3641. WORKSHEET H - ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

This worksheet provides for the recording of direct HHA costs such as salaries, fringe benefits, transportation, and contracted services as well as other costs from your accounting books and records to arrive at the identifiable agency cost. This data is required by 42 CFR 413.20. It also provides for the necessary reclassifications and adjustments to certain accounts prior to the cost finding calculations. Obtain these direct costs from your records. List the cost centers in a manner which facilitates the sequential listing of accounts and array of expense accounts for transfer of the various cost center data from Worksheets H-1, H-2, and H-3. For cost reporting periods beginning on or after 10/1/2000 the amounts in columns 1, 2 and 4 are to be input. All of the cost centers listed do not apply to all agencies.

Column 1--Obtain the expenses listed from Worksheet H-1, column 9. The sum of column 1 must equal Worksheet H-1, column 9, line 24.

Column 2--Obtain the expenses listed from Worksheet H-2, column 9. The sum of column 2 must equal Worksheet H-2, column 9, line 24.

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 assigned to a particular cost center, enter those costs in the appropriate cost center. If these costs are not identifiable to a particular cost center, enter them on line 4.

Column 4--Obtain the expenses listed from Worksheet H-3, column 9. The sum of column 4 must equal Worksheet H-3, column 9, line 24.

Column 5--From your books and records, enter on the applicable lines all other identifiable costs which have not been reported in columns 1 through 4.

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

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

Column 8--Add column 7 to column 6, and extend the net balances to column 8.

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

Column 10--Adjust the amounts in column 8 by the amounts in column 9, and extend the net balance to column 10.

Transfer the amounts in column 10, lines 1 through 24, to the corresponding lines on Worksheet H-4, Part I, column 0.

Line Descriptions

Lines 1 and 2--These cost centers include depreciation, leases and rentals for the use of facilities

and/or equipment, interest incurred in acquiring land or depreciable assets used for patient care, insurance on depreciable assets used for patient care, and taxes on land or depreciable assets used for patient care.

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

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

Line 5--Use this cost center to record the expenses of several costs which benefit the entire facility. Examples include fiscal services, legal services, accounting, data processing, taxes, and malpractice costs.

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

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

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

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

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

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

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

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

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

If the vaccine is administered in the course of an otherwise covered home health visit, the visit is 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 is entitled to separate payment for the vaccine and its administration under the Part B vaccine benefit.

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

Line 13.20.--For cost reporting periods ending on or after July 1, 2006, enter the cost incurred to administer pneumococcal, influenza, *and* hepatitis B vaccines on this line.

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

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

Lines 15-23--Lines 15-23 identify nonreimbursable services commonly provided by a home health agency. These include home dialysis aide services (line 15), respiratory therapy (line 16), private duty nursing (line 17), clinic (line 18), health promotion activities (line 19), day care program (line 20), home delivered meals program (line 21), and homemaker service (line 22). The cost of all other nonreimbursable services are aggregated on line 23. If you are reporting costs for telemedicine, these costs are to be reported on line 23.50. Use this line throughout all applicable worksheets.

3642. WORKSHEET H-1 - COMPENSATION ANALYSIS - SALARIES AND WAGES

A detailed analysis of salaries and wages compensation is required to explain data entered on Worksheet H, column 1. This data is required by 42 CFR 413.20. A small HHA, as defined in 42 CFR 413.24(d), does not have to complete Worksheet H-1. If Worksheet H-1 is not required, enter all salary and wage amounts in the appropriate cost center on Worksheet H, column 1.

For cost reporting periods beginning on or after October 1, 2000, worksheets H-1, H-2 and H-3 are no longer required to be completed for all home health agencies.

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

The HHA must maintain the records necessary to determine the split in salary (and employee-related benefits) between two or more cost centers and must adequately substantiate the method used to split the salary and employee-related benefits. These records must be available for audit by your intermediary. Your intermediary can accept or reject the method used to determine the split in salary. Any deviation or change in methodology to determine splits in salary and employee benefits must be requested in writing and approved by your intermediary before any change is effectuated. Where approval of a method has been requested in writing and this approval has been received (prior to the beginning of the cost reporting period), the approved method remains in effect for the requested period and all subsequent periods until you request in writing to change to another method or until your intermediary determines that the method is no longer valid due to changes in your operations.

Definitions

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

Administrators (Column 1)

Possible Titles: President, Chief Executive Officer

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

Directors (Column 2)

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

Duties: The medical director is responsible for helping to establish and assure that the quality of medical care is appraised and maintained. This individual advises the chief executive officer on medical and administrative problems and investigates and studies new developments in medical practices and techniques. The nursing director is responsible for establishing the objectives for

the department of nursing. This individual administers the department of nursing and directs and delegates management of professional and ancillary nursing personnel.

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

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

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

Physical Therapy	-	line 7
Occupational Therapy	-	line 8
Speech Pathology	-	line 9
Medical Social Services	-	line 10

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

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

Speech-language pathology is the provision of services to persons with impaired functional communications skills by or under the direction of a qualified speech-language pathologist as prescribed by a physician.

