speech, or occupational therapist. The assignment of a home health aide to a case must be made in accordance with a written plan of treatment established by a physician which indicates the patient's need for personal care services. The specific personal care services to be provided by the home health aide must be determined by a registered professional nurse and not by the home health aide.

Line 12.--The cost of medical supplies reported in this cost center are those costs which are directly identifiable supplies furnished to individual patients and for which a separate charge is made. These supplies are generally specified in the patient's plan of treatment and furnished under the specific direction of the patient's physician.

Medical supplies which are not reported on this line are those minor medical and surgical supplies which would not be expected to be specifically identified in the plan of treatment or for which a separate charge is not made. These supplies (e.g., cotton balls, alcohol prep) are items that are frequently furnished to patients in small quantities (even though in certain situations, these items may be used in greater quantity) and are reported in the administrative and general (A&G) cost center.

Line 13.--Enter the costs of vaccines and the cost of administering the vaccines. Also enter the cost and administration of pneumococcal and influenza vaccines to Medicare beneficiaries receiving services on or after January 1, 1998 in an HHA-based RHC and/or an HHA-based FQHC. A visit by an HHA nurse for the sole purpose of administering a vaccine is not covered as an HHA visit under the home health benefit, even though the patient may be an eligible home health beneficiary receiving services under a home health plan of treatment. Section 1862(a) (1) (B) of the Act excludes Medicare coverage of vaccines and their administration other than the Part B coverage contained in §1861 of the Act.

If the vaccine is administered in the course of an otherwise covered home health visit, the visit would be covered as usual, but the cost and charges for the vaccine and its administration must be excluded from the cost and charges of the visit. The HHA would be entitled to separate payment for the vaccine and its administration under the Part B vaccine benefit.

Some of the expenses includable in this cost center would be the costs of syringes, cotton balls, bandages, etc., but the cost of travel is not permissible as a cost of administering vaccines, nor is the travel cost includable in the A&G cost center. The travel cost is non-reimbursable. Attach a schedule detailing the methodology employed to develop the administration of these vaccines. These vaccines are reimbursable under Part B only.

In accordance with Change Request 4240, dated March 17, 2006, effective for services rendered on or after July 1, 2006, the cost of administering pneumococcal, influenza, and hepatitis B vaccines is reimbursed under the outpatient prospective payment system (OPPS), but the actual cost of the pneumococcal, influenza, and hepatitis B vaccines will remain cost reimbursed. For cost reporting periods ending on or after July 1, 2006, enter on this line the vaccine cost (exclusive of the cost to administer these vaccines) incurred for pneumococcal, influenza, and hepatitis B vaccines. Continue to include the cost of osteoporosis vaccines and the cost of administering the osteoporosis vaccines on this line.

Line 13.20.--Enter the cost incurred to administer pneumococcal, influenza, and hepatitis B vaccines. Use cost center code 1320 in accordance with table 5 of the electronic reporting specifications for the appropriate cost center code.

Line 14.--Enter the direct expenses incurred in renting or selling durable medical equipment (DME) items to the patient for the purpose of carrying out the plan of treatment. Also, include all the direct expenses incurred by you in requisitioning and issuing the DME to patients.

Line 15.--Enter the cost of home dialysis aide services furnished in connection with a home dialysis program.

Line 16.--These are services for the assessment, diagnostic evaluation, treatment, management, and monitoring of patients with deficiencies or abnormalities of cardiopulmonary function.

Line 23.--Enter the direct costs of all other non-reimbursable services. Enter the direct costs associated with TeleMedicine on line 23.20. See table 5 of the electronic reporting specifications for the appropriate cost center code.

Line 24.--Enter the direct costs of the HHA-based CORF.

Line 25.--Enter the direct costs associated with the HHA-based hospice.

Line 26.--Enter the direct costs associated with the HHA-based CMHC.

Line 27.--Enter the direct costs associated with the HHA-based RHC. *

Line 28.--Enter the direct costs associated with the HHA-based FQHC. *

Line 29.--Enter the total of lines 1 through 28.

* For cost reporting periods overlapping the January 1, 1998 effective date for the new RF worksheet series, enter the direct costs associated with the HHA-based RHC and/or FQHC as applicable for the entire cost reporting period. The A worksheet series will reflect costs for the entire cost reporting period, not just the costs for services rendered exclusively before or exclusively after the effective date.

3207. WORKSHEET A-1 - COMPENSATION ANALYSIS - SALARIES AND WAGES

A small HHA, as defined in 42 CFR 413.24(d), does not have to complete Worksheet A-1.

Enter all salaries and wages for the HHA on this worksheet for the actual work performed within the specific area or cost center in accordance with the column headings. For example, if the administrator also performs skilled nursing care which accounts for 25 percent of that person's time, then enter 75 percent of the administrator's salary on line 5 (A&G) and 25 percent of the administrator's salary enter on line 6 (skilled nursing care).

The records necessary to determine the split in salary between two or more cost centers must be maintained by the HHA and must adequately substantiate the method used to split the salary. These records must be available for audit by the *contractor* and the *contractor* can accept or reject the method used to determine the split in salary. When approval of a method has been requested in writing and this approval has been received prior to the beginning of a cost reporting period, the approved method remains in effect for the requested period and all subsequent periods until you request in writing to change to another method or until the *contractor* determines that the method is no longer valid due to changes in your operations.

Definitions

Salary.--This is gross salary paid to the employee before taxes and other items are withheld, including deferred compensation, overtime, incentive pay, and bonuses. (See CMS Pub. 15-*1*, Chapter 21.)

Administrators (Column 1).--

Possible Titles: President, Chief Executive Officer

Duties: This position is the highest occupational level in the agency. This individual is the chief management official in the agency. The administrator develops and guides the organization by taking responsibility for planning, organizing, implementing, and evaluating. The administrator is responsible for the application and implementation of established policies. The administrator may act as a liaison among the governing body, the medical staff, and any departments. The administrator provides for personnel policies and practices that adequately support sound patient care and maintains accurate and complete personnel records. The administrator implements the control and effective utilization of the physical and financial resources of the provider.

Directors (Column 2).--

Possible Titles: Medical Director, Director of Nursing, or Executive Director

Duties: The medical director is responsible for helping to establish and assure that the quality of

medical care is appraised and maintained. This individual advises the chief executive officer on medical and administrative problems and investigates and studies new developments in medical practices and techniques.

The nursing director is responsible for establishing the objectives for the department of nursing. This individual administers the department of nursing and directs and delegates management of professional and ancillary nursing personnel.

Supervisors (Column 4).--Employees in this classification are primarily involved in the direction, supervision, and coordination of HHA activities.

When a supervisor performs two or more functions, e.g., supervision of nurses and home health aides, the salaries and wages must be split in proportion with the percent of the supervisor's time spent in each cost center providing the HHA maintains the proper records (continuous time records) to support the split. If continuous time records are not maintained by the HHA, enter the entire salary of the supervisor on line 5 (A&G) and allocate to all cost centers through stepdown. However, if the supervisor's salary is all lumped in one cost center, e.g., skilled nursing care, and the supervisor's title coincides with this cost center, e.g., nursing supervisor, no adjustment is required.

Therapists (Column 6).--Include in column 6, on the line indicated, the cost attributable to the following services:

Physical therapy	-	line 7
Occupational therapy	-	line 8
Speech pathology	-	line 9
Medical social services	-	line 10

Physical therapy is the provision of physical or corrective treatment of bodily or mental conditions by the use of physical, chemical, and other properties of heat, light, water, electricity, sound, massage, and therapeutic exercise by or under the direction of a registered physical therapist as prescribed by a physician. The physical therapist provides evaluation, treatment planning, instruction, and consultation. Activities include, but are not limited to, the following: application of muscle tests and other evaluative procedures; formulation and provision of therapeutic exercise and other treatment programs upon physician referral or prescription; instructing and counseling patients, relatives, or other personnel; and consultation with other health workers concerning a patient's total treatment program.

Occupational therapy is the application of purposeful, goal-oriented activity in the evaluation, diagnosis, and/or treatment of persons whose function is impaired by physical illness or injury, emotional disorder, congenital or developmental disability, or the aging process, in order to achieve optimum functioning, to prevent disability, and to maintain health. Specific occupational therapy services include, but are not limited to, education and training in activities of daily living (ADL); the design, fabrication, and application of splints; sensorimotor activities; the use of specifically designed crafts; guidance in the selection and use of adaptive equipment; therapeutic activities to enhance functional performance; prevocational evaluation and training; and consultation concerning the adaptation of physical environments for the handicapped. These services are provided to individuals in their place of residence by or under the direction of an occupational therapist as prescribed by a physician.

Speech-language pathology is the provision of services to persons with impaired functional communications skills by or under the direction of a qualified speech-language pathologist as prescribed by a physician. This includes the evaluation and management of any existing disorders of the communication process centering entirely, or in part, on the reception and production of speech and language related to organic and/or nonorganic factors. Professional services provided by this cost center are grouped into a minimum of three major areas: (1) diagnostic assessment and evaluation, including clinical appraisal of speech, voice, and language competencies, through standardized and other tasks, to determine need for and types of rehabilitation required; (2) rehabilitative treatment, including planning and conducting treatment programs on an individual basis, to develop, restore, or improve communicative efficiency of persons disabled in the process of speech, voice, and/or language; and (3) continuing evaluation/periodic reevaluation, including both standardized and informal procedures, to monitor progress and verify current status. Additional activities include, but are not limited to, the following: preparation of written diagnostic, evaluative, and special reports; provision of extensive counseling and guidance to communicatively-handicapped individuals and their families; and consultation with other health care practitioners concerning a patient's total treatment program.

Medical social services is the provision of counseling and assessment activities which contribute meaningfully to the treatment of a patient's condition. These services must be under the direction of a physician and must be given by or under the supervision of a qualified medical or psychiatric social worker. Such services include, but are not limited to, the following: assessment of the social and emotional factors related to the patient's illness, the patient's need for care, the patient's response to treatment, and the patient's adjustment to care; appropriate action to obtain case work services to assist in resolving problems in these areas; and assessment of the relationship of the patient's medical and nursing requirements to the patient's home situation, the patient's financial resources, and the community resources available to the patient.

Aides (Column 7).--Included in this classification are specially trained personnel employed for providing personal care services to patients. These employees are subject to Federal wage and hour laws.

The reason for the home health aide services must be to provide hands-on, personal care services under the supervision of a registered professional nurse, and, if appropriate, a physical, speech, or occupational therapist or other qualified person.

This function is performed by specially trained personnel who assist individuals in carrying out physicians instructions and established plan of care. Additional services include, but are not limited to, assisting the patient with activities of daily living (helping patient to bathe, to get in and out of bed, to care for hair and teeth); to exercise; to take medications specially ordered by a physician which are ordinarily self-administered; and assisting the patient with necessary self-help skills.

Total (Column 9).--Add the amounts of each cost center, columns 1 through 8, and enter the total in column 9. Transfer these totals to Worksheet A, column 1, lines as applicable. To facilitate transferring amounts from Worksheet A-1 to Worksheet A, the same cost centers with corresponding line numbers are listed on both worksheets. Not all of the cost centers are applicable to all agencies. Therefore, use only those cost centers applicable to your HHA.

3208. WORKSHEET A-2 - COMPENSATION ANALYSIS - EMPLOYEE BENEFITS (PAYROLL RELATED)

A small HHA, as discussed in 42 CFR 413.24(d), does not have to complete Worksheet A-2. If Worksheet A-2 is not required, enter the employee benefit amounts in the appropriate cost center on Worksheet A, column 2.

Enter all payroll-related employee benefits for the HHA on this worksheet. See CMS Pub. 15-*1*, chapter 21, for a definition of fringe benefits. Use the same basis as that used for reporting salaries and wages on Worksheet A-1. Therefore, using the same example as given for Worksheet A-1, enter 75 percent of the administrator's payroll-related fringe benefits on line 5 (A&G) and enter 25 percent of the administrator's payroll-related fringe benefits on line 6 (skilled nursing care).

Payroll-related employee benefits must be reported in the cost center that the applicable employee's compensation is reported. This assignment can be performed on an actual basis or upon the following basis:

- FICA - actual expense by cost center;

- Pension and retirement and health insurance (nonunion) (gross salaries of participating individuals by cost center);

- Union health and welfare (gross salaries of participating union members by cost center); and

- All other payroll-related benefits (gross salaries by cost center). Include non payroll-related employee benefits in the A&G cost center, e.g., cost for personal education, recreation activities, and day care.

Add the amounts of each cost center, columns 1 through 8, and enter the total in column 9. Transfer these totals to Worksheet A, column 2, corresponding lines. To facilitate transferring amounts from Worksheet A-2 to Worksheet A, the same cost centers with corresponding line numbers are listed on both worksheets.

3209. WORKSHEET A-3 - COMPENSATION ANALYSIS - CONTRACTED SERVICES/ PURCHASED SERVICES

A small HHA, as defined in 42 CFR 413.24(d), does not have to complete Worksheet A-3.

All other agencies must enter on this worksheet all contracted and/or purchased services for the HHA. Enter the contracted/purchased cost on the appropriate cost center line within the column heading which best describes the type of services purchased. For example, where physical therapy services are purchased, enter the contract cost of the therapist in column 6, line 7. If a contracted/purchased service covers more than one cost center, then the amount applicable to each cost center is included on each affected cost center line. Add the amounts of each cost center, columns 1 through 8, and enter the total in column 9. Transfer these totals to Worksheet A, column 4, corresponding lines. To facilitate transferring amounts from Worksheet A-3 to Worksheet A, the same cost centers with corresponding line numbers are listed on both worksheets.

3210. WORKSHEET A-4 - RECLASSIFICATIONS

This worksheet provides for the reclassification of expense accounts to effect proper cost allocation under cost finding. The following are some examples of costs which may need to be reclassified.

A. Licenses and Taxes (Other Than Income Taxes).--This expense consists of the business license expense and tax expense incidental to the operation of the agency. Such expenses are normally included in the A&G cost centers.

Licenses and taxes applicable to buildings and fixtures must be reclassified to the capital related - buildings and fixtures account (Worksheet A, line 1). Any licenses and taxes which cannot be identified to a specific cost center and are incidental to the general overall operation of the agency must be included in the A&G account (Worksheet A, line 5).

B. Interest.--Interest expense related to loans for agency working capital is includable in A&G (Worksheet A, line 5). Interest expense attributable to mortgages on buildings is includable in capital related - buildings and fixtures (Worksheet A, line 1). Interest related to loans for movable equipment is includable in capital related - movable equipment (Worksheet A, line 2).

C. Insurance - Malpractice.--Malpractice insurance may be reclassified to cost centers, other than A&G, only if the insurance policy specifically identifies the premium for each cost center involved.

D. Services Under Arrangements.--Where a provider purchases services (e.g., physical therapy) under arrangements for Medicare patients, but does not purchase such services under arrangements for non-Medicare patients, the providers' books reflect only the cost of the Medicare services. However, if the provider does not use the grossing up technique for purposes of allocating overhead, and if the provider incurs related direct costs applicable to all patients, Medicare and non-Medicare (e.g., paramedics or aides who assist a physical therapist in performing physical therapy services), reclassify such related costs from the HHA reimbursable service cost center and allocate them as part of administrative and general expense.

E. Leases.--This expense consists of all rental costs of buildings and equipment incidental to the operation of the HHA. Leases applicable to buildings or movable equipment must be reclassified to the capital related account. Any lease which cannot be identified to a special cost center and is incidental to the general overall operation of the agency must be included in the A&G account (Worksheet A, line 5).

3211. WORKSHEET A-5 - ADJUSTMENTS TO EXPENSES

In accordance with 42 CFR 413.9(c) (3), if the provider's operating costs include amounts not related to patient care, these amounts are not reimbursable under the program. If operating costs include amounts flowing from the provision of luxury items or services (i.e., those items or services substantially in excess of or more expensive than those generally considered necessary for the provision of needed health services), such amounts are not allowable.

This worksheet provides for the adjustments to the expenses listed on Worksheet A, column 8. These adjustments, which are required under the Medicare principles of reimbursement, are to be made on the basis of cost or amount received (revenue) only if the costs (including direct costs and all applicable overhead) cannot be determined. If the total direct and indirect cost can be determined, enter the cost. Submit with the cost report a copy of any workpapers used to compute a cost adjustment. Once an adjustment to an expense is made on the basis of cost, you may not determine the required adjustment to the expense on the basis of revenue in future cost reporting periods. Enter the following symbols in column 1 to indicate the basis for adjustment: "A" for cost, "B" for amount received. Line descriptions indicate the more common activities which affect allowable costs or result in costs incurred for reasons other than patient care and, thus, require adjustments.

Types of items entered on Worksheet A-5 are: (1) those needed to adjust expenses to reflect actual expenses incurred; (2) those items which constitute recovery of expenses through sales, charges, fees, etc.; (3) those items needed to adjust expenses in accordance with the Medicare principles of reimbursement; and (4) those items which are provided for separately in the cost apportionment process.

When an adjustment to an expense affects several cost centers, record the adjustment to each cost center on a different line.

Line Descriptions

Line 1--Enter funds received from miscellaneous sources not specifically listed on this schedule.

Line 4--Enter allowable home office costs which have been allocated to the provider. Use additional lines to the extent that various provider cost centers are affected. (See CMS Pub. 15-*1*, chapter 21.)

Line 5--Enter the amount from Worksheet A-6, Part B, column 6, line 4. Note that Worksheet A-6, Part B, lines 1 through 3, represent the detail of the various cost centers to be adjusted on Worksheet A.

Line 6--Enter the amount received from the sale of medical records and abstracts and offset the amount against the A&G cost centers.

Line 7--Enter the cash received from imposition of interest, finance, or penalty charges on overdue receivables. This income must be used to offset the allowable A&G costs. (See CMS Pub. 15-*1*, chapter 21.)

Line 10--Where an HHA purchases physical therapy services furnished by an outside supplier, Worksheet A-8-3 must be completed to compute the reasonable cost determination. Enter any adjustment (excess cost over limitation) from Worksheet A-8-3, Part V, line 49 for physical therapy services furnished prior to April 10, 1998 and on or after April 10, 1998.

Line 10.1--Where an HHA purchases occupational therapy services furnished on or after April 10, 1998 by an outside supplier, Worksheet A-8-3 must be completed to compute the reasonable cost determination. Enter any adjustment (excess cost over limitation) from Worksheet A-8-3, Part V, line 49.

Line 10.2--Where an HHA purchases speech pathology services furnished on or after April 10 1998 by an outside supplier, Worksheet A-8-3 must be complete to compute the reasonable cost determination. Enter any adjustment (excess cost over limitation) from Worksheet A-8-3, Part V, line 49.

Line 11--Enter interest expense imposed by the *contractor* on Medicare overpayments to the provider. Also, enter the interest expense on loans incurred to repay Medicare overpayments to the provider.

Line 12--Enter the expense incurred for political and lobbying activities be identified and disallowed. For prior cost reporting periods, policy does not require identification, but does require disallowance of any identified portion in accordance with CMS Pub. 15-*1*, §§2139 - 2139.3

Lines 13 through 20--Enter any additional adjustments that are required under the Medicare principles of reimbursement that affects proper cost allocation of expenses. For example, the total costs incurred by an HHA pursuant to a contract, on behalf of the agency, are unallowable costs if (1) the contract is entered into a period exceeding 5 years, or (2) the amount payable by the HHA under the contract is based on a percentage of the agency's reimbursement, or claim for reimbursement, for services furnished by the agency.

Label the lines to indicate the nature of the required adjustments. (See CMS Pub. 15-1, §2117.)

3212 WORKSHEET A-6 STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS

In accordance with 42 CFR 413.17, costs applicable to services, facilities, and supplies furnished to the provider by organizations related by common ownership or control are includable in the allowable costs at the cost to the related organization except for the exceptions outlined in 42 CFR 413.17(d). This worksheet provides for the computation of any needed adjustments to costs applicable to services, facilities, and supplies furnished to the HHA by related organizations. In addition, certain information concerning the related organizations with which the provider has transacted business must be shown. (See CMS Pub. 15-*1*, §1004.)

Part A--This must be completed by all providers. If the answer to Part A is "Yes," Parts B and C must also be completed.

Part B--Costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control are includable in the allowable costs of the provider at the related organizations. However, such costs must not exceed the amount a prudent and cost conscious buyer would pay for the comparable services, facilities, or supplies that are purchased elsewhere.

Part C--This part shows the interrelationship of the provider to organizations, furnishing services, facilities, or supplies to the provider. The requested data relative to all individuals, partnerships, corporations, or other organizations having either a related interest to the provider, a common ownership with the provider, or control over the provider as defined in CMS Pub. 15-1, §1004, must be shown in columns 1 through 6, as appropriate.

Complete only those columns that are pertinent to the type of relationship indicated.

Column 1--Enter the appropriate symbol that describes the interrelationship of the provider to the related organization.

Column 2.--If the symbol A, D, E, F, or G is entered in column 1, enter the name of the related individual in column 2. If the symbol B or C is entered in column 1, enter the name of the related organization.

Column 3.--Enter the address of the individual or organization listed in column 2.

Column 4.--If the individual in column 2 or the provider has a financial interest in the related organization, enter the percent of ownership in such organization.

Column 5.--If the individual in column 2 or the organization in column 2 has a financial interest in the provider, enter the percent of ownership in the provider.

Column 6.--Enter the type of business in which the related organization engages (e.g., medical drugs and/or supplies, laundry and linen service).

3213. WORKSHEET A-7 - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCE

Columns 1 and 6.--Enter the balance recorded in your books at the beginning of your cost reporting period (column 1) and at the end of your cost reporting period (column 6).

Columns 2 through 4.--Enter the cost of capital assets acquired by purchase in column 2. In column 3, enter the fair market value, at date acquired, for donated assets. Enter the sum of columns 2 and 3 in column 4.

Column 5.--Enter the cost or other basis of all capital assets sold, traded or transferred, retired, or disposed of in any manner during your cost reporting period.

The sum of columns 1 and 4 minus column 5 equals column 6.

3214. WORKSHEET B - COST ALLOCATION - GENERAL SERVICE COSTS AND WORKSHEET B-1 - COST ALLOCATION - STATISTICAL BASIS

Worksheet B provides for the allocation of the expenses of each general service cost center to those cost centers which receive the services. The cost centers serviced by the general service cost centers include all cost centers within the provider organization, i.e., other general service cost centers, reimbursable cost centers, nonreimbursable cost centers, and special purpose cost centers. Obtain the total direct expenses from Worksheet A, column 10. To facilitate transferring amounts from Worksheet A to Worksheet B, the same cost centers with corresponding line numbers (lines 1 through 29) are listed on both worksheets.

Worksheet B-1 provides for the proration of the statistical data needed to equitably allocate the expenses of the general service cost centers on Worksheet B.

To facilitate the allocation process, the general format of Worksheets B and B-1 are identical. The column and line numbers for each general service cost center are identical on the two worksheets. In addition, the line numbers for each general, reimbursable, nonreimbursable, and special purpose cost centers are identical on the two worksheets. The cost centers and line numbers are also consistent with Worksheets A, A-1, A-2, and A-3. If the provider has subscripted any lines on these A worksheets, the provider must subscript the same lines on the B worksheets.

NOTE: General service columns 1 through 5 and subscripts thereof must be consistent on Worksheets B and B-1; CM-1, Parts I and III; and K-5, Parts I and II.

The statistical bases shown at the top of each column on Worksheet B-1 are the recommended bases of allocation of the cost centers indicated. If a different basis of allocation is used, the provider must indicate the basis of allocation actually used at the top of the column.

Most cost centers are allocated on different statistical bases. However, for those cost centers where the basis is the same (e.g., square feet), the total statistical base over which the costs are to be allocated will differ because of the prior elimination of cost centers that have been closed.

Close the general service cost centers in accordance with 42 CFR 413.24(d)(1) which states, in part, that the cost of nonrevenue-producing cost centers serving the greatest number of other centers, while receiving benefits from the least number of centers, is apportioned first. This is further clarified in CMS Pub. 15-*1*, §2306.1 which also clarifies the order of allocation for stepdown purposes. Consequently, first close those cost centers that render the most services to and receive the least services from other cost centers. The cost centers are listed in this sequence from left to right on the worksheet. However, the circumstances of an agency may be such that a more accurate result is obtained by allocating to certain cost centers in a sequence different from that followed on these worksheets.

NOTE: A change in order of allocation and/or allocation statistics is appropriate for the current fiscal year cost if received by the *contractor*, in writing, within 90 days prior to the end of that fiscal year. The *contractor* has 60 days to make a decision or the change is automatically accepted. The change must be shown to more accurately allocate the overhead or, if it is accurate, should be changed due to simplification of maintaining the statistics. If a change in statistics is made, the provider must maintain both sets of statistics until an approval is made. If both sets are not maintained and the request is denied, the provider will revert back to the previously approved methodology. The provider must include with the request all supporting documentation and a thorough explanation of why the alternative approach should be used. (See CMS Pub. 15-*1*, §2313.)

EXCEPTION: A small HHA, as defined in 42 CFR 413.24(d), does not have to request written permission to use the procedures outlined for small HHAs below.

If the amount of any cost center on Worksheet A, column 10, has a credit balance, show this amount as a credit balance on Worksheet B, column 0. Allocate the costs from the applicable overhead cost centers in the normal manner to the cost center showing a credit balance. After receiving costs from the applicable overhead cost centers, if a general service cost center has a credit balance at the point it is allocated; do not allocate the general service cost center. Rather, enter the credit balance on the first line of the column and on line 29. This enables column 6, line 29, to crossfoot to columns 0 and 4A, line 29. After receiving costs from the applicable overhead cost centers, if a revenue producing cost center has a credit balance on Worksheet B, column 6, do not carry forward a credit balance to any worksheet.

On Worksheet B-1, enter on the first line in the column of the cost center the total statistics applicable to the cost center being allocated (e.g., in column 1, capital-related - buildings and fixtures, enter on line 1 the total square feet of the building on which depreciation was taken). Use accumulated cost for allocating administrative and general expenses.

Such statistical base does not include any statistics related to services furnished under arrangements except where both Medicare and non-Medicare costs of arranged for services are recorded in your records.

For all cost centers (below the cost center being allocated) to which the service rendered is being allocated, enter that portion of the total statistical base applicable to each. The total sum of the statistical base applied to each cost center receiving the services rendered must equal the total statistics entered on the first line.

Enter on Worksheet B-1, line 30, the total expenses of the cost center to be allocated. Obtain this amount from Worksheet B from the same column and line number of the same column. In the case of capital-related costs - buildings and fixtures, this amount is on Worksheet B, column 1, line 1.

Divide the amount entered on line 30 by the total statistical base entered in the same column on the first line. Enter the resulting unit cost multiplier on line 31. Round the unit cost multiplier to at least the nearest six decimal places.

Multiply the unit cost multiplier by that portion of the total statistical base applicable to each cost center receiving the services rendered. Enter the result of each computation on Worksheet B in the corresponding column and line.

After the unit cost multiplier has been applied to all the cost centers receiving costs, the total expenses (line 30) of all of the cost centers receiving the allocation on Worksheet B must equal the amount entered on the first line of the cost center being allocated.

