CHAPTER 47

HOME HEALTH AGENCY COST REPORT
FORM CMS-1728-19

Section

CHAPTER 47

Section

4700. GENERAL

The Paperwork Reduction Act of 1995 requires that the private sector be informed why information is collected and how it will be used by the government. Under the authority of §§1815(a) and 1833(e) of the Social Security Act (the Act), home health agencies (HHAs) as defined under §1861(o), participating in the Medicare program are required to submit annual information to determine costs for health care services rendered to Medicare beneficiaries. HHAs are required to follow reasonable cost principles under §1861(v)(1)(A) when completing the Medicare cost report. The regulations at 42 CFR 413.20 and 413.24 require adequate cost data and cost reports from HHAs on an annual basis. The information reported on Form CMS-1728-19, must conform to the requirements and principles set forth in the Provider Reimbursement Manual, (CMS Pub. 15-1), as well as those set forth in the Medicare Benefit Policy Manual, (CMS Pub. 100-02, chapter 7), and the Medicare Claim Processing Manual, (CMS Pub. 100-04, chapter 10). These instructions are effective for cost reporting periods beginning on or after July 1, 2019, and ending on or after June 30, 2020.

The HHA cost report must be submitted to the Medicare administrative contractor (hereafter referred to as contractor) in an electronic format in accordance with 42 CFR 413.24(f)(4). Cost reports are due on or before the last day of the fifth month following the close of the period covered by the report. For cost reports ending on a day other than the last day of the month, cost reports are due 150 days after the last day of the cost reporting period, in accordance with 42 CFR 413.24(f)(2).

Form CMS-1728-19 must be used by all freestanding HHAs. HHAs that are considered part of a hospital healthcare complex must use Form CMS-2552 and HHAs that are considered part of a skilled nursing facility (SNF) healthcare complex must use Form CMS-2540.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0022. The expiration date of this information collection instrument is [XXXX XX, 2022]. The time required to complete this information collection is estimated to average 195 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Direct any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form to: Centers for Medicare and Medicaid Services, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documentation containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

4701. ROUNDING STANDARDS FOR FRACTIONAL COMPUTATIONS

Throughout the Medicare cost report, where computations result in the use of fractions, use the following rounding standards:

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

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

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

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

4702. ACRONYMS AND ABBREVIATIONS

Throughout the Medicare cost report and instructions, a number of acronyms and abbreviations are used. Commonly used acronyms and abbreviations are listed below.

A&G	-	Administrative and General
CAP REL	-	Capital-Related
CBSA	-	Core Based Statistical Area
CCN	-	CMS Certification Number
CFR	-	Code of Federal Regulations
CMS	-	Centers for Medicare & Medicaid Services
COL	-	Column
DME	-	Durable Medical Equipment
ECR	-	Electronic Cost Report
FR	-	Federal Register
FTE	-	Full Time Equivalent
HCHC	-	Hospice Continuous Home Care
HCRIS	-	Healthcare Cost Report Information System
HFS	-	Health Financial Systems
HGIP	-	Hospice General Inpatient Care
HHA	-	Home Health Agency
HIRC	-	Hospice Inpatient Respite Care
HRHC	-	Hospice Routine Home Care
IRS	-	Internal Revenue Service
KPMG	-	Klynveld, Peat, Marwick, & Goerdeler
LCC	-	Lesser of Reasonable Cost or Customary Charges
LOC	-	Level of Care
LUPA	-	Low Utilization Payment Adjustment
MBI	-	Medicare Beneficiary Identifier
NPR	-	Notice of Program Reimbursement

NPWT	-	Negative Pressure Wound Therapy
OPPS	-	Outpatient Prospective Payment System
PEP	-	Partial Episode Payment
PPS	-	Prospective Payment System
PS&R	-	Provider Statistical and Reimbursement Report (or System)
SNF	-	Skilled Nursing Facility
WKST	-	Worksheet

4703. RECOMMENDED SEQUENCE FOR COMPLETING FORM CMS-1728-19

All providers using Form CMS-1728-19 must adhere to the following sequence of completion. If worksheets are not completed because they are not applicable, do not include blank worksheets in the assembly of the cost report.

Step	Worksheet	Instructions
1	S-2	Read §§4705 through 4706. Complete entire worksheet.
2	S-3	Read §§4707 through 4707.5. Complete entire worksheet.
3	S-4	Read §§4708 through 4708.2. Complete entire worksheet.
4	A	Read §4709. Complete columns 1 through 6, lines 1 through 100.
5	A-6	Read §4710. Complete entire worksheet.
6	A	Read §4709. Complete columns 7 and 8, lines 1 through 100.
7	A-8-1	Read §4712. Complete entire worksheet.
8	A-8	Read §4711. Complete entire worksheet.
9	A	Read §4709. Complete columns 9 and 10, lines 1 through 100.

Step	Worksheet	Instructions
10	B and B-1	Read §4713. Complete all worksheets.
11	C	Read §§4714 through 4714.2. Complete entire worksheet.
12	D	Read §§4715 through 4715.2. Complete lines 1 through 37.
13	D-1	Read §4716. Complete lines 1 through 4.
14	D	Read §4715.2. Complete lines 38 through 41.
15	F	Read §4717. Complete entire worksheet.
16	F-1	Read §4718. Complete entire worksheet.
17	O-1, O-2, O-3, O-4	Read §4720. Complete all worksheets, if applicable.
18	O	Read §4719. Complete entire worksheet, if applicable.
19	O-5	Read §4721. Complete entire worksheet, if applicable.
20	O-6	Read §4722. Complete both worksheets in entirety, if applicable.
21	O-7	Read §4723. Complete entire worksheet, if applicable.
22	O-8	Read §4724. Complete entire worksheet, if applicable.
23	S	Read §§4704 through 4704.3. Complete Part III, then complete Parts I and II.

4704. WORKSHEET S - HOME HEALTH AGENCY COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

Worksheet S consists of the following three parts:

Part I - Cost Report Status
Part II - Certification
Part III - Settlement Summary

4704.1 Part I - Cost Report Status.--This section is to be completed by the HHA and contractor as indicated on the worksheet.

Provider use only.--The provider completes lines 1 through 4.

Line 1.--Indicate if the cost report is electronically prepared by entering "Y" for yes or "N" for no in column 1. If yes, enter the electronic file creation date and time in columns 2 and 3, respectively. If no, line 2 must be completed.

Line 2.--HHA cost reports are required to be prepared in an electronic format. If line 1 is no, indicate this cost report is a manual submission by entering "Y" for yes. This line is only completed by HHAs filing low utilization cost reports in accordance with CMS Pub. 15-2, chapter 1, §110, or HHAs demonstrating financial hardship in accordance with CMS Pub. 15-2, chapter 1, §133. If line 1 is yes, enter "N" for no on this line.

Line 3.--If this is an amended cost report, enter the number of times the cost report has been amended.

Line 4.--Enter an "F" if this is full cost report, an "L" if this is a low Medicare utilization cost report ("L" requires prior contractor approval, see CMS Pub. 15-2, chapter 1, §110), or an "N" if this is a no Medicare utilization cost report.

Contractor use only.--The contractor completes lines 5 through 12.

Line 5.--Enter the Healthcare Cost Report Information System (HCRIS) cost report status code that corresponds to the filing status of the cost report: 1=As submitted; 2=Settled without audit; 3=Settled with audit; 4=Reopened; or 5=Amended.

Line 6.--Enter the date (mm/dd/yyyy) the accepted cost report was received from the HHA.

Line 7.--Enter the 5 position contractor number.

Lines 8 and 9.--If this is an initial cost report, enter "Y" for yes in the box on line 8. If this is a final cost report, enter "Y" for yes in the box on line 9; if neither, enter "N". An initial report is the very first cost report for a particular HHA CMS certification number (CCN). A final cost report is a terminating cost report for a particular HHA CCN.

Line 10.--Enter the Notice of Program Reimbursement (NPR) date (mm/dd/yyyy). The NPR date must be present if the cost report status code is 2, 3, or 4.

Line 11.--Enter the software vendor code of the cost report software used by the contractor to process this HCRIS cost report file; use “4” for HFS or “3” for KPMG.

Line 12.--Complete this line only if the cost report status code on line 5 is “4”. If this is a reopened cost report (response to line 5 cost report status, is “4”), enter the number of times the cost report has been reopened.

4704.2 Part II - Certification.--This certification is read, prepared, and signed by a Chief Financial Officer or administrator of the HHA after the cost report has been completed in its entirety.

Effective for cost reporting periods ending on or after December 31, 2017--(1) A provider that is required to file an electronic cost report may elect to electronically submit the settlement summary and certification statement with an electronic signature of the provider's administrator or chief financial officer. The checkbox for electronic signature and submission immediately follows the certification statement as set forth in 42 CFR 413.24(f)(4)(iv)(B) and must be checked if electronic signature and submission is elected. (2) A provider that is required to file an electronic cost report but does not elect to submit the settlement summary and certification statement with an electronic signature, must submit a hard copy of the settlement summary and certification statement with an original signature of the provider's administrator or chief financial officer as set forth in 42 CFR 413.24(f)(4)(iv)(A) and (B) of this section.

4704.3 Part III - Settlement Summary.--Enter the balance due to or due from the Medicare program. Transfer the amount from Worksheet D, line 40.

4705. WORKSHEET S-2, PART I - IDENTIFICATION DATA

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

Lines 1 and 2.--Enter the street address, post office box (if applicable), the city, state, and ZIP code of the HHA.

Line 3.--Enter the HHA component name, CCN, and certification date in the appropriate columns.

Line 4.--Enter the component name, CCN, and certification date for the distinct part hospice, an HHA-based and separately certified component of the HHA, that 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 5.--Enter the inclusive dates covered by this cost report. Enter in column 1, the cost report beginning date and enter in column 2, the cost report ending date.

Line 6.--Indicate the type of control under which the HHA operates by entering a number from the list below.

1 = Voluntary Nonprofit, Church
2 = Voluntary Nonprofit, Other
3 = Proprietary, Individual
4 = Proprietary, Partnership
5 = Proprietary, Corporation
6 = Private Non-Profit
7 = Governmental and Private Combined
8 = Governmental, Federal
9 = Governmental, State
10 = Governmental, City
11 = Governmental, City-County
12 = Governmental, County
13 = Governmental, Health District

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

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

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

- Private Not-for-Profit.--This is a privately developed HHA governed as a non-profit organization that provides care of the sick in the home. This agency must qualify as a tax exempt organization under title 26 USC 501 of the Internal Revenue Code.

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

Line 7.--Did the HHA qualify as a nominal charge provider (as explained in 42 CFR 409.3)? Enter "Y" for yes or "N" for no.

Line 8.--Did the HHA contract with outside suppliers for physical therapy services? Enter "Y" for yes or "N" for no.

Line 9.--Did the HHA contract with outside suppliers for occupational therapy services? Enter "Y" for yes or "N" for no.

Line 10.--Did the HHA contract with outside suppliers for speech-language pathology services? Enter "Y" for yes or "N" for no.

Line 11.--Are there any costs included on Worksheet A that resulted from transactions with a related organization as defined in CMS Pub. 15-1, chapter 10, or home office as defined in CMS Pub. 15-1, chapter 21? Enter "Y" for yes or "N" for no. If yes, complete Worksheet A-8-1.

Line 12.--Is the HHA legally required to carry malpractice insurance? Enter "Y" for yes and "N" for no.

Line 13.--If line 12 is yes, is the malpractice insurance a claims-made or occurrence policy? Enter "1" for claims made or "2" for occurrence policy. A claims-made insurance policy covers claims first made (reported or filed) during the year the policy is in force for any incidents that occur that year or during any previous period during which the insured was covered under a "claims-made" contract. The occurrence policy covers an incident occurring while the policy is in force regardless of when the claim arising out of that incident is filed.

Line 14.--Enter the amount of malpractice insurance premiums paid in column 1, the total amount of paid losses in column 2, and the total amount of self-insurance in column 3.

Malpractice insurance premiums are money paid by the provider to a commercial insurer to protect the HHA against potential negligence claims made by their patients/clients. Malpractice paid losses is money paid by the HHA to compensate a patient/client for professional negligence. Malpractice self-insurance is money paid by the HHA where the HHA acts as its own insurance company (either as a sole or part-owner) to financially protect itself against professional negligence. Often HHAs will manage their own funds or purchase a policy referred to as captive insurance, which provides insurance coverage they need but could not obtain economically through the mainstream insurance market.

Line 15.--Are malpractice premiums and/or paid losses reported in a cost center other than the A&G cost center? Enter "Y" for yes or "N" for no. If yes, submit a supporting schedule listing the cost centers and amounts contained therein.

Line 16.--Did this HHA receive an allocation of costs from more than one home office (i.e. a corporate home office and a regional home office)? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the number of home offices in column 2.

Line 17.--Is this HHA part of a home office or chain organization as defined in CMS Pub. 15-1, chapter 21, §2150, and claiming home office or chain organization costs? Enter in column 1, "Y" for yes or "N" for no. If column 1 is "Y", enter in column 2 the home office CCN and complete lines 18 through 20. If line 16 is "Y", you received an allocation of cost from more than one home office, subscript lines 18 through 20 and report the information for each home office.

Lines 18.--Enter the name of the home office/chain organization in column 1, the home office contractor name in column 2, and the home office contractor number in column 3.

Line 19.--Enter the home office/chain organization street address in column 1, and the post office box number, if applicable, in column 2.

Line 20.--Enter the home office/chain organization city in column 1, the state in column 2, and the ZIP code in column 3.

4706. WORKSHEET S-2, PART II - REIMBURSEMENT DATA

This worksheet collects organizational, financial and statistical information previously reported on Form CMS-339. Where instructions for this worksheet direct the HHA to submit documentation/information, mail or otherwise transmit the requested documentation to the contractor with submission of the electronic cost report (ECR), the contractor has the right under §§1815(a) and 1833(e) of the Act to request any missing documentation.

For questions that require a yes or no response, enter a "Y" or "N," respectively. When the instructions require documentation, indicate on the documentation the Worksheet S-2, Part II, line number that the documentation supports. Lines 1 through 17 are required to be completed by all HHAs reported on Worksheet S-2, Part I, line 3.

Line 1.--Did the HHA change ownership? Enter "Y" or "N" in column 1. If column 1 is "Y", enter the date the change of ownership occurred in column 2. Also, submit the name and address of the new owner and a copy of the sales agreement with the cost report.

Line 2.--Did the HHA terminate participation in the Medicare program? Entering "Y" or "N" in column 1. If column 1 is "Y", enter the date of termination in column 2, and "V" for voluntary or "I" for involuntary in column 3.

Line 3.--Was the HHA involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the HHA or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? Enter "Y" or "N" in column 1. If column 1 is "Y," submit a list of the individuals, the organizations involved, and a description of the transactions with the cost report.

> NOTE for line 3: A related party transaction occurs when services, facilities, or supplies are furnished to the provider by organizations related to the provider through common ownership or control. (See CMS Pub. 15-1, chapter 10, and 42 CFR 413.17.)

Line 4.--Were the HHA's financial statements prepared by a certified public accountant? Enter "Y" or "N." If column 1 is "Y," enter in column 2 "A" for audited, "C" for compiled, or "R" for reviewed. Submit a complete copy of the financial statements (i.e., the independent public accountant's opinion, the statements themselves, and the footnotes) with the cost report. If the financial statements are not available for submission with the cost report, enter the date they will be available in column 3.

If column 1 is "N," submit a copy of the internally prepared financial statements, and written statements of significant accounting policy and procedure changes affecting Medicare reimbursement that occurred during the cost reporting period. You may submit the changed accounting or administrative procedures manual in lieu of written statements.

