

3539. WORKSHEET H - ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

This worksheet provides for recording of direct HHA costs such as salaries, fringe benefits, transportation, and contracted services, as well as other costs, to arrive at the identifiable agency cost in column 6. This data is required by 42 CFR 413.20. Obtain these direct costs from your records. The cost centers on this worksheet are listed in a manner which facilitates the sequential listing of accounts and array of expense accounts for transfer of the various cost center data from Worksheets H-1, H-2, and H-3. All of the cost centers listed do not apply to all agencies using these forms. Therefore, use only those cost centers applicable to your HHA.

NOTE: For cost reporting periods beginning on and after October 1, 2000, Worksheets H-1, H-2, and H-3 are not required to be filed. Obtain the information for columns 1, 2 and 4 below from your records.

Column 1.--Obtain the expenses listed in this column from **your records**.

Column 2.--Obtain the expenses listed in this column from **your records**.

Column 3.--Enter on each line (other than line 4) the cost of public transportation or the amount paid to employees for the use of private vehicles only when these costs can be identified and directly assigned to a particular cost center.

Where the agency owns (or rents) its vehicles, enter this cost on line 4 in the transportation cost center.

Report the transportation cost in this manner so that the identifiable costs can be recorded where applicable. Allocate unidentifiable costs during cost finding through the administrative and general cost center.

Column 4.--Obtain the expenses listed in this column from **your records**.

Column 5.--Enter on the applicable lines in column 5 all other identifiable agency costs which have not been reported in columns 1 through 4 from your books and records.

NOTE: Lines 12 through 14.--Costs for enteral and parenteral nutrition therapy (EPNT) items are not considered routine in conjunction with patient visits and must be included on lines 12 through 14, as appropriate, to be billed separately.

EPNT items, which are considered prosthetic devices and furnished by an SNF-based HHA on or after March 14, 1986, are reimbursed on a reasonable charge basis through billings submitted to the Part B specialty carrier. (As a prosthetic device, such services are only reimbursable under Part B.) Charges for these items must be included in total charges but excluded from the Title XVIII charge statistic in the apportionment of DME and medical supply costs on Worksheet H-5, lines 8, 9, and 10.

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

Line 23.50 -- Create this subscripted line to accumulate cost associated with "telemedicine" services rendered on and after October 1, 2000.

3540. WORKSHEET H-1 - COMPENSATION ANALYSIS - SALARIES AND WAGES

DO NOT COMPLETE THIS WORKSHEET FOR COST REPORTING PERIODS BEGINNING ON AND AFTER OCTOBER 1, 2000.

A detailed analysis of salaries and wages is required to explain data entered on Worksheet H, column 1. This data is required by 42 CFR 413.20.

Enter all salaries and wages for the HHA on this worksheet for the actual work performed within the specific work area or cost center in accordance with the column headings. For example, if the administrator spends 100 percent of his/her time in the HHA, and of this time, performs skilled nursing care which accounts for 25 percent of that person's time, then enter 75 percent of the administrator's salary and any employee related benefits on line 5 (Administrative and General-HHA), and enter 25 percent of the administrator's salary (and any employee-related benefits) on line 6 (skilled nursing care).

Maintain the records necessary to determine the split in salary (and employee related benefits) between two or more cost centers and adequately substantiate the method used to split the salary and employee related benefits. These records must be available for audit by the intermediary. The intermediary can accept or reject the method used to determine the split in salary. Any deviation or change in methodology to determine splits in salary and employee benefits must be requested in writing and approved by the intermediary before any change is effectuated. Where approval of a method has been requested in writing and this approval has been received (prior to the beginning of the 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. He/she develops and guides the organization by taking responsibility for planning, organizing, implementing, and evaluating. He/she is responsible for the application and implementation of established policies. He/she may act as a liaison among the governing body, the medical staff, and any departments. He/she provides for personnel policies and practices that adequately support patient care and maintains accurate and complete personnel records. He/she implements the control and effective utilization of the physical and financial resources of the provider.

Directors (Column 2)

Possible Titles: Medical, 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.

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

- o Physical therapy - line 7
- o Occupational therapy - line 8
- o Speech pathology - line 9
- o 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, 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.

NOTE: Prior to the Omnibus Reconciliation Act of 1980, only a physician was permitted to establish the required plan of treatment for outpatient speech pathology services. Effective January 1, 1981, a plan of treatment for outpatient speech pathology services may be established by either the physician or the speech pathologist providing such services.