The preceding procedures must be performed for each general service cost center. Each cost center must be completed on both Worksheets B and B-1 before proceeding to the next cost center.

After all the costs of the general service cost centers have been allocated on Worksheet B, enter in column 6 the sum of the expenses on lines 6 through 28. The total expenses entered in column 6, line 29, should equal the total expenses entered in column 0, line 29.

Transfer the amounts in column 6 to Worksheet C, column 2, as follows:

From Worksheet B Column 6	To Worksheet C Column 2
Line 6	Line 1
7	2
8	3
9	4
10	5
11	6
12	15
13	16

Column Descriptions

Column 1--Depreciation on buildings and fixtures and expenses pertaining to buildings and fixtures such as insurance, interest, rent, and real estate taxes are combined in this cost center to facilitate cost allocation. Allocate all expenses to the cost centers on the basis of square feet of area occupied. The square footage may be weighted if the person who occupies a certain area of space spends their time in more than one function. For example, if a person spends 10 percent of time in one function, 20 percent in another function, and 70 percent in still another function, the square footage may be weighted according to the percentages of 10 percent, 20 percent, and 70 percent to the applicable functions.

If an HHA occupies more than one building (e.g., several branch offices), it may allocate the depreciation and related expenses by building, using a supportive worksheet showing the detail allocation and transferring the accumulated costs by cost center to Worksheet B, column 1.

Column 2--Allocate all expenses (e.g., interest, personal property tax) for movable equipment to the appropriate cost centers on the basis of square feet of area occupied or dollar value.

Column 4--The cost of vehicles owned or rented by the agency and all other transportation costs which were not directly assigned to another cost center on Worksheet A, column 3, is included in this cost center. Allocate this expense to the cost centers to which it applies on the basis of miles applicable to each cost center.

This basis of allocation is not mandatory and a provider may use weighted trips rather than actual miles as a basis of allocation for transportation costs which are not directly assigned. However, an HHA must request the use of the alternative method in accordance with CMS Pub. 15-*1*, §2313. The HHA must maintain adequate records to substantiate the use of this allocation.

Column 5--The A&G expenses are allocated on the basis of accumulated costs after reclassifications and adjustments. Therefore, obtain the amounts to be entered on Worksheet B-1, column 5, from Worksheet B, columns 0 through 4.

A negative cost center balance in the statistics for allocating A&G expenses causes an improper distribution of this overhead cost center. Negative balances are excluded from the allocation statistics when A&G expenses are allocated on the basis of accumulated cost.

A&G costs applicable to contracted services may be excluded from the total cost (Worksheet B, column 0) for purposes of determining the basis of allocation (Worksheet B-1, column 5) of the A&G costs. This procedure may be followed when the HHA contracts for services to be performed for the HHA and the contract identifies the A&G costs applicable to the purchased services.

The contracted A&G costs must be added back to the applicable cost center after allocation of the HHA A&G cost before the reimbursable costs are transferred to Worksheet C. A separate worksheet must be included to display the breakout of the contracted A&G costs from the applicable cost centers before allocation and the adding back of these costs after allocation. *Contractor* approval does not have to be secured in order to use the above described method of cost finding for A&G.

Worksheet B-1, Column 5A--Enter the costs attributable to the difference between the total accumulated cost reported on Worksheet B, column 4A, line 29 and the accumulated cost reported on Worksheet B-1, column 5, line 5. Enter any amounts reported on Worksheet B, column 4A for (1) any service provided under arrangements to program patients that is not grossed up and (2) negative balances. Including these costs in the statistics for allocating administrative and general expenses causes an improper distribution of overhead. In addition, report on line 5 the administrative and general costs reported on Worksheet B, column 5, line 5 since these costs are not included on Worksheet B-1, column 5 as an accumulated cost statistic.

For fragmented or componentized A&G cost centers, the accumulated cost center line number must match the reconciliation column number. Include in the column number the alpha character "A", i.e., if the accumulated cost center for A&G is line 5 (A&G), the reconciliation column designation must be 5A.

Worksheet B-1, Column 5--The administrative and general expenses are allocated on the basis of accumulated costs. Therefore, the amount entered on Worksheet B-l, column 5, line 5, is the difference between the amounts entered on Worksheet B, column 4A and Worksheet B-1, column 5A. A negative cost center balance in the statistics for allocating administrative and general expenses causes an improper distribution of this overhead cost center. Exclude negative balances from the allocation statistics.

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HHAs may establish multiple A&G cost centers (referred to as componentized or fragmented) by using one of two possible methodologies. The rationale for allocating the shared A&G service cost center first is that shared A&G cost centers service all other cost centers, while 100 percent of HHA A&G reimbursable and 100 percent of HHA A&G nonreimbursable only service their respective cost centers. That is consistent with 42 CFR 413.24(d)(1), which states, in part, that "the cost of nonrevenue-producing cost centers serving the greatest number of other centers, while receiving benefits from the least number of centers, is apportioned first." Under the first methodology (also referred to as option 1), the HHA must classify all A&G costs as either A&G shared costs, A&G reimbursable costs, or A&G nonreimbursable costs. That is, 100 percent of the componentized A&G costs relate exclusively to either the HHA reimbursable or HHA nonreimbursable cost centers. The remaining costs are classified as A&G shared costs. The componentized A&G costs are allocated through cost finding to their respective cost centers in aggregate. First, allocate A&G shared costs to all applicable cost centers, including to the A&G reimbursable and A&G nonreimbursable cost centers on the basis of accumulated costs. Then allocate HHA A&G reimbursable costs to all applicable HHA reimbursable cost centers (not including special purpose cost centers) on the basis of accumulated costs and allocate HHA A&G nonreimbursable costs to all applicable HHA nonreimbursable cost centers on the basis of accumulated costs. Only A&G shared costs will be allocated to the special purpose cost centers. Accordingly, the total A&G costs in the CORF, Hospice, CMHC, RHC, and FQHC worksheets must equal the corresponding A&G shared costs on Worksheet B. The following three A&G cost center categories will be created: (1) A&G shared costs, (2) 100 percent HHA reimbursable costs, and (3) 100 percent HHA nonreimbursable costs, in this order only. Do not allocate A&G reimbursable costs to the A&G nonreimbursable cost center. Calculate the accumulated cost statistics as follows:

A&G Cost Center	Sum of Worksheet B	Transfer to Worksheet B-1
A&G Shared Costs	Col. 0-4, lines 5.02-28	Col. 5.01, lines 5.02-28
A&G Reimb. Costs	Col. 0-5.01, lines 6-14	Col. 5.02, lines 6-14
A&G Nonreimb. Costs	Col. 0-5.01, lines 15-23	Col. 5.03, lines 15-23

Under the second methodology (also referred to as option 2), unique A&G cost centers may be created (see CMS Pub. 15-*1*, §2313.1) to further refine the allocation process. The statistical basis upon which to allocate fragmented A&G costs must represent, as accurately as possible, the consumption or usage of A&G services by the benefiting cost centers. HHAs wishing to use an alternative allocation methodology (i.e., a change in allocation basis or the sequence of cost center allocation) must do so in accordance with CMS Pub. 15-*1*, §2313.

The fragmentation of A&G costs may constitute a direct assignment of A&G costs and as such must follow the policy established under §2307 of CMS Pub. 15-*1*.

Column Descriptions for Small HHAs

Small home health agencies, as defined in 42 CFR 413.24(d), may use the following procedures for completing Worksheet B. Certain alterations must be made to the worksheets to accommodate these procedures and not all of the columns are used. Worksheet B-1 is not used in these procedures.

Column 0.--Enter the costs on each line from the corresponding line on Worksheet A, column 10.

Column 1.--Disregard the column title. Enter on line 5 the sum of lines 1 through 5 of column 0. Enter on lines 6 through 28 the amounts from column 0 for the corresponding lines. Divide the total on line 5 by the total of lines 6 through 28. This results in the unit cost multiplier (UCM). Round the UCM to six places.

Column 2.--Multiply the cost on each of the lines 6 through 28 in column 1 by the UCM and enter the result in column 2 for each line.

Columns 3, 4, and 5.--Not needed.

Column 6.--For lines 6 through 28, add the amounts on each line in columns 1 and 2, and enter the result for each line.

3215. WORKSHEET C - APPORTIONMENT OF PATIENT SERVICE COSTS

This worksheet provides for the apportionment of home health patient service costs to Title XVIII only.

NOTE: Certain services may be rendered by an HHA that are not covered under the home health provision of §1832(a)(2)(A) of the Act. These services are covered under a different provision, i.e., §1832(a)(2)(B) of the Act. Under §1832(a)(2)(B) of the Act, any provider may render the services authorized under that section. An HHA is a provider. Therefore, an HHA may render medical and other health services. These services are reimbursed in accordance with §1833(a)(2)(B) of the Act. If a beneficiary receives any of these services, the beneficiary is liable for coinsurance, i.e., 20 percent of reasonable charges. The reimbursement for these services is subject to the lesser of reasonable cost or customary charges (LCC), and such reimbursement cannot exceed 80 percent of the reasonable cost of these services. These services are considered as Medicare services reimbursable under Title XVIII of the Act and are includable as Medicare visits for statistical purposes. However, the costs associated with the visits are not subject to the cost per visit limit. (See 42 CFR 413.30.) The provider must maintain auditable records of the number of visits, charges, deductibles and coinsurance applicable to those visits. A separate reimbursement computation and a separate LCC computation is required.

These services are reimbursable under Part B only and will be entered in lines 15 and 16, columns 7 and 10 and lines 25 through 27, columns 3 through 8.

Payment on Basis of Location of Service.--Section 4604 of the Balanced Budget Act (BBA) of 1997, appends §1891(g) of the Social Security Act, effective for cost reporting periods beginning on or after October 1, 1997, requiring home health agencies to submit claims for payment for home health services under Title XVIII on the basis of the geographic location at which the service is furnished. This requires home health agencies to make Medicare program cost limitation comparisons based on the geographic location (MSA/CBSA) or Non-MSA/Non-CBSA) of services furnished to program beneficiaries. To accomplish this, Worksheet C, Part I, the aggregate cost per visit computation is completed one time for the entire home health agency. Worksheet C, Part II, computes the aggregate Medicare cost and the aggregate Medicare cost per visit limitation. Worksheet C, Part II is performed once for each MSA/CBSA and/or Non-MSA/Non-CBSA where Medicare covered services were furnished during the cost reporting period. Section 4601 of BBA 1997 (See §3215.4) requires HHA net cost of covered services to be based on the lesser of the aggregate Medicare cost, the aggregate of the Medicare cost per visit limitation or the aggregate per beneficiary cost limitation.

3215.1 Part I - Aggregate Agency Cost Per Visit Computation.--This part provides for the computation of the average home health agency cost per visit used to derive each MSA/CBSA's total allowable cost attributable to Medicare patient care visits. Complete this part once for the entire home health agency. This computation is required by 42 CFR 413.30 and 42 CFR 413.53.

Column Descriptions for Cost Per Visit Computation

Column 2.--Enter in column 2 the amount for each discipline from Worksheet B, column 6, lines as indicated.

Column 3.--Enter the total agency visits from statistical data (Worksheet S-3, column 5, lines 1. through 6) for each type of discipline on lines 1 through 6.

Column 4.--Compute the average cost per visit for each type of discipline. Divide the number of visits (column 3) into the cost (column 2) for each discipline.

3215.2 Part II - Computation of the Aggregate Medicare Cost and the Aggregate of the Medicare Limitation.--This part provides for the computation of the cost of Medicare patient care visits and the corresponding reasonable cost limitation for Medicare services provided in the MSA/CBSA/CBSA identified. Complete this part one time for each MSA/CBSA where Medicare beneficiary visits were provided during the cost reporting period. Lines 1 through 6 and column 11 are subscripted to isolate pre October 1, 2000 costs to facilitate the application of the lesser of aggregate costs or aggregate visit limits. Effective for cost reporting periods beginning on or after October 1, 2000, do not complete lines 8 through 14 as all HHAs are reimbursed under PPS and no longer subject to per visit cost limitations; but continue to complete lines 1 through 7.

Column 4.--Transfer the average cost per visit from Worksheet C, Part I, column 4, lines as indicated. The average cost per visit for each discipline is identical for all MSAs/CBSAs.

Columns 5 and 8.--To determine the Medicare Part A cost of services, multiply the number of covered Part A visits made to beneficiaries prior to October 1, 2000 (column 5, lines 1 through 6, excluding subscripts) from your records by the average cost per visit amount in column 4 for each discipline. Enter the product in column 8.

Columns 6 and 9.--To determine the Medicare Part B cost of services not subject to deductibles and coinsurance, multiply the number of visits made to Part B beneficiaries prior to October 1, 2000 (column 6, lines 1 through 6, excluding subscripts) from your records by the average cost per visit amount in column 4 for each discipline. Enter the product in column 9.

Columns 5 and 6, lines 1.01, 2.01, 3.01, 4.01, 5.01, 6.01.--Enter in column 5 the Medicare Part A visits furnished to program beneficiaries on or after October 1, 2000, for episodes completed during the fiscal year. Multiply the number of covered Part A visits from your records by the average cost per visit amount in column 4 for each discipline. Enter the product in column 8. Enter in column 6 the Medicare Part B visits not subject to deductibles and coinsurance furnished to program beneficiaries on or after October 1, 2000, for episodes completed during the fiscal year. Multiply the number of visits made to Part B beneficiaries by the average cost per visit amount in column 4 for each discipline. Enter the product in column 9.

NOTE: For cost reporting periods which overlap October 1, 2000, the sum of Worksheets C, Part II, columns 5 and 6, lines 1.01, 2.01, 3.01, 4.01, 5.01 and 6.01, respectively, must equal the corresponding amounts on Worksheet S-3, Part IV, column 7, lines 30, 32, 34, 36, 38 and 40, respectively. For cost reporting periods which begin on or after October 1, 2000, the sum of Worksheets C, Part II, columns 5 and 6, lines 1 through 6, respectively, must equal the corresponding amounts on Worksheet S-3, Part IV, column 7, lines 30, 32, 34, 36, 38 and 40.

Columns 7 and 10.--**DO NOT USE THESE COLUMNS.** See §3215.5.

NOTE: For reporting periods overlapping October 1, 2000, the sum of all Worksheets C, Part II, Medicare program visits, sum of lines 1-6 (excluding subscripts) for columns 5 and 6 must be equal to or less than the sum of the visits shown on Worksheet S-3, Part I, column 1, lines 1 through 6.

Column 11.--Enter the total Medicare cost for each discipline (sum of columns 8 and 9) for visits rendered prior to October 1, 2000. Add the amounts on lines 1 through 6 (exclusive of subscripts). Enter this total on line 7. Enter in column 11.01 the total Medicare cost for each discipline (sum of columns 8 and 9, lines 1.01, 2.01, 3.01, 4.01, 5.01, 6.01) for visits rendered on or after October 1, 2000. Enter this total on line 7.

Column Descriptions for Cost Limitation Computation

Column 4.--Enter the Medicare limitation (see §1861(v)(1)(L) of the Act) for the applicable MSA for each discipline on lines 8 through 13. The *contractor* furnishes these limits to the provider.

Columns 5 and 8.--To determine the Medicare limitation cost for Part A cost of services, multiply the number of covered Part A visits made to beneficiaries prior to October 1, 2000 (column 5) from your records by the Medicare cost limit amount in column 4 for each discipline. Enter the product in column 8.

Columns 6 and 9.--To determine the Medicare limitation cost for Part B cost of services, multiply the number of visits made to Part B beneficiaries not subject to deductibles and coinsurance prior to October 1, 2000 (column 6) from your records by the Medicare cost limit amount in column 4 for each discipline. Enter the product in column 9.

NOTE: Column 5, line 7 may not equal column 5, line 14; Column 6, line 7 may not equal Column 6, line 14. Columns 5 and 6, respectively, lines 1-6 (excluding subscripts) must equal columns 5 and 6, lines 8-13.

Columns 7 and 10.--**DO NOT USE THESE COLUMNS.** See §3215.5.

Column 11.--Enter the total Medicare limitation cost for each discipline (sum of columns 8 and 9). Add the amounts on lines 8 through 13. Enter this total on line 14.

3215.3 Part III - Supplies and Drugs Cost Computation.--Certain items covered by Medicare and furnished by an HHA are not included in the visit for apportionment purposes. Since an average cost per visit and the cost limit per visit do not apply to these items, the ratio of total cost to total charges is developed and applied to Medicare charges to arrive at the Medicare cost for these items. Enteral/parenteral nutrition therapy (EPNT) items which are considered prosthetic devices furnished by an HHA on or after March 14, 1986, are reimbursed on a reasonable charge basis through billings submitted to the Part B specialty carrier. (As a prosthetic device, such items are reimbursable under Part B only.) Charges for these items must be included in the total charges, but excluded from Title XVIII charge statistics in the apportionment of medical supply costs on Worksheet C, Part III, line 15. Lines 15 and 16 are subscripted to isolate pre 10/1/2000 costs to facilitate the flow of these costs to Worksheet D in order to apply LCC.

NOTE: For services furnished on or after January 1, 1989, the HHA Part A reimbursement for DME, prosthetics, and orthotics was changed from cost reimbursement to a fee schedule reimbursement.

Additionally, certain items furnished by an HHA on or after January 1, 1990, are not considered as DME. This includes medical supplies such as catheters, catheter supplies, ostomy bags, and supplies relating to ostomy care.

Lines 15 and 16.--Enter in column 2 the total applicable costs for the entire cost reporting period for each line item from Worksheet B, column 6, lines 12 and 13, respectively (the costs entered on lines 15 and 15.01 must be equal; the costs entered on lines 16 and 16.01 must be equal). Enter in column 3 the total charges for the entire cost reporting period for each line (the charges entered on lines 15 and 15.01 must be equal; the charges entered on lines 16 and 16.01 must be equal). The language in the two preceding parentheticals is only applicable for cost reporting periods which overlap October 1, 2000. For cost reporting periods ending on or after July 1, 2006, enter in column 2 the total charges for services rendered on lines 15, 16, and 16.20, respectively. Enter in column 4 the ratio of costs (column 2) to charges (column 3) for each line.

Line 15.--Enter in columns 5, 6, and 7 the charges for medical supplies not paid on a fee schedule for services rendered prior to October 1, 2000. For cost reporting periods beginning on or after October 1, 2000, continue to capture medical supply charges in columns 5, 6, and 7 for

statistical purposes (has no reimbursement impact) as all medical supplies are covered under the PPS benefit for this period.

Line 15.01.--For cost reporting periods that overlap October 1, 2000, enter in columns 5, 6, and 7 the charges for medical supplies not paid on a fee schedule for services rendered from October 1, 2000 through the fiscal year end. For reporting periods that begin on or after October 1, 2000, eliminate line 15.01 and record all charges and resulting cost data on line 15.

Line 16.--Enter in column 6 the charges for pneumococcal vaccine and its administration, influenza vaccine and its administration, and hepatitis B vaccine and its administration for services rendered prior to April 1, 2001. Enter in column 7 the charge for covered osteoporosis drugs for services rendered prior to October 1, 2000.

For services rendered on or after April 1, 2001 through December 31, 2002, do not enter any amounts in column 6 as pneumococcal vaccine and its administration, influenza vaccine and its administration, and hepatitis B vaccine and its administration are reimbursed under OPPS, but continue to enter in column 7 the charge for covered osteoporosis drugs as they remain cost reimbursed. (See §1833(m)(5) of the Act.)

Effective for services rendered on or after January 1, 2003 through June 30, 2006, pneumococcal vaccines and its administration and influenza vaccine and its administration are cost reimbursed not subject to deductibles and coinsurance. For services rendered on and after January 1, 2003 through June 30, 2006, enter in column 6 program charges for hepatitis vaccines and its administration (OPPS reimbursed). Enter in column 6.01 program charges for pneumococcal vaccines and its administration and influenza vaccine and its administration. Continue to enter in column 7 the program charges for covered injectable osteoporosis drugs as they remain cost reimbursed.

Effective for cost reporting periods ending on or after July 1, 2006 (see section 3206, line 13), line 16 represents pneumococcal, influenza, and hepatitis B vaccines, and osteoporosis drugs, but not the administration of these vaccines. See the chart below for proper placement of charges.

Line 16.01.--For reporting periods which overlap April 1, 2001, enter in column 6 the charges for pneumococcal vaccine and its administration and influenza vaccine and its administration. For hepatitis B vaccine and its administration rendered on or after April 1, 2001 through December 31, 2002, enter the charges in column 6. Enter in column 7 the charges for covered osteoporosis drugs rendered on or after April 1, 2001 through the fiscal year end. (See §1833(m)(5) of the Act.) For reporting periods that begin on or after April 1, 2001, eliminate line 16.01 and record all charge and resulting cost data on line 16. Osteoporosis drugs will continue to be reimbursed on a cost basis for services rendered on and after April 1, 2001 and will use line 16 to record applicable data.

Line 16.20.--Effective for cost reporting periods ending on or after July 1, 2006 (see section 3206, line 13), line 16.20 represents the administration of pneumococcal, influenza, and hepatitis B vaccines. See the chart below for proper placement of charges.

Effective for cost reporting periods ending on or after July 1, 2006, enter vaccine charges according to the chart below:

Vaccines Charges

	Column 6	Column 7
Line 16	Enter charges for 7/1/2006 & subsequent hepatitis B vaccines.	Enter charges for the full fiscal year for osteoporosis drugs.

Vaccines Charges (Continued)

	Column 6	Column 7
Line 16	Enter charges for the full fiscal year for pneumococcal and influenza vaccines. Do not enter charges for pre 7/1/2006 hepatitis B vaccines.	
Line 16.20	Enter charges for pre 7/1/2006 pneumococcal and influenza vaccine drugs administration. Do not enter charges for the full fiscal Year for hepatitis B vaccine administration. Do not enter charges for 7/1/2006 & subsequent pneumococcal and influenza vaccine administration. For fiscal years beginning on or after 7/1/2006 enter 0 (zero).	This location is shaded as the administration of the osteoporosis is included in the skilled nursing visit.

Column 8.--To determine the Medicare Part A cost, multiply the Medicare charges (column 5) by the ratio (column 4) for each line item. Enter the product in column 8.

Column 9-9.01.--To determine the Medicare Part B cost, multiply the Medicare charges (column 6) by the ratio (column 4) for each line item. Enter the product in column 9. If applicable, multiply the Medicare charges (column 6.01) by the ratio (column 4) for each line item. Do not subscript column 9 for cost reporting periods ending after June 30, 2006.

Column 10.--To determine the Medicare Part B cost (subject to deductibles and coinsurance), multiply the Medicare charges (column 7) by the ratio (column 4). Enter the product in column 10.

3215.4 Part IV - Comparison of the Lesser of the Aggregate Medicare Cost, the Aggregate of the Medicare Per Visit Limitation and the Aggregate Per Beneficiary Cost Limitation.--This part provides for the comparison of the reasonable cost limitation applied to each home health agency's total allowable cost attributable to Medicare patient care visits. This comparison is required by 42 CFR 413.30 and 42 CFR 413.53. For cost reporting periods beginning on or after October 1, 1997, §1861(v)(1)(L) of the Social Security Act is amended by §4601 of BBA 1997, requiring home health
agency net cost of covered services to be based on the lesser of the aggregate Medicare cost, the aggregate of the Medicare cost per visit limitation or the aggregate per beneficiary cost limitation. The per beneficiary cost limitation is derived by totaling the application of each CBSA/non-CBSA's unduplicated census count (two decimal places) (see §3205) to the per-beneficiary cost limitation for the corresponding CBSA/non-CBSA. To accomplish this, the sum of all Worksheets C, Part II amounts in column 11, line 7, plus the applicable cost of medical supplies is compared with the sum of all Worksheets C, Part II amounts in column 11, line 14 plus the applicable cost of medical supplies and with the amount in column 6, line 24.

Line 17.--Enter in columns 3, 4, and 6, respectively, the sum of the amounts from each Worksheet C, Part II, columns 8, 9, and 11 (exclusive of subscripts), respectively, lines 1-6 (exclusive of subscripts).

Line 18.--Enter in columns 3 and 4, respectively, the cost of medical supplies from Part III, columns 8 and 9, respectively, line 15 (excluding subscripted lines). Enter in column 6 the sum of columns 3 and 4.

Line 19.--Enter the sum of lines 17 and 18 for columns 3 and 4. Enter in column 6 the sum of columns 3 and 4.

Effective for cost reporting periods beginning on or after October 1, 2000, do not complete lines 20 through 24 as all HHAs are reimbursed under PPS and no longer subject to cost per visit limitations or annual beneficiary limitations.

Line 20.--Enter in columns 3, 4 and 6, respectively, the sum the amounts from each Worksheet C, Part II, columns 8, 9 and 11, respectively, line 14.

Line 21.--Enter in columns 3 and 4, respectively, the cost of medical supplies from Part III, columns 8 and 9, respectively, line 15 (excluding subscripted lines). Enter in column 6 the sum of columns 3 and 4.

Line 22.--Enter the sum of lines 20 and 21 for columns 3 and 4. Enter in column 6 the sum of columns 3 and 4.

Line 23 and applicable subscripts.--For each MSA/non-MSA enter the following:

Column 0.--Enter the MSA/non-MSA code from Worksheet S-3, Part III, line 29, the corresponding subscripts thereof.

Column 1.--Enter the corresponding Medicare program (Title XVIII) unduplicated census count (two decimal places) from your records associated with services rendered prior to October 1, 2000. (See §3205.)

Column 2.--Enter the applicable per beneficiary annual limitation. Obtain this amount from your *contractor*.

Column 6.--For each MSA/non-MSA determine the beneficiary cost limitation by multiplying the unduplicated census count (column 1) by the per beneficiary annual cost limitation (column 2). Enter the result in column 6.

Line 24.--In columns 1 (two decimal places) and 6, respectively, enter the sum of lines 23 through 23.24. Enter in column 3 the result of column 3, line 19 divided by column 6, line 19 multiplied by column 6, line 24. Enter in column 4 the result of column 4, line 19 divided by column 6, line 19 multiplied by column 6, line 24. (The sum of columns 3 and 4 must equal column 6.)

NOTE: The Medicare (Title XVIII) unduplicated census count (Worksheet S-3, Part I, column 2, line 10.01 (Pre 10/1/2000 Unduplicated Census Count)) must be equal to or greater than the sum of the unduplicated census count for all MSAs (Worksheet C, Part IV, column 1, line 24).

3215.5 Part V - Outpatient Therapy Reduction Computation.--This section computes the reduction in the reasonable costs of outpatient physical therapy services (which includes outpatient speech language pathology) and outpatient occupational therapy provided under arrangement for beneficiaries who are not homebound and are not covered by a physician's plan of care as required by §1834(k) of the Act and enacted by §4541 of BBA 1997. The amount of the reduction is 10 percent for services rendered on or after January 1, 1998. For outpatient therapy services rendered on or after January 1, 1999, §4541 of BBA 1997 mandates a fee schedule payment basis for

outpatient physical therapy, outpatient occupational therapy, and outpatient speech pathology. Therefore, any outpatient therapy services furnished on or after January 1, 1999 **must not be included** in this section due to the application of a fee schedule for these services, but the corresponding visits must be recorded in column 5.01. These outpatient therapy services are reimbursed the lesser of the fee scheduled amount or the statutory limitation which is applied on a beneficiary specific basis through the Medicare claims system. This requires no provider input on the cost report. Columns 7 (visits) and 10 (costs) of Worksheet C, Part II represent data subject to deductible and coinsurance which should never have been subject to per visit cost limitations. This section (Worksheet C, Part V) was introduced in transmittal 6 (November 1998) to separately compile such visit and cost data not subject to deductible and coinsurance. As such, columns 7 and 10 of Worksheet C, Part II should not be used. Instead, such data should be captured in this section.