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

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

NOTE: Normally, the services of a medical social worker are not classified as therapy. However, include the medical social worker data in column 6 to simplify reporting.

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

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

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

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

3643. WORKSHEET H-2 - COMPENSATION ANALYSIS - EMPLOYEE BENEFITS (PAYROLL-RELATED)

A detailed analysis of employee benefits compensation is required to explain data entered on Worksheet H, column 2. This data is required by 42 CFR 413.20. A small HHA, as discussed in 42 CFR 413.24(d), does not have to complete Worksheet H-2. If Worksheet H-2 is not required, enter the employee benefit amounts in the appropriate cost center on Worksheet H, column 2.

Enter all payroll-related employee benefits for the HHA on this worksheet. See HCFA Pub. 15-I, §§2144 - 2145 for a definition of fringe benefits. Entries are made using the same basis as that used for reporting salaries and wages on Worksheet H-1. Therefore, using the example in §3642, 75 percent of the administrator's payroll-related fringe benefits is entered on line 5 (administrative and general - HHA) and 25 percent of the administrator's payroll-related fringe benefits is entered on line 6 (skilled nursing care).

Report payroll-related employee benefits in the cost center where the applicable employee's compensation is reported. This assignment is performed on an actual basis or upon the following basis:

- o FICA based on actual expense by cost center;
- o Pension and retirement and health insurance (non union) based on gross salaries of participating individuals by cost centers;
- o Union health and welfare based on gross salaries of participating union members by cost center; and
- o All other payroll-related benefits based on gross salaries by cost center.

Include nonpayroll-related employee benefits in the administrative and general-HHA cost center. Costs for such items as personal education, recreation activities, and day care are included in the administrative and general - HHA cost center.

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

Add the amounts in each column, lines 1 through 23, and enter this total on line 24 for each column. Transfer the totals in column 9 to Worksheet H, column 2, lines as applicable. To facilitate transferring amounts from Worksheet H-2 to Worksheet H, list the same cost centers with corresponding line numbers on both worksheets.

3644. WORKSHEET H-3 - COMPENSATION ANALYSIS - CONTRACTED SERVICES/PURCHASED SERVICES

A detailed analysis of contracted or purchased services is required to explain data entered on Worksheet H, column 4. This data is required by 42 CFR 413.20. A small HHA, as defined in 42 CFR 413.24(d), does not have to complete Worksheet H-3. If Worksheet H-3 is not required, enter the contracted and purchased services amounts in the appropriate cost center on Worksheet H, column 4.

All other provider-based agencies must enter on this worksheet all costs for contracted and/or purchased services for the HHA. Enter the contracted/purchased cost on the appropriate cost center line within the column heading which best describes type of services purchased. For example, when physical therapy services are purchased, enter the contract cost of the therapist in column 6, line 7. If a contracted/purchased service covers more than one cost center, then include the amount applicable to each cost center on each affected cost center line.

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

Add the amounts in each column, lines 1 through 23, and enter the total on line 24. Transfer the total in column 9 to Worksheet H, column 4, lines as applicable. To facilitate transferring amounts from Worksheet H-3 to Worksheet H, list the same cost centers with corresponding line numbers on both worksheets.

3645. WORKSHEET H-4 - COST ALLOCATION HHA STATISTICAL BASIS

Worksheet H-4, Part I, provides for the allocation of the expenses of each HHA 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 home health agency, i.e., other general service cost centers, reimbursable cost centers, and nonreimbursable cost centers. Obtain the total direct expenses from Worksheet H, column 10. To facilitate transferring amounts from Worksheet H to Worksheet H-4, Part I, the same cost centers with corresponding line numbers (lines 1 through 24) are listed on both worksheets.

Worksheet H-4, Part II, provides for the proration of the statistical data needed to equitably allocate the expenses of the home health agency general service cost centers on Worksheet H-4, Part I. If there is a difference between the total accumulated costs reported on the Part II statistics and the total accumulated costs calculated on Part I, use the reconciliation column on Part II for reporting any adjustments. See §3617 for the appropriate usage of the reconciliation columns. For componentized A&G cost centers, the accumulated cost center line number must match the reconciliation column number.

To facilitate the allocation process, the general format of Parts I and II are identical. The column and line numbers for each general service cost center are identical on both parts. In addition, the line numbers for each general, reimbursable, and nonreimbursable cost centers are identical on the two parts of the worksheet. The cost centers and line numbers are also consistent with Worksheets H, H-1, H-2, and H-3.

The statistical bases shown at the top of each column on Worksheet H-4, Part II, are the recommended bases of allocation of the cost centers indicated. If a different basis of allocation is used, the provider must indicate the basis of allocation actually used at the top of the column.

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

When closing the general service cost center, first close those cost centers that render the most services to and receive the least services from other cost centers. The cost centers are listed in this sequence from left to right on the worksheet. However, the circumstances of an agency may be such that a more accurate result is obtained by allocating to certain cost centers in a sequence different from that followed on these worksheets.