Any changes to a plan of treatment established by such speech pathologist must be in writing and signed by that pathologist or by the attending physician. A speech pathologist, however, may not alter a plan of treatment established by a physician.

Speech language pathology 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: 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; 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 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, 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, assessment of the social and emotional factors related to the patient's illness, his/her need for care, his/her response to treatment, and his/her adjustment to care; appropriate action to obtain casework services to assist in resolving problems in these areas; and assessment of the relationship of the patient's medical and nursing requirements to the home situation, his/her financial resources, and the community resources available to him/her.

NOTE: Normally, the services of a medical social worker are not classified as therapy. However, include the medical social worker data in column 5 to simplify reporting.

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.

Home health aide services are the provision of 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 plans 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.

Add the amounts of each cost center, columns 1 through 8, and enter the total in column 9.

Add the amounts in each column, lines 1 through 24, and enter this total on line 25 for each column. Transfer the totals in column 9 to Worksheet H, column 1, lines as applicable. To facilitate transferring amounts from Worksheet H-1 to Worksheet H, 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.

3541. WORKSHEET H-2 - COMPENSATION ANALYSIS - EMPLOYEE BENEFITS (PAYROLL-RELATED)

DO NOT COMPLETE THIS WORKSHEET FOR COST REPORTING PERIODS BEGINNING ON AND AFTER OCTOBER 1, 2000.

A detailed analysis of employee benefits compensation is required to explain data entered on Worksheet H, column 2. This data is required by 42 CFR 413.20.

Enter all payroll-related employee benefits for the HHA on this worksheet. See CMS Pub. 15-I, §§2144 - 2145 for definition of fringe benefits. Make entries using the same basis as that used for reporting salaries and wages on Worksheet H-1. Therefore, using the example above, enter 75 percent of the administrator's payroll-related fringe benefits on line 5 (Administrative and General-HHA), and enter 25 percent of the administrator's payroll-related fringe benefits on line 6 (skilled nursing care).

Report payroll-related employee benefits in the cost center that the applicable employee's compensation is reported. Perform this assignment based on an actual basis or upon the following basis:

- A. FICA (actual expense by cost center);
- B. Pension and retirement and health insurance (nonunion) (gross salaries of participating individuals by cost center);
- C. Union health and welfare (gross salaries of participating union members by cost center); or
- D. All other payroll-related benefits (gross salaries by cost center).

Include non payroll-related employee benefits in the Administrative and General - HHA cost center. Include costs for such items as personal education, recreation activities, and day care in the Administrative and General - HHA cost center.

Add the amounts of each cost center, columns 1 through 8, and enter the total in column 9.

Add the amounts in each column, lines 1 through 24, and enter this total on line 25 for each column. Transfer the totals in column 9 to Worksheet H, column 2, lines as applicable. To facilitate transferring amounts from Worksheet H-2 to Worksheet H, the same cost centers with corresponding line numbers are listed on both worksheets.

3542. WORKSHEET H-3 - COMPENSATION ANALYSIS - CONTRACTED SERVICES/PURCHASED SERVICES

DO NOT COMPLETE THIS WORKSHEET FOR COST REPORTING PERIODS BEGINNING ON AND AFTER OCTOBER 1, 2000.

A detailed analysis of contracted or purchased services is required to explain data entered on Worksheet H, column 4. This data is required by 42 CFR 413.20.

All provider-based agencies must enter on this worksheet all costs for 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 include the amount applicable to each cost center on each affected cost center line. Add the amounts of each cost center, columns 1 through 8, and enter the total in column 9. Add the amounts in each column, lines 1 through 24, and enter the total on line 25. Transfer the total in column 9 to Worksheet H, column 4, lines as applicable. To facilitate transferring amounts from Worksheet H-3 to Worksheet H, the same cost centers with corresponding line numbers are listed on both worksheets.

3543. WORKSHEET H-4 - ALLOCATION OF HHA ADMINISTRATIVE AND GENERAL COSTS

Use this worksheet to allocate the HHA administrative and general costs to the applicable HHA cost center.

3543.1 Part I -- Allocation of HHA Administrative and General Costs.--

Column Descriptions

Column 1--Enter the direct HHA costs from Worksheet B, Part I, column 18, lines as follows:

<u>From Worksheet B, Part I, Column 18</u>	TO	<u>Worksheet H-4, Part I, Column 1</u>
line 37		line 1
line 38		line 2
line 39		line 3
line 40		line 4
line 41		line 5
line 42		line 6
line 43		line 7
line 44		line 8
line 45		line 9
line 46		line 12
line 47		line 13

Enter in column 1 on line 13 the cost of any other program nonreimbursable HHA cost center which you may have identified on Worksheets A, B, Part I, and B-1.