Column 2.--Enter in column 2 the average cost per visit amount for each discipline from Worksheet C, Part I, column 4, lines as indicated.

Columns 3 and 4.--To determine the Medicare Part B cost of services subject to deductibles and coinsurance, multiply the number of covered Part B visits made before January 1, 1998 by non-homebound program beneficiaries to rehabilitation facilities under arrangement (column 3) from your records by the average cost per visit amount in column 2 for each discipline. Enter the result in column 4.

Columns 5, 5.01, 5.02 and 6.--Enter in column 5 the number of Medicare covered Part B visits from your records made by non-homebound (not covered by a physician's plan of care) program beneficiaries to rehabilitation facilities under arrangement for services furnished January 1, 1998 thru December 31, 1998 only. Enter in column 5.01 the number of Medicare covered Part B visits from your records made by non-homebound program beneficiaries to rehabilitation facilities under arrangement for services furnished from January 1, 1999 through September 30, 2000. Outpatient therapy service visits rendered between January 1, 1999 and September 30, 2000 are reimbursed based on a fee schedule as described above. Determine the Medicare cost of services subject to deductibles and coinsurance by multiplying the amount in column 5 by the average cost per visit amount in column 2 for each discipline. Enter the result in column 6. Enter in column 5.02 the number of Medicare covered Part B visits from your records made by non-homebound program beneficiaries to rehabilitation facilities under arrangement for services furnished on or after October 1, 2000. Outpatient therapy services furnished to non-homebound program beneficiaries not covered by a physician's plan of care on or after October 1, 2000 are reimbursed under outpatient PPS. The non-homebound visits captured in columns 5.01 and 5.02 are for statistical purposes only and do not impact the settlement.

Column 7.--Compute the reasonable cost reduction by multiplying the cost of Medicare services in column 6 by 90 percent (.90). This is the application of the 10 percent reasonable cost reduction. Enter the result in column 7.

Column 8.--Compute the reasonable costs net of the reduction by adding column 7 to column 4. Enter the result in column 8.

Line 28.--For columns 3 through 8, respectively, enter the sum of lines 25 through 27.

NOTE: For cost reporting periods beginning on or after October 1, 2000, the following lines and/or columns revert back to the standard lines or columns (eliminate the subscript(s)): lines 1-1.01, 2-2.01, 3-3.01, 4-4.01, 5-5.01, 6-6.01, respectively, revert to lines 1, 2, 3, 4, 5, 6, respectively; column 11-11.01, lines 1-6 reverts to column 11, lines 1-6; line 15-15.01 reverts to line 15; line 16-16.01 reverts to line 16.

3216. WORKSHEET D - CALCULATION OF REIMBURSEMENT SETTLEMENT - PART A AND PART B SERVICES

This worksheet applies to Title XVIII only and provides for the reimbursement calculation of Part A and Part B. This computation is required by 42 CFR 413.9, 42 CFR 413.13, and 42 CFR 413.30.

Worksheet D consists of the following two parts:

Part I - Computation of the Lesser of Reasonable Cost or Customary Charges. This part provides for the computation of the lesser of reasonable cost as defined in 42 CFR 413.13(b) or customary charges as defined in 42 CFR 413.13(e)(1).

Part II - Computation of Reimbursement Settlement.

3216.1 Part I - Computation of the Lesser of Reasonable Cost or Customary Charges.--Providers are paid the lesser of the reasonable cost of services furnished to beneficiaries or the customary charges for the same services. This part provides for the computation of the lesser of reasonable cost as defined in 42 CFR 413.13(b) or customary charges as defined in the 42 CFR 413.13(e).

NOTE: Nominal charge providers are not subject to the lesser of cost or charges (LCC). Therefore, a nominal charge provider only completes lines 1, 2, 3, and 11 of Part I. Transfer the resulting cost to line 12 of Part II.

Line Descriptions

Line 1--Reporting periods beginning prior to October 1, 2000, enter the cost of services from Worksheet C, Parts III, IV and V based on the following table. If the amount in column 6, line 19 is less than the amount in column 6, line 22, and the amount in column 6, line 24, transfer the aggregate Medicare cost. For cost reporting periods beginning on or after October 1, 2000, do not transfer any costs to line 1, column 1 of this worksheet. For cost reporting periods beginning on or after October 1, 2000, transfer the cost of osteoporosis drugs from Worksheet C, Part III, column 10, line 16 to column 3 of this worksheet.

For services rendered on or after January 1, 2003, do not transfer the cost of hepatitis vaccines from Worksheet C, Part III, column 9, line 16, as they are OPPS reimbursed; however, transfer the cost of pneumococcal and influenza vaccines from Worksheet C, Part III, column 9.01, line 16 to column 2 of this worksheet, and the cost of osteoporosis drugs from Worksheet C, Part III, column 10, line 16 to column 3 of this worksheet.

For cost reporting periods ending after July 1, 2006 (see §3206, line 13), transfer the cost of pneumococcal, influenza, and hepatitis vaccines from Worksheet C, Part III, column 9, line 16, to column 2 of this worksheet, and the cost of osteoporosis drugs from Worksheet C, Part III, column 10, line 16 to column 3 of this worksheet. Also transfer the administration of pneumococcal, influenza, and hepatitis B vaccines from Worksheet C, Part III, column 9, line 16.20, to column 2, for the portion of the reporting period before July 1, 2006.

To Worksheet D, Line 1	From Worksheet C
Col. 1, Part A	Part IV, col. 3, line 19
Col. 2, Part B	Part III, sum of col. 9 line 16 (excluding subscripted lines), and Part IV, col. 4, line 19
Col. 3, Part B	Part III, sum of col. 10, lines 15 (excluding subscripted lines), 16 and 16.01, and Part V, col. 8, line 28

If the amount in column 6, line 22 is less than the amount in column 6, line 19, and the amount in column 6, line 24, transfer (aggregate Medicare limitation):

To Worksheet D, Line 1	From Worksheet C
Col. 1, Part A	Part IV, col. 3, line 22
Col. 2, Part B	Part III, sum of col. 9, line 16 (excluding subscripted lines), and Part IV, col. 4, line 22
Col. 3, Part B	Part III, sum of col. 10, lines 15 (excluding subscripted lines), 16 and 16.01, and Part V, col. 8, line 28

If column 6, line 24 is less than the amount in column 6, line 19, and the amount in column 6, line 22, transfer (aggregate agency beneficiary limitation):

To Worksheet D, Line 1	From Worksheet C
Col. 1, Part A	Part IV, col. 3, line 24
Col. 2, Part B	Part III, sum of col. 9, line 16 (excluding subscripted lines), and Part IV, col. 4, line 24
Col. 3, Part B	Part III, sum of col. 10, lines 15 (excluding subscripted lines), 16 and 16.01, and Part V, col. 8, line 28

Line 2.--*Do not complete this line.*

Line 3.--In each column, enter the amount on line 1 plus the amount on line 2.

Line 4.--In columns 1, 2 and 3, enter from your records the charges for the applicable Medicare services rendered prior to October 1, 2000. Also, in columns 2 and 3, enter from your records the charges for the applicable Medicare covered drugs (see §3215.3) rendered prior to October 1, 2000. In column 3, also enter the Medicare charges applicable to all RHCs and FQHCs, respectively, for services furnished prior to January 1, 1998.

Line 4.01.--In column 2, enter from your records only the charges for applicable Medicare covered pneumococcal and influenza vaccines (see §3215.3) rendered on or after January 1, 2003 (from Worksheet C, line 16, column 6.01). In column 3, enter from your records only the charges for applicable Medicare covered osteoporosis drugs (see §3215.3) rendered on or after October 1, 2000 (from Worksheet C, line 16, column 7). For all other services rendered on or after October 1, 2000, do not enter any charges in columns 1 and 2.

Effective for cost reporting periods ending after June 30, 2006, in column 2, enter the charges for Medicare covered pneumococcal, influenza, and hepatitis B vaccines (from Worksheet C, Part III, lines 16 and 16.20, column 6). In column 3, enter the charges for Medicare covered osteoporosis drugs (from Worksheet C, Part III, lines 16, column 7).

Lines 5 through 8.--These lines provide for the accumulation of charges which relate to the reasonable cost on line 3.

Do not include on these lines (1) the portion of charges applicable to the excess costs of luxury items or services (see CMS Pub. 15-1, §2104.3) and (2) provider charges to beneficiaries for excess costs as described in CMS Pub. 15-1, §2570. When provider operating costs include amounts that flow from the provision of luxury items or services, such amounts are not allowable in computing reimbursable costs.

Lines 5, 6, 7, and 8.--These lines provide for the reduction of Medicare charges where the provider does not actually impose such charges (in the case of most patients liable for payment for services on a charge basis) or fails to make reasonable efforts to collect such charges from those patients. Enter on line 8 the product of multiplying the ratio on line 7 by line 4 for each column. For column 3, lines 5 and 6, prorate, based on the ratio derived in line 4, all amounts applicable to RHC/FQHCs. Providers which do impose these charges and make reasonable efforts to collect the charges from patients liable for payment for services on a charge basis are not required to complete lines 5, 6, and 7, but enter on line 8 the amount from line 4 for column 1 (excluding subscripted lines) and enter on line 8, columns 2 and 3 the sum of the amounts from lines 4 and 4.01. (See 42 CFR 413.13(b).) In no instance may the customary charges on line 8 exceed the actual charges on line 4.

Line 9.--Enter in each applicable column on line 9 the excess of total customary charges (line 8) over the total reasonable cost (line 3). In situations when in any column the total charges on line 8 are less than the total cost on line 3 of the applicable column, enter zero (0) on line 9.

Line 10.--Enter in each applicable column on line 10 the excess of total reasonable cost (line 3) over total customary charges (line 8). In situations when in any column the total cost on line 3 is less than the customary charges on line 8 of the applicable column, enter zero (0) on line 10.

Line 11.--Enter the amounts paid or payable by workers' compensation and other primary payers where program liability is secondary to that of the primary payer. Primary payer amounts relating to services paid under PPS are included on this line, which may result in line 12 being negative. There are several situations under which Medicare payment is secondary to a primary payer. Prorate, based on the ratio derived in line 4 (including subscripts), all amounts applicable to RHC/FQHCs. Some of the most frequent situations in which the

Medicare program in a secondary payer include:

1. Workers' compensation,
2. No fault coverage,
3. General liability coverage,
4. Working aged provisions,
5. Disability provisions, and
6. Working ESRD beneficiary provisions.

Generally, when payment by the primary payer satisfies the total liability of the program beneficiary, for cost reporting purposes only, the services are considered to be nonprogram services. (The primary payment satisfies the beneficiary's liability when the provider accepts that payment as payment in full. The provider notes this on no-pay bills submitted in these situations.) The patient visits and charges are included in total patient visits and charges, but are not included in program patient visits and charges. In this situation, no primary payer payment is entered on line 11.

However, when the payment by the primary payer does not satisfy the beneficiary's obligation, the program pays the lesser of (a) the amount it would otherwise pay (without regard to the primary payer payment or deductible and coinsurance) less the primary payer payment or (b) the amount it would otherwise pay (without regard to primary payer payment or deductibles and coinsurance) less applicable deductible and coinsurance. Primary payer payment is credited toward the beneficiary's deductible and coinsurance and are not entered on line 11.

When the primary payment does not satisfy the beneficiary's liability, include the covered visits and charges in program visits and charges, and include the total visits and charges in total visits and charges for cost apportionment purposes. Enter the primary payer payment on line 11 to the extent that primary payer payment is not credited toward the beneficiary's deductible and coinsurance. Primary payer payments that are credited toward the beneficiary's deductible and coinsurance are not entered on line 11. The primary payer rules are more fully explained in 42 CFR 411.

3216.2 Part II - Computation of Reimbursement Settlement.--

NOTE: For Part II, where applicable and not specifically instructed to do so, prorate, based on the ratio derived in Part I, line 4, all amounts applicable to RHCs and FQHCs, respectively.

Line 12.--Enter in column 1 the amount on line 3, column 1, minus the amount on line 11, column 1. Enter in column 2 the sum of the amounts on line 3, columns 2 and 3, minus the sum of the amounts on line 11, columns 2 and 3.

Lines 12.01 through 12.14.--Under PPS enter only payment amounts associated with episodes completed in the current cost reporting period. Payments for episodes of care which overlap fiscal years must be recorded in the fiscal year in which the episode was completed. Enter in columns 1 and 2 for lines 12.01 through 12.06, as applicable, the appropriate PPS payment for each episode of care payment category indicated on the worksheet. Enter in columns 1 and 2 for lines 12.07 through 12.10, as applicable, the appropriate PPS outlier payment for each episode of care payment category indicated on the worksheet. Enter in columns 1 and 2, line 12.11 the sum total of other payments. Enter in columns 1 and 2, lines 12.12 through 12.14, the gross payments for DME, oxygen, and prosthetics and orthotics payments, respectively associated with home health PPS services (bill types 32 and 33 only).

For lines 12.12 through 12.14 do not include any amounts associated with services billed on bill type 34. Obtain these amounts from your records or PS&R report.

Line 13.--Enter in column 2 the applicable Part B deductibles billed to Medicare patients. Exclude coinsurance amounts. Include any amounts of deductibles satisfied by primary payer payments. Prorate, based on the ratio derived in line 4, all amounts applicable to RHCs/FQHCs, respectively.
Do not enter deductibles for DME, oxygen, and prosthetics and orthotics.

Line 15.--If there is an excess of reasonable cost over customary charges, enter the Part A excess (line 10, column 1) in column 1 and the Part B excess (sum of line 10, columns 2 and 3) in column 2. If you are a nominal charge provider (response of “Y” to S-2, line 21), enter zero on this line.

Line 17.--Enter in column 2 all coinsurance billable to Medicare beneficiaries including amounts satisfied by primary payer payments. Coinsurance is applicable for services reimbursable under §1832(a)(2) of the Act and is entered in column 2. Prorate, based on the ratio derived in line 4, all amounts applicable to RHCs/FQHCs, respectively. Do not enter coinsurance for DME, oxygen, and prosthetics and orthotics.

NOTE: If the component qualifies as a nominal charge provider, enter 20 percent of costs subject to coinsurance on this line. Compute this amount by subtracting Part B deductibles on line 13 and Part B primary payment amounts in column 3, line 11 from Part B costs subject to coinsurance in column 3, line 1. Multiply the resulting amount by 20 percent and enter it on this line.

Line 19.--Enter the reimbursable bad debts, net of recoveries, in the appropriate columns. Columns 1 and 2 are shaded as HHAs cannot generate bad debts.

Line 20.--*Do not complete this line.*

Line 21.--For column 1, enter the sum of lines 18 and 19, column 1. For column 2, enter the sum of lines 18, 19, and 20, column 2.

Line 22.--Enter the program's share of any net depreciation adjustment applicable to prior years resulting from the gain or loss on the disposition of depreciable assets. (See CMS Pub. 15-1, §132.) Enter the amount of any excess depreciation taken as a negative amount.

NOTE: Effective for changes in ownership that occur on or after December 1, 1997, §4404 of BBA 1997 amends §1861(v)(1)(O) of the Act which states, in part, that "...a provider of services which has undergone a change of ownership, such regulations provide that the valuation of the asset after such change of ownership shall be the historical cost of the asset, as recognized under this title, less depreciation allowed, to the owner of record...." That is, no gain or loss is recognized for such transactions on or after December 1, 1997.

Line 23.--Enter the program's share of any recovery of excess depreciation applicable to prior years resulting from provider termination or a decrease in Medicare utilization. Submit the workpapers which have developed this amount. (See CMS Pub. 15-1, §136ff.)

Line 24.--Where a provider's cost limit is raised as a result of its request for review, amounts which were erroneously collected on the basis of the initial cost limit are required to be refunded to the beneficiary. Enter any amounts which are not refunded either because they are less than $5 collected from a beneficiary or because the provider is unable to locate the beneficiary. (See CMS Pub. 15-1, §2577.)

Line 25.--Enter in each column the amount on line 21, plus line 22 minus the sum of lines 23 and 24.

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Line 25.50.--Enter any other adjustments. For example, enter an adjustment resulting from changing the recording of vacation pay from cash basis to accrual basis. (See CMS Pub. 15-*1*, §2146.4.) For purposes of reimbursing costs associated with the Outcome and Assessment Information Set (OASIS) as required by Program Memorandum A-00-03 (cost reporting periods beginning in Federal fiscal year 2000 only), report on this line, in column 1, the result of multiplying the Medicare unduplicated census count on Worksheet S-3, column 2, line 10 (excluding subscripts), times $10, minus the interim OASIS payment made to the provider on April 1, 2000. Do not include this interim OASIS payment on Worksheet D-1, but rather attach documentation supporting the payment(s). (For contractor use only during final settlement.)

Line 26.--Enter the sequestration adjustment amount from the PS&R report.

Line 27.--Enter the amount on line 25 plus line 25.50 and subscripts minus line 26.

Line 28.--Enter the interim payment from Worksheet D-1, line 4. For contractor final settlement, report on line 28.5 the amount from Worksheet D-1, line 5.99.

Line 29.--Enter the balance due the provider or the program by entering the result of line 27 minus line 28. Indicate overpayments by parentheses ( ). Transfer the amount in column 1 to Worksheet S, Part II, line 1, and column 1. Transfer the amount in column 2 to Worksheet S, Part II, line 1, and column 2.

Line 30.--Enter the Medicare reimbursement effect of protested items. The reimbursement effect of the nonallowable items is estimated by applying reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See §115.2.) A schedule showing the supporting details and computations for this line must be attached.

Line 31.--Do not use this line.

3217. WORKSHEET D-1 - ANALYSIS OF PAYMENTS TO HOME HEALTH AGENCIES FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Complete this worksheet for Medicare interim payments only. (See 42 CFR 413.64.)

The column headings designate two categories of payments:

Category 1 - Part A
Category 2 - Part B

Complete the identifying information on lines 1 through 4. The remainder of the worksheet is completed by your contractor .

NOTE: DO NOT reduce any interim payments by recoveries as a result of medical review adjustments where the recoveries were based on a sample percent applied to the universe of claims reviewed and the Provider Statistical and Reimbursement Report (PS&R) was not also adjusted.

Line Descriptions

Line 1.--Enter the total Medicare interim payments paid to the HHA for all covered services rendered prior to October 1, 2000. Additionally, for services rendered on or after October 1, 2000, enter the total Medicare interim payments paid to the HHA for applicable covered osteoporosis drugs and any

other vaccines paid on a cost reimbursement basis. The amount entered reflects the sum of all interim payments paid on individual bills (net of adjustment bills) for services rendered in this cost reporting period and includes amounts withheld from the HHA's interim payments due to an offset against overpayments to the HHA applicable to prior cost reporting periods. It does not include any retroactive lump sum adjustment amounts based on a subsequent revision of the interim rate, or tentative or net settlement amounts; nor does it include interim amounts; nor does it include interim payments payable. If the HHA is reimbursed under the periodic interim payment method of reimbursement, enter the periodic interim payments received for this cost reporting period. Do not include payments received for services reimbursed on a fee schedule basis.

Also enter in columns 2 and 4, as applicable for HHA services furnished on or after October 1, 2000, the total Medicare PPS payments and the total Medicare PPS outlier payments paid to the HHA for all episode payment categories for related episodes completed during the current cost reporting period. The amounts entered reflect the sum of all interim PPS payments paid on individual claims (net of adjustments) for episodes completed in the current cost reporting period. Enter gross payments for total DME, oxygen, and prosthetics and orthotics, associated with home health PPS services only (bill types 32 and 33). Do not include any payment information associated with services recorded on bill type 34.

Line 2.--Enter the total Medicare interim payments payable on individual bills. Since the cost in the cost report is on an accrual basis, this line represents the amount of services rendered in the cost reporting period but not paid as of the end of the cost reporting period and does not include payments reported on line 1.

Line 3.--Enter the amount of each retroactive lump sum adjustment and the applicable date.

Line 4.--Enter the total amount of the interim payments (sum of lines 1, 2, and 3.99). Transfer these totals to the appropriate column on Worksheet D, Part II, line 28.

DO NOT COMPLETE THE REMAINDER OF WORKSHEET D-1. THE REMAINDER OF THE WORKSHEET IS COMPLETED BY YOUR CONTRACTOR.

Line 5.--List separately each tentative settlement payment after desk review together with the date of payment. If the cost report is reopened after the Notice of Program Reimbursement (NPR) has been issued, all settlement payments prior to the current reopening settlement are reported on line 5.

Line 6.--Enter the net settlement amount from Worksheet D, Part II, line 29, transferring the Part A amount to column 2 and Part B amount to column 4.

NOTE: On lines 3, 5, and 6, when an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment, even though total repayment is not accomplished until a later date.

Line 7.--Enter the total Medicare program liability. Enter the sum of the amounts on lines 4, 5.99, and 6.01 or 6.02 in columns 2 and 4, as appropriate. Enter amounts due the program in parentheses ( ).

3218. WORKSHEETS F, F-1, AND F-2 - FINANCIAL STATEMENTS

These worksheets are prepared from your accounting books and records. Additional worksheets may be submitted if necessary.

Complete all worksheets in the "F" series. Worksheets F and F-2 are completed by all providers maintaining fund-type accounting records. Providers not maintaining fund-type accounting records should only complete the General Fund columns of these worksheet. Cost reports received with incomplete "F" worksheets are returned to the provider for completion and the provider is considered as having failed to file a cost report.

3219. WORKSHEET A-8-3 - REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

This worksheet provides for the computation of any needed adjustments to costs applicable to physical therapy, occupational therapy, and speech pathology services furnished by outside suppliers. The information required on this worksheet provides, in the aggregate, all data for therapy services furnished by all outside suppliers in determining the reasonableness of therapy costs. (See CMS Pub. 15-*1*, chapter 14.)

Complete this worksheet for cost reporting periods beginning prior to October 1, 2000 for physical therapy, occupational therapy, or speech pathology services rendered prior to October 1, 2000. Do not complete this worksheet for cost reporting periods beginning on or after October 1, 2000.

NOTE: If you furnish physical therapy services under arrangement with outside suppliers, complete a separate worksheet A-8-3 for physical therapy services rendered before April 10, 1998 and a separate worksheet A-8-3 for physical therapy services rendered on or after April 10, 1998. In additional to physical therapy services, if you furnish either occupational therapy and/or speech pathology services on or after April 10, 1998, under arrangement with outside suppliers, complete a separate worksheet for each discipline. For physical therapy, occupational therapy, and speech pathology services that overlap April 10, 1998, prorate, based on total charges, any statistics and costs for purposes of calculating standards, allowances, or the actual reasonable cost determination, e.g., overtime hours. (See 42 CFR §413.106.)

Complete this worksheet once for each type of therapy service furnished by an outside supplier.

If you contract with an outside supplier for therapy services, the potential for limitation and the amount of payment you receive depends on several factors:

- An initial test to determine whether these services are categorized as intermittent part time or full time services;
- The location where the services are rendered, i.e., HHA home visit;
- For HHA services, whether detailed time and mileage records are maintained by the contractor and HHA;
- Add-ons for supervisory functions, aides, overtime, equipment, and supplies; and
- *Contractor* determinations of reasonableness of rates charged by the supplier compared with the going rates in the area.

3219.1 Part I - General Information.--This part provides for furnishing certain information concerning therapy services furnished by outside suppliers.

Line 1.--For services performed at the patient's residence, count only those weeks during which services were rendered by supervisors, therapists, or assistants to patients of the HHA. (See CMS Pub. 15-*1*, chapter 14.)

Line 2.--Multiply the amount on line 1 by 15 hours per week. This calculation is used to determine whether services are full time or intermittent part time.

Line 3.--Enter the number of unduplicated HHA visits made by the supervisor or therapist. Only count one visit when both the supervisor and therapist were present during the same visit.

Line 4.--Enter the number of unduplicated HHA visits made by the therapy assistant. Do not include in the count the visits when either the supervisor or therapist were present during the same visit.

Line 5.--Enter the standard travel expense rate applicable. (See CMS Pub. 15-*1*, chapter 14.)

Line 6.--Enter the optional travel expense rate applicable. (See CMS Pub. 15-*1*, chapter 14.) Use this rate only for home health patient services for which time records are available.

Line 7.--Enter in the appropriate columns the total number of hours worked for therapy supervisors, therapists, therapy assistants, and aides furnished by outside suppliers.

Line 8.--Enter in each column the appropriate adjusted hourly salary equivalency amount (AHSEA). This amount is the prevailing hourly salary rate plus the fringe benefit and expense factor described in CMS Pub. 15-*1*, chapter 14. This amount is determined on a periodic basis for appropriate geographical areas and is published as an exhibit at the end of CMS Pub. 15-*1*, chapter 14. Use the appropriate exhibit for the period of this cost report.

Enter in column 1 the supervisory AHSEA, adjusted for administrative and supervisory responsibilities. Determine this amount in accordance with the provisions of CMS Pub. 15-*1*, §1412.5. Enter in columns 2, 3, and 4 (for therapists, assistants, and aides respectively) the AHSEA from either the appropriate exhibit found in CMS Pub. 15-*1*, chapter 14 or from the latest publication of rates. If the going hourly rate for assistants in the area is unobtainable, use no more than 75 percent of the therapist AHSEA. The cost of services of a therapy aide or trainee is evaluated at the hourly rate, not to exceed the hourly rate paid to your employees of comparable classification and/or qualification, e.g., nurses' aides. (See CMS Pub. 15-*1*, §1412.2.)

Line 9.--Enter the standard travel allowance equal to one half of the AHSEA. Enter in columns 1 and 2 one half of the amount in column 2, line 8. Enter in column 3 one half of the amount in column 3, line 8. (See CMS Pub. 15-*1*, §1402.4.)

Lines 10 and 11.--Enter the number of travel hours and number of miles driven, respectively, if time records of visits are kept. (See CMS Pub. 15-*1*, §§1402.5 and 1412.6.)

NOTE: There is no travel allowance for aides employed by outside suppliers.

3219.2 Part II - Salary Equivalency Computation.--This part provides for the computation of the full time or intermittent part time salary equivalency.

When you furnish therapy services from outside suppliers to Medicare patients but simply arrange for such services for non health care program patients and do not pay the other Medicare portion of such services, your books reflect only the cost of the health care program portion. Where you can gross up costs and charges in accordance with provisions of CMS Pub. 15-*1*, §2314, complete Part II, lines 12 through 17 and 20 in all cases and lines 18 and 19, where appropriate. However, where you cannot gross up costs and charges, complete lines 12 through 17 and 20.