Line 5.--Do the total expenses and total revenues reported on the cost report differ from those on the filed financial statements? Enter "Y" or "N." If "Y," a reconciliation must be submitted with the cost report.

Line 6.--Are you are seeking reimbursement for bad debts resulting from Medicare deductible and/or coinsurance amounts that are uncollectible from Medicare beneficiaries? (See 42 CFR 413.89(e) and CMS Pub. 15-1, chapter 3, §§306 - 324, for the criteria for an allowable bad debt.) Enter "Y" or "N". If "Y," submit a completed Exhibit 1 to support the bad debt amount claimed.

Exhibit 1, Listing of Medicare Bad Debts and Appropriate Supporting Data, displayed at the end of this section requires the following documentation:

Columns 1, 2, 3, 4, and 5 - Patient Last Name, Patient First Name, Medicare Beneficiary Identifier (MBI) Number, and Dates of Service (From - To).--The documentation required for these columns is derived from the beneficiary's bill. Furnish the patient's name, MBI number, and dates of service that correlate to the claimed bad debt. (See CMS Pub. 15-1, chapter 3, §314, and 42 CFR 413.89.)

Columns 6 and 7 - Eligible Medicaid Beneficiary or Beneficiary Deemed Indigent.--If the beneficiary included in column 1 is eligible for Medicaid, enter the Medicaid beneficiary identification number in column 6. If the beneficiary is not eligible for Medicaid but has been deemed indigent, enter "yes" in column 7. See the criteria in CMS Pub. 15-1, chapter 3, §§312 and 322, and 42 CFR 413.89 for guidance on the billing requirements for indigent and Medicaid beneficiaries.

Column 8 - Medicare Remittance Advice Dates.--Enter the Medicare remittance advice date that correlates with the beneficiary name, MBI number, and dates of service shown in columns 1, 2, 3, 4, and 5, of this exhibit.

Column 9 - Medicaid Remittance Advice Dates (if applicable).--Enter the crossover Medicaid remittance advice date that correlates with the Medicare beneficiary name, MBI number, and dates of service shown in columns 1, 2, 3, 4, and 5, of this exhibit.

Column 10 - Beneficiary Responsibility.--Enter the amount the beneficiary is liable to pay. If the beneficiary is Medicaid eligible or deemed indigent by the provider, enter the dollar amount the beneficiary is deemed responsible to pay. For beneficiaries deemed indigent the application and documentation to support the indigent determination will be required to support the bad debts. For Medicaid eligible crossover claims, if there is a state cost sharing responsibility enter the amount. If the Medicaid eligible crossover claim is for a QMB, they are exempt from any Medicare cost sharing requirement; therefore, do not enter an amount but enter "QMB."

Column 11 - Date First Bill Sent to Beneficiary.--Enter the date that the first bill was sent to the beneficiary.

Column 12 - Accounts Receivable Write-Off Date.--Enter the date the beneficiary's liability was written off of the accounts receivable in the provider's financial accounting system. This should be evidenced by corresponding journal entries, as well as entries in the beneficiary's account history. However, this may not be the date the account was recorded as a Medicare bad debt. A bad debt cannot be claimed for Medicare purposes until it has been written off in the provider's financial accounting system and all collection efforts have ceased. If an account was sent to a collection agency, complete column 13.

Column 13 - Account Sent to Collection Agency.--Enter a response of "Y" for yes or "N" for no to indicate whether an account was sent to a collection agency.

Column 14 - Date Account Returned from Collection Agency.--Enter the date the account was returned to the provider from the collection agency. This is the date that the collection agency ceased collection effort on an account that had been referred to them. A bad debt must not be written off prior to the cessation of all collection efforts, internal and external.

Column 15 - Date Collection Effort Ceased.--Enter the date all collection effort ceased, both internal and external, including Medicaid.

Column 16 - Medicare Write-Off Date.--Enter the date the deductible and coinsurance amounts were written off as a Medicare bad debt. In order to be considered "written off" for Medicare purposes, the amount must be written off as a bad debt in the provider's own accounting system, all collection effort against the patient or other third parties (internal and external) must have ceased, and a valid Medicaid RA must have been received from the State for Medicaid beneficiaries.

Column 17 - Recoveries.--Enter the amount of recoveries for amounts previously written off as an allowable Medicare bad debt (see CMS Pub. 15-1, chapter 3, §316).

Columns 18 and 19 - Deductibles and Coinsurance.--Enter the beneficiary's deductible and coinsurance amounts, reflected on the Medicare remittance advice, that relate to covered services.

Column 20 - Current Year Payments.--Enter any payments received from the beneficiary, the beneficiary's estate, third party insurance, etc. that were applied towards the beneficiary's deductible and coinsurance liability.

Column 21 - Payment Type.--If column 20 contains an amount, identify the source of the payment in this column. Enter a general description of beneficiary, estate, third party, etc.

Column 22 - Allowable Medicare Bad Debts.--Enter the bad debt amount for each claim. This amount must be less than or equal to the amounts report in columns 18 and 19, less any payments received from the beneficiary. This total amount reported in this column must agree with the bad debts claimed on Worksheet D, line 27.

Column 23 - Comments.--This column is for informational purposes. Enter any comments or additional information as needed.

Line 7.--If line 6 is "Y", did the bad debt collection policy change during the cost reporting period? Enter "Y" or "N". If "Y", submit a copy of the revised bad debt policy.

Line 8.--If line 6 is "Y", were patient coinsurance amounts waived? Enter "Y" or "N" in column 1. If column 1 is "Y", ensure the coinsurance amounts are not included on the bad debt listing (Exhibit 1) submitted with the cost report.

Line 9.--Was this cost report prepared using the Provider Statistical & Reimbursement (PS&R) Report only. Enter "Y" or "N" in column 1. If column 1 is "Y", enter the paid through date of the PS&R in column 2. Also, submit a crosswalk between revenue codes and charges found on the PS&R to the cost center groupings on the cost report. This crosswalk will reflect a cost center to revenue code match only.

Line 10.--Was this cost report prepared using the PS&R for totals and HHA records for allocation? Enter "Y" or "N" in column 1. If column 1 is "Y" enter the paid-through date of the PS&R used to prepare this cost report in column 2. Also, submit a detailed crosswalk between revenue codes, departments, and charges on the PS&R to the cost center groupings on the cost report. This crosswalk must show dollars by cost center and include the revenue codes allocated to each cost center. The total revenue on the cost report must match the total charges on the PS&R (as appropriately adjusted for unpaid claims, etc.) to use this method. Supporting work papers must accompany this crosswalk to provide sufficient documentation as to the accuracy of the provider records. If the contractor does not find the documentation sufficient, the PS&R will be used in its entirety.

Line 11.--If you entered "Y" on either line 9 or 10, indicate whether adjustments were made to the PS&R data for additional claims that have been billed but not included on the PS&R used to file this cost report. Enter "Y" or "N" in column 1. If column 1 is "Y", include a schedule supporting any claims not included on the PS&R. This schedule should include totals consistent with the breakdowns on the PS&R, and should reflect claims that are unprocessed or unpaid as of the cut-off date of the PS&R used to file the cost report.

Line 12.--If you entered "Y" on either line 9 or 10, column 1, indicate whether adjustments were made to the PS&R data for corrections of other PS&R information. Enter "Y" or "N" in column 1. If column 1 is "Y", submit a detailed explanation and documentation to provide an audit trail from the PS&R to the cost report.

Line 13.--If you entered "Y" on either line 9 or 10, column 1, indicate whether other adjustments were made to the PS&R data. Enter "Y" or "N" in column 1. If column 1 is "Y", include a description of the other adjustments and documentation to provide an audit trail from the PS&R to the cost report.

Line 14.--Indicate whether the cost report was prepared using HHA records only. Enter "Y" or "N" in column 1. If column 1 is "Y", submit detailed documentation of the system used to support the data reported on the cost report. If detail documentation was previously supplied, submit only necessary updated documentation with the cost report.

The minimum requirements for detailed documentation of the system used to submit the data reported are:

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

NOTE for line 14: Additional information may be submitted, such as narrative documentation, internal flow charts, or outside vendor informational material, to further describe and validate the reliability of the system.

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

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

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

EXHIBIT 1
LISTING OF MEDICARE BAD DEBTS AND APPROPRIATE SUPPORTING DATA

HHA Name: _____ Prepared By: _____
HHA CCN: _____ Date Prepared: _____
FYE: _____

Patient Last Name	Patient First Name	MBI No.	Dates of Service		Eligible Medicaid Beneficiary Medicaid #	Beneficiary Deemed Indigent (Not Medicaid Eligible) Yes or No	Medicare Remittance Advice Dates	Medicaid Remittance Advice Dates (If Applicable)	Beneficiary Responsibility $ (Enter QMB if Medicaid QMB Beneficiary)	Date First Bill Sent to Beneficiary	Internal Accounts Receivable (A/R) Write-Off Date)	Account Sent to Collection Agency
			From	To								
1	2	3	4	5	6	7	8	9	10	11	12	13

Date Account Returned from Collection Agency (If Applicable)	Date Collection Efforts Ceased (Internal and External, Including Medicaid RA)	Medicare "Write-Off Date"	Recoveries Only	Medicare Deductible*	Medicare Coinsurance*	Current Year Payments (Prior to Account Write-Off)	Payment Type (Patient, Third Party Insurance, etc.)	Allowable Bad Debts (As Reported on Cost Report)	Comments
14	15	16	17	18	19	20	21	22	23

*These amounts must not be claimed unless the HHA or HHA-based entity bills for these services with the intention of payment. See instructions for columns 6 and 7 - Medicaid or Indigent Beneficiary, for possible exception.

4707. WORKSHEET S-3 - STATISTICAL DATA

Worksheet S-3 consists of the following five parts:

Part I - Visits Data
Part II - Employment Data (Full Time Equivalent)
Part II - Core Based Statistical Area (CBSA) Data
Part II - PPS Activity Data
Part II - Direct Care Expenditures

In accordance with 42 CFR 413.20, 42 CFR 413.24, you are required to maintain statistical records for proper determination of costs payable under titles XVIII and XIX. The statistics required on Part I of this worksheet pertain to an HHA. The data to be maintained, depending on the services provided by the HHA, includes the number of program visits, total number of HHA visits, number of program home health aide hours, total HHA home health aide hours, program patient census count, total patient census count, program patient unduplicated census count, and total patient unduplicated census count. Part II of this worksheet collects required FTE data by employee staff, contracted staff, and total staff. Part III of this worksheet identifies the total number of CBSAs where Medicare services were provided.

HHA Visits.--A visit is an episode of personal contact with the patient by staff of the HHA, or others under arrangements with the HHA, for the purpose of providing a covered home health service as described in 42 CFR 409.45 (b) through (g). Medicare type visits generally fall under the definition of Medicare visits as described in 42 CFR 409.48. In counting Medicare type visits, it is critical that non-Medicare visits are of the same type as those that would be covered by Medicare. This ensures that costs of services are comparable across insurers and that costs are apportioned appropriately between Medicare and non-Medicare. A visit is initiated with the delivery of covered home health services and ends at the conclusion of delivery of covered home health services. In those circumstances in which all reasonable and necessary home health services cannot be provided in the course of a single visit, HHA staff or others providing services under arrangements with the HHA may remain at the patient's home between visits (e.g., to provide non-covered services). However, if all covered services could be provided in the course of one visit, only one visit may be covered. (See 42 CFR 409.48(c)(4)).

Patient Census.--Each patient is counted once for each type of service. For example, if a patient receives multiple Medicare covered skilled nursing visits from a registered nurse and multiple Medicare covered medical social service visits, he or she is counted only once in column 2 for the corresponding service. Another example is if a patient receives both covered services and non-covered services, he or she is counted once as title XVIII (for covered services), once as other (for non-covered services), and only once as total.

Unduplicated Census Count.--Each patient is counted only once, no matter how many HHA services they receive during the cost reporting period. A patient who receives HHA services throughout the year should be counted and reported no more than one time. The unduplicated census count answers the question: How many patients did the HHA serve during this cost reporting period?

Use lines 1 through 10 to identify the number of visits and corresponding patient census count. The patient census count in columns 2, 4, 6, and 8 includes each individual who received each type of service. Include each individual patient only once for each type of service. For example, if a patient receives multiple Medicare covered skilled nursing visits from a registered nurse and multiple Medicare covered medical social service visits, he or she is counted only once in column 2 for the corresponding service. The total of lines 1 through 9 for columns 2 and 4 and the total of lines 1 through 10 for columns 6 and 8 may not equal line 13, unduplicated census count, since many patients receive more than one type of service. Beneficiaries who experience multiple spells of illnesses (multiple visits, multiple episodes, and/or multiple discharges and admissions) within a cost reporting period must be counted only once in the unduplicated census count.

4707.1 Part I - Visits Data.--

Columns 1 and 2.--Enter data pertaining to title XVIII-Medicare patients only. Enter in column 1 all Medicare visits rendered during the entire cost reporting period. See CMS Pub. 100-02, chapter 7, §70.2, for visit count determination. For each line, enter in column 2 the patient census count applicable to the Medicare visits reported in column 1.

Columns 3 and 4.--Enter data pertaining to title XIX-Medicaid patients only. Enter in column 3 all Medicaid visits rendered during the entire cost reporting period. For each line, enter in column 4 the patient census count applicable to the Medicaid visits reported in column 3.

Columns 5 and 6.--Enter data pertaining to Medicare Managed Care, Medicaid Managed Care, and all other patients. Do not include data reported in columns 1 through 4. Enter in column 5 all visits from patients not covered by Medicare (reported in column 1) or Medicaid (reported in column 3). For each line, enter in column 6 the patient census count applicable to all other patient visits reported in column 5.

Columns 7 and 8.--Enter total HHA visits and patient census count. Enter in column 7, all visits rendered for all patients during the cost reporting period for each discipline. For each line, enter in column 8, the patient census count for all patients during the cost reporting period. The sum of columns 1, 3, and 5 must equal column 7. The sum of columns 2, 4, and 6 may not equal column 8. For example if a patient receives both Medicare covered services (columns 1 and 2) and Medicare non-covered services (columns 5 and 6), count the patient once in column 2 (for covered services), once in column 6 (for non-covered services), and once in column 8, total.

Lines 1 through 9.--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 10.--This line may not be used for columns 1 through 4. Enter in columns 5 and 7 the total of all other visits provided by the HHA. Enter in columns 6 and 8 the patient census count applicable to the other visits furnished by the HHA.

Line 11.--Enter the sum of lines 1 through 9 for each of columns 1 through 4. Enter the sum of lines 1 through 10 for each of columns 5 through 8.

Line 12.--Enter the number of hours applicable to home health aide services.

Line 13.--Enter the unduplicated count of all patients receiving home visits or other care provided by employees of the HHA or under contractual arrangement in the appropriate column for the entire cost reporting period. 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 patient census counts. For purposes of calculating the unduplicated census count, if a beneficiary has received health care by more than one HHA, you must prorate the unduplicated census count based on the ratio of visits provided by this HHA to the total visits furnished to the beneficiary by all HHAs so as to not exceed a total of (1). For example, if an HHA furnishes 100 visits to an individual beneficiary in Maryland during the cost reporting period and the same individual received a total of 400 visits (the other 300 visits were furnished in Florida 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. An HHA must 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.

4707.2 Part II - Employment Data (Full Time Equivalent).--

Line 14.--Enter the number of hours in a normal work week (i.e. 40 hours per week or 35 hours per week).

Lines 15 through 34.--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 15 through 34. Enter any additional categories needed on line 34 and its subscripts.