Column 2--Enter the apportioned HHA costs from Worksheet H-4, Part II, column 3, lines as follows:

<u>From Part II, Column 3</u>	TO	<u>Worksheet H-4, Part I, Column 2</u>
line 1		line 3
line 2		line 4
line 3		line 5
line 4		line 10
line 5		line 11
line 6		line 14
line 7		line 15
line 8		line 16

Column 3.--Add columns 1 and 2 and enter the total in column 3.

Enter the sum of lines 2 through 13 on line 15. This becomes the basis of allocation for the Administrative and General - HHA cost. Divide the amount entered on line 1 by the basis entered on line 14. Enter the resulting unit cost multiplier on line 16. Round the unit cost multiplier to six decimal places. Multiply the unit cost multiplier by the amount on each line (lines 2 through 13) in column 3, and enter the result on the same line in column 4.

Column 4.--Enter on line 1 the amount of Administrative and General - HHA cost from column 3, line 1. Enter the allocated amount on each line using the unit cost multiplier from column 3. The sum of column 4 must equal zero.

Column 5.--Add the amounts in column 3 to the amounts in column 4 for each line, and enter the result in column 5 for that line.

Transfer the amounts in column 5 to Worksheet H-5, column 2, as follows:

<u>From Worksheet H-4,</u>	TO	<u>Worksheet H-5, Column 2</u>
line 2		line 1
line 3		line 2
line 4		line 3
line 5		line 4
line 6		line 5
line 7		line 6
line 10		line 15
line 11		line 16

3543.2 Part II - Apportionment of Cost of HHA Services Furnished by Shared Skilled Nursing Facility Departments.--Use this part only when the SNF complex maintains a separate department for any of the cost centers listed on this worksheet, and the departments provide services to patients of the skilled nursing facility's HHA.

Column 1.--When SNF departments provide services to the HHA, enter on the appropriate lines the charges applicable to the SNF-based HHA.

Column 2.--Where applicable, enter in column 2 the cost to charge ratio from Worksheet C, column 3, lines as indicated.

Column 3.--Multiply the amounts in column 1 by the ratios in column 2 and enter the result in column 3. Transfer the amounts in column 3 to Worksheet H-4, Part I as indicated.

3544. WORKSHEET H-5 - APPORTIONMENT OF PATIENT SERVICE COSTS

This worksheet provides for the apportionment of home health patient service costs. Complete a separate worksheet for each applicable title, Title V, Title XVIII, and Title XIX.

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 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 the 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, deductible 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 on lines 18 through 20, columns 3 through 6.

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 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 H-5, Part I, the aggregate cost per visit computation, must be completed only one time for the entire home health agency. Complete Worksheet H-5, Part II, computation of the lesser of aggregate Medicare cost or the aggregate of the Medicare limitation computation, once for each MSA where Medicare covered services were furnished during the cost reporting period.

3544.1 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 413.53 and 42 CFR 413.30.

Cost Per Visit ComputationColumn Descriptions

Column 2.--Enter the cost for each discipline from Worksheet H-4, Part I, column 5, lines as indicated.

Column 3.--Enter the total agency visits from statistical data (Worksheet S-4, column 8, 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.

3544.2 Part II - Computation of 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. Enter the MSA/Non-MSA code from Worksheet S-4, line 17, for which Medicare services were furnished. 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 cost or aggregate visit limits.

Effective for cost reporting periods beginning on or after October 1, 2000, the subscripted lines 1 through 6, and subscripted column 11 are not applicable, and should not be completed. Also, 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.

Lines 1 through 7-

Column 4--Transfer the average cost per visit from 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**. 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**.

NOTE: The sum of Worksheets H-5, Part II, columns 5 and 6, lines 1.01, 2.01, 3.01, 4.01, 5.01 and 6.01, respectively, may not necessarily equal the corresponding amounts on Worksheet S-4, Part III, column 7, lines 1, 3, 5, 7, 9 and 11, respectively, due to the difference between visits contained in episodes terminating in the current fiscal year (Worksheet S-4, Part III), and visits rendered through the fiscal year end (Worksheet H-5, Part III).

