

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. Also, 42 CFR 413.20 requires cost reports from providers on an annual basis. In accordance with these provisions, all home health agencies (HHAs) must complete Form CMS-1728-94, which provides data used by the fiscal intermediaries in determining program reimbursement. Besides determining program reimbursement, the data submitted on the cost report supports management of the Federal programs, e.g., data extraction in developing cost limits. In completing Form CMS-1728-94, the information reported must conform to the requirements and principles set forth in the Provider Reimbursement Manual, Part I (CMS Pub. 15-I). The instructions contained in this chapter are effective for cost reporting periods ending on or after December 31, 1994.

NOTE: This form is not used by HHAs that are hospital-based. Instead, they continue to use Form CMS-2552.

HHAs, as the term is used in this chapter, refers to institutions meeting the requirements of §1861(o) of the Act. Refer to the HHA Manual, CMS Pub. 11, and CMS Pub. 15-I for further definition of terms. Your intermediary will furnish any additions and revisions to the documents cited.

For cost reporting periods beginning on or after October 1, 1980, all HHAs must use the cost per visit by type-of-visit method of apportioning costs between Medicare and non-Medicare beneficiaries. Under this method, the total allowable cost of all visits for each type of service is divided by the total number of visits for that type of service. Next, for each type of service, the number of Medicare covered visits is multiplied by the average cost per visit just computed. This represents the cost Medicare will recognize as the cost for that service, subject to the cost limits published by CMS. (See 42 CFR 413.30.)

The cost data reported must be based on the stepdown 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.

Form CMS-1728-94 must be used by all HHAs which are not provider-based to which payment is made by Medicare and must be submitted to the HHA' Medicare fiscal intermediary in accordance with cost report filing date requirements contained in CMS Pub. 15-I, §2413. This form must be used for cost reporting periods ending on or after December 31, 1994.

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 that is not provider-based may be considered a small HHA if:

1. The HHA receives 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:

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

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

You may submit computer prepared forms in lieu of the forms provided by CMS. These computer prepared forms are acceptable if the forms are reviewed and accepted for provider use by CMS before being placed into use. (See §108 for the use of computer prepared cost reporting forms.)

If computer prepared cost reporting forms have been reviewed and accepted for provider use, they must be revised and resubmitted for review and acceptance whenever changes in the law, regulations, or program instructions are adopted which have an impact on Medicare cost reporting.

These forms include the stepdown method of cost finding which provides for the allocation of the cost of services rendered by each general service cost center to other cost centers which utilize such services. Once the costs of a general service cost center have been allocated, that cost center is considered closed. Once closed, it does not receive any of the costs that are subsequently allocated from the remaining general service cost centers. After all costs of the general service cost centers have been allocated to the remaining cost centers, the total costs of these remaining cost centers are further distributed to the departmental classification to which they pertain, e.g., physical therapy, skilled nursing care, HHA-based CORF.

HHAs that are not hospital-based (freestanding) are required to use the stepdown method of cost finding. (See CMS Pub. 15-I, §2308.) However, a freestanding 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)
 - b. Payment reduction (e.g., outpatient cost reduction)
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.

| <u>Step</u> | <u>Worksheet</u> | <u>Instructions</u> |
|-------------|------------------|--|
| 1 | S-2 | Read §3204. Complete entire worksheet. |
| 2 | S-3 | Read §3205. Complete worksheet. |
| 3 | 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.) |
| 4 | A | Read §3206. Complete columns 1 through 6, lines 1-29. |
| 5 | A-4 | Read §3210. Complete, if applicable. |
| 6 | A | Read §3206. Complete columns 7 and 8, lines 1-29. |
| 7 | A-6 | Read §3212. Complete Part A. If the answer to Part A is "Yes," complete Parts B and C. |