Report in column 1 the full time equivalent (FTE) employees on the HHA's payroll. These are staff for which an Internal Revenue Service (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: For each category listed on lines 15 through 34, add all hours that employees were paid 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. For each category listed on lines 15 through 34, add all hours that 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.

4707.3 Part III - Core Based Statistical Area (CBSA) Data.--

Line 35.--Enter the total number of CBSAs where Medicare covered services were provided during this cost reporting period. Each five-character CBSA code identifies the geographic area where Medicare covered services are furnished. Obtain these codes from your contractor.

Line 36.--List all CBSA codes where Medicare covered home health services were provided during the cost reporting period. Line 36 contains the first code. Enter one CBSA code on each line. If additional lines are needed, subscript line 36 beginning with lines 36.01, 36.02, etc., as necessary, entering one CBSA code on each subscripted line. Obtain these codes from your contractor.

4707.4 Part IV - PPS Activity Data.--

The statistics required on this worksheet pertain to home health services reimbursed under the HHA PPS in accordance with §1895 of the Act. Depending on the services provided by the HHA the data to be maintained for each episode/period of care payment category for each covered discipline include aggregate program visits, corresponding aggregate program charges, total visits, total charges, total episodes/period and total outlier episodes/periods, and total non-routine medical supply charges.

All data captured in Part IV of this worksheet is associated with episodes/periods of care that end during the current cost reporting period for payment purposes. Similarly, when an episode/period of care begins in one cost reporting period and ends in the subsequent cost reporting period, all data required in Part IV of this worksheet associated with that episode/period will appear in the cost reporting period on the PS&R in which the episode/period of care ended.

HHA Visits. See the second paragraph of §4707 for the definition of an HHA visit.

Episode/Period of Care. Home health services under a plan of care are paid based on a 60-day episode of care (beginning on or before December 31, 2019) or a 30-day period of care (beginning on or after January 1, 2020) as required by section 1895(b)(2)(B) of the Act, as amended by section 51001(a)(1) of the Bipartisan Budget Act (BBA) of 2018.

Episode of Care: Effective prior to January 1, 2020, under home health PPS, the 60-day episode is the basic unit of payment where the episode payment is specific to one individual beneficiary. The duration of a full-length episode will be 60 days. An episode begins with the start of care date on or prior to December 31, 2019 and must end by the 60th day from the start of care date. Beneficiaries are covered for an unlimited number of non-overlapping episodes provided that the start of care date is prior to January 1, 2020. **Note**: The latest a full 60-day episode that spans the crossover date effectuating the change to period of care on January 1, 2020 will end on February 28, 2020.

Period of Care: Effective beginning on or after January 1, 2020, under home health PPS, the 30-day period of care is the basic unit of payment where the period payment is specific to one individual beneficiary. A period begins with the start of care date on or after January 1, 2020 and must end by the 30th day from the start of care. Beneficiaries are covered for an unlimited number of non-overlapping periods.

Less than a full Episode/Period of Care.

For episodes of care beginning before January 1, 2020, if an HHA provides four or fewer visits in a 60-day episode, the result is a low utilization payment adjustment (LUPA). In this instance the HHA will be reimbursed based on a standardized per visit payment.

Additionally, 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.

For periods of care beginning on or after January 1, 2020, if an HHA provides fewer than the threshold of visits specified for the period's home health resources group, they will be paid a standardized per visit payment called a LUPA.

Additionally, a period may end before the 30th 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.

Use lines 1 through 12 to identify the number of visits and the corresponding visit charges for each discipline for each episode/period payment category. Lines 13 and 15 identify the total number of visits and the total corresponding charges, respectively, for each episode/period payment category. Line 16 identifies the total number of episodes/periods completed for each episode/period payment category. Line 17 identifies the total number of outlier episodes/periods completed for each episode/period payment category. Outlier episodes/periods do not apply to: 1) Full Episodes/Periods without Outliers, and 2) LUPA Episodes/Periods. Line 18 identifies the total non-routine medical supply charges incurred for each episode/period payment category. The statistics and data required on this worksheet are obtained from the PS&R report.

Columns 1 through 4.--Enter in the appropriate columns 1 through 4, lines 1 through 12, the number of aggregate program visits furnished in each episode/period of care payment category for each covered discipline and the corresponding aggregate program visit charges imposed for each covered discipline for each episode/period of care payment category. The visit counts and corresponding charge data are mutually exclusive for all episode/period of care payment categories.

Line 13.--Enter in columns 1 through 4 for each episode/period of care payment category, respectively, the sum total of visit from lines 1, 3, 5, 7, 9, and 11.

Line 14.--Enter in columns 1 through 4 for each episode/period of care payment category, respectively, the sum total of other charges for all other unspecified services reimbursed under PPS.

Line 15.--Enter in columns 1 through 4 for each episode/period of care payment category, respectively, the sum total of charges for services from lines 2, 4, 6, 8, 10, 12, and 14.

NOTE for lines 16 and 17: The standard episodes/periods entered on line 16 and outlier episodes/periods entered on line 17 are mutually exclusive.

Line 16.--Enter in columns 1, 3, and 4, for each episode/period of care payment category identified, respectively, the total number of standard episodes/periods of care rendered and concluded in the HHA's fiscal year.

Line 17.--Enter in columns 2 and 4 for each episode/period of care payment category identified, respectively, the total number of outlier episodes/periods of care rendered and concluded in the HHA's fiscal year. Outlier episodes/periods do not apply to columns 1 and 3 (Full Episodes/Periods without Outliers and LUPA Episodes/Periods, respectively).

Line 18.--Enter in columns 1 through 4 for each episode/period of care payment category, respectively, the total non-routine medical supply charges for services rendered and concluded in the provider's fiscal year.

Column 5.--Enter on lines 1 through 18, respectively, the sum total of amounts from columns 1 through 4.

4707.5 Part V - Direct Care Expenditures.--This part provides for the collection of HHA direct care expenditures. Complete this form for employees who are full-time and part-time, directly hired, and acquired under contract.

Column 1.--Enter the total of paid wages and salaries for the specified category of HHA employees including overtime, vacation, holiday, sick, lunch, and other paid-time-off, severance, and bonuses on lines 1 through 4 and 6 through 14.

Enter the amount paid (include only those costs attributable to services rendered in the HHA), rounded to the nearest dollar, for contracted direct patient care services on lines 15 through 18 and 20 through 28.

Column 2.--Enter on lines 1 through 4 and 6 through 14 the amount of fringe benefits.

Column 3.--Enter on each line the result of column 1 plus column 2.

Column 4.--Enter on each line the number of paid hours corresponding to the amount reported in column 3.

Column 5.--Enter on each line the average hourly wage resulting from dividing column 3 by column 4.

4708. WORKSHEET S-4 - HHA-BASED HOSPICE STATISTICAL 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(f) 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 an HHA-based hospice. Complete a separate Worksheet S-4 for each HHA-based hospice.

4708.1 Part I - Enrollment Days.--

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

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

Hospice Routine Home Care (HRHC) Day.--An HRHC day is a day when the hospice patient is at home and not receiving HRHC.

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

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

Lines 1 through 4.--Enter the enrollment days applicable to each level of care (LOC) in columns 1 through 3. Include dually eligible (Medicare/Medicaid) beneficiaries in column 1. Enrollment days are unduplicated days of care received by a hospice patient. Report a day for each day a hospice patient received one of four levels of care -- HCHC, HRHC, HIRC, or HGIP. When a patient was transferred from one LOC to another, count the day of transfer as one day of care at the LOC billed. Report an HIRC day on line 3 only when the hospice provided or arranged to provide the inpatient respite care.

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

4708.2 Part II - Contracted Statistical Data.--

This section collects unduplicated day's data for inpatient services at a contracted facility. The days reported in Part II are a subset of the days reported in Part I.

Lines 6 and 7.--Enter the contracted inpatient service enrollment days applicable to each LOC in columns 1 through 3. Include dually eligible (Medicare/Medicaid) beneficiaries in column 1. Enrollment days are unduplicated days of care received by a hospice patient. Report a day for each day a hospice patient received HIRC or HGIP care at a contracted facility. When a patient was transferred from one LOC to another, count the day of transfer as one day of care at the LOC billed. Enter the total unduplicated days by LOC (sum of columns 1 through 3) in column 4.

4709. WORKSHEET A - RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

Worksheet A provides for recording the trial balance of expense accounts from the HHA accounting books and records. The worksheet also provides for the necessary reclassifications and adjustments to certain accounts prior to the cost finding calculations. Also include on Worksheet A all expenses incurred for only those visits completed in the current cost reporting period when the episode of care overlaps the cost report year end. Enter directly on Worksheet A the total expenses for Salaries (column 1), Employee Benefits (column 2), Transportation (column 3), Contracted/Purchased Services (column 4), and Other Costs (column 5) in the appropriate cost center.

This worksheet lists cost centers in a manner that facilitates the transfer of the cost center expenses to the cost finding worksheets. Each of the cost centers listed does not apply to all providers using these forms. Therefore, use those cost centers applicable to your type of HHA.

Under certain conditions, a provider may elect to use different cost centers for allocation purposes. These conditions are stated in CMS Pub. 15-1, chapter 23, §2313.

Standard (i.e., preprinted) CMS line numbers and cost center descriptions cannot be changed. If a provider needs to use additional or different cost center descriptions, it may do so by adding additional lines to the cost report. Added cost centers must be appropriately coded. Identify the added line as a numeric subscript of the immediately preceding line, e.g., if two lines are added between lines 2 and 3, identify them as lines 2.01 and 2.02. If additional lines are added for general services cost centers, corresponding columns must be added to Worksheets B and B-1 for cost finding.

NOTE: Cost centers appearing on Worksheet A, lines 16 through 24, may not be subscripted beyond those which are preprinted. (See CMS Pub. 15-1, chapter 23, §2313.2c.)

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

Cost center coding is a methodology for standardizing the meaning of cost center labels as used by health care providers on the Medicare cost reports. The Form CMS-1728-19 provides for preprinted cost center descriptions on Worksheet A. In addition, a space is provided for a cost center code. The preprinted cost center labels are automatically coded by CMS approved cost reporting software. These cost center descriptions are hereafter referred to as the standard cost centers. An additional cost center with general meaning has been identified in the following sections: General Service Cost Centers, HHA Reimbursable Services, HHA Nonreimbursable Services and Special Purpose Cost Centers. These additional cost centers must contain a description if used, and will hereafter be referred to as nonstandard label cost centers to provide for situations where no match in meaning to the standard cost centers can be found. Refer to Worksheet A, lines 9, 30, 50, and 58.

The use of this coding methodology allows providers to continue to use labels for cost centers that have meaning within the individual institution. The four digit cost center codes that are associated with each provider label in their electronic file provide standardized meaning for data analysis. The preparer is required to compare any added or changed label to the descriptions offered on the standard or nonstandard cost center tables. A description of cost center coding and the table of cost center codes are in §4790, Table 5, of the electronic reporting specifications.

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

Column 1.--Salaries are the gross salaries paid to employees before taxes and other items are withheld. Salaries include deferred compensation, overtime, incentive pay, and bonuses. Enter salaries from the HHA accounting books and records.

Column 2.--Enter the costs of employee benefits from the HHA accounting books and records.

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

Column 4.--Enter the cost of contracted purchased services.

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

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

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

Worksheet A-6 reflects the reclassifications affecting the cost center expenses. This worksheet need not be completed by all providers, but is completed only to the extent reclassifications are needed and appropriate in the particular provider's circumstances. Show reductions to expenses in parentheses ( ).

The net total of the entries in column 7 must equal zero on line 100.

Column 8.--Adjust the amounts entered in column 6 by the amounts entered in column 7 (increase or decrease) and extend the net balances to column 8. The total of column 8 must equal the total of column 6 on line 100.

Column 9.--Enter on the appropriate lines the amounts of any adjustments to expenses. Enter on the appropriate lines the amounts of any adjustments to expenses indicated on Worksheet A-8, column 2. The amount on Worksheet A, column 9, line 100, must equal the amount on Worksheet A-8, column 2, line 50.

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

Transfer the amounts in column 10, lines 1 through 58, to the corresponding lines on Worksheet B, column 0.

Line Descriptions

General Service Cost Centers

Lines 1 and 2 - Capital Related - Buildings & Fixtures and Capital Related - Movable Equipment.--Capital related buildings and fixtures and capital related moveable equipment costs include depreciation, leases and rentals for the use of facilities and/or equipment, interest incurred in acquiring land or depreciable assets used for patient care, insurance on depreciable assets used for patient care, and taxes on land or depreciable assets used for patient care.

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

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

Line 5 - Remote Patient Monitoring.--Enter allowable administrative costs related to remote patient monitoring as described in 42 CFR 409.46(e). Remote patient monitoring is defined as the collection of physiologic data (for example, ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient or caregiver or both to the home health agency. If remote patient monitoring is used by the home health agency to augment the care planning process, the costs of the equipment, set-up, and service related to this system are allowable only as administrative costs. Visits to a beneficiary's home for the sole purpose of supplying, connecting, or training the patient on the remote patient monitoring equipment, without the provision of a skilled service are not separately billable. Do not report telehealth services on this line.

Line 6 - Administrative and General.--Enter all A&G costs, including services that are allowable as administrative costs as described in 42 CFR 409.46 (a) through (d). A&G costs are general service costs that benefit the entire HHA that are not included on lines 1 through 5. Examples include fiscal services, legal services, accounting, data processing, taxes, and malpractice costs. If the option to componentize A&G costs into more than one cost center is elected, eliminate line 6. Componentized A&G lines must begin with subscripted line 6.01 and continue in sequential order (e.g., 6.01 A&G shared costs). See §4713 for additional information on componentized A&G costs.

Line 7 - Nursing Administration.--Enter the cost of overall management and direction of the nursing services. Do not include the cost of direct nursing services assigned on lines 16 through 30, 39 through 50, or 57 and 58.

Line 8 - Medical Records.--Enter the direct cost of medical records including the medical record library. Costs associated with a general library and/or medical library are reported in administrative and general and must not be included in this cost center.

Line 9.--Use this line to identify expenses for other general service costs not identified on lines 1 through 8. Provide a description for the amount reported on this line. See Table 5 in §4790 for proper cost center coding for this line.

Lines 10 through 15.--Reserved for future use.

HHA Reimbursable Services

Line 16 - Skilled Nursing Care - Registered Nurse.--This cost center includes skilled nursing care which is a service that must be provided by or under the supervision of a registered nurse for the purpose of assessing a beneficiary's health needs, determining if the HHA can meet those health needs, and formulating a plan of care for the beneficiary are allowable administrative costs.

Line 17 - Skilled Nursing Care - Licensed Practical Nurse.--This cost center includes the costs of nursing care furnished by licensed practical nurses.

Line 18 - Physical Therapy.--This cost center includes the costs of physical therapy services provided by a qualified physical therapist as prescribed by a physician. These services meet the individual's medical needs, promote recovery, and ensure medical safety for the purpose of rehabilitation.

Line 19 - Physical Therapy Assistant.--This cost center includes the costs of physical therapy assistant services performed under the direct supervision of a qualified physical therapist as prescribed by a physician. These services are planned, delegated, and supervised by the physical therapist. The physical therapy assistant also provides support to the physical therapist as they assist in preparing clinical notes and progress reports, and participate in educating the patient and family.

Line 20 - Occupational Therapy.--This cost center includes the costs of occupational therapy services provided by a qualified occupational therapist as prescribed by a physician. These services meet the individual's medical needs, promote recovery, and ensure medical safety for the purpose of rehabilitation.