For cost reporting periods which overlap October 1, 2000, the sum of Worksheet H-5, 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-4, Part I, Column 2, lines 1 through 6. For cost reporting periods that begin on or after October 1, 2000, the sum of Worksheets H-5, Part II, columns 5 and 6, lines 1 through 6, respectively, must equal the corresponding amounts on Worksheet S-4, Part III column 7, lines 1, 3, 5, 7, 9, and 11.

Columns 7 and 10--**DO NOT USE THESE COLUMNS**, for cost reporting periods beginning on and after October 1, 1997.

NOTE: For reporting periods overlapping October 1, 2000, the sum of all Worksheets H-5, Part II, Medicare program visits, sums of line 1-6 (excluding subscripts) for columns 5 must be equal to or less than the sum of the visits shown on Worksheet S-4, Part I, Column 2, 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, and 6.01 for visits rendered on and after October 1, 2000. Enter this total on line 7.

Column Descriptions for Cost Limitation Computation

Lines 8 through 14-

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

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

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

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

Columns 7 and 10--**DO NOT USE THESE COLUMNS**, for cost reporting periods beginning on and after October, 1, 1997.

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

3544.3 Part III - Supplies and Drugs Cost Computation--Certain items covered by Medicare and furnished by an HHA are not included in the visit for apportionment purposes. Since an average cost per visit and the cost limit per visit do not apply to these items, the ratio of total cost to total charges is developed and applied to Medicare charges to arrive at the Medicare cost for these items. Enteral/parenteral nutrition therapy (EPNT) items which are considered prosthetic devices furnished by an HHA on or after March 14, 1986, are reimbursed on a reasonable charge basis through billings submitted to the DMERC. (As a prosthetic device, such services are reimbursable only under Part B.) Charges for these items must be included in the total charges, but excluded from Title XVIII charge statistics in the apportionment of medical supply costs on Part IV, line 15. Lines 15 and 16 are subscripted to isolate pre October 1, 2000, costs to facilitate the flow of these costs to Worksheet H-6 in order to apply LCC.

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

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

NOTE: Injectable drugs are a Part B service only.

Lines 15 and 16--Enter in column 2 the total applicable HHA costs for the entire cost reporting period for each line item from Worksheet H-4, Part I, column 5, lines 10 and 11, respectively (the costs entered on lines 15 and 15.01 must be equal; the costs entered on lines 16 and 16.01 must be equal). Enter in column 3 the total HHA charges for the entire cost reporting period for each line (the charges entered on lines 15 and 15.01 must equal; the charges entered on lines 16 and 16.01 must equal) Enter in column 4 the ratio of HHA costs (column 2) to HHA charges (column 3) for each line.

Line 15--Enter in columns 5, 6, and 7 the charges for medical supplies not paid on a fee schedule for services rendered prior to October 1, 2000.

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

Line 16--Enter in column 6 the charges for pneumococcal vaccine and its administration, influenza vaccine and its administration, and hepatitis B vaccine and its administration for services rendered prior to October 1, 2000. Enter in column 7 the charge for covered osteoporosis drugs for services rendered prior to October 1, 2000. (See §1833(m)(5) of the Act.)

Line 16.01—For reporting periods which overlap October 1, 2000, enter in column 6 the charges for pneumococcal vaccine and its administration, influenza vaccine and its administration, and hepatitis B vaccine and its administration rendered on or after October 1, 2000 through the fiscal year end. Enter in column 7 the charges for covered osteoporosis drugs rendered on or after October 1, 2000, through the fiscal year end. (See §1833(m)(5) of the Act.) For reporting periods that begin on or after October 1, 2000, eliminate line 16.01 and record all charge and resulting cost data on line 16. Osteoporosis drugs will continue to be reimbursed on a cost basis for services rendered on and after October 1, 2000.

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

Column 9--To determine the Medicare Part B cost, multiply the Medicare charges (column 6) by the ratio (column 4) for each line item. Enter the product in column 9.