| <u>Step</u> | <u>Worksheet</u> | <u>Instructions</u> |
|-------------|----------------------|--|
| 8 | A-7 | Read §3213. Complete entire worksheet. |
| 9 | Supp. A-8-3 | Read §3219. Complete entire worksheet, if applicable. |
| 10 | A-5 | Read §3219. Complete entire worksheet. |
| 11 | A | Read §3206. Complete columns 9 and 10, lines 1-29. |
| 12 | B and B-1 | Read §3214. Complete entire worksheets. |
| 13 | C | Read §3215. Complete entire worksheet. |
| 14 | Supps. RH-1 and RH-2 | Read §§3229-3230. Complete entire worksheets, if applicable. |
| 15 | Supps. FQ-1 and FQ-2 | Read §§3231-3232. Complete entire worksheets, if applicable. |
| 16 | D | Read §3216. Complete lines 1 through 27. |
| 17 | D-1 | Read §3217. Complete lines 1 through 4. |
| 18 | D | Read §3216. Complete lines 1 through 31. |
| 19 | F, F-1, F-2 | Read §3218. Complete all worksheets. |
| <u>CORF</u> | | |
| 20 | Supp. S-6 | Read §3220. Complete entire worksheet. |
| 21 | Supp. J-1, Pt I | Read §3221.1. Complete column 0, lines 1-15. |
| 22 | Supp. J-1, Pt III | Read §3221.3. Fully complete. |
| 23 | Supp. J-1, Pt I | Read §3221.3. Complete columns 1-6, lines 1-15. |
| 24 | Supp. J-1, Pt II | Read §3221.2. Fully complete. |
| 25 | Supp. J-1, Pt I | Read §3221.3. Fully complete. |

| <u>Step</u> | <u>Worksheet</u> | <u>Instructions</u> |
|-----------------|--------------------|---|
| 26 | Supp. J-2 | Read §3222. Complete entire worksheet. |
| 27 | Supp. J-3 | Read §3223. Complete lines 1-22. |
| 28 | Supp. J-4 | Read §3224. Complete lines 1-4. |
| 29 | Supp. J-3 | Read §3223. Complete lines 23-26. |
| <u>CMHC</u> | | |
| 30 | Supp. CM-1, Pt I | Read §3225.1. Complete column 0, lines 1-12. |
| 31 | Supp. CM-1, Pt III | Read §3225.3. Fully complete. |
| 32 | Supp. CM-1, Pt I | Read §3225.3. Complete columns 1-6, lines 1-12. |
| 33 | Supp. CM-1, Pt II | Read §3225.2. Fully complete. |
| 34 | Supp. CM-1, Pt I | Read §3225.3. Fully complete. |
| 35 | Supp. CM-2 | Read §3226. Complete entire worksheet. |
| 36 | Supp. CM-3 | Read §3227. Complete lines 1-24. |
| 37 | Supp. CM-4 | Read §3228. Complete lines 25-28. |
| 38 | Supp. CM-3 | Read §3227. Complete lines 23-26. |
| <u>RHC/FQHC</u> | | |
| 39 | S-4 | Read §3233. Complete entire worksheet. |
| 40 | RF-1 | Read §3234. Complete entire worksheet. |
| 41 | RF-2 | Read §3235. Complete entire worksheet. |
| 42 | RF-4 | Read §3237. Complete entire worksheet. |
| 43 | RF-5 | Read §3238. Complete entire worksheet. |
| 44 | RF-3 | Read §3236. Complete entire worksheet. |

| <u>Step</u> | <u>Worksheet</u> | <u>Instructions</u> |
|-------------|---------------------|--|
| 45 | S-5 | Read §3239. Complete entire worksheet. |
| 46 | K-1, K-2, K-3 | Read §§3241-3243. Complete all worksheets. |
| 47 | K | Read §3240. Complete entire worksheet. |
| 48 | K-4, Parts I and II | Read §3244. Complete entire worksheets. |
| 49 | K-5, Parts I - III | Read §§3245-3245.3. Complete entire worksheets. |
| 50 | K-6 | Read §3246. Complete entire worksheet. |
| 51 | S | Read §3203. Complete Part II entirely. Then complete Part I. |

3203. WORKSHEET S - HOME HEALTH AGENCY COST REPORT

The intermediary indicates in the appropriate box whether this is the initial cost report (first cost report filed for the period), 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 fiscal intermediary 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:

- o Home health agency from Worksheet D, Part II, line 29 (Part A from column 1 and Part B from column 2).
- o HHA-based CORF from Worksheet J-3, line 24.
- o HHA-based CMHC from Worksheet CM-3, line 26.
- o 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 names, provider identification numbers, and certification dates 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 identification number and which 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 identification number and which 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 identification number and which 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 identification number and which 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 identification number and which 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.