Line 21 - Certified Occupational Therapy Assistant.--This cost center includes the costs of certified occupational therapy assistant services performed under the direct supervision of a qualified occupational therapist as prescribed by a physician. These services are planned, delegated, and supervised by the occupational therapist. The certified occupational therapy assistant also provides support to the occupational therapist as they assist in preparing clinical notes and progress reports, and participate in educating the patient and family.

Line 22 - Speech-Language Pathology.--This cost center includes the costs of physician-prescribed services provided by or under the direction of a qualified speech-language pathologist to those with functionally impaired communications skills. This includes the evaluation and management of any existing disorders of the communication process centering entirely, or in part, on the reception and production of speech and language related to organic and/or nonorganic factors. Speech-language pathology services may be provided for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

Line 23 - Medical Social Services.--Enter the cost of medical social services. These services include (1) assessment of the social and emotional factors related to the individual's illness, need for care, response to treatment, and adjustment to care furnished by the HHA; (2) casework services to assist in resolving social or emotional problems that may have an adverse effect on the beneficiary's ability to respond to treatment; and, (3) assessment of the relationship of the individual's medical and nursing requirements to his or her home situation, financial resources, and the community resources available upon discharge from HHA care.

Line 24 - Home Health Aide.--Enter the cost of home health aide services. The primary function of a home health aide is the personal care of a patient. The services of a home health aide are given under the supervision of a registered professional nurse and, if appropriate, a physical therapist, speech-language pathologist, or occupational therapist. The assignment of a home health aide to a case must be made in accordance with a written plan of treatment, established by a physician, indicating the patient's need for personal care services. The specific personal care services to be provided by the home health aide must be determined by a registered professional nurse and not by the home health aide.

Line 25 - Medical Supplies.--The cost of medical supplies reported in this cost center are those costs that are directly identifiable supplies furnished to individual patients and for which a separate charge is made. These supplies are generally specified in the patient's plan of treatment and furnished under the specific direction of the patient's physician.

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

Line 26 - Drugs.--Enter the cost incurred for pneumococcal, influenza, and hepatitis B vaccines, and osteoporosis drugs. Do not include the cost of administering vaccines and drugs on this line. A visit by an HHA nurse for the sole purpose of administering a vaccine is not covered as an HHA visit under the home health benefit, even though the patient may be an eligible home health beneficiary receiving services under a home health plan of treatment. Section 1862(a)(1)(B) of the Act excludes Medicare coverage of vaccines and their administration other than the Part B coverage contained in §1861(s)(10).

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

Line 27 - Cost of Administering Vaccines.--Enter the cost of administering pneumococcal, influenza, and hepatitis B vaccines, and osteoporosis drugs.

Attach a schedule detailing the methodology employed to develop the administration of these vaccines. These vaccines are reimbursable under Part B only. The cost of travel is not permissible as a cost of administering vaccines, nor is the travel cost includable in the A&G cost center. The travel cost is nonreimbursable.

The cost of administering pneumococcal, influenza, and hepatitis B vaccines is reimbursed under the outpatient prospective payment system (OPPS). The cost of administering osteoporosis drugs is reimbursed under the home health benefit.

Line 28 - Durable Medical Equipment/Oxygen.--Enter the direct expenses incurred in renting or selling durable medical equipment (DME) items to the patient for the purpose of carrying out the plan of treatment. Also, include all the direct expenses incurred by you in requisitioning and issuing the DME to patients.

Line 29 - Disposable Devices.--Enter the cost of disposable devices, i.e., negative pressure wound therapy (NPWT) devices.

Line 30.--Use this line and subscripts of this line to identify expenses for other reimbursable services not identified on lines 16 through 29. Provide a description for each amount reported on this line and its subscripts. See Table 5 in §4790 for proper cost center coding for this line.

Lines 31 through 38.--Reserved for future use.

HHA Nonreimbursable Services

Line 39.--Enter the cost of home dialysis aide services furnished in connection with a home dialysis program.

Line 40.--For respiratory therapy services enter the cost incurred for the assessment, diagnostic evaluation, treatment, management, and monitoring of patients with deficiencies or abnormalities of cardiopulmonary function.

Lines 41 through 49.--Identify additional nonreimbursable services commonly provided by HHAs.

Line 41 - Private Duty Nursing.--Enter the costs of private duty nurses, who may be licensed as RNs or LPNs/LVNs (Licensed Practical Nurses) that provide private duty care work one-on-one with individual beneficiaries.

Line 42 - Clinic.--Enter the nonreimbursable clinic costs. A clinic is a facility that is primarily focused on the care of outpatients.

Line 43 - Health Promotion Activities.--Enter the costs of health promotion and disease prevention programs focus on keeping people healthy.

Line 44 - Day Care Program.--Adult day care programs provide frail seniors and persons with Alzheimer's with supervision and care in a structured setting during daytime hours allowing their primary caregivers to work or take a break from their caregiving responsibilities. Medicare does not cover adult day care programs.

Line 45 - Home Delivered Meals Program.--Home health coverage does not include home delivered meals or personal care as part of it coverage. Enter the costs of the HHA’s home delivered meals program on this line.

Line 46 - Homemaker Service.--Services such as shopping, cleaning, laundry, etc. are considered homemaker services and they are not reimbursed by Medicare. Enter the costs of homemaker services on this line.

Line 47 - Telehealth.--Enter the direct costs associated with telehealth. Remote patient monitoring is not a telehealth service. Telehealth services are subject to limitations, namely that the beneficiary must be located in a health professional shortage area (HPSA) or rural area, and that the beneficiary must be physically present at a specific site of service. Telehealth services are outside the scope of the Medicare home health benefit and home health PPS. Section 1895(e) does not provide coverage or payment for Medicare home health services provided via a telecommunications system. The law does not permit the substitution or use of a telecommunications system to provide any covered home health services paid under the home health PPS, or any covered home health service paid outside of the home health PPS. There is nothing to preclude an HHA from adopting telehealth or other technologies that they believe promote efficiencies, but those technologies will not be specifically recognized or reimbursed by Medicare under the home health benefit.

Line 48 - Advertising.--Enter the costs associated with nonallowable community education, business development, marketing and advertising. (See CMS Pub. 15-1, chapter 21, §2136.)

Line 49 - Fundraising.--Enter the costs associated with nonallowable fundraising. (See CMS Pub. 15-1, chapter 21, §2136.)

Line 50.--Use this line and subscripts of this line to identify expenses for other nonreimbursable services not identified on lines 39 through 49. Provide a description for each amount reported on this line and its subscripts. See Table 5 in §4790 for proper cost center coding for this line.

Lines 51 through 56.--Reserved for future use.

Special Purpose Cost Centers

Line 57 - Hospice.--Enter the direct costs associated with the HHA-based hospice.

Line 58.--Use this line and subscripts of this line to identify expenses for all other special purpose cost centers not identified on line 57. Provide a description for each amount reported on this line and its subscripts. See Table 5 in §4790 for the proper cost center coding for this line.

Lines 59 through 99.--Reserved for future use.

Line 100.--Enter the total of lines 1 through 58.

4710. WORKSHEET A-6 - RECLASSIFICATIONS

This worksheet provides for the reclassification of expense accounts to effect proper cost allocation under cost finding. Submit copies of any workpapers used to compute reclassification affected on this worksheet.

COMPLETE WORKSHEET A-6 ONLY TO THE EXTENT THAT EXPENSES HAVE BEEN INCLUDED IN COST CENTERS THAT DIFFER FROM THE RESULT THAT IS OBTAINED USING THE INSTRUCTIONS FOR THIS SECTION.

Examples of reclassifications that may be needed are:

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

Licenses and taxes applicable to buildings and fixtures must be reclassified to the capital related - buildings and fixtures account (Worksheet A, line 1). Any licenses and taxes that cannot be identified to a specific cost center and are incidental to the general overall operation of the HHA must be included in the A&G account (Worksheet A, line 6).

B. Interest.--Interest expense related to loans for HHA working capital is includable in A&G (Worksheet A, line 6). Interest expense attributable to mortgages on buildings is includable in capital related - buildings and fixtures (Worksheet A, line 1). Interest related to loans for movable equipment is includable in capital related - movable equipment (Worksheet A, line 2).

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

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

E. Leases.--This expense consists of all rental costs of buildings and equipment incidental to the operation of the HHA. Leases applicable to buildings or movable equipment must be reclassified to the capital related account. Any lease which cannot be identified to a special cost center and is incidental to the general overall operation of the HHA must be included in the A&G account (Worksheet A, line 6).

4711. WORKSHEET A-8 - ADJUSTMENTS TO EXPENSES

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

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

Types of items entered on Worksheet A-8 are: (1) those needed to adjust expenses to reflect actual expenses incurred; (2) those items which constitute recovery of expenses through sales, charges, fees, etc.; (3) those items needed to adjust expenses in accordance with the Medicare principles of reimbursement; and (4) those items which are provided for separately in the cost apportionment process. If an adjustment to an expense affects more than one cost center, record the adjustment to each cost center on a separate line on this worksheet.

Line Descriptions

Columns 2, 3, and 4.--For each adjustment, enter the amount in column 2, enter the Worksheet A cost center line number reference in column 4, and enter the corresponding cost center description in column 3.

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

Line 4.--Enter the amount from Worksheet A-8-1, Part I, column 6, line 5. The amount from Worksheet A-8-1, Part I, lines 1 through 4, represent the detail of the various cost centers for related party and home office costs that were allocated to the HHA and may or may not already be included on Worksheet A.

Line 5.--Enter the amount received from the sale of medical records and abstracts and offset the amount against the A&G cost centers.

Line 6.--Enter the cash received from imposition of interest, finance, or penalty charges on overdue receivables. This income must be used to offset the allowable A&G costs.

Line 9.--Enter interest expense imposed by the contractor on Medicare overpayments to the provider. Also, enter the interest expense on loans incurred to repay Medicare overpayments to the provider.

Line 10.--Enter the expense incurred for political and lobbying activities be identified and disallowed. (See CMS Pub. 15-1, chapter 21, §§2139 - 2139.3.)

Line 11.--Enter the expense incurred for advertising costs be identified and disallowed. (See CMS Pub. 15-1, chapter 21, §§2136 - 2136.2.)

Line 12 through 49.--Use these lines and any subscripts thereof to enter any additional adjustments required under the Medicare principals of reimbursement. Provide a description for each amount reported on these lines that indicates the nature of the required adjustment and the amount.

Line 50.--Enter the sum of lines 1 through 49. Transfer the amounts in column 2 to the appropriate lines on Worksheet A, column 9.

4712. WORKSHEET A-8-1 - STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Worksheet A-8-1 consists of the following two parts:

Part I - Costs Incurred and Adjustments Required as a Result of Transactions with Related Organizations or Claimed Home Office Costs
Part II - Interrelationship to Related Organizations and/or Home Office

In accordance with 42 CFR 413.17, costs applicable to services, facilities, and supplies furnished to the HHA by organizations related to the HHA by common ownership or control are includable in the HHA allowable cost at the cost to the related organization, see exceptions outlined in 42 CFR 413.17(d). This worksheet provides for the computation of any needed adjustments to costs applicable to services, facilities, and supplies furnished to the HHA by related organizations or costs associated with the home office.

Complete this worksheet if you answered yes to question 11 on Worksheet S-2, Part I, and there are costs included on Worksheet A resulting from transactions with related organizations as defined in CMS Pub. 15-1, chapter 10, or home office cost as described in CMS Pub. 15-1, chapter 21. If there are no costs incurred as a result of transactions with related organizations or home office cost allocations, DO NOT complete Worksheet A-8-1.

4712.1 Part I - Costs Incurred and Adjustments Required as a Result of Transactions with Related Organizations or Claimed Home Office Costs. This part of this worksheet provides for the computation of adjustments needed to properly report costs of services, facilities, and supplies furnished to the HHA by related organizations or costs associated with the home office. However, such costs must not exceed the amount a prudent and cost conscious buyer would pay for the comparable services, facilities, or supplies that are purchased elsewhere.

Columns 1 and 2.--Enter in column 1 the Worksheet A cost center line number to be adjusted. Enter the corresponding cost center description in column 2.

Column 3.--Enter the description of the related organization or home office expenses.

Column 4.--Enter the allowable costs from the books and/or records of the related organization or home office. Allowable costs are the actual costs incurred by the related organization or home office for services, facilities, and/or supplies and exclude any markup, profit or amounts that otherwise exceed the acquisition cost of such items.

Column 5.--Enter the amount included on Worksheet A for services, facilities, and/or supplies acquired from related organizations and/or home office.

Column 6.--Enter the result of column 4 minus column 5.

4712.2 Part II - Interrelationship to Related Organizations and/or Home Office. This part of the worksheet identifies the interrelationship between the HHA and individuals, partnerships, corporations, or other organizations having either a related interest to, a common ownership with, or control over the HHA as defined in CMS Pub. 15-1, chapter 10. Complete columns 1 through 6, as applicable, for each interrelationship. For additional information on home offices, see CMS Pub. 15-1, chapter 21.

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

Column 1.--Enter the symbol that represents the interrelationship between the HHA and the related organization or home office. Select from the following choices:

Symbol	Relationship
A	Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider
B	Corporation, partnership or other organization has financial interest in provider
C	Provider has financial interest in corporation, partnership, or other organization
D	Director, officer, administrator or key person of provider or organization
E	Individual is director, officer, administrator or key person of provider and related organization
F	Director, officer, administrator or key person of related organization or relative of such person has financial interest in provider
G	Other (financial or non-financial) -- specify

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

Column 3.--If the individual reported in column 2, or the organization reported in column 4, has a financial interest in the HHA, enter the percent of ownership.

Column 4.--Enter the name of each related corporation, partnership, or other organization.

Column 5.--If the HHA, or an individual reported in column 2, has a financial interest in the organization reported in column 4, enter the percent of ownership.

Column 6.--Enter the type of business applicable to the related organization (e.g., medical drugs and/or supplies, janitorial services).

4713. WORKSHEET B - COST ALLOCATION – ALLOCATION OF GENERAL SERVICE COSTS AND WORKSHEET B-1 - COST ALLOCATION - STATISTICAL BASIS

Worksheet B provides for the allocation of the expenses of each general service cost center to those cost centers which receive the services. The cost centers serviced by the general service cost centers include all cost centers within the provider organization, i.e., other general service cost centers, reimbursable cost centers, nonreimbursable cost centers, and special purpose cost centers. Obtain the total direct expenses from Worksheet A, column 10. To facilitate transferring amounts from Worksheet A to Worksheet B, the same cost centers with corresponding line numbers (lines 1 through 58) are listed on both worksheets.

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

To facilitate the allocation process, the general format of Worksheets B and B-1 are identical. The column and line numbers for each general service cost center are identical on the two worksheets. In addition, the line numbers for each general, reimbursable, nonreimbursable, and special purpose cost centers are identical on the two worksheets. The cost centers and line numbers are also consistent with Worksheets A.

NOTE: General service columns 1 through 9 must be consistent on Worksheets B and B-1.

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

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

Close the general service cost centers in accordance with 42 CFR 413.24(d)(1) which states, in part, that the cost of nonrevenue-producing cost centers serving the greatest number of other centers, while receiving benefits from the least number of centers, is apportioned first. This is further clarified in CMS Pub. 15-1, chapter 23, §2306.1 which also clarifies the order of allocation for step-down purposes. Consequently, first close those cost centers that render the most services to and receive the least services from other cost centers. The cost centers are listed in this sequence from left to right on the worksheet. However, the circumstances of an HHA may be such that a more accurate result is obtained by allocating to certain cost centers in a sequence different from that followed on these worksheets.