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

3544.4 Part IV - Comparison of the Lesser of Aggregate Medicare Cost, the Aggregate of the Medicare Cost Per Visit Limitation and the Aggregate Per Beneficiary Cost Limitation--This part provides for the comparison of the reasonable cost limitation, applied to each home health agency's total allowable cost attributable to Medicare patient care visits. This comparison is required by 42 CFR 413.53 and 42 CFR 413.30. For cost reporting periods beginning on or after October 1, 1997, §1861(v)(1)(L) of the Social Security Act is amended by §4601 of BBA 1997, requiring home health agency net cost of covered services to be based on the lesser of aggregate Medicare cost, the aggregate of the Medicare limitation, or the agency specific per beneficiary annual cost limit. The per beneficiary cost limitation is derived by totaling the application of each MSA/non-MSA's unduplicated census count (two decimal places) (see §3527) to the per beneficiary cost limitation for the corresponding MSA/non-MSA. To accomplish this, the sum of all worksheets H-5, Part II, amounts in column 11, line 7, plus the applicable cost of medical supplies is compared with the sum of all worksheet H-5, Part II amounts in column 11, line 14, plus the applicable cost of medical supplies and with the amount in column 6, line 24.

Line 18--Enter in columns 3, 4, and 6, respectively, the sum of the amounts from each Worksheet H-5 Part II, columns 8, 9, and 11, (exclusive of subscripts) respectively, lines 1-6, respectively, (exclusive of subscripts).

Line 19--Enter in columns 3 and 4, respectively, the cost of medical supplies from Part III, columns 8 and 9, respectively, line 15 (excluding subscripted lines). Enter in column 6 the sum of columns 3 and 4.

Line 20--Enter the sum of lines 18 and 19 for columns 3 and 4. Enter in column 6 the sum of columns 3 and 4.

Effective for cost reporting periods beginning on and after October 1, 2000, do not complete lines 21 through 25, as all HHA's are reimbursed under PPS and are no longer subject to cost per visit limitations or annual beneficiary limitations.

Line 21--Enter the total cost per visit limitation for Medicare services which is the sum of the amounts from each Worksheet H-5, Part II, columns 8, 9, and 10 respectively, line 14.

Line 22--Enter in columns 3 and 4, respectively, the cost of medical supplies from Part III, columns 8 and 9, respectively, line 15 (excluding subscripted lines). Enter in column 6 the sum of columns 3 and 4.

Line 23--Enter the sum of lines 21 and 22 for columns 3 and 4. Enter in column 6 the sum of columns 3 and 4.

Line 24--Enter the per beneficiary cost limitation for each MSA/non-MSA area serviced by the HHA. Line 24 will have to be subscripted for each area. For each MSA/non-MSA enter the following:

Column 0--Enter the MSA/nonMSA code from Worksheet S-4, Part II, line 17, and the corresponding subscripts thereof.

Column 1--Enter the corresponding Medicare program (Title XVIII) unduplicated census count (two decimal places) from your records associated with services rendered prior to October 1 2000, (See §3511.)

Column 2--Enter the applicable per beneficiary annual limit. Obtain this amount from your intermediary.

Columns 3 and 4--(Complete column 6 prior to the completion of columns 3 and 4.) Complete columns 3 and 4 only if column 6, line 25 is less than column 6, lines 18 and 21. Enter in column 3 the result of column 3, line 18 divided by column 6, line 18 multiplied by column 6, line 25. Enter on line 25 in column 4 the result of column 4, line 18 divided by column 6, line 18 multiplied by column 6, line 25.

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

Line 25--In column 1 (two decimal places) and 6, respectively, enter the sum of lines 24 (line 24 plus all subscripted lines 24). Enter in column 3, the result of column 3, line 20 divided by column 6, line 20, multiplied by column 6, line 25. Enter on line 25 in column 4, the result of column 4, line 20, divided by column 6, line 20, multiplied by column 6, line 25. (The sum of columns 3 and 4 must equal column 6.)

NOTE: The total Medicare (Title XVIII) unduplicated census count (Worksheet S-4, column 3, line 9 (Pre October 1, 2000, Unduplicated Census Count)) must equal the sum of the unduplicated census count for all MSAs (Worksheet H-5, Part IV, column 1, line 25).

3544.5 Part V - Outpatient Therapy Reduction Computation.--This section computes the reduction in the reasonable costs of outpatient physical therapy services (which includes outpatient speech language pathology and outpatient occupational therapy) provided under arrangement for beneficiaries who are not homebound as required by §1834(k) of the Act and enacted by §4541 of BBA 1997. The amount of the reduction is 10 percent for services rendered on or after January 1, 1998. For outpatient therapy services rendered on or after January 1, 1999, §4541 of the BBA 1997 mandates a fee schedule payment basis for outpatient physical, outpatient occupational therapy, and outpatient speech pathology. Therefore, any outpatient therapy services furnished on or after January 1, 1999, **must not be included** in this section due to the application of a fee schedule for these services, but the corresponding visits must be recorded in column 5.01. These outpatient therapy services are reimbursed the lesser of the fee schedule amount or the statutory limitation which is applied on a beneficiary specific basis through the Medicare claims system. This requires no provider input on the cost report.