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 §§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 intermediary 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 provider is conducted.

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

o 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.

o 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.

o 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.

o 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.

o 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. Refer to 42 CFR 413.24(h) for a definition of low Medicare utilization.

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-I, 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-I, 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-I, 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 home health agency 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 home health agency contract with outside suppliers for physical therapy services? (See CMS Pub. 15-I, chapter 14.) Enter "Y" for yes or "N" for no.

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

Line 22.02--Does the home health agency 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 home health agency componentized (or fragmented) its administrative and general 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.

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 home health agency. 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. 13-3, §§3118 and 3119, CMS Pub. 11, §§205 and 206, 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. 11 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

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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) Code Data.--

Line 28.--Enter the total number of MSAs where Medicare covered services were provided during the cost reporting period. MSA codes are four character numeric

codes that identify the geographic area at which Medicare covered service are furnished. Obtain these codes from your fiscal intermediary.

Line 29.--List all MSA and/or Non-MSA codes where Medicare covered home health services were provided. Enter one MSA code on each line as necessary. If additional lines are needed, continue subscribing with lines 29.01, 29.02 et cetera, as necessary entering one MSA code on each subscribed line. Obtain these codes from your fiscal intermediary. 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.

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.

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.

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.

Line 45.--Enter in columns 1 and 3 through 6 for each episode of care payment category, respectively, the total number of 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.

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-I, §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 5 and 6, identify them as lines 5.01 and 5.02. 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, Lines 6 -11 may not be subscripted beyond those which are preprinted. (See CMS Pub. 15-I §2313.2c)

Also, 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 27 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 27 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 **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 intermediary.

Column 1.--Obtain the expenses listed from Worksheet A-1. The sum of column 1 must equal Worksheet A-1, column 9, line 29.

Column 2.--Obtain the expenses listed from Worksheet A-2. The sum of column 2 must equal Worksheet A-2, column 9, line 29.

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.

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 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.

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.

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 any subscript of line 23. 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. Sections 3229 and 3230 implement the methodology to segregate costs before and after the effective date for proper input of data in the RH and FQ worksheet series.

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 intermediary and the intermediary 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 intermediary 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-I, 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:

- o FICA - actual expense by cost center;
- o Pension and retirement and health insurance (nonunion) (gross salaries of participating individuals by cost center);
- o Union health and welfare (gross salaries of participating union members by cost center); and
- o 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-I, 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-I, 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 intermediary 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-I, §§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-I, §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; J-1, Parts I and III; CM-1, Parts I and III; RH-1, Parts I and III; FQ-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-I, §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 intermediary, in writing, within 90 days prior to the end of that fiscal year. The intermediary 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-I, §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:

| <u>From Worksheet B</u> <u>Column 6</u> | <u>To Worksheet C</u> <u>Column 2</u> |
|--|--|
| 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-I, §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. Intermediary 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-1, 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.

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:

| <u>A&G Cost Center</u> | <u>Sum of Worksheet B</u> | <u>Transfer to Worksheet B-1</u> |
|----------------------------|---------------------------|----------------------------------|
| 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-I, §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 benefitting 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-I, §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-I.

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 (Metropolitan Statistical Area (MSA) or Non-MSA) 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 and/or non-MSA where Medicare covered services were furnished during the cost reporting period. Section 4601 of BBA 1997 (See §3215.4) requires 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.

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'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 identified. Complete this part one time for each MSA 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.

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.