NOTE: A change in order of allocation and/or allocation statistics is appropriate for the current fiscal year cost if received by the contractor, in writing, within 90 days prior to the end of that fiscal year. The contractor has 60 days to make a decision or the change is automatically accepted. The change must be shown to more accurately allocate the overhead or, if it is accurate, should be changed due to simplification of maintaining the statistics. If a change in statistics is made, the provider must maintain both sets of statistics until an approval is made. If both sets are not maintained and the request is denied, the provider will revert back to the previously approved methodology. The provider must include with the request all supporting documentation and a thorough explanation of why the alternative approach should be used. (See CMS Pub. 15-1, chapter 23, §2313.)

If the amount of any cost center on Worksheet A, column 10, has a credit balance, show this amount as a credit balance on Worksheet B, column 0. Allocate the costs from the applicable overhead cost centers in the normal manner to the cost center showing a credit balance. After receiving costs from the applicable overhead cost centers, if a general service cost center has a credit balance at the point it is allocated; do not allocate the general service cost center. Rather, enter the credit balance on the first line of the column and on line 100. This enables column 10, line 100, to crossfoot to columns 0 and 5A, line 100. After receiving costs from the applicable overhead cost centers, if a revenue producing cost center has a credit balance on Worksheet B, column 10, do not carry forward a credit balance to any worksheet.

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

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

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

Enter on Worksheet B-1, line 100, the total expenses of the cost center to be allocated. Obtain this amount from Worksheet B from the same column and line number of the same column. In the case of Capital-Related costs - Buildings and Fixtures, this amount is on Worksheet B, column 1, line 1.

Divide the amount entered on line 100 by the total statistical base entered in the same column on the first line. Enter the resulting unit cost multiplier on line 101. Round the unit cost multiplier to at least the nearest six decimal places.

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

After the unit cost multiplier has been applied to all the cost centers receiving costs, the total expenses (line 100) of all of the cost centers receiving the allocation on Worksheet B must equal the amount entered on the first line of the cost center being allocated.

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

After all the costs of the general service cost centers have been allocated on Worksheet B, enter in column 10 the sum of the expenses on lines 16 through 58. The total expenses entered in column 10, line 100, should equal the total expenses entered in column 0, line 100.

Transfer the amounts in column 10 to Worksheet C, column 2, as follows:

From Worksheet B Column 10, Line:	To Worksheet C Column 2, Line:
16	1
17	2
18	3
19	4
20	5
21	6
22	7
23	8
24	9

Column Descriptions

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

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

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

Column 3.--Allocate all expenses for plant operation and maintenance to the appropriate cost centers on the basis of square feet.

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

This basis of allocation is not mandatory and a provider may use weighted trips rather than actual miles as a basis of allocation for transportation costs that are not directly assigned. However, an HHA must request the use of the alternative method in accordance with CMS Pub. 15-1, chapter 23, §2313. The HHA must maintain adequate records to substantiate the use of this allocation.

Column 5.--Allocate all expenses for remote patient monitoring to the appropriate cost centers on the basis of time spent.

Column 6.--The A&G expenses are allocated on the basis of accumulated costs after reclassifications and adjustments. Therefore, obtain the amounts to be entered on Worksheet B-1, column 6, from Worksheet B, columns 0 through 5.

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

A&G costs applicable to contracted services may be excluded from the total cost (Worksheet B, column 0) for purposes of determining the basis of allocation (Worksheet B-1, column 6) of the A&G costs. This procedure may be followed when the HHA contracts for services to be performed for the HHA or HHA-based hospice and the contract identifies the A&G costs applicable to those purchased services.

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

Worksheet B-1, Column 6A.--Enter the costs attributable to the difference between the total accumulated cost reported on Worksheet B, column 5A, line 100, and the accumulated cost reported on Worksheet B-1, column 6, line 6. Enter any amounts reported on Worksheet B, column 5A, for (1) any service provided under arrangements to program patients that is not grossed up and (2) negative balances. Including these costs in the statistics for allocating administrative and general expenses causes an improper distribution of overhead. In addition, report on line 6 the administrative and general costs reported on Worksheet B, column 6, line 6, since these costs are not included on Worksheet B-1, column 6 as an accumulated cost statistic.

For fragmented or componentized A&G cost centers, the accumulated cost center line number must match the reconciliation column number. Include in the column number the alpha character "A", i.e., if the accumulated cost center for A&G is line 6 (A&G), the reconciliation column designation must be 6A.

Worksheet B-1, Column 6.--The administrative and general expenses are allocated on the basis of accumulated costs. Therefore, the amount entered on Worksheet B-l, column 6, line 6, is the difference between the amounts entered on Worksheet B, column 5A, and Worksheet B-1, column 6A. A negative cost center balance in the statistics for allocating administrative and general expenses causes an improper distribution of this overhead cost center. Exclude negative balances from the allocation statistics.

HHAs may establish multiple A&G cost centers (referred to as componentized or fragmented) by using one of two possible methodologies. The rationale for allocating the shared A&G service cost center first is that shared A&G cost centers service all other cost centers, while 100 percent of HHA A&G reimbursable and 100 percent of HHA A&G nonreimbursable only service their respective cost centers. That is consistent with 42 CFR 413.24(d)(1), which states, in part, that "the cost of nonrevenue-producing cost centers serving the greatest number of other centers, while receiving benefits from the least number of centers, is apportioned first." Under the first methodology (also referred to as option 1), the HHA must classify all A&G costs as either A&G shared costs, A&G reimbursable costs, or A&G nonreimbursable costs. That is, 100 percent of the componentized A&G costs relate exclusively to either the HHA reimbursable or HHA nonreimbursable cost centers. The remaining costs are classified as A&G shared costs. The componentized A&G costs are allocated through cost finding to their respective cost centers in aggregate.

First, allocate A&G shared costs to all applicable cost centers, including to the A&G reimbursable and A&G nonreimbursable cost centers on the basis of accumulated costs. Then allocate HHA A&G reimbursable costs to all applicable HHA reimbursable cost centers (not including special purpose cost centers) on the basis of accumulated costs and allocate HHA A&G nonreimbursable costs to all applicable HHA nonreimbursable cost centers on the basis of accumulated costs. Only A&G shared costs will be allocated to the special purpose cost centers. Accordingly, the total A&G costs in the Hospice worksheets must equal the corresponding A&G shared costs on Worksheet B. The following three A&G cost center categories will be created: (1) A&G shared costs, (2) 100 percent HHA reimbursable costs, and (3) 100 percent HHA nonreimbursable costs, in this order only. Do not allocate A&G reimbursable costs to the A&G nonreimbursable cost center. Calculate the accumulated cost statistics as follows:

A&G Cost Center	Sum of Worksheet B	Transfer to Worksheet B-1
A&G Shared Costs	Col. 0-5, lines 6.02-58	Col. 6.01, lines 6.02-58
A&G Reimb. Costs	Col. 0-6.01, lines 16-30	Col. 6.02, lines 16-30
A&G Nonreimb. Costs	Col. 0-6.01, lines 39-49	Col. 6.03, lines 39-49

Under the second methodology (also referred to as option 2), unique A&G cost centers may be created (see CMS Pub. 15-1, chapter 23, §2313.1) to further refine the allocation process. The statistical basis used to allocate fragmented A&G costs must represent, as accurately as possible, the consumption or usage of A&G services by the benefiting cost centers. HHAs wishing to use an alternative allocation methodology (i.e., a change in allocation basis or the sequence of cost center allocation) must do so in accordance with CMS Pub. 15-1, chapter 23, §2313.

The fragmentation of A&G costs may constitute a direct assignment of A&G costs and, as such, must follow the policy established under CMS Pub. 15-1, chapter 23, §2307.

4714. WORKSHEET C - APPORTIONMENT OF PATIENT SERVICE COSTS

Worksheet C consists of the following two parts:

Part I - Aggregate HHA Cost per Visit and Aggregate Medicare Cost Computation
Part II - Supplies, Drugs, and Disposable Devices Cost Computation

Certain services may be rendered by an HHA that are not covered under the home health provision of §1832(a)(2)(A) of the Act. These services are covered under a different provision, i.e., §1832(a)(2)(B) of the Act. Under §1832(a)(2)(B) of the Act, any provider may render the services authorized under that section. An HHA is a provider. Therefore, an HHA may render medical and other health services and are reimbursed in accordance with §1833(a)(2)(B) of the Act under OPPS. If a beneficiary receives any of these services, the beneficiary is liable for coinsurance (i.e., 20 percent of reasonable charges) and/or deductibles. 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. The HHA must maintain auditable records of the number of visits, charges, deductibles, and coinsurance applicable to those visits. A separate reimbursement computation and a separate LCC computation is required.

4714.1 Part I - Aggregate HHA Cost per Visit and Aggregate Medicare Cost Computation.--This part provides for the computation of the average HHA cost per visit used to derive the total allowable cost attributable to Medicare patient care visits. This part also provides for the computation of the reasonable cost for Medicare services provided by the HHA. Complete this part once for the entire HHA. This computation is required by 42 CFR 413.30 and 42 CFR 413.53.

Column Descriptions for Cost per Visit and Aggregate Medicare Cost Computation

Column 2.--Enter in column 2 the amount for each discipline from Worksheet B, column 10, lines as indicated on the worksheet.

Column 3.--Enter the total HHA visits from Worksheet S-3, Part I, column 7, lines 1 through 9, for each type of discipline on lines 1 through 9.

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

Column 5.--Enter from the HHA records or the PS&R the Medicare visits for each discipline.

Column 6.--To determine the Medicare cost of services, multiply the average cost per visit amount in column 4 by the number of Medicare covered visits in column 5, lines 1 through 9, for each discipline. Enter the product in column 6.

Line 10.--For each column 2, 3, 5, and 6, respectively, enter the sum total of lines 1 through 9.

4714.2 Part II - Supplies, Drugs, and Disposable Devices 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 does 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.

Lines 11 through 13.--Enter in column 1 the total applicable costs for the entire cost reporting period for each line item from Worksheet B, column 10, lines 25, 26, and 29. Enter in column 2 the corresponding total charges for the entire cost reporting period. Enter in column 3 the ratio of costs in column 1 to charges in column 2 for each line.

Line 11.--Enter in columns 5 (not subject to deductibles and coinsurance) and 6 (subject to deductibles and coinsurance) charges for medical supplies from the HHA records or the PS&R. These charges are captured for statistical purposes only (has no reimbursement impact) as all medical supplies are covered under the HHA PPS.

Line 12.--Enter in column 5 the charges for pneumococcal vaccine, influenza vaccine, and hepatitis B vaccine. These vaccines are not subject to deductibles and coinsurance. Enter in column 6 the charge for covered osteoporosis drugs. Osteoporosis drugs are subject to deductibles and coinsurance. Do not include the charges for administering vaccines or drugs.

Line 13.--Enter in column 4 the charges for covered disposable devices from the HHA records or the PS&R. Disposable devices are subject to deductibles and coinsurance.

Column 7.--To determine the Medicare cost of disposable devices reimbursed under OPPS, multiply the cost to charge ratio column 3 by the Medicare charges in column 4. Enter the product in column 7.

Column 8.--To determine the Medicare cost not subject to deductibles and coinsurance, multiply the cost to charge ratio in column 3 by the Medicare charges in column 5 for each line item as applicable. Enter the product in column 8.

Column 9.--To determine the Medicare cost subject to deductibles and coinsurance, multiply the cost to charge ratio in column 3 by the Medicare charges in column 6 for each line item, as applicable. Enter the product in column 9.

4715. WORKSHEET D - CALCULATION OF REIMBURSEMENT SETTLEMENT

Worksheet D consists of the following two parts:

Part I - Computation of the Lesser of Reasonable Cost or Customary Charges for Vaccines
Part II - Computation of Reimbursement Settlement

This worksheet applies to title XVIII only. This computation is required by 42 CFR 413.9, 42 CFR 413.13, and 42 CFR 413.30.

4715.1 Part I - Computation of the Lesser of Reasonable Cost or Customary Charges for Vaccines.--Providers are paid the lesser of the reasonable cost of services furnished to beneficiaries or the customary charges for the same services. This part provides for the computation of the lesser of reasonable cost as defined in 42 CFR 413.13(b) or customary charges as defined in the 42 CFR 413.13(e).

NOTE: Nominal charge providers (42 CFR 413.13(a) and (f)) are not subject to the LCC. Therefore, a nominal charge HHA (Worksheet S-2, Part I, line 7, is "Y" for yes) only completes lines 1 and 9 of Part I. Transfer the resulting cost to line 10 of Part II.

Line Descriptions

Line 1.--Transfer the cost of pneumococcal, influenza, and hepatitis vaccines from Worksheet C, Part II, column 8, line 12, to column 1 of this worksheet, and the cost of osteoporosis drugs from Worksheet C, Part II, column 9, line 12, to column 2 of this worksheet.

Line 2.--In columns 1 and 2, enter from the HHA records or the PS&R charges for the applicable Medicare covered vaccines and drugs.

Lines 3 through 6.--These lines provide for the accumulation of charges which relate to the reasonable cost on line 1.

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

Line 7.--Enter in each applicable column on this line the excess of total customary charges (line 6) over the total reasonable cost (line 1). In situations when in any column the total charges on line 6 are less than the total cost on line 1 of the applicable column, enter zero (0) on line 7.

Line 8.--Enter in each applicable column on this line the excess of total reasonable cost (line 1) over total customary charges (line 6). In situations when in any column the total cost on line 1 is less than the customary charges on line 6 of the applicable column, enter zero (0) on line 8. A nominal charge provider (response of "Y" to Worksheet S-2, Part I, line 7) enters zero on this line.

Line 9.--Enter the sum of the amounts on line 1, columns 1 and 2, minus the sum of the amounts on line 8, columns 1 and 2.

4715.2 Part II - Computation of Reimbursement Settlement.--

Lines 10 through 13.--Under PPS, enter only payment amounts associated with episodes/periods completed in the current cost reporting period (see §4707.4 for additional information on episodes and periods). Payments for episodes/periods of care that overlap fiscal years must be recorded in the fiscal year in which the episode was completed. Enter on lines 10 through 13, as applicable, the appropriate PPS payment for each episode of care payment category indicated on the worksheet.

Lines 14 and 15.--Enter as applicable, the appropriate PPS outlier payment for each episode/period of care payment category indicated on the worksheet.

Line 16.--Enter the total of other payments, excluding NPWT.

Line 17.--Enter OPPS payment amounts for services rendered. This includes OPPS payments for disposable devices such as NPWT devices.

Lines 18 through 20.--Enter the gross payments for DME, oxygen, and prosthetics and orthotics payments, respectively, associated with home health PPS services (bill type 32x only). Obtain these amounts from the HHA records or PS&R report.

Line 21.--Enter the amounts paid or payable by the primary payer and reported on the PS&R. The primary payer rules are more fully explained in 42 CFR 411.

Line 22.--Enter the applicable Part B deductibles billed to Medicare patients. Exclude coinsurance amounts. Include any amounts of deductibles satisfied by primary payer payments. Do not enter deductibles for DME, oxygen, and prosthetics and orthotics.

Line 23.--Enter the sum of lines 9 through 20, minus lines 21 and 22.

Line 26.--Enter all coinsurance billable to Medicare beneficiaries, including amounts satisfied by primary payer payments. Coinsurance is applicable for services reimbursable under §1832(a)(2) of the Act. Do not enter coinsurance for DME, oxygen, and prosthetics and orthotics.

> NOTE for line 26**:** If the component qualifies as a nominal charge provider, enter 20 percent of costs subject to coinsurance on this line. Compute this amount by subtracting deductibles on line 22 and primary payment amount on line 21, from the costs subject to coinsurance in column 2, line 1. Multiply the resulting amount by 20 percent and enter it on line 26.