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

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

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

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

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

Line 29--For columns 3 through 8, enter the sum of lines 26 through 28.

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

3545. WORKSHEET H-6 - CALCULATION OF HHA REIMBURSEMENT SETTLEMENT - PART A AND PART B SERVICES

Worksheet H-6 consists of the following two parts:

- Part I - Computation of the Lesser of Reasonable Cost or Customary Charges. This part provides for the reimbursement calculation of title XVIII, Part A and Part B, and title V and title XIX. This computation is required by 42 CFR 413.9, 42 CFR 413.13, and 42 CFR 413.30. Use column 1 for Titles V and XIX.
- Part II - Computation of HHA Reimbursement Settlement. Complete this part for Titles, XVIII, and XIX, as applicable.

3545.1 Part I - Computation of Lesser of Reasonable Cost or Customary Charges.--Services not paid for based on a fee schedule are paid the lesser of the reasonable cost of services furnished to beneficiaries or the customary charges made by the providers for the same services. This part provides for the computation of the lesser of reasonable cost as defined in 42 CFR 413.13(b) or customary charges as defined in 42 CFR 413.13(e). Use column 1 for Titles V and XIX.

NOTE: Nominal charge providers are not subject to the lesser of cost or charges (LCC). Therefore, a nominal charge provider completes only lines 1 and 7 of Part I. Transfer the resulting cost to line 8 of Part II.

Line Descriptions

Line 1.—For reporting periods beginning prior to October 1, 2000, enter the cost of services from Worksheet H-5 as follows. This line provides for the computation of reasonable cost of Title XVIII, Part A and Part B services. For cost reporting periods beginning on or after October 1, 2000, transfer only the cost of osteoporosis drugs from Worksheet H-5, Part III, column 10, line 16 to column 3 of this worksheet.

If the amount in column 6, line 20 is less than the amount in column 6, line 23, and the amount in column 6, line 25, transfer (aggregate Medicare cost):

To Worksheet H-6, Line 1

From Worksheet H-5

Col. 1, Part A .	Part IV, Col. 3, line 20
Col. 2, Part B..	Part III, Sum of col. 9, line 16 (excluding subscripted lines) and Part IV, col. 4, line 20
Col. 3, Part B..	Part III, Sum of col. 10, line 15 (excluding subscripted lines), 16 and 16.01 and Part V, col. 8, line 29

If the amount in column 6, line 23 is less than the amount in column 6, line 20, and the amount in column 6, line 25, transfer (aggregate Medicare limitation):

To Worksheet H-6, Line 1From Worksheet H-5

Col. 1, Part A .

Part IV, Col. 3, line 23

Col. 2, Part B

Part III, Sum of col. 9, line 16 (excluding subscripted lines) and Part IV, col. 4, line 23

Col. 3, Part B..

Part III, Sum of col. 10, line 15 (excluding subscripted lines), 16 and line 16.01 and Part V, col. 8, line 29.

If column 6, line 25 is less than the amount in column 6, line 20, and the amount in column 6, line 23, transfer (aggregate per beneficiary limitation):

To Worksheet H-6, Line 1From Worksheet H-5

Col. 1, Part A .

Part IV, Col. 3, line 25

Col. 2, Part B

Part III, Sum of col. 9, line 16 (excluding subscripted lines) and Part IV, col. 4, line 25

Col. 3, Part B..

Part III, Sum of col. 10, line 15 (except subscripted lines), 16 and line 16.01 and Part V, col. 8, line 29

Lines 2 through 6.--These lines provide for the accumulation of charges which relate to the reasonable cost on line 1. Do not include on these lines (1) the portion of charges applicable to the excess costs of luxury items or services (see CMS Pub. 15-I, chapter 21) and (2) provider charges to beneficiaries for excess costs as described in CMS Pub. 15-I, §2570. Where your operating costs include amounts that flow from the provision of luxury items or services, such amounts are not allowable in computing reimbursable costs.

Line 2.-- In columns 1, 2 and 3, enter from your records the charges for the applicable Medicare services rendered prior to October 1, 2000. Additionally, in columns 2 and 3, enter from your records the charges for the applicable Medicare covered drugs (see §3215.3) rendered prior to October 1, 2000.

