## 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:

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

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

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

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

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

Lines 2 through 6--On the appropriate lines and columns indicated, enter the 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.

Line 29-29.03--If this provider is part of a chain organization, enter “Y” for yes and enter the home office name, home office number, address of the home office, and FI/contractor name and identifying number of the FI/contractor who receives the Home Office cost statement; otherwise, enter “N” for no.

## 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 HCFA Pub. 13-3, §§3118 and 3119, HCFA 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 HCFA 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

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

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

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

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

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

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

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

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

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

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

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

Less than a full Episode of Care.--

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3233. WORKSHEET S-4 - HHA-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER PROVIDER STATISTICAL DATA

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

In accordance with 42 CFR 413.20(a), 42 CFR 413.24(a), and 42 CFR 413.24(c), you are required to maintain statistical records for proper determination of costs payable under the Medicare program. The statistics reported on this worksheet pertain to provider-based rural health clinics (RHCs) and provider-based Federally qualified health centers (FQHCs). If you have more than one of these clinics, complete a separate worksheet for each facility.

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

Line 2.--For FQHCs only, enter your appropriate designation (urban or rural). See §505.2 of the RHC/FQHC Manual for information regarding urban and rural designations. If you are uncertain of your designation, contact your intermediary. RHCs do not complete this line.

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

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

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

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

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

Line 13.--If the facility has been approved for an exception to the productivity standard, enter Y (yes) or N (no).

Line 14.--If this facility is filing a consolidated cost report, as defined in CMS Pub. 27, §508(D), enter Y (yes) or N (no). If the response is yes, enter in column 2 the number of providers included in this report.

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

Line 16.--If this facility is claiming allowable and/or non-allowable Graduate Medical Education (GME) costs as a result of substantial payment for interns and residents, enter Y (yes) or N (no) and enter the number of Medicare visits in column 2 performed by interns and residents. Complete Worksheet RF-1, lines 20 and 27 as applicable.

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

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

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

DO NOT COMPLETE THE REMAINDER OF WORKSHEET RF-5. THE REMAINDER OF THE WORKSHEET IS COMPLETED BY YOUR FISCAL INTERMEDIARY.

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

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

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

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

3239. WORKSHEET S-5 - HOSPICE IDENTIFICATION DATA

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

3239.1 Part I - Enrollment Days.--Based on level of care.

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

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

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

**Continuous Home Care Day** - A continuous home care day is a day on which the hospice patient is not in an inpatient facility. A day consists of a minimum of 8 hours and a maximum of 24 hours of predominantly nursing care. **Convert continuous home care hours into days so that a true accountability can be made of days provided by the hospice.**

**Routine Home Care Day** - A routine home care day is a day on which the hospice patient is at home and not receiving continuous home care.

**Inpatient Respite Care Day** - An inpatient respite care day is a day on which the hospice patient receives care in an inpatient facility for respite care.

**General Inpatient Care Day** - A general inpatient care day is a day on which the hospice patient receives care in an inpatient facility for pain control or acute or chronic symptom management which cannot be managed in other settings.

Column Descriptions

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

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

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

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

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

3239.2 Part II - Census Data.--

Line 6.--Enter on line 6 the total number of patients receiving hospice care within the cost reporting period for the appropriate payer source. Do not include the number of patients receiving care under subsequent election periods. (See CMS Pub. 21 §204.)

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

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

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

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

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

The statistics for a patient who had periods of stay with the hospice under more than one program is included in the respective columns. For example, patient A enters the hospice under Medicare hospice benefit, stays 90 days, revokes the election for 70 days (and thus goes back into regular Medicare coverage), then reelects the Medicare hospice benefits for an additional 45 days, under a new benefit period and dies (patient B). Medicare patient C was in the program on the first day of the year and died on January 29 for a total length of stay of 29 days. Patient D was admitted with private insurance for 27 days, then their private insurance ended and Medicaid covered an additional 92 days. Patient E, with private insurance, received hospice care for 87 days. The average length of stay (LOS) (assuming these are the only patients the hospice served during the cost reporting period) is computed as follows:

| | |
|---|---|
| Medicare Days (90 & 45 & 29) Patient (A, B & C) | 135 days |
| Medicare Patients | /3 |
| | ---- |
| Average LOS Medicare | 54.67 Days |
| Medicaid Days Patient D (92) | 92 Days |
| Medicaid Patient | 1 |
| Average LOS Medicaid | 92 Days |
| Other (Insurance) Days (87 & 27) | 114 Days |
| Other Payments (D & E) | 2 |
| Average LOS (Other) | 54 Days |
| All Patients (90+45+29+92+87+27) | 370 Days |
| Total number of patients | 6 |
| Average LOS for all patients | 61.67 Days |