Lines 12 through 17.--To compute the total salary equivalency allowance amounts, multiply the total hours worked (line 7) by the adjusted hourly salary equivalency amount for supervisors, therapists, assistants, and aides.

Lines 18 and 19.--If the sum of hours in columns 1 through 3, line 7, is less than or equal to the product found on line 2, complete these lines. (See the exception above where you cannot gross up costs and charges, and services are provided to program patients only.)

Line 20.--If there are no entries on lines 18 and 19, enter the amount on line 17. Otherwise, enter the sum of the amounts on lines 16 and 19.

3219.3 Part III - Travel Allowance and Travel Expense Computation - HHA Services.--This part provides for the computation of the standard travel allowance, the standard travel expense, the optional travel allowance, and the optional travel expense. (See CMS Pub. 15-*1*, §§1402ff, 1403.1 and 1412.6.)

Lines 21 through 24.--Complete these lines for the computation of the standard travel allowance and standard travel expense for therapy services performed in conjunction with HHA visits. Use these lines only if you do not use the optional method of computing travel. A standard travel allowance is recognized for each visit to a patient's residence. If services are furnished to more than one patient at the same location, only one standard travel allowance is permitted, regardless of the number of patients treated.

Lines 25 through 28.--Complete the optional travel allowance and optional travel expense computations for therapy services in conjunction with home health services only. Compute the optional travel allowance on lines 25 through 27. Compute the optional travel expense on line 28.

Lines 29 through 31.--Choose and complete only one of the options on lines 29 through 31. However, use lines 30 and 31 only if you maintain time records of visits. (See CMS Pub. 15-*1*, §1402.5.)

3219.4 Part IV - Overtime Computation.--This part provides for the computation of an overtime allowance when an individual employee of the outside supplier performs services for you in excess of your standard work week. No overtime allowance is given to a therapist who receives an additional allowance for supervisory or administrative duties. (See CMS Pub. 15-*1*, §1412.4.)

Line 32.--Enter in the appropriate columns the total overtime hours worked. Where the total hours in column 4 are either zero or equal to or greater than 2080, the overtime computation is not applicable. Make no further entries on lines 33 through 40. Enter zero in each column of line 41. Enter the sum of the hours recorded in columns 1 through 3 in column 4.

Line 33.--Enter in the appropriate column the overtime rate (the AHSEA from line 8, column as appropriate, multiplied by 1.5).

Line 35.--Enter the percentage of overtime hours by class of employee. Determine this amount by dividing each column on line 32 by the total overtime hours in column 4, line 32.

Line 36.--Use this line to allocate your standard work year for one full time employee. Enter the numbers of hours in your standard work year for one full time employee in column 4. Multiply the standard work year in column 4 by the percentage on line 35 and enter the result in the corresponding columns.

Line 37.--Enter in columns 1 through 3 the AHSEA from Part I, line 10, columns 2 through 4, as appropriate.

3219.5 Part V - Computation of Therapy Limitation and Excess Cost Adjustment.--This part provides for the calculation of the adjustment to therapy service costs in determining the reasonableness of therapy cost.

Lines 45 and 46--When the outside supplier provides the equipment and supplies used in furnishing direct services to your patients, the actual cost of the equipment and supplies incurred by the outside supplier (as specified in CMS Pub. 15-*1*, §1412.1) is considered an additional allowance in computing the limitation.

Line 48--Enter the amounts paid and/or payable to the outside suppliers for therapy services rendered during the period as reported in the cost report. This includes any payments for supplies, equipment use, overtime, or any other expenses related to supplying therapy services for you. For physical therapy, occupational therapy, and speech pathology services rendered to non-homebound beneficiaries on or after January 1, 1999, prorate, based on total HHA visits, the amounts paid and/or payable to outside suppliers, e.g., multiply the amount paid and/or payable to outside suppliers by the ratio of visits made by non-homebound beneficiaries to CORFs (and/or OPTs) to total HHA visits. The result is the amount of the reduction.

Line 49--Enter the excess cost over the limitation, i.e., line 48 minus line 47. Transfer this amount to Worksheet A-5, line 10 for physical therapy services, line 10.1 for occupational therapy services and line 10.2 for speech pathology services. If the amount is negative, enter a zero.

3220. *Removed and reserved*
3221. *Removed and reserved*
3221.1 *Removed and reserved*
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3222. *Removed and reserved*
3222.1 *Removed and reserved*
3222.2 *Removed and reserved*
3222.3 *Removed and reserved*
3223. *Removed and reserved*
3223.1 *Removed and reserved*
3223.2 *Removed and reserved*
3224. *Removed and reserved*

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3225. WORKSHEET CM-1 - ALLOCATION OF GENERAL SERVICE COSTS TO *HHA-BASED* CMHC COST CENTERS

Use this worksheet only if you operate a certified HHA-based CMHC as part of your complex. If you have more than one HHA-based CMHC, complete a separate worksheet for each.

3225.1 Part I - Allocation of General Service Costs to *HHA-Based* CMHC Cost Centers.--Worksheet CM-1, Part I, provides for the allocation of the expenses of each general service cost center to those cost centers which receive the services. Obtain the total direct expenses (column 0, line 12) from Worksheet A, column 10, line 26. Obtain the cost center allocation (column 0, lines 1 through 11) from your records. The amounts on line 12, columns 0 through 5, must agree with the corresponding amounts on Worksheet B, columns 0 through 5, line 26. Complete the amounts entered on lines 1 through 11, columns 1 through 8, in accordance with the instructions contained in §3225.3.

NOTE: There is no revenue code specifically entitled "Diagnostic Services." Therefore, use revenue code 918 (testing) when billing for these services.

3225.2 Part II - Computation of Unit Cost Multiplier for Allocation of *HHA-Based* CMHC Administrative and General Costs.--Use this part to compute the unit cost multiplier used to allocate CMHC administrative and general costs to the revenue producing CMHC cost centers.

Line 1.--Enter the amount from Part I, column 6, line 12.

Line 2.--Enter the amount from Part I, column 6, line 1.

Line 3.--Subtract the amount on line 2 from the amount on line 1 and enter the result.

Line 4.--Divide line 2 by line 3 and enter the result. Multiply each amount in Part I, column 6, lines 2 through 11, by the unit cost multiplier and enter the result on the corresponding line of column 7.

3225.3 Part III - Allocation of General Service Costs to *HHA-Based CMHC* Cost Centers - Statistical Basis.--Worksheet CM-1, Parts II and III, provide for the proration of the statistical data needed to equitably allocate the expenses of the general service cost centers on Worksheet CM-1, Part I. If there is a difference between the total accumulated costs reported on the Part III statistics and the total accumulated costs calculated on Part I, use the reconciliation column on Part III for reporting any adjustments. See §3214 for the appropriate usage of the reconciliation columns. For componentized A&G cost centers, the accumulated cost center line must match the reconciliation column number.

To facilitate the allocation process, the general format of Worksheet CM-1, Parts I and III, is identical.

The statistical basis shown at the top of each column on Worksheet CM-1, Part III, is the recommended basis of allocation of the cost center indicated.

NOTE: If you wish to change your allocation basis for a particular cost center, you must make a written request to your *contractor* for approval of the change and submit reasonable justification for such change prior to the beginning of the cost reporting period for which the change is to apply. The effective date of the change is the beginning of the cost reporting period for which the request has been made. (See CMS Pub. 15-*1*, §2313.)

Lines 1 through 11.--On Worksheet CM-1, Part III, for all cost centers to which the general service cost center is being allocated, enter that portion of the total statistical base applicable to each.

Line 12.--Enter the total of lines 1 through 11 for each column. The total in each column must

be the same as shown for the corresponding column on Worksheet B-1, line 26.

Line 13.--Enter the total expenses for the cost center allocated. Obtain this amount from Worksheet B, line 26, from the same column used to enter the statistical base on Worksheet CM-1, Part III (e.g., in the case of capital-related cost buildings and fixtures, this amount is on Worksheet B, column 1, line 26).

Line 14.--Enter the unit cost multiplier which is obtained by dividing the cost entered on line 13 by the total statistic entered in the same column on line 12. Round the unit cost multiplier to six decimal places.

Multiply the unit cost multiplier by that portion of the total statistics applicable to each cost center receiving the services. Enter the result of each computation on Worksheet CM-1, Part I, in the corresponding column and line.

After the unit cost multiplier has been applied to all the cost centers receiving the services, the total cost (line 12, Part I) must equal the total cost on line 13, Part III.

Perform the preceding procedures for each general service cost center.

In column 6, Part I, enter the total of columns 4A through 5.

In column 7, Part I, for lines 2 through 11, multiply the amount in column 6 by the unit cost multiplier on line 4, Part II, and enter the result in this column. On line 12, enter the total of the amounts on lines 2 through 11. The total on line 12 equals the amount in column 6, line 1.

In column 8, Part I, enter on lines 2 through 11 the sum of the amounts in columns 6 and 7. The total on line 12 equals the total in column 6, line 12.

3226. WORKSHEET CM-2 - COMPUTATION OF *HHA-BASED* CMHC COSTS

Use this worksheet only if you operate an HHA-based CMHC. If you have more than one *HHA*-based CMHC, complete a separate worksheet for each. Partial hospitalization services provided by *HHA-based* CMHCs are reimbursed based on a Prospective Payment System (PPS).

All CMHC services rendered on or after August 1, 2000 are reimbursed based on a PPS subject to a transitional corridor payment. Vaccines furnished *by HHA-based* CMHCs are reimbursed based on outpatient PPS.

3226.1 Part I - Apportionment of *HHA-Based* CMHC Cost Centers.--

Column 1.--Enter on each line the total cost for the cost center as previously computed on Worksheet CM-1, Part I, column 8. To facilitate the apportionment process, the line numbers are the same on both worksheets.

Column 2.--Enter the charges for each cost center. Obtain the charges from your records.

Column 3.--For each cost center, enter the ratio derived by dividing the cost in column 1 by the charges in column 2.

Column 3.01.-- For each cost center, enter the corresponding charges from your records for total Title XVIII *HHA-based* CMHC services rendered during the entire cost reporting period.

Column 3.02.--For each cost center, enter the total Title XVIII *HHA-based* CMHC costs by multiplying the charges in column 3.01 by the ratio in column 3.

Column 4.--For each cost center, enter the corresponding charges from your records for Title XVIII *HHA-based* CMHC services rendered on or after August 1, 2000, January 1, 2002, January 1, 2003, or January 1, 2004. For cost reporting periods beginning on or after January 1, 2004, enter zero (0).

Column 5.--For each cost center, enter the costs on or after August 1, 2000, January 1, 2002, January 1, 2003, or January 1, 2004, by multiplying the charges in column 4 by the ratio in column 3.

Column 6.-- For each cost center, enter the costs associated with services rendered prior to August 1, 2000, January 1, 2002, January 1, 2003, or January 1, 2004, by subtracting the amount in column 5 from the amount in column 3.02.

Line 12.--Enter the totals for columns 1, 2, 3.01, 3.02, 4, 5 and 6.

3226.2 Part II - Apportionment of Cost of *HHA-Based* CMHC Services Furnished by *Shared* HHA Departments.--Use this part only when the *HHA* complex maintains a separate department for any of the cost centers listed on this worksheet, and the department provides services to patients of the HHA's CMHC.

Column 1.--Enter on each line the total cost for the HHA cost center as previously computed on Worksheet B, column 6, for the corresponding cost centers only when *HHA-based* CHMC services are furnished by shared HHA departments.

Column 2.--Enter the total charges for each cost center. Obtain the charges from your records.

Column 3.--For each of the cost centers listed, enter the ratio of cost to charges (column 1 divided by column 2).

Column 3.01.-- For each cost center, enter the corresponding charges from your records for total Title XVIII *HHA-based* CMHC services rendered during the entire cost reporting period.

Column 3.02.--For each cost center, enter the total Title XVIII *HHA-based* CMHC costs by multiplying the charges in column 3.01 by the ratio in column 3.

Column 4.--For each cost center, enter the charges from your records for Title XVIII *HHA-based* CMHC services rendered on or after August 1, 2000, January 1, 2002, January 1, 2003, or January 1, 2004. For cost reporting periods beginning on or after January 1, 2004, enter zero (0).

Column 5.--For each cost center, enter the costs on or after August 1, 2000, January 1, 2002, January 1, 2003, or January 1, 2004 obtained by multiplying the charges in column 4 by the ratio in column 3.

Column 6.-- For each cost center, enter the costs associated with services rendered prior to August 1, 2000, January 1, 2002, January 1, 2003, or January 1, 2004, by subtracting the amount in column 5 from the amount in column 3.02.

Line 16.--Enter the sum lines 13 through 15 for columns 1, 2, 3.01, 3.02, 4, 5 and 6.

3226.3 Part III - Total *HHA-Based* CMHC Costs.--

Columns 3.01, 3.02 and 4-6.--Enter the sum total of Part I, line 12 plus Part II, line 16 for each column, respectively.

Column 6.--Enter the total costs from Part I, column 6, line 12 plus Part II, column 6, line 16. Transfer this amount to Worksheet CM-3, line 1, column 1.

3227. WORKSHEET CM-3 - CALCULATION OF REIMBURSEMENT SETTLEMENT - *HHA-BASED* CMHC SERVICES

Submit a Worksheet CM-3 only if you operate a *HHA*-based CMHC. If you have more than one *HHA*-based CMHC, complete a separate worksheet for each.

NOTE: Column 1 is subscripted for lines 1 through 18 for cost reporting periods which overlap August 1, 2000, January 1, 2002, January 1, 2003, or January 1, 2004, to accommodate the transitional corridor payment calculation associated with the portion of the cost reporting period which overlaps any of the aforementioned dates. For cost reporting periods which overlap a transition date enter in column 1 any data applicable to CMHC services rendered prior to the transition and enter in column 1.01 data applicable to CMHC services rendered on or after the transition date. For cost reporting periods that do not overlap transition dates and for cost reporting periods beginning on or after January 1, 2004, only complete column 1.

3227.1 Part I - Computation of Lesser of Reasonable Cost or Customary Charges.--

Line 1.--For cost reporting periods ending prior to August 1, 2000, enter in column 1 the applicable cost from Worksheet CM-2, column 5, line 17. CMHCs with cost reporting periods overlapping August 1, 2000, January 1, 2002, January 1, 2003, or January 1, 2004, enter in the applicable column the cost of services provided prior to the applicable transition date from Worksheet CM-2, column 6, line 17, and enter in the applicable column the cost of services provided on or after the applicable transition date from Worksheet CM-2, column 5, line 17. *HHA-based* CMHCs with cost reporting periods beginning on or after January 1, 2004, enter zero (0) as CMHC services are reimbursed under 100% PPS.

Lines 1.01 through 1.05 are to be completed by *HHA-based* CMHCs for Title XVIII services rendered on or after August 1, 2000.

Line 1.01.--Enter the gross PPS payments (includes deductible and coinsurance) received including payments for drugs and outliers.

Line 1.02.--Enter the 1996 CMHC specific payment to cost ratio provided by your *contractor*.

Line 1.03.--Line 1 times line 1.02.

Line 1.04.--Line 1.01 divided by line 1.03. Express the results as a percentage to 3 decimal places, i.e., 94.824%. If this line is equal to or greater than 100%, enter zero on line 1.05.

Line 1.05.-- Enter the transitional corridor payment amount calculated based on the following:

For services rendered August 1, 2000 through December 31, 2001:
a. If line 1.04 is => 90% but < 100% enter 80% of line 1.03 minus line 1.01.
b. If line 1.04 is => 80% but < 90% enter the result of .71 times line 1.03 minus .70 times line 1.01.
c. If line 1.04 is => 70% but < 80% enter the result of .63 times line 1.03 minus .60 times line 1.01.
d. If line 1.04 is < 70% enter 21% of line 1.03.

For services rendered January 1, 2002 through December 31, 2002:
a. If line 1.04 is => 90% but < 100% enter 70% of line 1.03 minus line 1.01.
b. If line 1.04 is => 80% but < 90% enter the result of .61 times line 1.03 minus .60 times line 1.01.
c. If line 1.04 is < 80% enter 13% of result line 1.03.

For services rendered January 1, 2003 through December 31, 2003:
a. If line 1.04 is => 90% but < 100% enter 60% of line 1.03 minus line 1.01.
b. If line 1.04 is < 90% enter 6% of line 1.03.

Do not use lines 2 through 8, 12 and 14, columns as applicable for a) any part of the cost reporting period on or after August 1, 2000 when the reporting period overlaps August 1, 2000; and b) for all cost reporting periods beginning on or after August 1, 2000 as these lines are not applicable for the previously mentioned periods.

Line 2.--For cost reporting periods ending prior to August 1, 2000, enter in column 1 the charges from Worksheet CM-2, column 3.01, line 17. For cost reporting periods that overlap August 1, 2000, enter in column 1 the pre-transition Medicare charges. For cost reporting periods which overlap August 1, 2000, January 1, 2002, January 1, 2003, or January 1, 2004, do not enter charge data for services rendered on or after August 1, 2000, as services are 100 percent OPPS reimbursed and not subject to LCC.

Lines 3 through 6.--These lines provide for the reduction of program charges when you do not actually impose such charges (in the case of most patients liable for payment for services on a charge basis) or when you fail to make reasonable efforts to collect such charges from the patients. Enter on line 6 the product of line 5 times line 2. In no instance may the customary charges on line 6 exceed the actual charges on line 2. This line is not applicable for services rendered on or after August 1, 2000.

If you impose these charges and make reasonable efforts to collect the charges from patients liable for payment for services on a charge basis, you are not required to complete lines 3, 4, and 5, but enter on line 6 the amount on line 2. (See 42 CFR 413.13(b).)

Line 7.--If line 6 is greater than line 1, column 1, enters the excess of customary charges over reasonable cost. This line is not applicable for services rendered on or after August 1, 2000.

Line 8.--If line 1, column 1 is greater than line 6, enter the excess of reasonable cost over customary charges. This line is not applicable for services rendered on or after August 1, 2000.

Line 9.--Enter the amounts paid and payable by Workers' Compensation and other primary payers (from your records).

3227.2 Part II - Computation of *HHA-Based CMHC* Reimbursement Settlement.--

Line 10.--For cost reporting periods overlapping August 1, 2000, enter in column 1 the cost of CMHC services from Part I, line 1, column 1 minus line 9, column 1 and enter in column 1.01 the cost of CMHC services from Part I, line 1.01, column 1.01 plus line 1.05, column 1.01 minus line 9, column 1.01.

For cost reporting periods beginning on or after August 1, 2000, enter in column 1 the cost of CMHC services from Part I, line 1.01, and column 1, plus line 1.05, column 1 minus line 9, column 1. Follow the same procedures for column 1.01.

Line 11.--Enter the Part B deductibles billed to *HHA-based* CMHC patients (from your records) excluding any coinsurance amounts.

Line 12.--Enter excess reasonable cost from line 8. This line is not applicable for services rendered on or after August 1, 2000 as PPS reimbursed services are not subject to LCC.

Line 13.--Enter the result of line 10 minus lines 11 and 12.

Line 14.--Enter in the applicable column 80 percent of the amount shown on line 13.
HHA-based CMHCs enter 0 (zero) for services on or after August 1, 2000 reimbursed under OPPS.

Line 15.--For services rendered prior to August 1, 2000, enter in the appropriate column the actual coinsurance billed program patients from your records. For services rendered on or after August 1, 2000, enter in the appropriate column the gross coinsurance amount billed to Medicare beneficiaries.

Line 17.--For services rendered prior to August 1, 2000, enter reimbursable bad debts, net of recoveries, for *HHA-based* CMHC services. The amount entered for services rendered on or after August 1, 2000 must not exceed the discounted coinsurance applicable to Medicare beneficiaries.

Line 17.01.--Enter in column 1 the result of line 17 (including negative amounts) times 88 percent for cost reporting periods that begin on or after October 1, 2012, 76 percent for cost reporting periods that begin on or after October 1, 2013, and 65 percent for cost reporting periods that begin on or after October 1, 2014.

Line 17.02.--Enter the gross allowable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. These amounts must also be reported on line 17.

Line 18.--For services rendered prior to August 1, 2000, enter in the appropriate column the result of line 17 plus the lesser of lines 14 or 16. For services rendered on or after August 1, 2000, enter in the appropriate column the result of line 16 plus line 17. For cost reporting periods that begin on or after October 1, 2012, enter in column 1 the result of line 16 plus line 17.01.

Line 19.--Enter the program's share of any net depreciation adjustment applicable to prior years resulting from the gain or loss on the disposition of depreciable assets. (See CMS Pub. 15-*1*, §132ff.) Enter the amount of any excess depreciation taken in parenthesis ( ).

NOTE: Effective for changes in ownership that occur on or after December 1, 1997, §4404 of BBA 1997 amends §1861(v)(1)(O) of the Act which states, in part, that "...a provider of services which has undergone a change of ownership, such regulations provide that the valuation of the asset after such change of ownership shall be the historical cost of the asset, as recognized under this title, less depreciation allowed, to the owner of record...." That is, no gain or loss is recognized for such transactions on or after December 1, 1997.

Line 20.--Enter the program's share of any recovery of excess depreciation applicable to prior years resulting from your termination or a decrease in Medicare utilization. (See CMS Pub. 15-*1*, §136ff.)

Line 21.--Enter any other adjustment. For example, if you change the recording of vacation pay from the cash basis to the accrual basis, enter the adjustment. (See CMS Pub. 15-*1*, §2146.4.) Specify the adjustment in the space provided.

Line 22.--Enter the total cost (sum of line 18, columns 1 and 2, minus lines 19 and 20, plus or minus line 21).

Line 23.--For cost reporting periods that overlap or begin on or after April 1, 2013, enter the sequestration adjustment amount as [(2 percent times (total days in the cost reporting period that occur during the sequestration period beginning on or after April 1, 2013, divided by total days in the entire cost reporting period, rounded to four decimal places)) times line 22].

Line 24.--Enter the amount due the *HHA-based CMHC* (line 22 minus line 23).

Line 25.--Enter the total interim payments from Worksheet CM-4, column 2, line 4. For contractor final settlement, report on line 25.5 the amount from Worksheet CM-4, line 5.99.

Line 26.--Enter the balance due *HHA-based CMHC*/program (line 24 minus line 25) and transfer the amount to Worksheet S, Part II, column 2, and line 3.

Line 27.--Enter the program reimbursable effect of nonallowable cost report items which you are disputing. Compute the reimbursement effect in accordance with CMS Pub. 15-2, §115.2. Attach a schedule showing the supporting details and computation.

Line 28.--Do not use this line for periods beginning on or after October 1, 1997.

3228. WORKSHEET CM-4 - ANALYSIS OF PAYMENTS TO *HHA-BASED* CMHC *FOR* SERVICES RENDERED TO PROGRAM BENEFICIARIES

Complete this worksheet for Medicare interim payments only. (See 42 CFR 413.64.) If there is more than one HHA-based CMHC, complete a separate worksheet for each.

Complete the identifying information on lines 1 through 4. The remainder of the worksheet is completed by your contractor.

Line Descriptions

Line 1.--Enter the total Medicare interim payments paid to the HHA-based CMHC. The amount entered reflects the sum of all interim payments paid on individual bills (net of adjustment bills) for services rendered in this cost reporting period. The amount entered must include amounts withheld from the *HHA-based* CMHC's interim payments due to an offset against overpayments to the *HHA-based* CMHC applicable to prior cost reporting periods. It does not include any retroactive lump sum adjustment amounts based on a subsequent revision of the interim rate or tentative or net settlement amounts; nor does it include interim payments payable. If the *HHA-based* CMHC is reimbursed under the periodic interim payment method of reimbursement, enter the periodic interim payments received for this cost reporting period.

Line 2.--Enter the total Medicare interim payments payable on individual bills. Since the cost in the cost report is on an accrual basis, this line represents the amount of services rendered in the cost reporting period, but not paid as of the end of the cost reporting period, and does not include payments reported on line 1.

Line 3.--Enter the amount of each retroactive lump sum adjustment and the applicable date.

Line 4.--Enter the total amount of the interim payments (sum of lines 1, 2, and 3.99). Transfer these totals to Worksheet CM-3, line 25.

DO NOT COMPLETE THE REMAINDER OF WORKSHEET CM-4. THE REMAINDER OF THE WORKSHEET IS COMPLETED BY YOUR CONTRACTOR.

Line 5.--List separately each tentative settlement payment after desk review together with the date of payment. If the cost report is reopened after the Notice of Program Reimbursement (NPR) has been issued, report all settlement payments prior to the current reopening settlement on line 5.

Line 6.--Enter the net settlement amount (balance due to the *HHA-based CMHC* or balance due to the program) for the NPR, or, if this settlement is after a reopening of the NPR, for this reopening.

NOTE: On lines 3, 5, and 6, when an amount is due *HHA-based CMHC* to program, show the amount and date on which the *HHA-based CMHC* agrees to the amount of repayment, even though total repayment is not accomplished until a later date.

Line 7.--Enter the sum of the amounts on lines 4 and 5.99. The amount must equal Worksheet CM-3, line 24.

3229 *Removed and reserved*
3229.1. *Removed and reserved*
3229.2. *Removed and reserved*
3229.3. *Removed and reserved*
3230. *Removed and reserved*
3230.1 *Removed and reserved*
3230.2 *Removed and reserved*
3230.3 *Removed and reserved*
3231. *Removed and reserved*
3231.1. *Removed and reserved*
3231.2. *Removed and reserved*
3231.3. *Removed and reserved*
3232. *Removed and reserved*
3232.1 *Removed and reserved*
3232.2 *Removed and reserved*
3232.3 *Removed and reserved*

Pages 58.2 through 64 are reserved for future use.

3233. WORKSHEET S-4 - HHA-BASED *RHC/FQHC* STATISTICAL DATA

COMPLETE THE S-4 AND RF SERIES WORKSHEETS FOR SERVICES RENDERED ON OR AFTER JANUARY 1, 1998.

In accordance with 42 CFR 413.20(a), 42 CFR 413.24(a), and 42 CFR 413.24(c), you are required to maintain statistical records for proper determination of costs payable under the Medicare program. The statistics reported on this worksheet pertain to *HHA*-based rural health clinics (RHCs) and *HHA*-based federally qualified health centers (FQHCs). If you have more than one of these clinics *or centers*, complete a separate worksheet for each. *Effective for cost reporting periods beginning on and after October 1, 2014, FQHCs cannot file as an HHA-based FQHC, and must file as a free standing or independent FQHC on the form CMS-224-14.*

Lines 1 and 1.01.--Enter the full address of the *HHA-based* RHC/FQHC.

Line 2.--For *HHA-based* FQHCs only, enter your appropriate designation (urban or rural). See CMS Pub. 100-0*4*, *c*hapter *9*, §*20.6.2* for information regarding urban and rural designations. If you are uncertain of your designation, contact your contractor. *HHA-based* RHCs do not complete this line.

Lines 3 through 8.--In column 1, enter the applicable grant award number(s). In column 2, enter the date(s) awarded.

Line 9.--Subscript line 9 as needed to list all physicians furnishing services at the *HHA-based* RHC/FQHC. Enter the physician name in column 1, and the physician's Medicare billing number in column 2.