Line 2.01--In column 3, enter from your records only the charges for applicable Medicare covered osteoporosis drugs (see 3215.3) rendered on and after October 1, 2000. LCC is applicable only for drug costs for services rendered on and after October 1, 2000. For all other services rendered on or after October 1, 2000, do not enter any charges in columns 1 and 2.

Line 7.--Enter the amounts paid or payable by workmen's compensation and other primary payers where program liability is secondary to that of the primary payer. There are six situations under which Medicare payment is secondary to a primary payer:

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

Generally, when payment by the primary payer satisfies the total liability of the program beneficiary, for cost reporting purposes only, the services are treated as if they were non-program services. (The primary payment satisfies the beneficiary's liability when you accept that payment as payment in full.

This is noted on no-pay bills submitted in these situations.) The patient visits and charges are included in total patient visits and charges, but are not included in program patient visits and charges. In this situation, enter no primary payer payment on line 7. In addition, exclude amounts paid by other primary payers for outpatient dialysis services which are reimbursed under the composite rate system.

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

When the primary payment does not satisfy the beneficiary's liability, include the covered days and charges in program visits and charges, and include the total visits and charges in total visits and charges for apportionment purposes. Enter the primary payer payment on Line 9 to the extent that primary payer payment is not credited toward the beneficiary's deductible and coinsurance. Primary payer payments that are credited toward the beneficiary's deductible and coinsurance are not entered on line 7.

3545.2 Part II - Computation of HHA Reimbursement Settlement.--Check the applicable title for When the primary payment does not satisfy the beneficiary's liability, include the covered days and charges in program visits and charges, and include the total visits and charges in total visits and charges for cost apportionment purposes. Enter the primary payer payment on line 9 to the extent that primary payer payment is not credited toward the beneficiary's deductible and coinsurance. this form.

Line 8.--Enter in column 1 the lesser of the amount in column 1, line 1 or line 6 less the amount on line 7. Enter in column 2 the sum of the lesser of the amounts in column 2, line 1 or line 6, plus the lesser of the amounts in column 3, line 1 or line 6 minus the amounts on line 7, columns 2 and 3.

Lines 8.01 through 8.15—Under PPS enter only payment amounts associated with episodes completed in the current cost reporting period. Payments for episodes of care which overlap fiscal years must be recorded in the fiscal year in which the episode was completed. Enter in column 1 for lines 8.01 through 8.06, as applicable, the appropriate PPS reimbursement amount for each episode of care payment category as indicated on the worksheet. Enter in column 1 for lines 8.07 through 8.10, as applicable, the appropriate PPS outlier reimbursement amount for each episode of care payment category as indicated on the worksheet. Enter in column 1, line 8.11 the sum total of other payments. Enter in column 1, lines 8.12 through 8.14, the total DME, oxygen, prosthetics and orthotics payments, respectively. Obtain these amounts from your PS&R report.

Line 9.--Enter in column 2 the Part B deductibles billed to Medicare patients. Exclude coinsurance amounts. Include any amounts of deductibles satisfied by primary payer payments.

Line 11.--Enter all coinsurance billable to Medicare beneficiaries including amounts satisfied by primary payer payments.

NOTE: If the component qualifies as a nominal charge provider, enter 20 percent of costs subject to coinsurance. Compute this amount by subtracting Part B deductibles on line 9 and primary payment amounts on line 7, column 3 from Part B costs subject to coinsurance on line 1, column 3. The resulting amount is multiplied by 20 percent and entered on this line.

Line 13.--Enter program reimbursable bad debts for deductibles and coinsurance (from your records), excluding deductibles and coinsurance for physicians' professional services and net of bad debt recoveries.

NOTE: Effective for services rendered on or after August 5, 1997, a State is not required to provide any payment for any expenses incurred relating to payment for deductibles, coinsurance, or copayments for Medicare cost sharing to the extent that payment under

Title XVIII for the service would exceed the payment amount required to be made by the State through the State plan. For example, if the amount the State is required to pay for a Qualified Medicare Beneficiary (QMB) is less than the amount billed for deductible or coinsurance, the provider is precluded from claiming as a bad debt the balance.

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

NOTE: Section 1861 (v) (1) (O) sets a limit on the valuation of a depreciable asset that may be recognized in establishing an appropriate allowance for depreciation, and for interest on capital indebtedness after a change of ownership that occurs on or after December 1, 1997.

Line 16.--Enter the program's share of any recovery of excess depreciation applicable to prior years resulting from provider termination or a decrease in Medicare utilization. Submit the work papers which have developed this amount. (See CMS Pub. 15-I, chapter 1.)