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

Line 9.--Enter the unduplicated census count of the hospice for all patients initially admitted and filing an election statement with the hospice within a reporting period for the appropriate payer source. Do not include the number of patients receiving care under subsequent election periods (see CMS Pub. 21 §204). However, the patient who initially elects the hospice benefit, is discharged or revokes the benefits, and elects the benefit again within the reporting period is considered a new admission with each new election and is counted twice.

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

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

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

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

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

3220. WORKSHEET S-6 - HHA-BASED CORF STATISTICAL DATA

In accordance with 42 CFR 413.20(a), 42 CFR 413.24(a) and 42 CFR 413.24(c), maintain statistical records for proper determination of costs payable under the Medicare program. The statistics reported on this worksheet pertain to an HHA-based CORF. If you have more than one provider-based CORF, complete a separate worksheet for each facility. The data maintained, depending on the services provided by the CORF, include number of program treatments, total number of treatments, number of program patients, and total number of patients. In addition, FTE data is required by employee staff, contracted staff, and total. Do not complete this worksheet if all services are paid under an established fee schedule for CORF providers for cost reporting periods ending on or after June 30, 2001.

CORF Treatments.--Use lines 1 through 8 to identify the number of service treatments and corresponding number of patients. The patient count in columns 2 and 4 includes each individual who received each type of service. The sum of the patient count in columns 2 and 4 equals the total in column 6 for each line.

Columns 1 and 3--Enter the number of treatments for title XVIII and other, respectively, for each discipline. Enter the total for each column on line 9.

Columns 2 and 4--Enter the number of patients corresponding to the number of treatments in columns 1 and 3 for title XVIII and other, respectively, for each discipline.

Columns 5 and 6--Enter in column 5 the total of columns 1 and 3. Enter in column 6 the total of columns 2 and 4.

Line Descriptions

Lines 1 through 7--These lines identify the type of CORF services which are reimbursable by the program. These lines reflect the number of times a person was a patient receiving a particular service.

Line 8--This line identifies other services not listed on lines 1 through 7 which are not reimbursable by the program.

Line 9--Enter in column 1 the total of the amounts on lines 1 through 7. Enter in columns 3 and 5 the total of the amounts on lines 1 through 8.

Lines 10 through 28--These lines provide statistical data related to the human resources of the CORF. The human resources statistics are required for each of the job categories specified on lines 10 through 26. Enter any additional categories needed on lines 27 and 28.

Enter the number of hours in your normal work week in the space provided.

Report in column 1 the full time equivalent (FTE) employees on the CORF'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 CORF.

Compute FTEs as follows. Add hours for which employees or contractors were paid, divide by 2080 hours, and round to two decimal places.

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

3221. WORKSHEET J-1 - ALLOCATION OF GENERAL SERVICE COSTS TO CORF COST CENTERS

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

3221.1 Part I - Allocation of General Service Costs to CORF Cost Centers.--Worksheet J-1, Part I provides for the allocation of the expenses of each general service cost center to those cost centers which receive the services. Obtain the total direct expenses (column 0, line 15) from Worksheet A, column 10, line 24. Obtain the cost center allocation (column 0, lines 1 through 14) from your records. The amounts on line 15, columns 0 through 6, must agree with the corresponding amounts on Worksheet B, columns 0 through 6, line 24. Complete the amounts entered on lines 1 through 15, columns 1 through 8, in accordance with the instructions contained in §3221.3. If all CORF services are paid under established fee schedules, these worksheets no longer need to be completed for cost reporting periods ending on or after June 30, 2001.

3221.2 Part II - Computation of Unit Cost Multiplier for Allocation of CORF Administrative and General Costs.--Use this part to compute the unit cost multiplier used to allocate CORF administrative and general costs to the revenue producing CORF cost centers.

Line 1--Enter the amount from Part I, column 6, line 15.

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

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

Line 4--Divide line 2 by line 3 and enter the result. Multiply each amount in column 6, lines 2 through 15, by the unit cost multiplier and enter the result on the corresponding line of column 7.