Line 10.--Subscript line 10 as needed to list all supervisory physicians. Enter the physician name in column 1, and the number of hours the physician spent in supervision in column 2.

Line 11.--If the *HHA-based RHC/FQHC* provides other than RHC or FQHC services (e.g., laboratory or physician services), answer Y (yes) in column 1, then indicate the number of other operations in column 2, and enter the type(s) of operation(s) and hour(s) on subscripts of line 12. If the facility does not provide other services, enter N (no) on line 11, and do not complete subscripts of line 12.

Lines 12.--Enter the starting and ending hours in the applicable columns 1 through 14 for the days that the clinic is available to provide *HHA-based* RHC/FQHC services. For facilities providing other than RHC or FQHC services, enter on subscripts of line 12, columns 1 through 14 the starting and ending hours in the applicable columns for the days that the facility is available to provide *HHA-based* RHC/FQHC services.

Line 13.--If the *HHA-based RHC/FQHC* has been approved for an exception to the productivity standard, enter Y (yes) or N (no).

Line 14.--If this *HHA-based RHC/FQHC* is filing a consolidated cost report, as defined in CMS Pub. *100-04, chapter 9, §30.8*, enter Y (yes) or N (no). If the response is yes, enter in column 2 the number of providers included in this report.

Line 15.--If the response to question 14 is yes, list all associated *site* names and the corresponding *CCN* included in this report.

Line 16.--If this facility is claiming allowable GME costs as a result of substantial payment for interns and residents, enter "Y" for yes or "N" for no in column 1. If yes, enter the number of Medicare visits performed by interns and residents in column 2 and total visits performed by interns and residents in column 3. Complete Worksheet RF-1, lines 20 and 27 as applicable. (See 42 CFR 405.2468 (f)(2).)

3234. WORKSHEET RF-1 - ANALYSIS OF HHA-BASED RHC/*FQHC* COSTS

Effective for services rendered on or after January 1, 1998, use this worksheet only if you operate a *HHA-based* certified rural health clinic (RHC) or *f*ederally qualified health center (FQHC). Only those cost centers that represent services for which the facility is certified are used. If you have more than one *HHA*-based RHC and/or FQHC, complete a separate worksheet for each facility. *Effective for cost reporting periods beginning on and after October 1, 2014, FQHCs cannot file as an HHA-based FQHC, and must file as a free standing or independent FQHC on the form CMS-224-14.*

This worksheet is for the recording of direct *HHA-based* RHC/FQHC costs from your accounting books and records to arrive at the identifiable agency cost. This data is required by 42 CFR 413.20. It also provides for the necessary reclassifications and adjustments to certain accounts prior to the cost finding calculations.

Column Descriptions

Columns 1 through 6.--The expenses listed in these columns must be in accordance with your accounting books and records. If the cost elements of a cost center are maintained separately on your books, a reconciliation of costs per the accounting books and records to those on this worksheet must be maintained by you and are subject to review by your contractor.

Enter on the appropriate lines in columns 1 through 6 the total expenses incurred during the reporting period. Detail the expenses as Compensation (column 1), Employee Benefits (column 2), Contracted Services (column 3), Transportation (column 4) and Other (column 5). The sum of columns 1 through 5 must equal column 6.

Column 7.--Enter any reclassifications among the cost center expenses listed in column 6 which are needed to effect proper cost allocation. This column need not be completed by all providers, but is completed only to the extent reclassifications are needed and appropriate in the particular circumstances. (See §3210 for examples of reclassifications that may be needed.) Submit with the cost report copies of any workpapers used to compute the reclassifications reported in this column. Show reductions to expenses in parentheses ( ).

The net total of the entries in column 7 must equal zero on line 30.

Column 8.--Add column 6 to column 7, and extend the net balances to column 8. The total of column 8 must equal the total of column 6 on line 30.

Column 9.--In accordance with 42 CFR 413ff, enter on the appropriate lines the amounts of any adjustments to expenses required under the Medicare principles of reimbursement. (See §3211.) Submit with the cost report copies of any workpapers used to compute the adjustments reported in this column.

NOTE: The allowable cost of the services furnished by *Public Health Service* personnel may be included in your *clinic/cente*r's costs. Obtain this amount from your contractor, and include this as an adjustment to the appropriate lines on column 9.

Column 10.--Adjust the amounts in column 8 by the amounts in column 9, and extend the net balance to column 10. The total *HHA-based RHC/FQHC* costs on line 30 must equal the net expenses for cost allocation on Worksheet A for the *HHA-based* RHC/FQHC cost center.

Line Descriptions

Lines 1 through 9.--Enter the costs of your health care staff.

Line 10.--Enter the sum of the amounts on lines 1 through 9.

Line 11.--Enter the cost of physician medical services furnished under agreement.

Line 12.--Enter the expenses of physician supervisory services furnished under agreement.

Line 14.--Enter the sum of the amounts on lines 11 through 13.

Lines 15 through 20.--Enter the expenses of other health care costs.

Line 20.--If the clinic incurred all or substantially all training costs for interns and residents, enter the total allowable direct GME cost. (See 42 CFR 405.2468 (f)(2).)

Line 21.--Enter the sum of the amounts on lines 15 through 20.

Line 22.--Enter the sum of the amounts on lines 10, 14, and 21. Transfer this amount to Worksheet RF-2, line 10.

Lines 23 through 26.--Enter the expenses applicable to services that are not reimbursable under the RHC/FQHC benefit.

Line 27.--If the clinic does not provide all or substantially all training costs, enter the total non-allowable direct GME cost.

Line 28.--Enter the sum of the amounts on lines 23 through 27. Transfer the total amount in column 7 to Worksheet RF-2, line 11.

Line 29.--Enter the overhead expenses directly costed to the *HHA-based RHC/FQHC*. These expenses may include rent, insurance, interest on mortgage or loans, utilities, depreciation of buildings and fixtures, depreciation of equipment, housekeeping and maintenance expenses, and property taxes. Submit with the cost report supporting documentation to detail and compute the costs reported on this line.

Line 30.--Enter the expenses related to the administration and management of the *HHA-based* RHC/FQHC that are directly costed to the *clinic/center*. These expenses may include office salaries, depreciation of office equipment, office supplies, legal fees, accounting fees, insurance, telephone service, fringe benefits, and payroll taxes. Submit with the cost report supporting documentation to detail and compute the administrative costs reported on this line.

Line 31.--Enter the sum of the amounts on lines 29 and 30. Transfer the total amount in column 7 to Worksheet RF-2, line 14.

Line 32.--Enter the sum of the amounts on lines 22, 28 and 31. This is the total *clinic/center* cost.

3235. WORKSHEET RF-2 - ALLOCATION OF OVERHEAD TO HHA-BASED RHC/FQHC SERVICES

Use this worksheet only if you operate a certified *HHA*-based RHC or FQHC as part of your complex. If you have more than one *HHA*-based RHC and/or FQHC, complete a separate worksheet for each facility.

3235.1 Visits and Productivity.--This section summarizes the number of visits furnished by the health care staff and calculates the number of visits to be used in the rate determination. Lines 1 through 9 list the types of practitioners (positions) for whom visits must be counted and reported.

Column descriptions

Column 1.--Record the number of all full time equivalent (FTE) personnel in each of the

applicable staff positions in the *clinic/center*'s practice. (See CMS Pub. 100-02, chapter 13, §70.4 for a definition of FTEs.)

Column 2.--Record the total visits actually furnished to all patients by all personnel in each of the applicable staff positions in the reporting period. Count visits in accordance with instructions in 42 CFR 405.2401(b) defining a visit.

Column 3.--Productivity standards established by CMS are applied as a guideline that reflects the total combined services of the staff. Apply a level of 4200 visits for each physician and a level of 2100 visits for each nonphysician practitioner. If you were granted an exception to the productivity standards (answered yes to question 13 of Worksheet S-4), enter the number of productivity visits approved by the contractor on lines 1-3.

Contractors have the authority to waive the productivity guideline in cases where you have demonstrated reasonable justification for not meeting the standard. In such cases, the contractor could set any number of visits as reasonable (not just your actual visits) if an exception is granted. For example, if the guideline number is 4200 visits and you have only furnished 1000 visits, the contractor need not accept the 1000 visits but could permit 2500 visits to be used in the calculation.

Column 4.--For lines 1 through 3, enter the product of column 1 and column 3. This is the minimum number of facility visits the personnel in each staff position are expected to furnish.

Column 5.--On line 4, enter the greater of the subtotal of the actual visits in column 2 or the minimum visits in column 4.

On lines 5 through 7 and 9, enter the actual number of visits for each type of position.

Line Descriptions

Line 1.--Enter in column 1 the number of staff physician FTEs and in column 2 the total visits furnished to facility patients by staff physicians working at the facility on a regular ongoing basis. Include on this line, physician data (FTEs and visits) for services furnished to facility patients by staff physicians working under contractual agreement with you on a regular ongoing basis in the *HHA-based* RHC facility. These physicians are subject to productivity standards. (See 42 CFR 405.2468(d)(2)(v).)

Line 7.01.--For medical nutrition therapy services performed by a registered dietitian, enter the corresponding FTE count in column 1 and total visits performed in column 2. (See CMS Pub. 100-02, chapter 13, §210.2.4.) For FQHC only.

Line 7.02.--For diabetes self-management training performed by a registered dietitian, enter the corresponding FTE count in column 1 and total visits performed in column 2. (See CMS Pub. 100-02, chapter 13, §210.2.4.) For FQHC only.

Line 8.--Enter the total of lines 4 through 7 (and subscripts).

Line 9.--Enter the number of visits furnished to *HHA-based RHC/FQHC* patients by physicians under agreement with you who do not furnish services to patients on a regular ongoing basis in the *HHA-based* RHC/FQHC. Physicians services under agreements with you are (1) all medical services performed at your site by a physician who is not the owner or an employee of the facility, and (2) medical services performed at a location other than your site by such a physician for which the physician is compensated by you. While all physician services at your site are included in HHA-based RHC/FQHC services, physician services furnished in other locations by physicians who are not on your full time staff are paid to you only if your agreement with the physician provides for compensation for such services.

3235.2 Determination of Total Allowable Cost Applicable To HHA-Based RHC/FQHC Services.--This section determines the amount of the overhead costs incurred by both the parent provider and the facility which apply to HHA-based RHC/FQHC services.

Line 10.--Enter the cost of health care services from Worksheet RF-1, column 10, line 22 less the amount on Worksheet RF-1, column 10, line 20.

Line 11.--Enter the total nonreimbursable costs from Worksheet RF-1, column 10, line 28.

Line 12.--Enter the sum of lines 10 and 11 for the cost of all services (excluding overhead).

Line 13.--Enter the percentage of HHA-based RHC/FQHC services. This percentage is determined by dividing the amount on line 10 (the cost of health care services) by the amount on line 12 (the cost of all services, excluding overhead).

Line 14.--Enter the total overhead costs incurred from Worksheet RF-1, column 10, line 31.

Line 15.--If you are claiming allowable GME cost (line 20 of Worksheet RF-1 completed), enter the amount of GME overhead costs. To determine the amount of GME overhead, multiply the amount of facility overhead (from line 14) by the ratio of Intern and Resident visits (from Worksheet S-4, column 3, line 16) over total visits (from Worksheet RF-3, line 6). If you are not claiming GME enter zero.

Line 16.--Enter the net overhead costs by subtracting line 15 from line 14.

Line 17.--Enter the overhead cost incurred by the *HHA* allocated to the *HHA-based* RHC/FQHC. This amount is the difference between the total costs after allocation from the corresponding *HHA-based* RHC/FQHC cost center on the B worksheet, column 6 and Worksheet B, column 0.

Line 18.--Enter the sum of lines 16 and 17 to determine the total overhead costs related to the *HHA-based* RHC/FQHC.

Line 19.--Enter the overhead amount applicable to *HHA-based* RHC/FQHC services. It is determined by multiplying the amount on line 13 (the ratio of *HHA-based* RHC/FQHC services to total services) by the amount on line 18 (total overhead costs).

Line 20.--Enter the total allowable cost of *HHA-based* RHC/FQHC services. It is the sum of line 10 (cost of *HHA-based* RHC/FQHC health care services) and line 19 (total overhead costs).

3236. WORKSHEET RF-3 - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR *HHA-BASED* RHC/FQHC SERVICES

This worksheet applies to title XVIII only and provides for the reimbursement calculation *for services rendered*. Use this worksheet to determine the interim all inclusive rate of payment and the total Medicare payment due you for the reporting period.

3236.1 Determination of Rate For *HHA-Based* RHC/FQHC Services.--This section calculates the cost per visit for *HHA-based* RHC/FQHC services and applies the screening guideline established by CMS on your health care staff productivity.

Line Descriptions

Line 1.--Enter the total allowable cost from Worksheet RF-2, line 20.

Line 2.--Enter the total cost of pneumococcal and influenza vaccine from Worksheet RF-4, line 15.

Line 3.--Subtract the amount on line 2 from the amount on line 1 and enter the result.

Line 4.--Enter the greater of the minimum or actual visits by the health care staff from Worksheet RF-2, column 5, line 8.

Line 5.--Enter the visits made by physicians under agreement from Worksheet RF-2, column 5, line 9.

Line 6.--Enter the total adjusted visits (sum of lines 4 and 5).

Line 7.--Enter the adjusted cost per visit. This is determined by dividing the amount on line 3 by the visits on line 6.

Lines 8 and 9.--Per visit payment limits are revised each January 1, (except calendar year 2003 updates that occurred January 1 and March 1 (see PM A-03-21)). Complete columns 1, 2 and 3, if applicable (add column 3 for lines 8-14 if the cost reporting period overlaps 3 limit update periods) for lines 8 and 9 to identify costs and visits affected by different payment limits during a cost reporting period. Enter the rates and the corresponding data chronologically in the appropriate column as they occur during the cost reporting period.

For services rendered from January 1, 2010, through December 31, 2013, the maximum rate per visit entered on line 8 and the outpatient mental health treatment service limitation applied on line 14 both correspond to the same time period (calendar year). Consequently, both are entered in the same column, and no subscripting of the columns are necessary.

Line 8.--Enter your applicable per visit payment limit. Obtain this amount from your contractor. *See* CMS Pub. 100-02, chapter 13, §70.1.*1* for RHCs or §70.*1*.2 for FQHCs.

Line 9.--Enter the lesser of the amount on line 7 or line 8.

NOTE: If only one payment limit is applicable during the cost reporting period, or the cost per visit (line 7) is less than both payment limits (line 8), complete column 2 only.

3236.2 Calculation of *HHA-Based RHC/FQHC* Settlement.--Use this section to determine the total Medicare payment due you for covered HHA-based RHC/FQHC services furnished to Medicare beneficiaries during the reporting period.

Complete columns 1 and 2 of lines 10 through 14 to identify costs and visits affected by different payment limits during a cost reporting period.

Line Descriptions

Line 10.--Enter the number of Medicare covered visits excluding visits subject to the outpatient mental health services limitation from the PS&R.

Line 11.--Enter the subtotal of Medicare cost. This cost is determined by multiplying the rate per visit on line 9 by the number of visits on line 10 (the total number of covered Medicare beneficiary visits for HHA-based RHC/FQHC services during the reporting period).

Line 12.--Enter the number of Medicare covered visits subject to the outpatient mental health services limitation from the PS&R.

Line 13.--Enter the Medicare covered cost for outpatient mental health services by multiplying the rate per visit on line 9 by the number of visits on line 12.

Line 14.--Enter the limit adjustment. In accordance with MIPPA 2008, §102, the outpatient mental health treatment service limitation applies as follows: For services rendered through December 31, 2009, the limitation is 62.50 percent; services from January 1, 2010, through

December 31, 2011, the limitation is 68.75 percent; services from January 1, 2012, through December 31, 2012, the limitation is 75 percent; services from January 1, 2013, through December 31, 2013 the limitation is 81.25 percent; and services on or after January 1, 2014, the limitation is 100 percent. This is computed by multiplying the amount on line 13 by the corresponding outpatient mental health service limit percent. This limit applies only to therapeutic services, not initial diagnostic services.

Line 15.--Enter the total allowable GME pass-through costs determined by dividing Medicare visits performed by Interns and Residents (from Worksheet S-4, column 2, line 16) by the total visits (from Worksheet S-4, column 3, line 16,) and multiply that result by the (sum of total allowable GME cost reported on Worksheet RF-1, column 10, line 20 and allowable GME overhead costs from Worksheet RF-2, line 15) and enter that result on this line. For cost reporting periods that overlap January 1, 2011, prorate the result using a ratio of days before January 1, 2011, to days on and after January 1, 2011, for the applicable columns. For cost reporting periods beginning on or after January 1, 2011, do not use column 1; instead enter the result in column 2.

NOTE: If there are no allowable GME pass-through costs, this line is zero.)

Line 15.5.--Enter the primary payers (from the PS&R). For cost reporting periods that overlap January 1, 2011, prorate the result using a ratio of days before January 1, 2011, to days on and after January 1, 2011, for the applicable columns. For cost reporting periods beginning on or after January 1, 2011, do not use column 1; instead enter the result in column 2.

Line 16.--Enter the total Medicare cost. This is equal to the sum of the amounts on line 11, columns 1 and 2, plus line 14, columns 1 and 2, plus line 15, column 1 minus line 15.5. For cost reporting period that overlap January 1, 2011, enter in column 1 the sum of the amounts on lines 11, 14, and 15, column 1, minus line 15.5. Enter in column 2 the sum of the amounts on lines 11, 14, and 15, column 2, minus line 15.5. For cost reporting periods that begin on or after January 1, 2011, enter the sum of lines 11, 14, and 15, columns 1 and 2, minus line 15.5 in column 2.

NOTE: Section 4104 of ACA eliminates coinsurance and deductible for preventive services, effective for dates of service on or after January 1, 2011. *HHA-based* RHCs and FQHCs must provide detailed HCPCS coding for preventive services to ensure that coinsurance and deductible are not applied. *HHA-based RHCs and FQHCs* must maintain this documentation to apply the appropriate reductions on lines 16.03 and 16.04.

Line 16.01.--Enter the total program charges from the contractor's records (PS&R). For cost reporting periods that overlap January 1, 2011, do not complete column 1 and enter total program charges for services rendered on or after January 1, 2011 in column 2. For cost reporting periods beginning on or after January 1, 2011, enter total program charges in column 2.

Line 16.02.--Enter the total program preventive charges from the provider's records. For cost reporting periods that overlap January 1, 2011, do not complete column 1 and enter total program preventive charges for services rendered on or after January 1, 2011 in column 2. For cost reporting periods beginning on or after January 1, 2011, enter total program preventive charges in column 2.

Line 16.03.--Enter the total program preventive costs. For cost reporting periods that overlap January 1, 2011, do not complete column 1 and enter the total program preventive costs ((line 16.02 divided by line 16.01) times line 16) for services rendered on or after January 1, 2011, in column 2. For cost reporting periods beginning on or after January 1, 2011, enter the total program preventive costs ((line 16.02 divided by line 16.01) times line 16, *column 2*).

Line 16.04.--Enter the total program non-preventive costs. For cost reporting periods that overlap January 1, 2011, do not complete column 1 and enter the total program non- preventive

costs ((line 16 minus lines 16.03 and 17) times .80) for services rendered on or after January 1, 2011, in column 2. For cost reporting periods beginning on or after January 1, 2011, enter the total program non- preventive costs ((line 16, column 2, minus lines 16.03 and 17, column 2) times .80) in column 2.

Line 16.05.--Enter the total program costs. For cost reporting periods that overlap January 1, 2011, enter total program costs (line 16 times .80) for services rendered prior to January 1, 2011, in column 1, and enter the sum of lines 16.03 and 16.04, in column 2. For cost reporting periods beginning on or after January 1, 2011, enter the sum of lines 16.03 and 16.04, in column 2.

Line 17.--Enter the amount credited to the *HHA-based* RHC's Medicare patients, to satisfy their deductible liabilities on the visits on lines 10 and 12 as recorded by the contractors from clinic bills processed during the reporting period. *HHA-based* RHCs determine this amount from their PS&R. *HHA-based* FQHCs enter zero on this line as deductibles do not apply.

Line 17.5--Enter the coinsurance amount applicable to the *HHA-based* RHC or FQHC for program patient visits on lines 10 and 12 as recorded by the contractor from clinic bills processed during the reporting period. This line captures data for informational and statistical purposes only. This line does not impact the settlement calculation.

Line 18.--Enter the net Medicare cost, excluding vaccines. This is equal to the result of subtracting the amount on line 17 from the amount on line 16. Do not complete this line for cost reporting periods ending on or after January 1, 2011.

Line 19.--Enter the net program costs, excluding vaccines. For cost reporting periods ending prior to January 1, 2011, enter 80% of the amount on line 18. Do not complete this line for cost reporting periods ending on or after January 1, 2011.

Line 20.--Enter the Medicare cost of pneumococcal and influenza vaccines and their administration from Worksheet RF-4, line 16.

Line 21.--Enter the total reimbursable Medicare cost. This is equal to the sum of the amounts on lines 19 and 20. For cost reporting periods ending on or after January 1, 2011, enter the sum of line 16.05, columns 1 and 2, plus line 20.

Line 22.--Enter your total reimbursable bad debts, net of recoveries, from your records.

Line 22.01.--Enter the result of line 22 (including negative amounts) times 88 percent for cost reporting periods that begin on or after October 1, 2012, 76 percent for cost reporting periods that begin on or after October 1, 2013, and 65 percent for cost reporting periods that begin on or after October 1, 2014.

Line 22.02.--Enter the gross allowable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. These amounts must also be reported on line 22.

Line 23.--Enter any other adjustment. For example, if you change the recording of vacation pay from the cash basis to the accrual basis, enter the adjustment. (See CMS Pub. 15-1, §2146.4.) Specify the adjustment in the space provided.

Line 24.--This is the sum of lines 21 and 22, plus or minus line 23. For cost reporting periods that begin on or after October 1, 2012, enter the sum of lines 21 and 22.01, plus or minus line 23.

Line 24.01.--For cost reporting periods that overlap or begin on or after April 1, 2013, enter the sequestration adjustment amount as [(2 percent times (total days in the cost reporting period that occur during the sequestration period beginning on or after April 1, 2013, divided by total days in the entire cost reporting period, rounded to four decimal places)) times line 24].

Line 25--Enter the interim payments from Worksheet RF-5, line 4. For contractor final settlement, report on line 25.5 the amount from Worksheet RF-5, line 5.99.

Line 26.--Enter the total amount due to/from the Medicare program (line 24 minus lines 24.01 and 25.) Transfer this amount to Worksheet S, Part II, column 2, line:

- 3.50 - 3.58 for *HHA-based* RHCs
- 3.60 - 3.68 for *HHA-based* FQHCs

3237. WORKSHEET RF-4 - COMPUTATION OF *HHA-BASED RHC/FQHC* PNEUMOCOCCAL AND INFLUENZA VACCINE COST

The cost and administration of pneumococcal and influenza vaccines to Medicare beneficiaries is 100 percent reimbursable by Medicare. This worksheet provides for the computation of these vaccines for services rendered on or after April 1, 2001. Use this worksheet only for vaccines rendered to patients who, at the time of receiving the vaccine(s), are not also receiving services under HHA PPS. If a patient simultaneously received vaccine(s) with any Medicare covered services under HHA PPS, those vaccine costs are reimbursed through the *HHA* under HHA PPS, and cannot be claimed by the *HHA-based* RHC *o*r FQHC.

Effective for services rendered on or after September 1, 2009, the administration of influenza H1N1 vaccines furnished by *HHA-based* RHCs and FQHCs are cost reimbursed. However, no cost will be incurred for the H1N1 vaccine as this is provided free of charge to providers/suppliers.

To account for the cost of administering seasonal influenza vaccines, influenza H1N1 vaccines, and/or both vaccines administered during the same patient visit, column 2 is subscripted adding column 2.01 (administration of only H1N1 vaccines) and 2.02 (administration of both the seasonal influenza and H1N1 vaccines during the same patient visit). The data entered in all columns (1, 2, and applicable subscripts) for lines 4, 11, and 13 are mutually exclusive. That is, the vaccine costs, the total number of vaccines administered, and the total number of Medicare covered vaccines shall be represented only one time in the appropriate column. Columns 2.01 and 2.02 will not reflect the cost of H1N1 vaccines as it is furnished at no cost to the provider. However, the cost of seasonal influenza vaccines is required in columns 2 and 2.02, line 4.

Line 1.--Enter the health care staff cost from Worksheet RF-1, column 10, line 10.

Line 2.--Enter the ratio of the estimated percentage of time involved in administering pneumococcal and influenza vaccine injections to the total health care staff time. Do not include physician service under agreement time in this calculation.

Line 3.--Multiply the amount on line 1 by the amount on line 2 and enter the result.

Line 4.--Enter the cost of pneumococcal and influenza vaccine medical supplies from your records.

Line 5.--Enter the sum of lines 3 and 4.

Line 6.--Enter the amount on Worksheet RF-1, column 10, line 22. This is your total direct cost of the *HHA-based RHC/FQHC*.

Line 7.--Enter the amount from Worksheet RF-2, line 18.

Line 8.--Divide the amount on line 5 by the amount on line 6 and enter the result.

Line 9.--Multiply the amount on line 7 by the amount on line 8 and enter the result.

Line 10.--Enter the sum of the amounts on lines 5 and 9.

Line 11.--Enter the total number of pneumococcal and influenza vaccine injections from your records.

Line 12.--Enter the cost per pneumococcal and influenza vaccine injection by dividing the amount on line 10 by the number on line 11 and entering the result.

Line 13.--Enter the number of pneumococcal and influenza vaccine injections from your records.

Line 14.--Enter the Medicare cost for vaccine injections by multiplying the amount on line 12 by the amount on line 13.

Line 15.--Enter the total cost of pneumococcal and influenza vaccine and their administration and the administration of H1N1 vaccines by entering the sum of the amount in column 1, line 10 and the amount in column 2 (and applicable subscripts), line 10. Transfer this amount to Worksheet RF-3, line 2.

Line 16.--Enter the Medicare cost of pneumococcal and influenza vaccine and its (their) administration and the administration of H1N1 vaccines. This is equal to the sum of the amount in column 1, line 14 and column 2 (and applicable subscripts), line 14. Transfer the result to Worksheet RF-3, line 20.

3238. WORKSHEET RF-5 - ANALYSIS OF PAYMENTS TO *HHA*-BASED RHC/FQHC FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Complete this worksheet for Medicare interim payments only. (See 42 CFR 413.64.) If there is more than one HHA-based RHC/FQHC, complete a separate worksheet for each.

Complete the identifying information on lines 1 through 4. The remainder of the worksheet is completed by your contractor.

NOTE: DO NOT reduce any interim payments by recoveries as a result of medical review adjustments where the recoveries were based on a sample percent applied to the universe of claims reviewed, and the PS&R was not also adjusted.