Line 27.--Enter Medicare allowable bad debts, reduced by bad debt recoveries. If recoveries exceed the current year's bad debts, lines 27 and 28 will be negative.

Line 28.--Multiply the amount (including negative amounts) from line 27 by 65 percent.

Line 29.--Enter the gross reimbursable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. These amounts also are included on line 27.

Line 30.--Enter the result of line 25 minus line 26, plus line 28.

Line 31.--Use this line to enter any other adjustments not identified on lines 10 through 29. Provide a description for the amount reported on this line in the space provided.

Line 32.--Enter all demonstration payment adjustment amounts before sequestration.

Line 33.--Enter the result of line 30 plus or minus line 31, minus line 32.

Line 34.--Enter the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur during the sequestration period, divided by total days in the entire cost reporting period, rounded to four decimal places)) times line 33]. Do not apply the sequestration calculation when gross reimbursement is less than zero.

Line 35.--Enter the result of line 33 minus line 34 due after sequestration adjustment.

Line 36.--Enter all demonstration payment adjustment amounts after sequestration.

Line 37.--Enter the result of line 35 minus line 36.

Line 38.--Enter the amount of interim payments from Worksheet D-1, column 2, line 4.

Line 39.--FOR CONTRACTOR USE ONLY.--Enter the tentative settlement amount from Worksheet D-1, column 2, line 5.99.

Line 40.--Enter the total amount from line 37 minus the amounts on lines 38 and 39. This represents the amount due to or from the provider. Indicate overpayments by parentheses ( ). Transfer this amount to Worksheet S, Part III, column 1, line 1.

Line 41.--Enter the Medicare reimbursement effect of protested items. The reimbursement effect of the nonallowable items is estimated by applying a reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See CMS Pub 15-2, chapter 1, §115.2.) A schedule showing the supporting details and computations for this line must be attached.

4716. WORKSHEET D-1 - ANALYSIS OF PAYMENTS TO HHA FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Complete lines 1 through 4 for Medicare interim payments only. (See 42 CFR 413.64.) Do not report interim payments for title XIX.

The remainder of the worksheet is completed by the Medicare contractor. All amounts reported on this worksheet must be for services rendered during the cost reporting period for which the costs are included in this cost report.

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

Line Descriptions

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

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 Worksheet D, line 38.

DO NOT COMPLETE THE REMAINDER OF WORKSHEET D-1. LINES 5 THROUGH 7 ARE FOR CONTRACTOR USE ONLY. (EXCEPTION: IF WORKSHEET S, PART I, LINE 3, IS GREATER THAN ZERO (AMENDED COST REPORT), THE HHA MAY COMPLETE LINES 5 THROUGH 7.)

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

Line 6.--Enter the net settlement amount from Worksheet D, line 40, transferring the amount to column 2.

NOTE**:** On lines 3, 5, and 6, when an amount is due HHA to program, show the amount and date on which the HHA 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, 5.99, and 6.01 or 6.02, in column 2, as appropriate. Enter amounts due the program in parentheses ( ). The amount in column 2 must equal the amount on Worksheet D, line 37.

Line 8.--Enter the contractor's name, contractor number, and NPR date, in columns 0, 1, and 2, respectively.

4717. WORKSHEET F - BALANCE SHEET

Prepare this worksheet from the HHA's accounting books and records. Where applicable, the worksheets must be consistent with the HHA financial statements.

Line 1 - Cash on hand and in banks.--Enter the amount of cash on deposit in banks and immediately available for use in financing activities, amounts on hand for minor disbursements and amounts invested in savings accounts and certificates of deposit. Typical accounts would be cash, general checking accounts, payroll checking accounts, other checking accounts, impress cash funds, saving accounts, certificates of deposit, treasury bills and treasury notes and other cash accounts.

Line 2 - Temporary investments.--Enter current securities evidenced by certificates of ownership or indebtedness. Typical accounts would be marketable securities and other current investments.

Line 3 - Notes receivable.--Enter current unpaid amounts evidenced by certificates of indebtedness.

Line 4 - Accounts receivable.--Enter unpaid inpatient and outpatient billings. Include direct billings to patients for deductibles, co-insurance and other patient chargeable items not included elsewhere.

Line 5 - Other receivable.--Enter other unpaid amounts due to the HHA.

Line 6 - Less: Allowances for uncollectible notes and accounts receivable.--Enter the estimated amount of the HHA accounts receivable not expected to be paid.

Line 7 - Inventory.--Enter the costs of unused HHA supplies. Perpetual inventory records may be maintained and adjusted periodically to physical count. The extent of inventory control and detailed record-keeping will depend upon the size and organizational complexity of the hospice. The inventories may be valued by any generally accepted method, but the method must be consistently applied from year to year.

Line 8 - Prepaid expenses.--Enter the costs incurred that are properly chargeable to a future accounting period.

Line 9 - Other current assets.--Enter the balances of all other current assets not identified and reported on lines 1 through 8.

Line 10 - Total current assets.--Enter the sum of lines 1 through 9.

Line 11 - Land.--Enter the cost of land as defined in CMS Pub. 15-1, chapter 1, §104.6.

Lines 12 and 13 - Land improvements.--Enter on line 12 the costs of land improvements as defined in CMS Pub. 15-1, chapter 1, §104.7. Enter accumulated depreciation on line 13.

Lines 14 and 15 - Buildings.--Enter on line 14 the costs of the HHA buildings as defined in CMS Pub. 15-1, chapter 1, §104.2. Enter accumulated depreciation on line 15.

Lines 16 and 17 - Leasehold improvements.--Enter on line 16 the costs of leasehold improvements as defined in CMS Pub. 15-1, chapter 1, §104.8. Enter accumulated depreciation on line 17.

Lines 18 and 19 - Fixed equipment.--Enter on line 18 the costs of building equipment as defined in CMS Pub. 15-1, chapter 1, §104.3. Enter accumulated depreciation on line 19.

Lines 20 and 21 - Automobiles and trucks.--Enter on line 20 the costs of automobiles and trucks used in HHA operations. Enter accumulated depreciation on line 21.

Lines 22 and 23 - Major movable equipment.--Enter on line 22 the costs of equipment as defined in CMS Pub. 15-1, chapter 1, §104.4. Enter accumulated depreciation on line 23.

Lines 24 and 25 - Minor equipment depreciable.--Enter on line 24 the costs of minor equipment as defined in CMS Pub. 15-1, chapter 1, §106(c). Enter accumulated depreciation on line 25.

Line 26 - Minor equipment (nondepreciable).--Enter the costs of minor equipment non-depreciable as defined in CMS Pub. 15-1, chapter 1, §106(c).

Line 27 - Total fixed assets.--Enter the sum of lines 11 through 26.

Line 28 - Investments.--Enter the cost of investments purchased with HHA funds and the fair market value (at date of donation) of securities donated to the HHA.

Line 29 - Deposits on leases.--Enter the amount of deposits on leases including security deposits.

Line 30 - Due from owners/officers.--Enter the amount loaned to the owner's and/or officers by the HHA.

Line 31 - Total other assets.--Sum of lines 28 through 30.

Line 32 - Total assets.--Sum of lines 10, 27, and 31.

Line 33 - Accounts payable.--Enter amounts due trade creditors and others for supplies and services purchased.

Line 34 - Salaries, wages and fees payable.--Enter the actual or estimated liabilities of salaries and wages/fees payable.

Line 35 - Payroll taxes payable.-- Enter the actual or estimated liabilities of amounts payable for payroll taxes withheld from salaries and wages, payroll taxes to be paid and other payroll deductions, such as hospitalization insurance premiums.

Line 36 - Notes and loans payable (short term).--Enter amounts payable on notes and loans as evidenced by certificates of indebtedness due in the next 12 months.

Line 37 - Deferred income.--Enter the amount of deferred income received or accrued applicable to services to be rendered within the next accounting period. Deferred income applicable to accounting periods extending beyond the next accounting period is included as other current liabilities.

Line 38 - Accelerated payments.--Enter the amounts payable for accelerated payments in accordance with CMS Pub 15-1, chapter 24, §2412.

Line 39 - Other current liabilities.--Enter the balances of all other current liabilities not identified and reported on lines 33 through 38.

Line 40 - Total current liabilities.--Enter the sum of lines 33 through 39.

Line 41 - Mortgage payable.--Enter the long-term financing obligation as evidenced by certificates of indebtedness used to purchase real estate/property.

Line 42 - Notes payable.--Enter amounts payable on notes and loans as evidenced by certificates of indebtedness due after the next 12 months.

Line 43 - Unsecured loans.--Enter amounts payable for unsecured liabilities due after the next 12 months.

Line 44 - Other long-term liabilities.--Enter the balances of all other long-term liabilities not identified and reported on lines 41 through 43.

Line 45 - Total long-term liabilities.--Enter the sum of lines 41 through 44.

Line 46- Total liabilities.--Enter the sum of lines 40 and 45.

Line 47 - Fund balance.--Enter the end of period fund balance.

Line 48 - Total liabilities and fund balance.--Enter the sum of lines 46 and 47.

4718. WORKSHEET F-1 - STATEMENT OF REVENUES AND EXPENSES

This worksheet is prepared from the HHA's accounting books and records. It requires the reporting of total patient revenues (specifically including Medicare, Medicaid and other revenues) for the entire HHA and operating expenses for the entire HHA. Additional worksheets may be submitted if necessary.

Line 1.--Enter total patient revenue from the HHA accounting books and/or records in columns 1 through 3, by program as indicated. Note: revenue from a managed care program must be entered in column 3, "Other". Enter the sum of columns 1 through 3 in column 4.

Line 2.--Enter allowances and discounts in columns 1 through 3, by program as indicated. These allowances and discounts are total patient revenues not received including:

Provision for Bad Debts,
Contractual Adjustments,
Charity Discounts,
Teaching Allowances,
Policy Discounts,
Administrative Adjustments, and
Other Deductions from Revenue

Line 3.--Enter in each column the sum of line 1 minus line 2.

Line 4.--Enter in column 2, total operating expenses from Worksheet A, column 6, line 100.

Lines 5 through 10.--Use these lines to enter any additions to operating expenses in column 1. Provide a description for each amount reported on these lines and any subscripts thereof.

Lines 11 through 16.--Use these lines to enter any subtractions to operating expenses in column 1. Provide a description for each amount reported on these lines and any subscripts thereof.

Line 17.--Enter in column 2, the sum of line 4, column 2, and lines 5 through 16, column 1.

Line 18.--Enter in column 2, the sum of line 3, column 4, minus line 17, column 2.

Lines 19 through 27.--Enter all other income as specified in column 1.

Lines 28 through 31.--Use these lines to enter any other revenues in column 1. Provide a description for each amount reported on these lines and any subscripts thereof.

Line 32.--Enter in column 2, the sum of the amounts on lines 19 through 31, column 1.

Line 33.--Enter in column 2, the sum of line 18 plus line 32, column 2.

4719. WORKSHEET O - ANALYSIS OF HHA-BASED HOSPICE COSTS

The O series of worksheets must be completed by all HHA-based hospices. This worksheet is to record the trial balance of expense accounts from the provider's accounting books and records. It also provides for reclassification and adjustments to certain accounts. The cost centers on this worksheet are listed in a manner that facilitates the combination of the various groups of cost centers for purposes of cost finding. Cost centers listed may not apply to every provider using these forms. Complete only those lines that are applicable.

Column Descriptions

For columns 1, 2, 4, and 6, direct patient care service costs (lines 25 through 46) are reported by LOC on Worksheet O-1, O-2, O-3, and O-4. For each cost center on Worksheet O, enter the sum of the amounts from Worksheets O-1, O-2, O-3, and O-4, for salaries, other costs, reclassifications, and adjustments, in columns 1, 2, 4, and 6, respectively.

Column 1.--Enter salaries from the provider's accounting books and records. Salaries for the direct patient care service cost centers (lines 25 through 46) must equal the sum of amounts reported in column 1 of Worksheets O-1, O-2, O-3, and O-4. The total salaries for column 1, line 100, must equal the salaries reported on Worksheet A, column 1, line 57.

Column 2.--Enter all costs other than salaries from the provider's accounting books and records. Other costs for the direct patient care service cost centers (lines 25 through 46) must equal the sum of amounts reported in column 2 of Worksheet O-1, O-2, O-3, and O-4. The total other costs for column 2, line 100, must equal the other costs reported on Worksheet A, the sums of columns 2 through 5, line 57.

Column 3.--For each cost center, enter the total of columns 1 plus 2.

Column 4.--Enter any reclassifications among cost center expenses in column 3 that are needed to effect proper cost allocation. This column need not be completed by all providers, but is completed to the extent reclassifications are needed or reported on Worksheet A, line 57. Show reductions to expenses as negative amounts.

If reclassifications are needed for direct patient care service cost centers (lines 25 through 46), enter the reclassification amounts on the appropriate Worksheet O-1, O-2, O-3, and O-4, column 4, for each level of care.

Reclassifications for the direct patient care service cost centers (lines 25 through 46) must equal the sum of amounts reported on the corresponding lines in column 4 of Worksheets O-1, O-2, O-3, and O-4. The total reclassifications for column 4, line 100, must equal the reclassifications reported on Worksheet A, column 7, line 57.

Column 5.--For each cost center, enter the total of the amount in column 3 plus or minus the amount in column 4.

Column 6.--In accordance with 42 CFR 413.9(c)(3), enter on the appropriate lines, the amounts of any adjustments to expenses required under Medicare principles of reimbursements. (See §4711). This column need not be completed by all providers, but is completed only to the extent adjustments are needed or reported on Worksheet A, column 9, line 57. Show reductions to expenses as negative amounts.

If adjustments are needed for direct patient care service cost centers (lines 25 through 46), enter the adjustment amounts on the appropriate Worksheet O-1, O-2, O-3, and O-4, column 6, for each level of care.

Adjustments for the direct patient care service cost centers (lines 25 through 46) must equal the sum of amounts reported on the corresponding lines in column 6 of Worksheet O-1, O-2, O-3, and O-4. The total adjustments for column 6, line 100, must equal the adjustments reported on Worksheet A, column 9, line 57.

Column 7.--For each cost center, enter the total of the amount in column 5 plus or minus the amount in column 6. Transfer the amounts in column 7 for cost centers marked with an asterisk (*) to Worksheet O-5, as follows:

From Worksheet O, Column 7, Line Number and Cost Center Description	To Worksheet O-5, Column 1:
1 Cap Rel Costs-Bldg & Fixt	Line 1
2 Cap Rel Costs-Mvble Equip	Line 2
3 Employee Benefits Department	Line 3
4 Administrative & General	Line 4
5 Plant Operation & Maintenance	Line 5
6 Laundry & Linen	Line 6
7 Housekeeping	Line 7
8 Dietary	Line 8
9 Nursing Administration	Line 9
10 Routine Medical Supplies	Line 10
11 Medical Records	Line 11
12 Staff Transportation	Line 12
13 Volunteer Service Coordination	Line 13
14 Pharmacy	Line 14
15 Physician Administrative Services	Line 15
16 Other General Service	Line 16
60 Bereavement Program	Line 60
61 Volunteer Program	Line 61
62 Fundraising	Line 62
63 Hospice/Palliative Medicine Fellows	Line 63
64 Palliative Care Program	Line 64
65 Other Physician Services	Line 65
66 Residential Care	Line 66
67 Advertising	Line 67
68 Telehealth/Telemonitoring	Line 68
69 Thrift Store	Line 69
70 Nursing Facility Room & Board	Line 70
71 Other Nonreimbursable	Line 71

Line Descriptions

The Worksheet O cost centers are segregated into general service, direct patient care service, and nonreimbursable categories to facilitate the transfer of costs to the various worksheets. For example, the general service cost centers appear on Worksheet O-5, and Worksheets O-6, Parts I and II, using the same line numbers as Worksheet O. The direct patient care service cost centers appear on Worksheets O-1, O-2, O-3, and O-4, using the same line numbers as Worksheet O.