Line 17.-- Where your cost limit is raised as a result of your request for review, amounts which were erroneously collected on the basis of the initial cost limit are required to be refunded to the beneficiary. Enter any amounts which are not refunded, either because they are less than \$5 collected from a beneficiary or because you are unable to locate the beneficiary. (See CMS Pub. 15-I, §2577.)

Line 18.--Enter line 14 minus the sum of lines line 16 and 17, plus or minus the amount on line 15.

Line 18.01.--Enter any other adjustments. For example, enter an adjustment resulting from changing the recording of vacation pay from a cash basis to an accrual basis. (See CMS Pub. 15-1, §2146.4.) For purposes of reimbursing costs associated with the Outcome and Assessment Information Set (OASIS) (cost reporting periods beginning in Federal fiscal year 2000 only) report on this line in column 1, the result of multiplying the Medicare unduplicated census count on Worksheet S-4, column 2, line 9,(excluding subscripts) by \$10.00, minus the interim OASIS payment made to the provider on April 1, 2000. Do not include this interim OASIS payment on Worksheet S-7, but rather attach documentation supporting the payment(s). (For intermediary use only during final settlement.)

Line 19.--Enter the applicable sequestration adjustment. (See §120 for a detailed explanation.)

Line 20—Enter the amount on line 18 plus line 18.01 minus line 19.

Line 21—Enter the interim payments from Worksheet H-7, line 4. For intermediary final settlement, report on line 21.01 the amount from Worksheet H-7, line 5.99.

Line 22.--Enter the amount on line 20 minus the amount of line 21. The amounts on this line show the balance due to you or to the program and are transferred to Worksheet S, Part II, columns 2, 3, or 4, as appropriate, line 4. Indicate overpayments by parentheses ().

Line 23.--Enter the Medicare reimbursement effect of protested items. Estimate the reimbursement effect of the nonallowable items by applying reasonable methodology which closely approximates the actual effect of items as if it had been determined through the normal cost finding process. (See §115.2.) Attach a schedule showing the supporting details and computation for this line.

3546. WORKSHEET H-7 - ANALYSIS OF PAYMENTS TO PROVIDER-BASED HOME HEALTH AGENCIES FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

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

The column headings designate two categories of payments: Part A and Part B.

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

Do not include any payments made for DME or medical supplies charged to patients that are paid on the basis of a fee schedule on this worksheet.

Line Descriptions

Line 1.--Enter the total Medicare interim payments paid to you for all covered services rendered prior to October 1, 2000. Additionally, for services rendered on and after October 1, 2000, enter only the total Medicare interim payments paid to the HHA for applicable Medicare covered osteoporosis drugs. The amount entered reflects the sum of all interim payments paid on individual bills (net of adjustment bills) for services rendered in this cost reporting period. The amount entered includes amounts withheld from your interim payments due to an offset against overpayments applicable to prior cost reporting periods. It does not include any retroactive lump sum adjustment amounts based on a subsequent revision of the interim rate, or tentative or net settlement amounts, nor does it include interim payments payable. If you are reimbursed under the periodic interim payment method of reimbursement, enter the periodic interim payments received for this cost reporting period. Do not include payments received for services reimbursed on a fee schedule basis

Also, enter in column 1, as applicable for HHA services furnished on or after October 1, 2000, the total Medicare PPS payments and the total PPS outlier payments paid to the HHA for all episode payment categories for related episodes completed during the current cost reporting period. The amounts entered reflects the sum of all interim PPS payments paid on individual claims (net of adjustments) for episodes completed in the current cost reporting period.

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

NOTE: Include on lines 1 and 2 the appropriate amounts applicable for respite care services.

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 3.11). Transfer these totals to the appropriate column on Worksheet H-6, Part II, line 21.

DO NOT COMPLETE THE REMAINDER OF WORKSHEET H-7. THE REMAINDER OF THE WORKSHEET IS COMPLETED BY YOUR 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 in column 2 the amount on Worksheet H-6, Part II, column 1, line 22. Enter in column 4 the amount on Worksheet H-6, Part II, column 2, line 22.

Line 7.--Enter the net settlement amount (balance due to you or balance due to the program) for the NPR, or, if this settlement is after a reopening of the NPR, for this reopening. Enter the total of the amount on line 6 plus or minus the total amount on line 5.99. Enter amounts due the program in parentheses ().

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