Line Descriptions

Line 1.--Enter the total Medicare interim payments paid to the HHA-based RHC/FQHC. The amount entered reflects the sum of all interim payments paid on individual bills (net of adjustment bills) for services rendered in this cost reporting period. The amount entered must include amounts withheld from the *HHA-based* RHC/FQHC's interim payments due to an offset against overpayments to the *HHA-based* RHC/FQHC applicable to prior cost reporting periods. It does not include any retroactive lump sum adjustment amounts based on a subsequent revision of the interim rate or tentative or net settlement amounts; nor does it include interim payments payable. If the *HHA-based* RHC/FQHC is reimbursed under the periodic interim payment method of reimbursement, enter the periodic interim payments received for this cost reporting period.

Line 2.--Enter the total Medicare interim payments payable on individual bills. Since the cost in the cost report is on an accrual basis, this line represents the amount of services rendered in the cost reporting period, but not paid as of the end of the cost reporting period, and does not include payments reported on line 1.

Line 3--Enter the amount of each retroactive lump sum adjustment and the applicable date.

Line 4--Enter the total amount of the interim payments (sum of lines 1, 2, and 3.99). Transfer these totals to Worksheet RF-3, line 25.

DO NOT COMPLETE THE REMAINDER OF WORKSHEET RF-5. THE REMAINDER OF THE WORKSHEET IS COMPLETED BY YOUR *CONTRACTOR*.

Line 5--List separately each tentative settlement payment after desk review together with the date of payment. If the cost report is reopened after the Notice of Program Reimbursement (NPR) has been issued, report all settlement payments prior to the current reopening settlement on line 5.

Line 6--Enter the net settlement amount (balance due to the provider or balance due to the program) for the NPR, or, if this settlement is after a reopening of the NPR, for this reopening.

NOTE: On lines 3, 5, and 6, when an amount is due *HHA-based RHC/FQHC* to program, show the amount and date on which the *HHA-based RHC/FQHC* agrees to the amount of repayment, even though total repayment is not accomplished until a later date.

Line 7--Enter the sum of the amounts on lines 4 and 5.99. The amount must equal Worksheet RF-3, line 24.

3239. WORKSHEET S-5 - *HHA-BASED* HOSPICE IDENTIFICATION DATA

In accordance with 42 CFR 418.310 hospice providers of service participating in the Medicare program are required to submit annual information for health care services rendered to Medicare beneficiaries. Also, 42 CFR 413.24 requires cost reports from providers on an annual basis. The data submitted on the cost reports supports management of Federal programs. The statistics required on this worksheet pertain to a HHA-based hospice. Complete a separate S-5 for each HHA-based hospice.

3239.1 Part I - Enrollment Days *For Cost Reporting Periods Beginning Before October 1, 2014*.--

Lines 1 *through* 4.--Enter on lines 1 through 4 the enrollment days applicable to each *level* of care *(LOC)*. Enrollment days are unduplicated days of care received by a hospice patient. A day is recorded for each day a hospice patient receives one of four *levels* of care. Where a patient moves from one (*LOC)* to another, count only one day of care for that patient for the last type of care rendered. For line 4, an inpatient care day should be reported only where the hospice provides or arranges to provide the inpatient care.

Line 5.--Enter the total of lines 1 through 4 for columns 1 through 4.

For the purposes of the Medicare and Medicaid hospice programs, a patient electing hospice can receive only one of the following four types of care per day:

Hospice Continuous Home Care *(HCHC)* Day - A*n HCHC* day is a day on which the hospice patient is not in an inpatient facility*, and receives continuous care during a period of crisis in order to maintain the individual at home*. A day consists of a minimum of 8 hours and a maximum of 24 hours of predominantly nursing care. *For each day a beneficiary received 8 or more hours of predominantly nursing care, count the day as one HCHC day. Note: Do not count days by dividing the total hours by 24.*

Hospice Routine Home Care *(HRHC)* Day - A*n HRHC day is a day on* which the hospice patient is at home and not receiving *HRHC*.

Hospice Inpatient Respite Care *(HIRC)* Day - An *HIRC* day is a day on which the hospice patient receives care in an *approved* inpatient facility, *to provide respite for the individual's family or other persons caring for the individual at home.*

Hospice General Inpatient Care *(HGIP)* Day - A*n HGIP* day is a day on which the hospice patient receives care in a *Medicare certified hospice* facility, *hospital or SNF* for pain control or acute or chronic symptom management which cannot be managed in other settings.

Column Descriptions

Column 1.--Enter only the unduplicated Medicare days applicable to the four types of care. Enter on line 5 the total unduplicated Medicare days.

Column 2.-- Enter only the unduplicated Medicare days applicable to the four types of care for all Medicare hospice patients residing in a skilled nursing facility. Enter on line 5 the total unduplicated days.

Column 3.-- Enter in column 3 only the days applicable to the four types of care for all non-Medicare or other hospice patients. Enter on line 5 the total unduplicated days.

Column 4.--Enter the total days for each type of care, (i.e., sum of columns 1 and 3). The amount entered in column 4, line 5 should represent the total days provided by the hospice.

NOTE: Convert continuous home care hours into days so that column 4, line 5 reflects the actual total number of days provided by the hospice.

3239.2 Part II - Census *Data for Cost Reporting Periods Beginning Before October 1, 2014*.--

Line 6.--Enter on line 6 the total number of patients receiving hospice care within the cost reporting period for the appropriate pay*o*r source. Do not include the number of patients receiving care under subsequent election periods. (See CMS *Pub.* 100-02, chapter 9, §20.2.)

The total under this line should equal the actual number of patients served during the cost reporting period for each program. Thus, if a patient's total stay overlapped two reporting periods, the stay should be counted once in each reporting period. The patient who initially elects the hospice benefit, is discharged or revokes the benefit, and then elects the benefit again within a reporting period is considered to be a new admission with a new election and is counted twice.

A patient transferring from another hospice is considered to be a new admission and is included in the count. If a patient entered a hospice under a payer source other than Medicare and then subsequently elects *the* Medicare hospice benefit, count the patient once for each *payor* source.

The difference between line 6 and line 9 is that line 6 equals the actual number of patients served during the reporting period for each program, whereas under line 9, patients are counted once, even if their stay overlaps more than one reporting period.

Line 7.--Enter the total Title XVIII Unduplicated Continuous Care hours billable to Medicare. When computing the Unduplicated Continuous Care hours, count only one hour regardless of *the* number of services or therapies provided simultaneously within that hour.

Line 8.-- Enter the average length of stay for the reporting period by dividing the amount on line 5 by the amount on line 6. Include only the days for which a hospice election was in effect. The average length of stay for patients with a payor source other than Medicare and Medicaid is not limited to the number of days under a hospice election.

The statistics for a patient who had periods of stay with the hospice under more than one program is included in the respective columns. For example, patient A enters the hospice under *the* Medicare hospice benefit, stays 90 days, revokes the election for 70 days (and thus goes back into regular Medicare coverage), then reelects the Medicare hospice benefits for an additional 45 days, under a new benefit period and dies (patient B).

Medicare patient C was in the program on the first day of the year and died on January 29 for a total length of stay of 29 days. Patient D was admitted with private insurance for 27 days, then their private insurance ended and Medicaid covered an additional 92 days. Patient E, with private insurance, received hospice care for 87 days. The average length of stay (LOS) (assuming these are the only patients the hospice served during the cost reporting period) is computed as follows:

Medicare Days (90 & 45 & 29) Patient (A, B & C)		*164* days
Medicare Patients		/3

Average LOS Medicare		54.67 Days
Medicaid Days Patient D (92)		92 Days
Medicaid Patient		1
Average LOS Medicaid		92 Days
Other (Insurance) Days (87 & 27)		114 Days
Other Payments (D & E)	2	
Average LOS (Other)		54 Days
All Patients (90+45+29+92+87+27)		370 Days
Total number of patients		6
Average LOS for all patients		61.67 Days

Enter the hospice's average length of stay, without regard to payor source, in column 4, line 8.

Line 9.--Enter the unduplicated census count of the hospice for all patients initially admitted and filing an election statement with the hospice within a reporting period for the appropriate payor source. Do not include the number of patients receiving care under subsequent election periods (see CMS Pub. *100-02, chapter 9*, §20.*2*). However, the patient who initially elects the hospice benefit, is discharged or revokes the benefits, and elects the benefit again within the reporting period is considered a new admission with each new election and is counted twice.

The total under this line equals the unduplicated number of patients served during the reporting period for each program. Thus, you do not include a patient if their stay was counted in a previous cost reporting period. If a patient enters a hospice source other than Medicare and subsequently becomes eligible for Medicare and elects the Medicare hospice benefit, then count that patient only once in the Medicare column, even though he/she may have had a period in another payor source prior to the Medicare election. A patient transferring from another hospice is considered a new admission and *is* included in the count.

3239.3 Part III - Enrollment Days for Cost Reporting Periods Beginning On or After October 1, 2014.--This section collects unduplicated day's data.

Lines 10 through 13.--Enter the enrollment days applicable to each level of care (LOC) in columns 1 through 3. Include dually eligible (Medicare/Medicaid) beneficiaries in column 1. Enrollment days are unduplicated days of care received by a hospice patient. Report a day for each day a hospice patient received one of four levels of care -- HCHC, HRHC, HIRC, or HGIP. When a patient was transferred from one LOC to another, count the day of transfer as one day of care at the LOC billed. Report an HIRC day on line 12 only when the hospice provided or arranged to provide the inpatient respite care.

Enter the total unduplicated days by LOC (sum of columns 1 through 3) in column 4.

Line 14.--Enter the total unduplicated days (sum of lines 10 through 13) in each column as applicable.

3239.4 Part IV - Contracted Statistical Data for Cost Reporting Periods Beginning On or After October 1, 2014.--This section collects unduplicated day's data for inpatient services at a contracted facility. The days reported in Part IV are a subset of the days reported in Part III.

Lines 15 and 16.--Enter the contracted inpatient service enrollment days applicable to each LOC in columns 1 through 3. Include dually eligible (Medicare/Medicaid) beneficiaries in column 1. Enrollment days are unduplicated days of care received by a hospice patient. Report a day for each day a hospice patient received HIRC or HGIP care at a contracted facility. When a patient was transferred from one LOC to another, count the day of transfer as one day of care at the LOC billed. Enter the total unduplicated days by LOC (sum of columns 1 through 3) in column 4.

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3240. WORKSHEET K - *ANALYSIS OF HOSPICE COSTS*

In accordance with 42 CFR 413.20, the methods of determining costs payable under Title XVIII involve making use of data available from the institution's basic accounts, as usually maintained to arrive at equitable and proper payment for services. The K series worksheets must be completed by all hospices. This worksheet provides for recording the trial balance of expense accounts from your accounting books and records. It also provides for reclassification and adjustments to certain accounts. The cost centers on this worksheet are listed in a manner which facilitates the transfer of the various cost center data to the cost finding worksheets (e.g., on Worksheets K, K-4, Parts I & II, the line numbers are consistent, and the total line is set at 34). Not all of the cost centers listed apply to all providers using these forms. Complete a separate worksheet K for each HHA-based hospice. *Effective for cost reporting periods beginning on or after October 1, 2014, do not complete these worksheets, but complete the O series worksheets.*

Column 1.--Obtain salaries to be reported from Worksheet K-1, col. 9, lines 3-34.

Column 2.--Obtain employee benefits to be reported from Worksheet K-2 col. 9 lines 3-34.

Column 3.--If the transportation costs, i.e., owning or renting vehicles, public transportation expenses, or payments to employees for driving their private vehicles can be directly identified to a particular cost center, enter those costs in the appropriate cost center. If these costs are not identified to a particular cost center enter them on line 22.

Column 4.--Obtain the contracted services to be reported from Worksheet K-3, col. 9 lines 3-34.

Column 5.--Enter in the applicable lines in column 5 all costs which have not been reported in columns 1 through 4.

Column 6.--Add the amounts in columns 1 through 5 for each cost center and enter the total in column 6.

Column 7.--Enter any reclassifications among cost center expenses in column 6 which are needed to effect proper cost allocation. This column need not be completed by all providers, but is completed only to the extent reclassifications are needed and appropriate in the particular circumstances. Show reductions to expenses as negative amounts.

Column 8.--Adjust the amounts entered in column 6 by the amounts in column 7 (increases and decreases) and extend the net balances to column 8. The total of column 8 must equal the total of column 6 on line 34.

Column 9.--In accordance with 42 CFR 413ff, enter on the appropriate lines the amounts of any adjustments to expenses required under Medicare principles of reimbursements. (See §3613.)

Column 10.--Adjust the amounts in column 8 by the amounts in column 9, (increases or decreases) and extend the net balances to column 10.

Transfer the amounts in column 10, lines 1 through 34, to the corresponding lines on worksheet K-4, Part I, column 0.

Line Descriptions

Lines 1 and 2 - Capital Related Cost - Buildings and Fixtures and Capital Related Cost -Movable Equipment.--These cost centers include depreciation, leases and rentals for the use of the facilities and/or equipment, interest incurred in acquiring land and depreciable assets used for patient care, insurance on depreciable assets used for patient care, and taxes on land or depreciable assets used for patient care.

Do not include in these cost centers the following costs: costs incurred for the repair or maintenance of equipment or facilities; amounts included in the rentals or lease or lease payments for repair and/or maintenance agreements; interest expense incurred to borrow working capital or for any purpose other than the acquisition of land or depreciable assets used for patient care; general liability insurance or any other form of insurance to provide protection other than the replacement of depreciable assets; or taxes other than those assessed on the basis of some valuation of land or depreciable assets used for patient care.

Line 3 - Plant Operation and Maintenance.--This cost center contains the direct expenses incurred in the operation and maintenance of the plant and equipment, maintaining general cleanliness and sanitation of the plant, and protecting employees, visitors, and agency property.

Plant Operation and Maintenance include the maintenance and service of utility systems such as heat, light, water, air conditioning and air treatment. This cost center also includes the cost of maintenance and repair of buildings, parking facilities and equipment, painting, elevator maintenance, performance of minor renovation of buildings, and equipment. The maintenance of grounds such as landscape and paved areas, streets on the property, sidewalks, fenced areas, fencing, external recreation areas and parking facilities are part of this cost center. The care or cleaning of the interior physical plant, including the care of floors, walls, ceilings, partitions, windows (inside and outside), fixtures and furnishings, and emptying of trash containers, as well as the costs of similar services purchased from an outside organization which maintains the safety and well-being of personnel, visitors and the provider's facilities, are all included in this cost center.

Line 4 - Transportation - Staff.--Enter all of the cost of transportation except those costs previously directly assigned in column 3. This cost is allocated during the cost finding process.

Line 5 - Volunteer Service Coordination.--Enter all of the cost associated with the coordination of service volunteers. This includes recruitment and training costs.

Line 6 - Administrative and General.--Use this cost center to record expenses of several costs which benefit the entire facility. Examples include fiscal services, legal services, accounting, data processing, taxes, and malpractice costs.

Line 7 - Inpatient - General Care.--This cost center includes costs applicable to patients who receive this level of care because their condition is such that they can no longer be maintained at home. Generally, they require pain control or management of acute and severe clinical problems which cannot be managed in other settings. The costs incurred on this line are those direct costs of furnishing routine and ancillary services associated with inpatient general care for which other provisions are not made on this worksheet.

If a hospice maintains its own inpatient beds, direct patient care costs include 24-hour nursing care within the facility, patient meals, laundry and linen services, and housekeeping. (Plant operation and maintenance costs are recorded on line 3.)

If a hospice does not maintain its own inpatient beds:

Show any costs for furnishing direct patient care services in the Visiting Services section, and;

Show any costs for furnishing inpatient general care services through a contract with another facility on Worksheet K-3.

Line 8 - Inpatient - Respite Care.--This cost center includes costs applicable to patients who receive this level of care on an intermittent, nonroutine, and occasional basis. The costs included on this line are those direct costs of furnishing routine and ancillary services associated with inpatient respite care for which other provisions are not made on this worksheet. Costs incurred by the hospice in furnishing direct patient care services to patients receiving inpatient respite care either directly by the hospice or under a contractual arrangement in an inpatient facility are to be included in visiting service costs section.

For a hospice that maintains its own inpatient beds, these costs include (but are not limited to) the costs of furnishing 24-hour nursing care within the facility, patient meals, laundry and linen services and housekeeping. Plant operation and maintenance costs would be recorded on line 3.

For a hospice that does not maintain its own inpatient beds, but furnishes inpatient respite care through a contractual arrangement with another facility, record contracted/purchased costs on Worksheet K-3. Do not include any costs associated with providing direct patient care. These costs are recorded in the visiting service costs section**.**

Line 9 - Physician Services.--In addition to the palliation and management of terminal illness and related conditions, hospice physician services also include meeting the general medical needs of the patients to the extent that these needs are not met by the attending physician. The amount entered on this line includes costs incurred by the hospice or amounts billed through the hospice for physicians' direct patient care services.

Line 10 - Nursing Care.--Generally, nursing services are provided as specified in the plan of care by or under the supervision of a registered nurse at the patient's residence.

Line 10.20 - Nursing Care–Continuous Home Care.--Enter the continuous home care portion of costs for nursing services provided by a registered nurse, licensed practical nurse or licensed vocational nurse as specified in the plan of care by or under the supervision of a registered nurse at the patient's residence.

Line 11 - Physical Therapy.--Physical therapy is the corrective treatment of bodily or mental conditions by the use of physical, chemical, and other properties of heat, light, water, electricity, sound massage, and therapeutic exercise by or under the direction of a registered physical therapist as prescribed by a physician. Therapy and speech-language pathology services may be provided for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

Line 12 - Occupational Therapy.--Occupational therapy is the application of purposeful goal-oriented activity in the evaluation and diagnosis for the persons whose function is impaired by physical illness or injury, emotional disorder, congenital or developmental disability, and to maintain health. Therapy and speech-language pathology services may be provided for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

Line 13 - Speech/Language Pathology.--These are physician-prescribed services provided by or under the direction of a qualified speech-language pathologist to those with functionally impaired communications skills. This includes the evaluation and management of any existing disorders of the communication process centering entirely, or in part, on the reception and production of speech and language related to organic and/or nonorganic factors. Speech-language pathology services may be provided for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

Line 14 - Medical Social Services.--This cost center includes only direct expenses incurred in providing medical social services. Medical social services consist of counseling and assessment

activities which contribute meaningfully to the treatment of a patient's condition. These services must be provided by a qualified social worker under the direction of a physician.

Lines 15-16 - Counseling.--Counseling services must be available to both the terminally ill individual and family members or other persons caring for the individual at home. Counseling, including dietary counseling, may be provided both for the purpose of training the individual's family or other care giver to provide care, and for the purpose of helping the individual and those caring for him or her to adjust to the individual's approaching death. This includes dietary, spiritual, and other counseling services provided while the individual is enrolled in the hospice. Costs associated with the provision of such counseling are accumulated in the appropriate counseling cost center. (Costs associated with bereavement counseling are recorded on line 30.)

Line 18 - Home Health Aide and Homemaker.--Enter the cost of a home health aide and homemaker services. Home health aide services are provided under the general supervision of a registered professional nurse and may be provided only by individuals who have successfully completed a home health aide training and competency evaluation program or competency evaluation program as required in 42 CFR 484.36.

Home health aides may provide personal care services. Aides may also perform household services to maintain a safe and sanitary environment in areas of the home used by the patient, such as changing the bed or light cleaning and laundering essential to the comfort and cleanliness of the patient.

Homemaker services may include assistance in personal care, maintenance of a safe and healthy environment and services to enable the individual to carry out the plan of care.

Line 18.20 - Home Health Aide and Homemaker-Continuous Home Care.--Enter the continuous care portion of cost for home health aide and/or homemaker services provided as specified in the plan of care and under the supervision of a registered nurse.

Line 19 - Other.--Enter on this line any other visiting cost which cannot be appropriately identified in the services already listed.

Line 20 - Drugs, Biological and Infusion Therapy.--Only drugs as defined in §1861(t) of the Act and which are used primarily for the relief of pain and symptom control related to the individual's terminal illness are covered. The amount entered on this line includes costs incurred for drugs or biologicals provided to the patients while at home. If a pharmacist dispenses prescriptions and provides other services to patients while the patient is both at home and in an inpatient unit, a reasonable allocation of the pharmacist cost must be made and reported respectively on line 20 (drugs and biologicals) and on line 7 (Inpatient General Care) or line 8 (Inpatient Respite Care) of worksheet K.

A hospice may, for example, use the number of prescriptions provided in each setting to make that allocation, or may use any other method that results in a reasonable allocation of the pharmacist's cost in relation to the service rendered.

Infusion therapy may be used for palliative purposes if you determine that these services are needed for palliation. For the purposes of a hospice, infusion therapy is considered to be the therapeutic introduction of a fluid other than blood, such as saline solution, into a vein.

Line 20.30 - Analgesics.--Enter the cost of analgesics.

Line 20.31 - Sedatives/Hypnotics.--Enter the cost of sedatives/hypnotics.

Line 20.32 - Other Specify.--Specify the type and enter the cost of any other drugs which cannot be appropriately identified in the drug cost center already listed.

Line 21 - Durable Medical Equipment/Oxygen.--Durable medical equipment as defined in 42 CFR 410.38 as well as other self-help and personal comfort items related to the palliation or management of the patient's terminal illness are covered. Equipment is provided by the hospice for use in the patient's home while he or she is under hospice care.

Line 22 - Patient Transportation.--Enter all of the cost of transportation except those costs previously directly assigned in column 3. This cost is allocated during the cost finding process.

Line 23 - Imaging Services.--Enter the cost of imaging services including MRI.

Line 24 - Labs and Diagnostics.--Enter the cost of laboratory and diagnostic tests.

Line 25 - Medical Supplies.--The cost of medical supplies reported in this cost center are those costs which are directly identifiable supplies furnished to individual patients.

These supplies are generally specified in the patient's plan of treatment and furnished under the specific direction of the patient's physician.

Line 26 - Outpatient Services.--Use this line for any outpatient services costs not captured elsewhere. This cost may include the cost of an emergency room department.

Lines 27-28 - Radiation Therapy and Chemotherapy.--Radiation, chemotherapy and other modalities may be used for palliative purposes if you determine that these services are needed for palliation. This determination is based on the patient's condition and your care giving philosophy.

Line 29 - Other.--Enter any additional costs involved in providing visiting services which has not been provided for in the previous lines.

Lines 30-33 - Non Reimbursable Costs.--Enter in the appropriate lines the applicable costs. Bereavement program costs consist of counseling services provided to the individual's family after the individual's death. In accordance with §1814 (i)(1)(A) of the Act, bereavement counseling is a required hospice service, but it is not reimbursable.

3241. WORKSHEET K-1 - *HOSPICE* - COMPENSATION ANALYSIS - SALARIES AND WAGES

Enter all salaries and wages for the hospice on this worksheet for the actual work performed within the specific area or cost center in accordance with the column headings. For example, if the administrator also performs visiting services which account for 25 percent of that person's time, then enter 75 percent of the administrator's salary on line 6 (A&G) and 25 percent of the administrator's salary enter on line 10 (nursing care). Complete a separate worksheet K-1 for each HHA-based hospice.

The records necessary to determine the split in salary between two or more cost centers must be maintained by the hospice and must adequately substantiate the method used to split the salary. These records must be available for audit by the *contractor*, and the *contractor* can accept or reject the method used to determine the split in salary. When approval of a method has been requested in writing and this approval has been received prior to the beginning of a cost reporting period, the approved method remains in effect for the requested period and all subsequent periods until you request in writing to change to another method or until the *contractor* determines that the method is no longer valid due to changes in your operations.

Definitions

Salary.--This is gross salary paid to the employee before taxes and other items are withheld, includes deferred compensation, overtime, incentive pay, and bonuses. (See CMS Pub. 15-*1*, Chapter 21.)

Administrator (Column 1).--

Possible Titles: President, Chief Executive Officer

Duties: This position is the highest occupational level in the agency. This individual is the chief management official in the agency. The administrator develops and guides the organization by taking responsibility for planning, organizing, implementing, and evaluating. The administrator is responsible for the application and implementation of established policies. The administrator may act as a liaison among the governing body, the medical staff, and any departments. The administrator provides for personnel policies and practices that adequately support sound patient care, and maintains accurate and complete personnel records. The administrator implements the control and effective utilization of the physical and financial resources of the provider.

Director (Column 2).--

Possible Titles: Medical Director, Director of Nursing, or Executive Director

Duties: The medical director is responsible for helping to establish and assure that the quality of medical care is appraised and maintained. This individual advises the chief executive officer on medical and administrative problems and investigates and studies new developments in medical practices and techniques.

The nursing director is responsible for establishing the objectives for the department of nursing. This individual administers the department of nursing and directs and delegates management of professional and ancillary nursing personnel.

Social Worker (Column 3).--The medical social worker is an individual who has at least a bachelor's degree from a school accredited or approved by the council of social work education. These services must be under the direction of a physician and must be provided by a qualified social worker.

Supervisors (Column 4).--Employees in this classification are primarily involved in the direction, supervision, and coordination of the hospice activities.

When a supervisor performs two or more functions, e.g., supervision of nurses and home health aides, the salaries and wages must be split in proportion with the percent of the supervisor's time spent in each cost center, provided the hospice maintains the proper records (continuous time records) to support the split. If continuous time records are not maintained by the hospice, enter the entire salary of the supervisor on line 6 (A&G) and allocate to all cost centers through stepdown. However, if the supervisor's salary is all lumped in one cost center, e.g., nursing care, and the supervisor's title coincides with this cost center, e.g., nursing supervisor, no adjustment is required.

Total Therapists (Column 6).--Include in column 6, on the line indicated, the cost attributable to the following services:

Physical therapy	-	line 11
Occupational therapy	-	line 12
Speech/language pathology	-	line 13

Therapy and speech/language pathology may be provided for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skill.

Physical therapy is the provision of corrective treatment of bodily or mental conditions by the use of physical, chemical, and other properties of heat, light, water, electricity, sound, massage, and therapeutic exercise by or under the direction of a registered physical therapist as prescribed by a physician.

Occupational therapy is the application of purposeful, goal-oriented activity in the evaluation, diagnosis, and/or treatment of persons whose ability to work is impaired by physical illness or injury, emotional disorder, congenital or developmental disability, or the aging process, in order to achieve optimum functioning, to prevent disability, and to maintain health.

Speech/language pathology provides services to persons with impaired functional communications skills by or under the direction of a qualified speech-language pathologist as prescribed by a physician. This includes the evaluation and management of any existing disorders of the communication process centering entirely, or in part, on the reception and production of speech and language related to organic and/or nonorganic factors.

Aides (Column 7).--Included in this classification are specially trained personnel employed for providing personal care services to patients. These employees are subject to Federal wage and hour laws. This function is performed by specially trained personnel who assist individuals in carrying out physician instructions and established plans of care. The reason for the home health aide services must be to provide hands-on, personal care services under the supervision of a registered professional nurse.

Aides may provide personal care services and household services to maintain a safe and sanitary environment in areas of the home used by the patient, such as changing the bed or light cleaning and laundering essential to the comfort and cleanliness of the patient. Additional services include, but are not limited to, assisting the patient with activities of daily living.