General service cost centers (lines 1 through 17) include expenses incurred in operating the hospice as a whole that are not directly associated with furnishing patient care such as mortgage, rent, plant operations, administrative salaries, utilities, telephone, and computer hardware and software costs. General service cost centers furnish services to other general service cost centers and to reimbursable and nonreimbursable cost centers.

Lines 1 and 2 - Capl Rel Costs-Bldg & Fixt and Cap Rel Costs-Mvble Equip.--Enter in column 2, the capital-related costs for buildings and fixtures and the capital-related costs for moveable equipment on lines 1 and 2, respectively.

Line 3 - Employee Benefits Department.--This cost center includes the costs of the employee benefits department. In addition, this cost center includes the fringe benefits paid to, or on behalf of, an employee when a provider's accounting system is not designed to accumulate the benefits on a departmentalized or cost center basis. (See CMS Pub. 15-1, chapter 21, §2144, and CMS Pub. 15-1, chapter 23, §2307.) Enter the employee benefits.

Line 4 - Administrative & General.--Enter in columns 1 and 2, the salary and other costs of A&G.

If the option to subscript A&G costs into more than one cost center is elected (in accordance with CMS Pub. 15-1, chapter 23, §2313), eliminate line 4. Begin numbering the subscripted A&G cost centers with line 4.01 and continue in sequential order.

Line 5 - Plant Operation & Maintenance.--This cost center includes expenses incurred in the operation and maintenance of the plant and equipment (see §4709). Enter in columns 1 and 2, the costs of plant operation and maintenance.

Line 6 - Laundry & Linen Service.--This cost center includes the cost of routine laundry and linen services whether performed in-house or by outside contractors.

Line 7 - Housekeeping.--This cost center includes the cost of routine housekeeping activities such as mopping, vacuuming, cleaning restrooms, lobbies, waiting areas and otherwise maintaining patient and non-patient care areas.

Line 8 - Dietary.--This cost center includes the cost of preparing meals for patients. Do not include the cost of dietary counseling in this cost center; report dietary counseling on line 35.

Line 9 - Nursing Administration.--This cost center includes the cost of overall management and direction of the nursing services. Do not include the cost of direct nursing services reported on lines 27 through 29. The salary cost of direct nursing services, including the salary cost of nurses who render direct service in more than one patient care area, is directly assigned to the various patient care cost centers in which the services were rendered. However, if the hospice accounting system fails to specifically identify all direct nursing services to the applicable direct patient care cost centers, then the salary cost of all direct nursing service is included in this cost center.

Line 10 - Routine Medical Supplies.--This cost center includes the cost of supplies used in the normal course of caring for patients, such as gloves, masks, swabs, or glycerin sticks, that generally are not traceable to individual patients. Do not include the costs of non-routine medical supplies that can be traced to individual patients; report non-routine medical supplies on line 42.

Line 11 - Medical Records.--This cost center includes cost of the medical records department where patient medical records are maintained. The general library and the medical library are not included in this cost center but are included in the A&G cost center.

Line 12 - Staff Transportation.--This cost center includes the cost of owning or renting vehicles, public transportation expenses, parking, tolls, or payments to employees for driving their private vehicles to see patients or for other hospice business. Staff transportation costs do not include patient transportation costs; report patient transportation costs on line 39.

Line 13 - Volunteer Service Coordination.--This cost center includes the cost of the overall coordination of service volunteers including their recruitment and training costs of volunteers.

Line 14 - Pharmacy.--This cost center includes the costs of drugs (both prescription and over-the-counter), pharmacy supplies, pharmacy personnel, and pharmacy services. Do not report the cost of palliative chemotherapy drugs on this line; report the cost of palliative chemotherapy on line 46. For additional information, please refer to the instructions for line 43 – Drugs Charged to Patients prior to completing this line.

Line 15 - Physician Administrative Services.--This cost center includes the costs for physicians' administrative and general supervisory activities that are included in the hospice payment rates. These activities include participating in the establishment, review and updating of plans of care, supervising care and services, conducting required face-to-face encounters for recertification, and establishing governing policies. These activities are generally performed by the physician serving as the medical director and the physician member of the interdisciplinary group. Nurse practitioners may not serve as or replace the medical director or physician member of the interdisciplinary group.

Line 16.-- Use this line to identify expenses for other general service costs not identified on lines 1 through 15. Provide a description for the amount reported on this line. See Table 5 in §4790 for proper cost center coding for this line.

Line 17 - Patient/Residential Care Services.--Do not use this line on this worksheet. This cost center is used on Worksheet O-5 to accumulate in-facility costs not separately identified as HIRC, HGIP, or residential care services that are not part of a separate and distinct residential care unit (e.g., depreciation related to in-facility areas that provide HIRC, HGIP, or residential care). The amounts allocated to this cost center on Worksheet O-5 are allocated to HIRC, HGIP, and residential care services that are not part of a separate and distinct residential care unit, based on in-facility days. This cost center does not include any costs related to contracted inpatient services.

When a residential care unit is separate and distinct and only used for resident care services (such as hospice home care provided in a residential unit), costs are reported directly on line 66.

Lines 18 through 24.--Reserved for future use.

Direct patient care service costs are reported by LOC on Worksheets O-1, O-2, O-3, and O-4. For each cost center on Worksheet O, enter the sum of the amounts from Worksheets O-1, O-2, O-3, and O-4, for salaries, other costs, reclassifications, and adjustments in columns 1, 2, 4, and 6, respectively.

Line 25 - Inpatient Care - Contracted.--This cost center includes the contractual costs paid to another facility for use by the hospice for hospice inpatient care (HIRC or HGIP) in accordance with 42 CFR 418.108(c). This cost center does not include the cost of any direct patient care services or nonreimbursable services provided by hospice staff in the contracted setting. Costs of any services provided by hospice staff in the contracted setting are included in the appropriate direct patient care service or nonreimbursable cost center. Costs in this cost center are excluded from the allocation of A&G costs.

Line 26 - Physician Services.--This cost center includes the costs incurred by the hospice for physicians, or nurse practitioners providing physician services, for direct patient care services and general supervisory services, participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care, and establishment of governing policies by the physician member of the interdisciplinary group. (See 42 CFR 418.304.) Reclassify the cost for the portion of time physicians spent on general supervisory services or other hospice administrative activities to Physician Administrative Services (line 15). This cost center must not include costs associated with palliative care or other nonreimbursable physician services. Those nonreimbursable physician services must be reported in the appropriate nonreimbursable cost center.

Line 27 - Nurse Practitioner.--This cost center includes the costs of nursing care provided by nurse practitioners. Do not include costs for nurse practitioners providing physician services on this line; report the costs for nurse practitioners providing physician services on line 26.

Line 28 - Registered Nurse.--This cost center includes the costs of nursing care provided by registered nurses other than nurse practitioners.

Line 29 - LPN/LVN.--This cost center includes the costs of nursing care provided by licensed practical nurses (LPN) or licensed vocational nurses (LVN). Do not include costs for certified nursing assistant (CNA) services on this line; report the costs for CNA services on line 37.

Line 30 - Physical Therapy.--This cost center includes the costs of physical or corrective treatment of bodily or mental conditions by the use of physical, chemical, and other properties of heat, light, water, electricity, sound massage, and therapeutic exercise by or under the direction of a registered physical therapist as prescribed by a physician. Physical therapy services may be provided for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

Line 31 - Occupational Therapy.--This cost center includes the costs of purposeful goal-oriented activities in the evaluation, diagnosis, and/or treatment of persons whose function is impaired by physical illness or injury, emotional disorder, congenital or developmental disability, or the aging process, in order to achieve optimum functioning, to prevent disability, and to maintain health. Occupational therapy services may be provided for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

Line 32 - Speech-Language Pathology.--This cost center includes the costs of physician-prescribed services provided by or under the direction of a qualified speech-language pathologist to those with functionally impaired communications skills. This includes the evaluation and management of any existing disorders of the communication process centering entirely, or in part, on the reception and production of speech and language related to organic and/or nonorganic factors. Speech-language pathology services may be provided for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

Line 33 - Medical Social Services.--This cost center includes the cost of the medical social services defined in CMS Pub. 100-02, chapter 9, §40.1.2. Costs for nonreimbursable activities included in this cost center must be reclassified to the appropriate nonreimbursable cost center.

Line 34 - Spiritual Counseling.--This cost centers includes the cost of spiritual counseling services. Costs for nonreimbursable activities included in this cost center must be reclassified to the appropriate nonreimbursable cost center.

Line 35 - Dietary Counseling.--This cost center includes the costs of dietary counseling services.

Line 36 - Counseling - Other.--This cost center include the cost of counseling services not already identified as spiritual, dietary or bereavement counseling. Costs for nonreimbursable activities included in this cost center must be reclassified to the appropriate nonreimbursable cost center.

Line 37 - Hospice Aide and Homemaker Services.--This cost center includes the costs of:

- Hospice aide services such as personal care services and household services to maintain a safe and sanitary environment in areas of the home used by the patient; and,

- Homemaker services such as assistance in the maintenance of a safe and healthy environment and services to enable the individual to carry out the plan of care.

Include the cost of CNAs that meet the criteria for an aide in this cost center.

Line 38 - Durable Medical Equipment/Oxygen.--This cost center includes the costs of DME and oxygen, as defined in 42 CFR 410.38 and 42 CFR 418.202(f), furnished to individual HRHC or HCHC patients. Report DME costs by the LOC the patient was receiving at the time the DME/oxygen was delivered. If the LOC of a patient changed after delivery of the DME/Oxygen, the hospice may report the costs proportionally between HRHC and HCHC based on patient days.

Line 39 - Patient Transportation.--This cost center includes the costs of ambulance transports of hospice patients, related to the terminal prognosis and occurring after the effective date of the hospice election, that are the responsibility of the hospice. (See CMS Pub. 100-02, chapter 9, §40.1.9.) When a patient is transferred to a new LOC, report the transportation cost to that LOC. For example, a patient in a HGIP LOC is transferred to HRHC LOC and transported to their home, the transportation cost associated with the transfer must be included in the HRHC LOC.

Line 40 - Imaging Services.--This cost center includes the costs of imaging services.

Line 41 - Labs and Diagnostics.--This cost center includes the costs of laboratory and diagnostic tests.

Line 42 - Medical Supplies - Non routine.--This cost center includes the costs of medical supplies furnished to individual patients for which a separate charge would be applicable. These supplies are specified in the patient's plan of treatment and furnished under the specific direction of the patient's physician. Do not include the cost of routine medical supplies used in the normal course of caring for patients, (such as gloves, masks, swabs, or glycerin sticks) on this line; report routine medical supplies on line 10. When a provider does not track the use of non-routine medical supplies by LOC, the provider may report the costs proportionally between LOCs based on patient days.

Line 43 - Drugs Charged to Patients.--This cost center includes the costs of drugs furnished to individual patients for which a separate charge would be applicable. These drugs are specified in the patient's plan of treatment and furnished under the specific direction of the patient's physician. When a provider does not track the use of drugs by LOC, the provider must report the costs on Line 14.

Line 44 - Outpatient Services.--This cost center includes the costs of outpatient services costs not captured elsewhere. This cost can include the cost of an emergency room department visit when related to the terminal condition.

Lines 45 and 46 - Palliative Radiation Therapy and Palliative Chemotherapy.--These cost centers include costs of radiation, chemotherapy and other modalities used for palliative purposes based on the patient's condition and the hospice's caregiving philosophy.

Line 47.-- Use this line and subscripts of this line to identify expenses for other direct patient care service costs not identified on lines 25 through 46. Provide a description for each amount reported on this line and its subscripts. See Table 5 in §4790 for proper cost center coding for this line.

Lines 48 and 49.--Reserved for future use.

Lines 50 through 53.--Reserved for use on Worksheet O-6, Parts I and II.

Lines 54 through 59.--Reserved for future use.

Nonreimbursable cost centers include costs of nonreimbursable services and programs. Report the costs applicable to nonreimbursable cost centers to which general service costs apply. If additional lines are needed for nonreimbursable cost centers other than those shown, subscript one or more of these lines with a numeric code. The subscripted lines must be appropriately labeled to indicate the purpose for which they are being used. However, when the expense (direct and all applicable overhead) attributable to any non-allowable cost area is so insignificant as to not warrant establishment of a nonreimbursable cost center, remove the expense on Worksheet A-8. (See CMS Pub. 15-1, chapter 23, §2328.)

Line 60 - Bereavement Program.--This cost center includes the cost of bereavement services, defined as emotional, psychosocial, and spiritual support and services provided before and after the death of the patient to assist with grief, loss, and adjustment (42 CFR 418.3). Bereavement counseling is a required hospice service, but it is not reimbursable (see §1814(i)(1)(A) of the Act).

Line 61 - Volunteer Program.--This cost center includes costs of volunteer programs. (See 42 CFR 418.78 and CMS Pub. 15-1, chapter 7.)

Line 62 - Fundraising.--This cost center includes costs of fundraising. (See CMS Pub. 15-1, chapter 21, §2136.2.)

Line 63 - Hospice/Palliative Medicine Fellows.--This cost center includes costs of hospice and palliative medicine fellows.

Line 64 - Palliative Care Program.--Enter in columns 1 and 2, the salary and other costs of palliative care provided to non-hospice patients. This includes physician services.

Line 65 - Other Physician Services.--Enter in columns 1 and 2, the salary and other costs of other physician services that are provided outside of a palliative care program to non-hospice patients.

Line 66 - Residential Care.--Enter in columns 1 and 2, the salary and other costs of residential care for patients living in the hospice, but who are not receiving inpatient hospice services. Patients living in the hospice are considered residents, where the hospice is their home. These patients are liable for their room and board charges; however, the outpatient hospice care services provided must be recorded in the direct patient care cost centers on the appropriate HRHC and/or HCHC LOC worksheet.

Lines 67 - Advertising.--Enter in columns 1 and 2, the salary and other costs of nonallowable community education, business development, marketing and advertising (see CMS Pub. 15-1, chapter 21, §2136).

Lines 68 - Telehealth/Telemonitoring.--Enter in columns 1 and 2, the salary and other costs of telehealth/telemonitoring services. These costs are nonreimbursable since a hospice is not an approved originating site (see 42 CFR 410.78(b)(3)).

Lines 69 - Thrift Store.--Enter in columns 1 and 2, the salary and other costs of thrift stores.

Line 70 - Nursing Facility Room & Board.--Enter the costs incurred by a hospice for dually eligible beneficiaries residing in a nursing facility (NF) when room and board is paid by the State to the hospice. The full amount paid to the NF by the hospice must be included on this line and offset by the State payment via an adjustment on Worksheet A-8. The residual cost is the net cost incurred.

For example, a dually eligible beneficiary is residing in a NF and has elected the Medicare hospice benefit. The NF charges $100 per day for room and board. The State pays the hospice $95 for the NF room and board. The hospice has a written agreement with the NF that requires full room and board payment of $100 per day. The hospice receives $95 per day, but pays the NF $100 per day, thereby incurring a net cost of $5 per day.

Line 71.-- Use this line and subscripts of this line to identify expenses for other nonreimbursable costs not identified on lines 60 through 70. Provide a description for each amount reported on this line and its subscripts. See Table 5 in §4790 for proper cost center coding for this line.

Lines 72 through 99.--Reserved for future use.

4720. WORKSHEETS O-1, O-2, O-3, AND O-4 - ANALYSIS OF HHA-BASED HOSPICE COSTS

Worksheet O-1 - Analysis of HHA-Based Hospice Costs - Continuous Home Care
Worksheet O-2 - Analysis of HHA-Based Hospice Costs - Routine Home Care
Worksheet O-3 - Analysis of HHA-Based Hospice Costs - Inpatient Respite Care
Worksheet O-4 - Analysis of HHA-Based Hospice Costs - General Inpatient Care

Worksheets O-1, O-2, O-3, and O-4 provide for recording the direct patient care costs by LOC, including reclassifications and adjustments. The general format of these worksheets is identical to Worksheet O in order to facilitate the transfer of direct patient care costs to Worksheet O. For each cost center, the sums of the amounts reported in columns 1, 2, 4, and 6 of these worksheets are transferred to the corresponding columns on Worksheet O.

Column 1.--For each LOC worksheet, enter salaries from the provider's accounting books and records.

Column 2.--For each LOC worksheet, enter all costs other than salaries from the provider's accounting books and records.

Column 3.--For each cost center, add the amounts in columns 1 and 2 and enter the total in column 3.

Column 4.--For each LOC worksheet enter any reclassification of direct patient care service costs needed to effect proper cost allocation. For each line, the sum of the reclassification entries on Worksheet O-1, O-2, O-3, and O-4, column 4, must equal the amount on the corresponding line on Worksheet O, column 4.

Column 5.--For each cost center, enter the total of the amount in column 3 plus or minus the amount in column 4.

Column 6.--For each LOC worksheet, enter any adjustments for direct patient care service costs (lines 25 through 46) required under Medicare principles of reimbursements. (See §4711.) Show reductions to expenses as negative amounts. For each line, the sum of the adjustment entries on Worksheets O-1, O-2, O-3, and O-4, column 6, must equal the amount on the corresponding line of Worksheet O, column 6.

Column 7.--For each cost center, enter the total of the amount in column 5 plus or minus the amount in column 6. For each LOC worksheet, transfer the amount on line 100 to the corresponding LOC line on Worksheet O-5, column 1, as follows:

From line 100 of:	To Worksheet O-5, column 1, line:
Worksheet O-1	50
Worksheet O-2	51
Worksheet O-3	52
Worksheet O-4	53

4721. WORKSHEET O-5 - DETERMINATION OF HHA-BASED HOSPICE TOTAL EXPENSES FOR ALLOCATION

Worksheet O-5 determines total expenses of each general service cost center for proper allocation of general service costs to each LOC and to nonreimbursable cost centers. This worksheet combines the direct general services costs reported on Worksheet O, lines 1 through 17, with the overhead allocation of the HHA general services costs reported on Worksheet B, line 57, columns 1 through 7.

Column Descriptions

Column 1.--For each general service and nonreimbursable cost center, transfer the amount from the corresponding cost center on Worksheet O, column 7. For each LOC line, transfer amounts as follows:

Line:	From column 7, line 100 of:
50	Worksheet O-1
51	Worksheet O-2
52	Worksheet O-3
53	Worksheet O-4

The total on line 100 of column 1 must equal the amount on Worksheet A, column 10, line 57.

Column 2.--For each general service cost center, transfer the amount from the corresponding column on Worksheet B, line 57 as follows:

Line:	From Worksheet B, line 57, column(s):	Line:	From Worksheet B, line 57, column(s):
1	1	9	7
2	2	10	N/A
3	N/A	11	8
4	6	12	4
5	3	13	N/A
6	N/A	14	N/A
7	N/A	15	N/A
8	N/A	16	9

Column 3.--For each line, enter the sum of columns 1 and 2. The total on line 100, column 3 must equal the amount on Worksheet B, column 10, line 57. Transfer the amount from each cost center to the corresponding line on Worksheet O-6, Part I, column 0.

4722. WORKSHEET O-6 - COST ALLOCATION - HHA-BASED HOSPICE

Worksheet O-6 consists of the following two parts:

Part I - Allocation of HHA-Based Hospice General Service Costs
Part II - Statistical Bases

In accordance with 42 CFR 413.24, cost data must be based on an approved method of cost finding and on the accrual basis of accounting except where governmental institutions operate on a cash basis of accounting.

Worksheet O-6, Parts I and II, facilitate the step-down method of cost finding. This method recognizes that general services of the hospice are utilized by other general service, LOC, and nonreimbursable cost centers. Worksheet O-6, Part I, provides for the equitable allocation of general service costs based on statistical data reported on Worksheet O-6, Part II. To facilitate the allocation process, the general format of Worksheet O-6, Part I, is identical to that of Worksheet O-6, Part II. The column and line numbers for each general service cost center are identical on the two worksheets. The direct patient care service cost centers (lines 25 through 46 of Worksheet O) are reported by LOC on lines 50 through 53 of Worksheets O-6, Parts I and II. The line numbers for nonreimbursable cost centers are identical on Worksheet O and Worksheet O-6, Parts I and II.

When certain general services costs are related to in-facility days and are not separately identifiable by LOC or service, Worksheet O-6, Parts I and II, provide for the accumulation of these costs on line 17, Patient/Residential Care Services. The amounts accumulated in this cost center are allocated based on the in-facility days for HIRC, HGIP, and residential care services that are not part of a separate and distinct residential care unit. This cost center does not include any costs related to contracted inpatient services.

The statistical basis shown at the top of each column on Worksheet O-6, Part II, is the recommended basis of allocation. The total statistic for cost centers using the same basis (e.g., square feet) may differ with the closing of preceding cost centers. A hospice can elect to change the order of allocation and/or allocation statistics, as appropriate, for the current cost reporting period if a request is submitted in accordance with CMS Pub. 15-1, chapter 23, §2313.

Close the general service cost centers in accordance with 42 CFR 413.24(d)(1) so that the cost centers rendering the most services to and receiving the least services from other cost centers are closed first (see CMS Pub. 15-1, chapter 23, §2306.1). If a more accurate result is obtained by allocating costs in a sequence that differs from the recommended sequence, the hospice must request approval in accordance with CMS Pub. 15-1, chapter 23, §2313.

If the amount of any cost center on Worksheet O-5, column 3, has a negative balance, show this amount as a negative balance on Worksheet O-6, Part I, column 0. Allocate the costs from the overhead cost centers in the normal manner, including to those cost centers with a negative balance. Close a general service cost center with a negative balance by entering the negative balance in parentheses on the first line and on lines 99 and 100 of the column, and do not allocate. This enables Worksheet O-6, Part I, line 100, column 18, to cross foot to Worksheet O-6, Part I, line 100, column 0. After receiving costs from overhead cost centers, LOC cost centers with negative balances on Worksheet O-6, Part I, column 18, are not transferred to Worksheet O-7.

On Worksheet O-6, Part II, enter on the first available line of each column the total statistics applicable to the cost center being allocated (e.g., in column 1, Capital-Related Cost - Buildings & Fixtures, enter on line 1 the total square feet of the building on which depreciation was taken). Use accumulated cost for allocating A&G expenses.

Such statistical base, including accumulated cost for allocating A&G expenses, does not include any statistics related to services furnished under arrangements except where:

- Both Medicare and non-Medicare costs of arranged for services are recorded in the hospice's accounting books and records; or

- The contractor determines that the hospice is able to and does gross up the costs and charges for services to non-Medicare patients so that both cost and charges are recorded as if the hospice had furnished such services directly to all patients. (See CMS Pub. 15-1, chapter 23, §2314.)

For each cost center being allocated, enter that portion of the total statistical base applicable to each cost center receiving services. For each column, the sum of the statistics entered for cost centers receiving services must equal the total statistical base entered on the first line.

For each column on Worksheet O-6, Part II, enter on line 101, the total expenses of the cost center to be allocated. Obtain the total expenses from the first line of the corresponding column on Worksheet O-6, Part I, which includes the direct expenses from Worksheet O-6, Part I, column 0, plus the allocated costs from previously closed cost centers. Divide the amount entered on Worksheet O-6, Part II, line 101, by the total statistical base entered in the same column on the first line. Enter the resulting unit cost multiplier (rounded to six decimal places) on line 102.

For each column on Worksheet O-6, Part II, multiply the unit cost multiplier on line 102 by the portion of the total statistical base applicable to each cost center receiving services and enter the result in the corresponding column and line on Worksheet O-6, Part I. For each column on Worksheet O-6, Part I, the sum of the costs allocated (line 100) must equal the total cost on the first line.

After the costs of the general service cost centers have been allocated on Worksheet O-6, Part I, enter on each line 50 through 71, column 18, the sum of the costs in columns 3A through column 17. The total costs entered on Worksheet O-6, Part I, column 18, line 100, must equal the total costs entered in column 0, line 100.

Column Descriptions

Column 0.--For each line, enter the total direct costs from the corresponding line on Worksheet O-5, column 3.

Column 3A.--For each line, enter the sum of columns 0 through 3. The sum for each line is the accumulated cost and, unless an adjustment is required, is the Worksheet O-6, Part II, column 4, statistic for allocating A&G costs.

If an adjustment to the accumulated cost statistic on Worksheet O-6, Part II, column 4, is required to properly allocate A&G costs, enter the adjustment amount on Worksheet O-6, Part II, column 4A, for the applicable line. For example, when the hospice contracts for HIRC or HGIP services and the contractual costs include A&G costs, the contractual costs reported on Worksheet O-3, column 7, line 25, or Worksheet O-4, column 7, line 25, may be used to reduce the accumulated cost statistic on Worksheet O-6, Part II, column 4A, line 52 or line 53, respectively.

For each line, the accumulated cost statistic on Worksheet O-6, Part II, column 4, is the difference between the amount on Worksheet O-6, Part I, column 3A, and the adjustment amount on Worksheet O-6, Part II, column 4A. Accumulated cost for A&G is not included in the total statistic for the A&G cost center; therefore, transfer the amount on Worksheet O-6, Part I, column 3A, line 4, to Worksheet O-6, Part II, column 4A, line 4.

The total accumulated cost statistic for Worksheet O-6, Part II, column 4, line 4, is the difference between the total on Worksheet O-6, Part I, column 3A, line 101, and the amounts in column 4A of Worksheet O-6, Part II.

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

Column 18.--Transfer the amounts on lines 50 through 53 as follows:

From Worksheet O-6, Part I, column 18:	To Worksheet O-8, column 3:
Line 50	Line 1
Line 51	Line 6
Line 52	Line 11
Line 53	Line 16

4723. WORKSHEET O-7 - APPORTIONMENT OF HHA-BASED HOSPICE SHARED SERVICE COSTS BY LEVEL OF CARE

This worksheet calculates the cost of ancillary services provided by HHA departments to HHA-based hospice patients.

Column Descriptions

Column 1.--For each cost center, enter in column 1, the cost for each discipline from Worksheet B, column 10, lines as indicated.

Column 2.--For each cost center, enter on the appropriate lines the total HHA charges from the provider's records, applicable to the HHA-based hospice.

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

Columns 4 through 7.--For each cost center, enter the charges, from the provider's records, for ancillary services provided by HHA ancillary departments to HHA-based hospice patients. Enter the charges by LOC in the appropriate LOC column.

Columns 8 through 11.--For each column, calculate cost of ancillary services provided by HHA ancillary departments to HHA-based hospice patients as follows:

Column:	Calculation:
8	col. 3 x col. 4
9	col. 3 x col. 5
10	col. 3 x col. 6
11	col. 3 x col. 7

For each column 8 through 11, enter the sum of lines 1 through 9 on line 10.

4724. WORKSHEET O-8 - CALCULATION OF HHA-BASED HOSPICE PER DIEM COST

Worksheet O-8 calculates the average cost per diem by level of care and in total.

Line 1.--Enter in column 3, the total HCHC cost from Worksheet O-6, Part I, column 18, line 50, plus Worksheet O-7, column 8, line 9.

Line 2.--Enter in column 3, the total HCHC days from Worksheet S-4, column 4, line 1.

Line 3.--Enter in column 3, the average HCHC cost per diem by dividing column 3, line 1, by column 3, line 2.

Line 4.--Enter in column 1, the title XVIII - Medicare HCHC days from Worksheet S-4, Part I, column 1, line 1. Enter in column 2, the title XIX - Medicaid HCHC days from Worksheet S-4, Part I, column 2, line 1.

Line 5.--Enter in column 1, the title XVIII - Medicare program cost calculated by multiplying column 3, line 3, by column 1, line 4. Enter in column 2, the title XIX - Medicaid program cost calculated by multiplying column 3, line 3, by column 2, line 4.

Line 6.--Enter in column 3, the total HRHC cost from Worksheet O-6, Part I, column 18, line 51, plus Worksheet O-7, column 9, line 9.

Line 7.--Enter in column 3, the total HRHC days from Worksheet S-4, column 4, line 2.

Line 8.--Enter in column 3, the average HRHC cost per diem by dividing column 3, line 6, by column 3, line 9.

Line 9.--Enter in column 1, the title XVIII - Medicare HRHC days from Worksheet S-4, column 1, line 2. Enter in column 2, the title XIX - Medicaid HRHC days from Worksheet S-4, column 2, line 2.

Line 10.--Enter in column 1, the title XVIII - Medicare program cost calculated by multiplying column 3, line 8, by column 1, line 9. Enter in column 2, the title XIX - Medicaid program cost calculated by multiplying column 3, line 8, by column 2, line 9.

Line 11.--Enter in column 3, the total HIRC cost from Worksheet O-6, Part I, column 18, line 52, plus Worksheet O-7, column 10, line 9.

Line 12.--Enter in column 3, the total HIRC days from Worksheet S-4, column 4, line 3.

Line 13.--Enter in column 3, the average HIRC cost per diem by dividing column 3, line 11, by column 3, line 12.

Line 14.--Enter in column 1, the title XVIII - Medicare HIRC days from Worksheet S-4, column 1, line 3. Enter in column 2, the title XIX - Medicaid HIRC days from Worksheet S-4, column 2, line 3.

Line 15.--Enter in column 1, the title XVIII - Medicare program cost calculated by multiplying column 3, line 13, by column 1, line 14. Enter in column 2, the title XIX - Medicaid program cost calculated by multiplying column 3, line 13, by column 2, line 14.

Line 16.--Enter in column 3, the total HGIP cost from Worksheet O-6, Part I, column 18, line 53, plus Worksheet O-7, column 11, line 9.

Line 17.--Enter in column 3, the total HGIP days from Worksheet S-4, column 4, line 4.

Line 18.--Enter in column 3, the average HGIP cost per diem by dividing column 3, line 16, by column 3, line 17.

Line 19.--Enter in column 1, the title XVIII - Medicare HGIP days from Worksheet S-4, column 1, line 4. Enter in column 2, the title XIX - Medicaid HGIP days from Worksheet S-4, column 2, line 4.

Line 20.--Enter in column 1, the title XVIII - Medicare program cost calculated by multiplying column 3, line 18, by column 1, line 19. Enter in column 2, the title XIX - Medicaid program cost calculated by multiplying column 3, line 18, by column 2, line 19.

Line 21.--Enter in column 3, the sum of lines 1, 6, 11, and 16.

Line 22.--Enter in column 3, total days from Worksheet S-4, column 4, line 5.

Line 23.--Enter the average cost per diem by dividing column 3, line 21, by column 3, line 22.

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FORM CMS-1728-19 Worksheets

The following is a listing of the FORM CMS-1728-19 worksheets and the page number location.

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