All Other (Column 8).--Employees in this classification are those not included in columns 1-7, e.g., dietary, spiritual, and other counseling services provided while the individual is enrolled in the hospice. Counseling Services must be available to both the terminally ill individual and the family members or other persons caring for the individual at home. Counseling, including dietary counseling, may be provided both for the purpose of training the individual's family or other care giver to provide care, and for the purpose of helping the individual and those caring for him or her to adjust to the individual's approaching death.

Total (Column 9).--Add the amounts of each cost center, columns 1 through 8, and enter the total in column 9. Transfer these totals to Worksheet K, column 1, lines as applicable. To facilitate transferring amounts from Worksheet K-1 to Worksheet K, the same cost centers with corresponding line numbers are listed on both worksheets. Not all of the cost centers are applicable to all agencies. Therefore, use only those cost centers applicable to your hospice.

3242. WORKSHEET K-2 - *HOSPICE* - COMPENSATION ANALYSIS - EMPLOYEE BENEFITS (PAYROLL RELATED)

Enter all payroll-related employee benefits for the hospice on this worksheet. See CMS Pub. 15-*1*, chapter 20, for a definition of fringe benefits. Use the same basis as that used for reporting salaries and wages on Worksheet K-1. Therefore, using the same example as given for Worksheet K-1, enter 75 percent of the administrator's payroll-related fringe benefits on line 6 (A&G) and enter 25 percent of the administrator's payroll-related fringe benefits on line 10 (nursing care). Payroll-related employee benefits must be reported in the cost center in which the applicable employee's compensation is reported. Complete a separate worksheet K-2 for each HHA-based hospice.

This assignment can be performed on an actual basis or the following basis:

- o FICA - actual expense by cost center;

- o Health insurance (nonunion) and pension and retirement (gross salaries of participating individuals by cost center);

- Union health and welfare (gross salaries of participating union members by cost center); and;

- All other payroll-related benefits (gross salaries by cost center). Include non payroll-related employee benefits in the A&G cost center, e.g., cost for personal education, recreation activities, and day care.

Add the amounts of each cost center, columns 1 through 8, and enter the total in column 9. Transfer these totals to Worksheet K, column 2, corresponding lines. To facilitate transferring amounts from Worksheet K-2 to Worksheet K, the same cost centers with corresponding line numbers are listed on both worksheets.

3243. WORKSHEET K-3 - *HOSPICE* - COMPENSATION ANALYSIS - CONTRACTED SERVICES/ PURCHASED SERVICES

The hospice may contract with another entity to provide non-core hospice services. However, nursing care, medical social services and counseling are core hospice services and must routinely be provided directly by hospice employees. Supplemental services may be contracted in order to meet unusual staffing needs that cannot be anticipated and that occur so infrequently it would not be practical to hire additional staff to fill these needs. You may also contract to obtain physician specialty services. If contracting is used for any services, maintain professional, financial, and administrative responsibility for the services and assure that all staff meet the regulatory qualification requirements. Complete a separate worksheet K-3 for each hospice.

Enter on this worksheet all contracted and/or purchased services for the hospice. Enter the contracted/purchased cost on the appropriate cost center line within the column heading which best describes the type of services purchased. Costs associated with contracting for general inpatient or respite care are recorded on this worksheet. For example, where physical therapy services are purchased, enter the contract cost of the therapist in column 6, line 11. If a contracted/purchased service covers more than one cost center, then the amount applicable to each cost center is included on each affected cost center line. Add the amounts of each cost center, columns 1 through 8, and enter the total in column 9. Transfer these totals to Worksheet K, column 4, corresponding lines. To facilitate transferring amounts from Worksheet K-3 to Worksheet K, the same cost centers with corresponding line numbers are listed on both worksheets.

3244. WORKSHEET K-4, PART I - *HOSPICE* COST ALLOCATION - GENERAL SERVICE COSTS AND WORKSHEET K-4, PART II - HOSPICE COST ALLOCATION - STATISTICAL BASIS

Worksheet K-4 provides for the allocation of the expenses of each hospice general service cost center to those hospice cost centers which receive the services. The cost centers serviced by the general service cost centers include all cost centers within the provider organization, i.e., other general service cost centers, reimbursable cost centers, and nonreimbursable cost centers. Obtain the total direct expenses from Worksheet K, column 10. To facilitate transferring amounts from Worksheet K to Worksheet K-4, part I, the same cost centers with corresponding line numbers (lines 3 through 34) are listed on both worksheets. Complete a separate worksheet K-4, part 1 and 2 for each HHA-based hospice.

Worksheet K-4, part II, provides for the proration of the statistical data needed to equitably allocate the expenses of the general service cost centers on Worksheet K-4, part I.

To facilitate the allocation process, the general format of Worksheets K-4, part I & II are identical. The column and line numbers for each general service cost center are identical on the two worksheets. In addition, the line numbers for each general, reimbursable, nonreimbursable,

and special purpose cost centers are identical on the two worksheets. The cost centers and line numbers are also consistent with Worksheets K, K-1, K-2, and K-3.

NOTE: General service columns 1 through 5 and subscripts thereof must be consistent on Worksheets K-4, parts I & II.

The statistical bases shown at the top of each column on Worksheet K-4, Part II are the recommended bases of allocation of the cost centers indicated. If a different basis of allocation is used, the provider must indicate the basis of allocation actually used at the top of the column.

Most cost centers are allocated on different statistical bases. However, for those cost centers where the basis is the same (e.g., square feet), the total statistical base over which the costs are to be allocated will differ because of the prior elimination of cost centers that have been closed.

Close the general service cost centers in accordance with 42 CFR 413.24(d)(1) which states, in part, that the cost of nonrevenue-producing cost centers serving the greatest number of other centers, while receiving benefits from the least number of centers, is apportioned first. This is clarified in CMS Pub. 15-*1*, §2306.1 which further clarifies the order of allocation for stepdown purposes. Consequently, first close those cost centers that render the most services to and receive the least services from other cost centers. The cost centers are listed in this sequence from left to right on the worksheet. However, the circumstances of an agency may be such that a more accurate result is obtained by allocating to certain cost centers in a sequence different from that followed on these worksheets.

NOTE: A change in order of allocation and/or allocation statistics is appropriate for the current fiscal year cost if received by the *contractor*, in writing, within 90 days prior to the end of that fiscal year. The *contractor* has 60 days to make a decision or the change is automatically accepted. The change must be shown to more accurately allocate the overhead or, if the allocation is accurate, to simplify maintaining the statistics. If a change in statistics is made, the provider must maintain both sets of statistics until approved. If both sets are not maintained and the request is denied, the provider reverts back to the previously approved methodology. The provider must include with the request all supporting documentation and a thorough explanation of why the alternative approach should be used. (See CMS Pub. 15-*1*, §2313.)

If the amount of any cost center on Worksheet K, column 10, has a credit balance, show this amount as a credit balance on Worksheet K-4, part I, column 0. Allocate the costs from the applicable overhead cost centers in the normal manner to the cost center showing a credit balance. After receiving costs from the applicable overhead cost centers, if a general service cost center has a credit balance at the point it is allocated, do not allocate the general service cost center. Rather, enter the credit balance on the first line of the column and on line 34. This enables column 7, line 34, to crossfoot to columns 0 and 5A, line 34. After receiving costs from the applicable overhead cost centers, if a revenue producing cost center has a credit balance on Worksheet K-4, part I, column 7, do not carry forward a credit balance to any worksheet.

On Worksheet K-4, part II, enter on the first line in the column of the cost center the total statistics applicable to the cost center being allocated (e.g., in column 1, capital-related cost - buildings and fixtures, enter on line 1 the total square feet of the building on which depreciation was taken). Use accumulated cost for allocating administrative and general expenses.

Such statistical base does not include any statistics related to services furnished under arrangements except where both Medicare and non-Medicare costs of arranged-for services are recorded in your records.

For all cost centers (below the cost center being allocated) to which the service rendered is being allocated, enter that portion of the total statistical base applicable to each.

The total sum of the statistical base applied to each cost center receiving the services rendered must equal the total statistics entered on the first line.

Enter on Worksheet K-4, part II line 34, the total expenses of the cost center to be allocated. Obtain this amount from Worksheet K-4, part I from the same column and line number of the same column. In the case of capital-related costs - buildings and fixtures, this amount is on Worksheet K-4, part I, column 1, line 1.

Divide the amount entered on line 34 by the total statistical base entered in the same column on the first line. Enter the resulting unit cost multiplier on line 35. Round the unit cost multiplier to at least the nearest six decimal places.

Multiply the unit cost multiplier by that portion of the total statistical base applicable to each cost center receiving the services rendered. Enter the result of each computation on Worksheet K-4, part I in the corresponding column and line.

After the unit cost multiplier has been applied to all the cost centers receiving costs, the total expenses (line 34) of all of the cost centers receiving the allocation on Worksheet K-4, part I, must equal the amount entered on the first line of the cost center being allocated.

The preceding procedures must be performed for each general service cost center. Each cost center must be completed on both Worksheets K-4, part I & II before proceeding to the next cost center.

After all the costs of the general service cost centers have been allocated on Worksheet K-4, part I, enter in column 7 the sum of the expenses on lines 7 through 33. The total expenses entered in column 7, line 34, must equal the total expenses entered in column 0, line 34.

Column Descriptions

Column 1.--Depreciation on buildings and fixtures and expenses pertaining to buildings and fixtures such as insurance, interest, rent, and real estate taxes are combined in this cost center to facilitate cost allocation.

Allocate all expenses to the cost centers on the basis of square feet of area occupied. The square footage may be weighted if the person who occupies a certain area of space spends their time in more than one function. For example, if a person spends 10 percent of time in one function, 20 percent in another function, and 70 percent in still another function, the square footage may be weighted according to the percentages of 10 percent, 20 percent, and 70 percent to the applicable functions.

Column 2.--Allocate all expenses (e.g., interest or personal property tax) for movable equipment to the appropriate cost centers on the basis of square feet of area occupied or dollar value.

Column 4.--The cost of vehicles owned or rented by the agency and all other transportation costs which were not directly assigned to another cost center on Worksheet K, column 3, is included in this cost center. Allocate this expense to the cost centers to which it applies on the basis of miles applicable to each cost center.

This basis of allocation is not mandatory and a provider may use weighted trips rather than actual miles as a basis of allocation for transportation costs which are not directly assigned. However, a hospice must request the use of the alternative method in accordance with CMS Pub. 15-*1*, §2313. The hospice must maintain adequate records to substantiate the use of this allocation.

Column 6.--The A&G expenses are allocated on the basis of accumulated costs after reclassifications and adjustments.

Therefore, obtain the amounts to be entered on Worksheet K-4, part II, column 6, from Worksheet K-4, part I, columns 0 through 5.

A negative cost center balance in the statistics for allocating A&G expenses causes an improper distribution of this overhead cost center. Negative balances are excluded from the allocation statistics when A&G expenses are allocated on the basis of accumulated cost.

A&G costs applicable to contracted services may be excluded from the total cost (Worksheet K-4, part I, column 0) for purposes of determining the basis of allocation (Worksheet K-4, part II, column 5) of the A&G costs. This procedure may be followed when the hospice contracts for services to be performed for the hospice and the contract identifies the A&G costs applicable to the purchased services.

The contracted A&G costs must be added back to the applicable cost center after allocation of the hospice A&G cost before the reimbursable costs are transferred to Worksheet K-5, part I. A separate worksheet must be included to display the breakout of the contracted A&G Costs from the applicable cost centers before allocation and the adding back of these costs after allocation. *Contractor* approval does not have to be secured in order to use the above described method of cost finding for A&G.

Worksheet K-4, Part II, Column 6A.--Enter the costs attributable to the difference between the total accumulated cost reported on Worksheet K-4, part I, column 5A, line 34 and the accumulated cost reported on Worksheet K-4, part II, column 6, line 6. Enter any amounts reported on Worksheet K-4, part I, column 5A for (1) any service provided under arrangements to program patients that is not grossed up and (2) negative balances. Including these costs in the statistics for allocating administrative and general expenses causes an improper distribution of overhead.

In addition, report on line 6 the administrative and general costs reported on Worksheet K-4, Part I, column 6, line 6 since these costs are not included on Worksheet K-4, Part II, column 6 as an accumulated cost statistic.

Worksheet K-4, Part II, Column 6.--The administrative and general expenses are allocated on the basis of accumulated costs. Therefore, the amount entered on Worksheet K-4, part II, column 6, line 6, is the difference between the amounts entered on Worksheet K-4, part I, column 5A and Worksheet K-4, part II, column 6A. A negative cost center balance in the statistics for allocating administrative and general expenses causes an improper distribution of this overhead cost center. Exclude negative balances from the allocation statistics.

3245. WORKSHEET K-5 - ALLOCATION OF GENERAL SERVICE COSTS HOSPICE COST CENTERS

Use this worksheet only if you operate a certified HHA-based Hospice as part of your complex. If you have more than one HHA-based Hospice, complete a separate worksheet for each.

3245.1 Part I - Allocation of General Service Costs to Hospice Cost Centers.--Worksheet K-5, part I, provides for the allocation of the expenses of each general service cost center of the HHA to those hospice cost centers which receive the services. Worksheet K-5, parts I and II, provide for the proration of the statistical data needed to equitably allocate the expenses of the general service cost centers on Worksheet K-5, part I.

Obtain the total direct expenses (column 0, line 29) from Worksheet A, column 10, line 25. Obtain the cost center allocation (column 0, lines 1 through 28) from Worksheet K-4, part I, lines as indicated. The amounts on line 29, column 0 through column 5 must agree with the corresponding amounts on Worksheet B, part I, column 0 through column 5, line 25. Complete the amounts entered on lines 1 through 28, columns 1 through 4 and column 5.

Line 30.--Enter the unit cost multiplier (column 6, line 1, divided by the sum of column 6, line 29 minus column 6, line 1, rounded to 6 decimal places). Multiply each amount in column 6, lines 2 through 28, by the unit cost multiplier, and enter the result on the corresponding line of column 7.

3245.2 Part II - Allocation of General Service Costs to Hospice Cost Centers -Statistical Basis.--To facilitate the allocation process, the general format of Worksheet K-5, Parts I and II, are identical.

The statistical basis shown at the top of each column on Worksheet K-5, Part II, is the recommended basis of allocation of the cost center indicated.

NOTE: If you wish to change your allocation basis for a particular cost center, you must make a written request to your *contractor* for approval of the change and submit reasonable justification for such change prior to the beginning of the cost reporting period for which the change is to apply. The effective date of the change is the beginning of the cost reporting period for which the request has been made. (See CMS Pub. 15-*1*, §2313.)

Except for non-PPS providers, unless there is a change in ownership, the hospital must continue the same cost finding methods (including its cost finding bases) in effect in the hospital's last cost reporting period ending on or before October 1, 1991. (See 42 CFR 412.302(d).) If there is a change in ownership, the new owners may request that the *contractor* approve a change in order to be consistent with their established cost finding practices. (See CMS Pub. 15-*1*, §2313.)

Lines 1 through 28.--On Worksheet K-5, Part II, for all cost centers to which the general service cost center is being allocated, enter that portion of the total statistical base applicable to each.

Line 29.--Enter the total of lines 1 through 28 for each column. The total in each column must be the same as shown for the corresponding column on Worksheet B-1, line 25.

Line 30.--Enter the total expenses for the cost center allocated. Obtain this amount from Worksheet B, line 25 from the same column used to enter the statistical base on Worksheet K-5, Part II (e.g., in the case of capital-related cost buildings and fixtures, this amount is on Worksheet B, column 1, line 25).

Line 31.--Enter the unit cost multiplier, which is obtained by dividing the cost entered on line 30 by the total statistic entered in the same column on line 29. Round the unit cost multiplier to six decimal places.

Multiply the unit cost multiplier by that portion of the total statistics applicable to each cost center receiving the services. Enter the result of each computation on Worksheet K-5, Part I, in the corresponding column and line.

After the unit cost multiplier has been applied to all the cost centers receiving the services, the total cost (line 29, Part I) must equal the total cost on line 30, Part II.

Perform the preceding procedures for each general service cost center.

In column 6, Part I, enter the total of columns 4A through 5.

In column 7, Part I, for lines 2 through 28, multiply the amount in column 6 by the unit cost multiplier on line 30, Part I, and enter the result in this column. On line 29, enter the total of the amounts on lines 2 through 28. The total on line 29 equals the amount in column 6, line 1.

In column 8, Part I, enter on lines 2 through 28 the sum of columns 6 and 7. The total on line 29 equals the total in column 6, line 29.

3245.3 Part III- *Apportionment of* Hospice Shared *Services*.--Use this part only when the complex maintains a separate department for any of the cost centers listed on this worksheet, and the department provides services to patients of the HHA's hospice. This worksheet provides for the shared therapy, drugs, or medical supplies from the HHA to the hospice.

Column Description

Column 2.--Where HHA departments provides services to the hospice, enter in column 2 the cost for each discipline from Worksheet B, col. 6, lines as indicated.

Column 3.--Where HHA departments provide services to the hospice, enter on the appropriate lines the total HHA charges, from the provider's records, applicable to the HHA-based hospice.

Column 4.--Where applicable, determine the cost to charge ratio by dividing column 2 by column 3. Enter the results in column 4.

Column 5.-- Where HHA departments provides services to the hospice, enter on the appropriate lines the total hospice charges, from the provider's records, applicable to the HHA-based hospice.

Column 6.--Multiply the ratio in column 4 by the amount in column 5. Enter the result in column 6.

Line 7.--Enter the sum of column 6, lines 1 through 6.

3246. WORKSHEET K-6 - CALCULATION OF *HOSPICE* PER DIEM COST

Worksheet K-6 calculates the average cost per days in providing care for a hospice patient. It is only an average and should not be misconstrued as the absolute. If you have more than one HHA-based Hospice, complete a separate worksheet for each.

Line 1.--Total cost from Worksheet K-5, Part I, column 8, line 29 less column 8, line 28, plus Worksheet K-5, Part III, column 6, line 7. This line reflects the true cost without any non-hospice related costs.

Line 2.--Total unduplicated days from Worksheet S-5, line 5, col. 4.

Line 3.--Average cost per day. Divide the total cost from line 1 by the total number of days from line 2.

Line 4.--Unduplicated Medicare days from Worksheet S-5, line 5, column 1.

Line 5.--Aggregate Medicare cost. Multiply the average cost from line 3 by the number of unduplicated Medicare days on line 4 to arrive at the aggregate Medicare cost.

Line 6 and 7.--**NOT APPLICABLE**.

Line 8.--Unduplicated SNF days from Worksheet S-5, line 5, column 2.

Line 9.--Aggregate SNF cost. Multiply the average cost from line 3 by the number of unduplicated SNF days on line 8 to arrive at the aggregate SNF cost.

Line 10.--**NOT APPLICABLE**.

Line 11.--**NOT APPLICABLE**.

Line 12.--Other Unduplicated days from Worksheet S-5, line 5, column 3.

Line 13.--Aggregate cost for other days. Multiply the average cost from line 3 by the number of Unduplicated Other days on line 12 to arrive at the aggregate cost for other days.

3247. WORKSHEET O - ANALYSIS OF HHA-BASED HOSPICE COSTS

The O series of worksheets must be completed by all HHA-based hospices effective for cost reporting periods beginning on or after October 1, 2014. This worksheet is to record the trial balance of expense accounts from the provider's accounting books and records. It also provides for reclassification and adjustments to certain accounts. The cost centers on this worksheet are listed in a manner that facilitates the combination of the various groups of cost centers for purposes of cost finding. Cost centers listed may not apply to every provider using these forms. Complete only those lines that are applicable.

Column Descriptions

For columns 1, 2, 4, and 6, direct patient care service costs (lines 25 through 46) are reported by LOC on Worksheets O-1, O-2, O-3 and O-4. For each cost center on Worksheet O, enter the sum of the amounts from Worksheets O-1, O-2, O-3, and O-4 for salaries, other costs, reclassifications, and adjustments, in columns 1, 2, 4, and 6, respectively.

Column 1.--Enter salaries from the provider's accounting books and. Salaries for the direct patient care service cost centers (lines 25 through 46) must equal the sum of amounts reported in column 1 of Worksheets O-1, O-2, O-3, and O-4. The total salaries for column 1, line 100, must equal the salaries reported on Worksheet A, column 1, line 25.

Column 2.--Enter all costs other than salaries from the provider's accounting books and records. Other costs for the direct patient care service cost centers (lines 25 through 46) must equal the sum of amounts reported in column 2 of Worksheets O-1, O-2, O-3, and O-4. The total other costs for column 2, line 100, must equal the other costs reported on Worksheet A, the sums of columns 2 through 5, line 25.

Column 3.--For each cost center, enter the total of columns 1 plus 2.

Column 4.--Enter any reclassifications among cost center expenses in column 3 that are needed to effect proper cost allocation. This column need not be completed by all providers, but is completed to the extent reclassifications are needed or reported on Worksheet A, line 25. Show reductions to expenses as negative amounts.

If reclassifications are needed for direct patient care service cost centers (lines 25 through 46), enter the reclassification amounts on the appropriate Worksheets O-1, O-2, O-3, and O-4, column 4, for each level of care.

Reclassifications for the direct patient care service cost centers (lines 25 through 46) must equal the sum of amounts reported on the corresponding lines in column 4 of Worksheets O-1, O-2, O-3, and O-4. The total reclassifications for column 4, line 100, must equal the reclassifications reported on Worksheet A, column 7, line 25.

Column 5.--For each cost center, enter the total of the amount in column 3 plus or minus the amount in column 4.

Column 6.--In accordance with 42 CFR 413.9(c)(3), enter on the appropriate lines, the amounts of any adjustments to expenses required under Medicare principles of reimbursements. (See §3211). This column need not be completed by all providers, but is completed only to the extent adjustments are needed or reported on Worksheet A, column 9, line 25. Show reductions to expenses as negative amounts.

If adjustments are needed for direct patient care service cost centers (lines 25 through 46), enter the adjustment amounts on the appropriate Worksheets O-1, O-2, O-3, and O-4, column 6, for each level of care.

Adjustments for the direct patient care service cost centers (lines 25 through 46) must equal the sum of amounts reported on the corresponding lines in column 6 of Worksheets O-1, O-2, O-3, and O-4. The total adjustments for column 6, line 100, must equal the adjustments reported on Worksheet A, column 9, line 25.

Column 7.--For each cost center, enter the total of the amount in column 5 plus or minus the amount in column 6. Transfer the amounts in column 7 for cost centers marked with an asterisk (*) to Worksheet O-5, as follows:

From Worksheet O, Column 7, Line Number and Cost Center Description	To Worksheet O-5, Column 1:
1 Cap Rel Costs-Bldg & Fixt	Line 1
2 Cap Rel Costs-Mvble Equip	Line 2
3 Employee Benefits Department	Line 3
4 Administrative & General	Line 4
5 Plant Operation & Maintenance	Line 5
6 Laundry & Linen	Line 6
7 Housekeeping	Line 7
8 Dietary	Line 8
9 Nursing Administration	Line 9
10 Routine Medical Supplies	Line 10
11 Medical Records	Line 11
12 Staff Transportation	Line 12
13 Volunteer Service Coordination	Line 13
14 Pharmacy	Line 14
15 Physician Administrative Services	Line 15
16 Other General Service	Line 16
60 Bereavement Program	Line 60
61 Volunteer Program	Line 61
62 Fundraising	Line 62
63 Hospice/Palliative Medicine Fellows	Line 63
64 Palliative Care Program	Line 64
65 Other Physician Services	Line 65
66 Residential Care	Line 66
67 Advertising	Line 67
68 Telehealth/Telemonitoring	Line 68
69 Thrift Store	Line 69
70 Nursing Facility Room & Board	Line 70
71 Other Nonreimbursable	Line 71

Line Descriptions

The Worksheet O cost centers are segregated into general service, direct patient care service, and nonreimbursable categories to facilitate the transfer of costs to the various worksheets. For example, the general service cost centers appear on Worksheets O-5, Part I, and O-5, Part II, using the same line numbers as Worksheet O. The direct patient care service cost centers appear on Worksheets O-1, O-2, O-3, and O-4 using the same line numbers as Worksheet O.

General service cost centers (lines 1 through 17) include expenses incurred in operating the facility as a whole that are not directly associated with furnishing patient care such as mortgage, rent, plant operations, administrative salaries, utilities, telephone, and computer hardware and software costs. General service cost centers furnish services to other general service cost centers and to reimbursable and nonreimbursable cost centers.

Lines 1 and 2 - Capl Rel Costs-Bldg & Fixt and Cap Rel Costs-Mvble Equip.--Enter in column 2, the capital-related costs for buildings and fixtures and the capital-related costs for moveable equipment on lines 1 and 2, respectively.

Line 3 - Employee Benefits Department.--This cost center includes the costs of the employee benefits department. In addition, this cost center includes the fringe benefits paid to, or on behalf of, an employee when a provider's accounting system is not designed to accumulate the benefits on a departmentalized or cost center basis. (See CMS Pub. 15-1, chapter 21, §2144 and CMS Pub. 15-1, chapter 23, §2307.) Enter the employee benefits.

Line 4 - Administrative & General.--Enter in columns 1 and 2, the salary and other costs of A&G.

If the option to subscript A&G costs into more than one cost center is elected (in accordance with CMS Pub. 15-1, chapter 23, §2313), eliminate line 4. Begin numbering the subscripted A&G cost centers with line 4.01 and continue in sequential order.

Line 5 - Plant Operation & Maintenance.--This cost center includes expenses incurred in the operation and maintenance of the plant and equipment (see §3206). Enter in columns 1 and 2, the costs of plant operation and maintenance.

Line 6 - Laundry & Linen Service.--This cost center includes the cost of routine laundry and linen services whether performed in-house or by outside contractors.

Line 7 - Housekeeping.--This cost center includes the cost of routine housekeeping activities such as mopping, vacuuming, cleaning restrooms, lobbies, waiting areas and otherwise maintaining patient and non-patient care areas.

Line 8 - Dietary.--This cost center includes the cost of preparing meals for patients. Do not include the cost of dietary counseling in this cost center; report dietary counseling on line 35.

Line 9 - Nursing Administration.--This cost center includes the cost of overall management and direction of the nursing services. Do not include the cost of direct nursing services reported on lines 27 through 29. The salary cost of direct nursing services, including the salary cost of nurses who render direct service in more than one patient care area, is directly assigned to the various patient care cost centers in which the services were rendered. However, if the hospice accounting system fails to specifically identify all direct nursing services to the applicable direct patient care cost centers, then the salary cost of all direct nursing service is included in this cost center.

Line 10 - Routine Medical Supplies.--This cost center includes the cost of supplies used in the normal course of caring for patients, such as gloves, masks, swabs, or glycerin sticks, that generally are not traceable to individual patients. Do not include the costs of non-routine medical supplies that can be traced to individual patients; report non-routine medical supplies on line 42.

Line 11 - Medical Records.--This cost center includes cost of the medical records department where patient medical records are maintained. The general library and the medical library are not included in this cost center but are included in the A&G cost center.

Line 12 - Staff Transportation.--This cost center includes the cost of owning or renting vehicles, public transportation expenses, parking, tolls, or payments to employees for driving their private vehicles to see patients or for other hospice business. Staff transportation costs do not include patient transportation costs; report patient transportation costs on line 39.

Line 13 - Volunteer Service Coordination.--This cost center includes the cost of the overall coordination of service volunteers including their recruitment and training costs of volunteers.

Line 14 - Pharmacy.--This cost center includes the costs of drugs (both prescription and over-the-counter), pharmacy supplies, pharmacy personnel, and pharmacy services. Do not report the cost of palliative chemotherapy drugs on this line; report the cost of palliative chemotherapy on line 45.

Line 15 - Physician Administrative Services.--This cost center includes the costs for physicians' administrative and general supervisory activities that are included in the hospice payment rates. These activities include participating in the establishment, review and updating of plans of care, supervising care and services, conducting required face-to-face encounters for recertification, and establishing governing policies. These activities are generally performed by the physician serving as the medical director and the physician member of the interdisciplinary group. Nurse practitioners may not serve as or replace the medical director or physician member of the interdisciplinary group.

Line 17 - Patient/Residential Care Services.--Do not use this line on this worksheet. This cost center is used on Worksheet O-5 to accumulate in-facility costs not separately identified as HIRC, HGIP, or residential care services that are not part of a separate and distinct residential care unit (e.g., depreciation related to in-facility areas that provide HIRC, HGIP or residential care). The amounts allocated to this cost center on Worksheet O-5 are allocated to HIRC, HGIP and residential care services that are not part of a separate and distinct residential care unit, based on in-facility days. This cost center does not include any costs related to contracted inpatient services.

When a residential care unit is separate and distinct and only used for resident care services (such as hospice home care provided in a residential unit), costs are reported directly on line 66.

Lines 18 through 24.--Reserved for future use.

Direct patient care service costs are reported by LOC on Worksheets O-1, O-2, O-3 and O-4. For each cost center on Worksheet O, enter the sum of the amounts from Worksheets O-1, O-2, O-3, and O-4 for salaries, other costs, reclassifications, and adjustments in columns 1, 2, 4, and 6, respectively.

Line 25- Inpatient Care - Contracted.--This cost center includes the contractual costs paid to another facility for use by the hospice for hospice inpatient care (HIRC or HGIP) in accordance with 42 CFR 418.108(c). This cost center does not include the cost of any direct patient care services or nonreimbursable services provided by hospice staff in the contracted setting. Costs

of any services provided by hospice staff in the contracted setting are included in the appropriate direct patient care service or nonreimbursable cost center. Costs in this cost center are excluded from the allocation of A&G costs.

Line 26 - Physician Services.--This cost center includes the costs incurred by the hospice for physicians, or nurse practitioners providing physician services, for direct patient care services and general supervisory services, participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care, and establishment of governing policies by the physician member of the interdisciplinary group. (See 42 CFR 418.304.) Reclassify the cost for the portion of time physicians spent on general supervisory services or other hospice administrative activities to Physician Administrative Services (line 15). This cost center must not include costs associated with palliative care or other nonreimbursable physician services. Those nonreimbursable physician services must be reported in the appropriate nonreimbursable cost center.

Line 27 - Nurse Practitioner.--This cost center includes the costs of nursing care provided by nurse practitioners. Do not include costs for nurse practitioners providing physician services on this line; report the costs for nurse practitioners providing physician services on line 26.

Line 28 - Registered Nurse.--This cost center includes the costs of nursing care provided by registered nurses other than nurse practitioners.

Line 29 - LPN/LVN.--This cost center includes the costs of nursing care provided by licensed practical nurses (LPN) or licensed vocational nurses (LVN). Do not include costs for certified nursing assistant (CNA) services on this line; report the costs for CNA services on line 37.

Line 30 - Physical Therapy.--This cost center includes the costs of physical or corrective treatment of bodily or mental conditions by the use of physical, chemical, and other properties of heat, light, water, electricity, sound massage, and therapeutic exercise by or under the direction of a registered physical therapist as prescribed by a physician. Physical therapy services may be provided for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

Line 31 - Occupational Therapy.--This cost center includes the costs of purposeful goal-oriented activities in the evaluation, diagnosis, and/or treatment of persons whose function is impaired by physical illness or injury, emotional disorder, congenital or developmental disability, or the aging process, in order to achieve optimum functioning, to prevent disability, and to maintain health. Occupational therapy services may be provided for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

Line 32 - Speech/Language Pathology.--This cost center includes the costs of physician-prescribed services provided by or under the direction of a qualified speech/language pathologist to those with functionally impaired communications skills. This includes the evaluation and management of any existing disorders of the communication process centering entirely, or in part, on the reception and production of speech and language related to organic and/or nonorganic factors. Speech/language pathology services may be provided for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

Line 33 - Medical Social Services.--This cost center includes the cost of the medical social services defined in CMS Pub. 100-02, chapter 9, §40.1.2. Costs for nonreimbursable activities included in this cost center must be reclassified to the appropriate nonreimbursable cost center.

Line 34 - Spiritual Counseling.--This cost centers includes the cost of spiritual counseling services. Costs for nonreimbursable activities included in this cost center must be reclassified to the appropriate nonreimbursable cost center.

Line 35 - Dietary Counseling.--This cost center includes the costs of dietary counseling services.

Line 36 - Counseling - Other.--This cost center include the cost of counseling services not already identified as spiritual, dietary or bereavement counseling. Costs for nonreimbursable activities included in this cost center must be reclassified to the appropriate nonreimbursable cost center.

Line 37 - Hospice Aide & Homemaker Services.--This cost center includes the costs of:

- *Hospice aide services such as personal care services and household services to maintain a safe and sanitary environment in areas of the home used by the patient; and,*

- *Homemaker services such as assistance in the maintenance of a safe and healthy environment and services to enable the individual to carry out the plan of care.*

Include the cost of CNAs that meet the criteria for an aide in this cost center.

Line 38 - Durable Medical Equipment/Oxygen.--This cost center includes the costs of DME and oxygen, as defined in 42 CFR 410.38 and 42 CFR 418.202(f), furnished to individual HRHC or HCHC patients. Report DME costs by the LOC the patient was receiving at the time the DME/oxygen was delivered. If the LOC of a patient changed after delivery of the DME/Oxygen, the hospice may report the costs proportionally between HRHC and HCHC based on patient days.

Line 39 - Patient Transportation.--This cost center includes the costs of ambulance transports of hospice patients, related to the terminal prognosis and occurring after the effective date of the hospice election, that are the responsibility of the hospice. (See CMS Pub. 100-02, chapter 9, §40.1.9.) When a patient is transferred to a new LOC, report the transportation cost to that LOC. For example, a patient in a HGIP LOC is transferred to HRHC LOC and transported to their home, the transportation cost associated with the transfer must be included in the HRHC LOC.

Line 40 - Imaging Services.--This cost center includes the costs of imaging services.

Line 41 - Labs & Diagnostics.--This cost center includes the costs of laboratory and diagnostic tests.

Line 42 - Medical Supplies - Non-routine.--This cost center includes the costs of medical supplies furnished to individual patients for which a separate charge would be applicable. These supplies are specified in the patient's plan of treatment and furnished under the specific direction of the patient's physician. Do not include the cost of routine medical supplies used in the normal course of caring for patients, (such as gloves, masks, swabs, or glycerin sticks) on this line; report routine medical supplies on line 10. When a provider does not track the use of non-routine medical supplies by LOC, the provider may report the costs proportionally between LOCs based on patient days

Line 43 - Outpatient Services.--This cost center includes the costs of outpatient services costs not captured elsewhere. This cost can include the cost of an emergency room department visit when related to the terminal condition.

Lines 44 and 45 - Palliative Radiation Therapy & Palliative Chemotherapy.--These cost centers include costs of radiation, chemotherapy and other modalities used for palliative purposes based on the patient's condition and the hospice's caregiving philosophy.

Lines 47 through 49.--Reserved for future use.

Lines 50 through 53.--Reserved for use on Worksheets O-6, Parts I and II.

Lines 54 through 59.--Reserved for future use.

Nonreimbursable cost centers include costs of nonreimbursable services and programs. Report the costs applicable to nonreimbursable cost centers to which general service costs apply. If additional lines are needed for nonreimbursable cost centers other than those shown, subscript one or more of these lines with a numeric code. The subscripted lines must be appropriately labeled to indicate the purpose for which they are being used. However, when the expense (direct and all applicable overhead) attributable to any non-allowable cost area is so insignificant as to not warrant establishment of a nonreimbursable cost center, remove the expense on Worksheet A-8. (See CMS Pub. 15-1, chapter 23, §2328.)

Line 60 - Bereavement Program.--This cost center includes the cost of bereavement services, defined as emotional, psychosocial, and spiritual support and services provided before and after the death of the patient to assist with grief, loss, and adjustment (42 CFR 418.3). Bereavement counseling is a required hospice service, but it is not reimbursable (see §1814(I)(1)(A) of the Act).

Line 61 - Volunteer Program.--This cost center includes costs of volunteer programs. (See CMS Pub. 15-1, chapter 7.)

Line 62 - Fundraising.--This cost centers include costs of fundraising. (See CMS Pub. 15-1, chapter 21, §2136.)

Line 63 - Hospice/Palliative Medicine Fellows.--This cost center includes costs of hospice and palliative medicine fellows.

Line 64 - Palliative Care Program.--Enter in columns 1 and 2, the salary and other costs of palliative care provided to non-hospice patients. This includes physician services.

Line 65 - Other Physician Services.--Enter in columns 1 and 2, the salary and other costs of other physician services that are provided outside of a palliative care program to non-hospice patients.

Line 66 - Residential Care.--Enter in columns 1 and 2, the salary and other costs of residential care for patients living in the hospice, but who are not receiving inpatient hospice services. Patients living in the hospice are considered residents, where the hospice is their home. These patients are liable for their room and board charges; however, the outpatient hospice care services provided must be recorded in the direct patient care cost centers on the appropriate HRHC and/or HCHC LOC worksheet.

Lines 67 - Advertising.--Enter in columns 1 and 2, the salary and other costs of nonallowable community education, business development, marketing and advertising (see CMS Pub. 15-1, chapter 21, §2136).

Lines 68 - Telehealth/Telemonitoring.--Enter in columns 1 and 2, the salary and other costs of telehealth/ telemonitoring services. These costs are nonreimbursable since a hospice is not an approved originating site (see 42 CFR 410.78(b)(3)).

Lines 69 - Thrift Store.--Enter in columns 1 and 2, the salary and other costs of thrift stores.

Line 70 - Nursing Facility Room & Board.--Enter the costs incurred by a hospice for dually eligible beneficiaries residing in a nursing facility (NF) when room and board is paid by the State to the hospice. The full amount paid to the NF by the hospice must be included on this line and offset by the State payment via an adjustment on Worksheet A-8. The residual cost is the net cost incurred.

For example, a dually eligible beneficiary is residing in a NF and has elected the Medicare hospice benefit. The NF charges $100 per day for room and board. The State pays the hospice $95 for the NF room and board. The hospice has a written agreement with the NF that requires full room and board payment of $100 per day. The hospice receives $95 per day, but pays the NF $100 per day, thereby incurring a net cost of $5 per day.

Lines 72 through 99.--Reserved for future use.

3248. WORKSHEETS O-1, O-2, O-3, AND O-4 - ANALYSIS OF HHA-BASED HOSPICE COSTS

Worksheet O-1 - Analysis of HHA-Based Hospice Costs for Hospice Continuous Home Care
Worksheet O-2 - Analysis of HHA-Based Hospice Costs for Hospice Routine Home Care
Worksheet O-3 - Analysis of HHA-Based Hospice Costs for Hospice Inpatient Respite Care
Worksheet O-4 - Analysis of HHA-Based Hospice Costs for Hospice General Inpatient Care

Worksheets O-1, O-2, O-3, and O-4 provide for recording the direct patient care costs by LOC, including reclassifications and adjustments. The general format of these worksheets is identical to Worksheet O in order to facilitate the transfer of direct patient care costs to Worksheet O. For each cost center, the sums of the amounts reported in columns 1, 2, 4, and 6 of these worksheets are transferred to the corresponding columns on Worksheet O.

Column 1.--For each LOC worksheet, enter salaries from the provider's accounting books and records.

Column 2.--For each LOC worksheet, enter all costs other than salaries from the provider's accounting books and records.

Column 3.--For each cost center, add the amounts in columns 1 and 2 and enter the total in column 3.

Column 4.--For each LOC worksheet enter any reclassification of direct patient care service costs needed to effect proper cost allocation. For each line, the sum of the reclassification entries on Worksheets O-1, O-2, O-3, and O-4, column 4, must equal the amount on the corresponding line on Worksheet O, column 4.

Column 5.--For each cost center, enter the total of the amount in column 3 plus or minus the amount in column 4.

Column 6.--For each LOC worksheet, enter any adjustments for direct patient care service costs (lines 25 through 46) required under Medicare principles of reimbursements. (See §3212.) Show reductions to expenses as negative amounts. For each line, the sum of the adjustment entries on Worksheets O-1, O-2, O-3 and O-4, column 6, must equal the amount on the corresponding line of Worksheet O, column 6.

Column 7.--For each cost center, enter the total of the amount in column 5 plus or minus the amount in column 6. For each LOC worksheet, transfer the amount on line 100 to the corresponding LOC line on Worksheet O-5, column 1, as follows:

From line 100 of:	*To Worksheet O-5, column 1, line:*
Worksheet O-1	*50*
Worksheet O-2	*51*
Worksheet O-3	*52*
Worksheet O-4	*53*

3249. WORKSHEET O-5 - COST ALLOCATION - DETERMINATION OF HHA-BASED HOSPICE NET EXPENSES FOR ALLOCATION

Worksheet O-5 determines total expenses of each general service cost center for proper allocation of general service costs to each LOC and to nonreimbursable cost centers. This worksheet combines the direct general services costs reported on Worksheet O, lines 1 through 17 with the overhead allocation of the HHA general services costs reported on Worksheet B, line 25, columns 1 through 5.

Column Descriptions

Column 1.--For each general service and nonreimbursable cost center, transfer the amount from the corresponding cost center on Worksheet O, column 7. For each LOC line, transfer amounts as follows:

Line:	From column 7, line 100 of:
50	Worksheet O-1
51	Worksheet O-2
52	Worksheet O-3
53	Worksheet O-4

The total on line 100 of column 1 must equal the amount on Worksheet A, column 10, line 25.

Column 2.--For each general service cost center, transfers the amount from the corresponding column on Worksheet B, line 25 as follows:

Line:	From Worksheet B, line 25, column(s):	Line:	From Worksheet B, line 25, column(s):
1	1	9	N/A
2	2	10	N/A
3	N/A	11	N/A
4	5	12	4
5	3	13	N/A
6	N/A	14	N/A
7	N/A	15	N/A
8	N/A	16	N/A

Column 3.--For each line, enter the sum of columns 1 and 2. The total on line 100 of column 3 must equal the amount on Worksheet B, column 6, line 25. Transfer the amount from each cost center to the corresponding line on Worksheet O-6, Part I, column 0.

3250 WORKSHEET O-6 - PART I - COST ALLOCATION - HHA-BASED HOSPICE GENERAL SERVICE COSTS AND WORKSHEET O-6 - PART II - COST ALLOCATION - HHA-BASED HOSPICE GENERAL SERVICE COSTS STATISTICAL BASIS

In accordance with 42 CFR 413.24, cost data must be based on an approved method of cost finding and on the accrual basis of accounting except where governmental institutions operate on a cash basis of accounting.

Worksheet O-6, Parts I and II, facilitate the step-down method of cost finding. This method recognizes that general services of the hospice are utilized by other general service, LOC, and nonreimbursable cost centers. Worksheet O-6, Part I provides for the equitable allocation of general service costs based on statistical data reported on Worksheet O-6, Part II. To facilitate the allocation process, the general format of Worksheet O-6, Part I is identical to that of Worksheet O-6, Part II. The column and line numbers for each general service cost center are identical on the two worksheets. The direct patient care service cost centers (lines 25 through 46 of Worksheet O) are reported by LOC on lines 50 through 53 of Worksheets O-6, Parts I and II. The line numbers for nonreimbursable cost centers are identical on Worksheet O and Worksheet O-6, Parts I and II.

When certain general services costs are related to in-facility days and are not separately identifiable by LOC or service, Worksheet O-6, Parts I and II, provide for the accumulation of these costs on line 17, Patient/Residential Care Services. The amounts accumulated in this cost center are allocated based on the in-facility days for HIRC, HGIP, and residential care services that are not part of a separate and distinct residential care unit. This cost center does not include any costs related to contracted inpatient services.

The statistical basis shown at the top of each column on Worksheet O-6, Part II is the recommended basis of allocation. The total statistic for cost centers using the same basis (e.g., square feet) may differ with the closing of preceding cost centers. A hospice can elect to change the order of allocation and/or allocation statistics, as appropriate, for the current cost reporting period if a request is submitted in accordance with CMS Pub. 15-1, chapter 23, §2313.

Close the general service cost centers in accordance with 42 CFR 413.24(d)(1) so that the cost centers rendering the most services to and receiving the least services from other cost centers are closed first (see CMS Pub. 15-1, chapter 23, §2306.1). If a more accurate result is obtained by allocating costs in a sequence that differs from the recommended sequence, the hospice must request approval in accordance with CMS Pub. 15-1, chapter 23, §2313.

If the amount of any cost center on Worksheet O-5, column 3, has a negative balance, show this amount as a negative balance on Worksheet O-6, Part I, column 0. Allocate the costs from the overhead cost centers in the normal manner, including to those cost centers with a negative balance. Close a general service cost center with a negative balance by entering the negative balance in parentheses on the first line and on lines 99 and 100 of the column, and do not allocate. This enables Worksheet O-6, Part I, column 18, line 100 to cross foot to Worksheet O-6, Part I, column 0, line 100. After receiving costs from overhead cost centers, LOC cost centers with negative balances on Worksheet O-6, Part I, column 18, are not transferred to Worksheet O-7.

On Worksheet O-6, Part II, enter on the first available line of each column the total statistics applicable to the cost center being allocated (e.g., in column 1, Capital-Related Cost - Buildings & Fixtures, enter on line 1 the total square feet of the building on which depreciation was taken). Use accumulated cost for allocating A&G expenses.

Such statistical base, including accumulated cost for allocating A&G expenses, does not include any statistics related to services furnished under arrangements except where:

- *Both Medicare and non-Medicare costs of arranged for services are recorded in the hospice's books/records; or*

- *The contractor determines that the hospice is able to and does gross up the costs and charges for services to non-Medicare patients so that both cost and charges are recorded as if the hospice had furnished such services directly to all patients. (See CMS Pub. 15-1, chapter 23, §2314.)*

For each cost center being allocated, enter that portion of the total statistical base applicable to each cost center receiving services. For each column, the sum of the statistics entered for cost centers receiving services must equal the total statistical base entered on the first line.

For each column on Worksheet O-6, Part II, enter on line 101, the total expenses of the cost center to be allocated. Obtain the total expenses from the first line of the corresponding column on Worksheet O-6, Part I, which includes the direct expenses from Worksheet O-6, Part I, column 0 plus the allocated costs from previously closed cost centers. Divide the amount entered on Worksheet O-6, Part II, line 101 by the total statistical base entered in the same column on the first line. Enter the resulting unit cost multiplier (rounded to six decimal places) on line 102.

For each column on Worksheet O-6, Part II, multiply the unit cost multiplier on line 102 by the portion of the total statistical base applicable to each cost center receiving services and enter the result in the corresponding column and line on Worksheet O-6, Part I. For each column on Worksheet O-6, Part I, the sum of the costs allocated (line 100) must equal the total cost on the first line.

After the costs of the general service cost centers have been allocated on Worksheet O-6, Part I, enter on each line of column 18, the sum of the costs in columns 3A through column 17 for lines 50 through 71. The total costs entered on Worksheet O-6, Part I, column 18, line 100 must equal the total costs entered in column 0, line 100.

Column Descriptions

Column 0.--For each line, enter the total direct costs from the corresponding line on Worksheet O-5, column 3.

Column 3A.--For each line, enter the sum of columns 0 through 3. The sum for each line is the accumulated cost and, unless an adjustment is required, is the Worksheet O-6, Part II, column 4 statistic for allocating A&G costs.

If an adjustment to the accumulated cost statistic on Worksheet O-6, Part II, column 4, is required to properly allocate A&G costs, enter the adjustment amount on Worksheet O-6, Part II, column 4A for the applicable line. For example, when the hospice contracts for HIRC or HGIP services and the contractual costs include A&G costs, the contractual costs reported on Worksheet O-3, column 7, line 25, or Worksheet O-4, column 7, line 25, may be used to reduce the accumulated cost statistic on Worksheet O-6, Part II, column 4A, line 52 or line 53, respectively.

For each line, the accumulated cost statistic on Worksheet O-6, Part II, column 4, is the difference between the amount on Worksheet O-6, Part I, column 3A and the adjustment amount on Worksheet O-6, Part II, column 4A. Accumulated cost for A&G is not included in the total statistic for the A&G cost center; therefore, transfer the amount on Worksheet O-6, Part I, column 3A, line 4, to Worksheet O-6, Part II, column 4A, line 4.

The total accumulated cost statistic for Worksheet O-6, Part II, column 4, line 4 is the difference between the total on Worksheet O-6, Part I, column 3A, line 101 and the amounts in column 4A of Worksheet O-6, Part II.

A negative cost center balance in the statistics for allocating A&G expenses causes an improper distribution of this overhead cost center. Negative balances are excluded from the allocation statistics when A&G expenses are allocated on the basis of accumulated cost.

Column 18--Transfer the amounts on lines 50 through 53 as follows:

From Worksheet O-6, Part I, column 18:	To Worksheet O-8, column 3:
Line 50	Line 1
Line 51	Line 6
Line 52	Line 11
Line 53	Line 16

3251. WORKSHEET O-7 - APPORTIONMENT OF HHA-BASED HOSPICE SHARED SERVICE COSTS BY LEVEL OF CARE

This worksheet calculates the cost of ancillary services provided by HHA departments to HHA-based hospice patients.

Column Descriptions

Column 1.--For each cost center, enter in column 1, the cost for each discipline from Worksheet B, column 6, lines as indicated.

Column 2.--For each cost center, enter on the appropriate lines the total HHA charges from the provider's records, applicable to the HHA-based hospice.

Column 3.--For each cost center, enter in column 3, the cost-to-charge ratio by dividing the HHA cost in column 1 by the HHA charges in column 2.

Columns 4 through 7.--For each cost center, enter the charges, from the provider's records, for ancillary services provided by HHA ancillary departments to HHA-based hospice patients. Enter the charges by LOC in the appropriate LOC column.

Columns 8 through 11.--For each column, calculate cost of ancillary services provided by HHA ancillary departments to HHA-based hospice patients as follows:

Column:	Calculation:
8	col. 3 x col. 4
9	col. 3 x col. 5
10	col. 3 x col. 6
11	col. 3 x col. 7

For each column 8 through 11, enter the sum of lines 1 through 6 on line 7.

3252. WORKSHEET O-8 - CALCULATION OF HHA-BASED HOSPICE PER DIEM COST

Worksheet O-8 calculates the average cost per diem by level of care and in total.

Line 1.--Enter in column 3 the total HCHC cost from Worksheet O-6, Part I, column 18, line 50, plus Worksheet O-7, column 8, line 7.

Line 2.--Enter in column 3 the total HCHC days from Worksheet S-5, column 4, line 10.

Line 3.--Enter in column 3 the average HCHC cost per diem by dividing column 3, line 1 by column 3, line 2.

Line 4.--Enter in column 1 the title XVIII - Medicare HCHC days from Worksheet S-5, column 1, line 10. Enter in column 2 the title XIX - Medicaid HCHC days from Worksheet S-5, column 2, line 10.

Line 5.--Enter in column 1 the title XVIII - Medicare program cost calculated by multiplying column 3, line 3 by column 1, line 4. Enter in column 2 the title XIX - Medicaid program cost calculated by multiplying column 3, line 3 by column 2, line 4.

Line 6.--Enter in column 3 the total HRHC cost from Worksheet O-6, Part I, column 18, line 51, plus Worksheet O-7, column 9, line 7.

Line 7.--Enter in column 3 the total HRHC days from Worksheet S-5, column 4, line 11.

Line 8.--Enter in column 3 the average HRHC cost per diem by dividing column 3, line 6 by column 3, line 7.

Line 9.--Enter in column 1 the title XVIII - Medicare HRHC days from Worksheet S-5, column 1, line 11. Enter in column 2 the title XIX - Medicaid HRHC days from Worksheet S-5, column 2, line 11.

Line 10.--Enter in column 1 the title XVIII - Medicare program cost calculated by multiplying column 3, line 8 by column 1, line 9. Enter in column 2 the title XIX - Medicaid program cost calculated by multiplying column 3, line 8 by column 2, line 9.

Line 11.--Enter in column 3 the total HIRC cost from Worksheet O-6, Part I, column 18, line 52, plus Worksheet O-7, column 10, line 7.

Line 12.--Enter in column 3 the total HIRC days from Worksheet S-5, column 4, line 12.

Line 13.--Enter in column 3 the average HIRC cost per diem by dividing column 3, line 11 by column 3, line 12.

Line 14.--Enter in column 1 the title XVIII - Medicare HIRC days from Worksheet S-5, column 1, line 12. Enter in column 3 the title XIX - Medicaid HIRC days from Worksheet S-5, column 2, line 12.

Line 15.--Enter in column 1 the title XVIII - Medicare program cost calculated by multiplying column 3, line 13 by column 1, line 14. Enter in column 2 the title XIX - Medicaid program cost calculated by multiplying column 3, line 13 by column 2, line 14.

Line 16.--Enter in column 3 the total HGIP cost from Worksheet O-6, Part I, column 18, line 53, plus Worksheet O-7, column 11, line 7.

Line 17.--Enter in column 3 the total HGIP days from Worksheet S-5, column 4, line 13.

Line 18.--Enter in column 3 the average HGIP cost per diem by dividing column 3, line 16 by column 3, line 17.

Line 19.--Enter in column 1, the title XVIII - Medicare HGIP days from Worksheet S-5, column 1, line 13. Enter in column 3, the title XIX - Medicaid HGIP days from Worksheet S-5, column 2, line 13.

Line 20.--Enter in column 1 the title XVIII - Medicare program cost calculated by multiplying column 3, line 18 by column 1, line 19. Enter in column 2 the title XIX - Medicaid program cost calculated by multiplying column 3, line 18 by column 2, line 19.

Line 21.--Enter in column 3 the sum of lines 1, 6, 11 and 16.

Line 22.--Enter in column 3 total days from Worksheet S-5, column 4, line 14.

Line 23.--Enter the average cost per diem by dividing column 3, line 21 by column 3, line 22.

This page is reserved for future use.

FORM CMS-1728-94

The following is a listing of the FORM CMS-1728-94 worksheets and the page number location.

Worksheets	Page(s)
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Wkst. S-2-1	*32-304.1*
Wkst. S-3, Parts I-III	32-305
Wkst. S-3, Part IV	32-305.1
Wkst. S-4	32-305.2
Wkst. S-5	32-306
Wkst. S-6, Parts I & II	*REMOVED*
Wkst. A	32-308
Wkst. A-1	32-309
Wkst. A-2	32-310
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