NOTE: An HHA wishing to change its allocation basis for a particular cost center or the order in which the cost centers are allocated must make a written request to its intermediary for approval of the change and submit reasonable justification for such change prior to the beginning of the cost reporting period for which the change is to apply. The effective date of the change is the beginning of the cost reporting period for which the request has been made. (See HCFA Pub. 15-I, chapter 23.) In requesting the change, the agency must establish that the alternate basis or sequence of allocation is more accurate than that indicated on the official form. A mere demonstration that a cost allocation is different is not adequate to establish that it is more accurate.

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

On Worksheet H-4, Part II, enter on the first line in the column of the cost center the total statistics applicable to the cost center being allocated (e.g., in column 1, capital-related - buildings and fixtures, enter on line 1 the total square feet of the building on which depreciation was taken). Use accumulated cost for allocating administrative and general expenses.

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

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

Enter on Worksheet H-4, Part II, line 25, the total expenses of the cost center to be allocated. Obtain this amount from Worksheet H-4, Part I, from the same column and line number of the same column. In the case of capital-related costs - buildings and fixtures, this amount is on Worksheet H-4, Part I, column 1, line 1. Exclude from line 24 for each column the first line of that column which is used to compute the unit cost multiplier on line 26. The first line of each column and the corresponding line 24 of the column must match.

Divide the amount entered on line 25 by the total statistical base entered in the same column on the first line. Enter the resulting unit cost multiplier on line 26. 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 H-4, Part I, in the corresponding column and line.

After the unit cost multiplier has been applied to all the cost centers receiving costs, the total expenses (line 24) of all of the cost centers receiving the allocation on Worksheet H-4, Part I, must equal the amount entered on the first line of the cost center being allocated.

The preceding procedures must be performed for each general service cost center. Each cost center must be completed on both Part I and Part II before proceeding to the next cost center.

After all the costs of the general service cost centers have been allocated on Worksheet H-4, Part I, enter in column 6 the sum of the expenses on lines 6 through 23. The total expenses entered in column 6, line 24, equals the total expenses entered in column 0, line 24.

Column Descriptions

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

functions.

If an HHA occupies more than one building (e.g., several branch offices), it may allocate the depreciation and related expenses by building, using a supportive worksheet showing the detail allocation and transferring the accumulated costs by cost center to Worksheet B, column 2.

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

Column 3--Allocate all expenses for plant operation and maintenance based on square feet or dollar value.

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

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

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

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

A&G costs applicable to contracted services may be excluded from the total cost (Worksheet H-4, Part I, column 0) for purposes of determining the basis of allocation (Worksheet H-4, Part II, column 5) of the A&G costs. This procedure may be followed when the HHA contracts for services to be performed for the HHA and the contract identifies the A&G costs applicable to the purchased services. The contracted A&G costs must be added back to the applicable cost center after allocation of the HHA A&G cost before the reimbursable costs are transferred to Worksheet H-5. A separate worksheet must be included to display the breakout of the contracted A&G costs from the applicable cost centers before allocation and the adding back of these costs after allocation. Intermediary approval does not have to be secured in order to use the above described method of cost finding for A&G.

Column 6--For lines 6 through 23, add the amounts on each line in columns 0 through 5, and enter the result for each line in this column.

Line 24--Add lines 1 through 23 of columns 0 and 6.

Transfer the amounts in column 6 to Worksheet H-5, Part I, column 0, as follows:

From Worksheet H-4 Part I, Column 6	To Worksheet H-5, Part I Column 0
Line 6	Line 2
7	3

From Worksheet H-4 Column 6	To Worksheet H-5, Part I Column 0
8	4
9	5
10	6
11	7
12	8
13	9
13.20	9.20
14	10
15	11
16	12
17	13
18	14
19	15
20	16
21	17
22	18
23	19

3646. WORKSHEET H-5 - ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

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

3646.1 Part I - Allocation of General Service Costs to HHA Cost Centers.- Worksheet H-5, Part I, provides for the allocation of the expenses of each general service cost center of the hospital to those cost centers which receive the services. Worksheet H-5, Part II provides for the proration of the statistical data needed to equitably allocate the expenses of the general service cost centers on Worksheet H-5, Part I.

Obtain the total direct expenses (column 0, line 20) from Worksheet A, column 7, line 71. Obtain the cost center allocation (column 0, lines 1 through 19) from Worksheet H-4, lines as indicated. The amounts on line 20, columns 0 through 24 and column 26 must agree with the corresponding amounts on Worksheet B, Part I, columns 0 through 24 and column 26, line 71. Complete the amounts entered on lines 1 through 19, columns 1 through 24 and column 26.

NOTE: Worksheet B, Part I, established the method used to reimburse direct graduate medical education cost (i.e., reasonable cost or the per resident amount). Therefore, this worksheet must follow that method. If Worksheet B, Part I, column 26, excluded the costs of interns and residents, column 26 on this worksheet must also exclude these costs.

Line 21--Enter the unit cost multiplier (column 27, line 1, divided by the sum of column 27, line 20 minus column 27, line 1, rounded to 6 decimal places. Multiply each amount in column 27, lines 2 through 19, by the unit cost multiplier, and enter the result on the corresponding line of column 28.

3646.2 Part II - Allocation of General Service Costs to HHA Cost Centers -Statistical Basis--To facilitate the allocation process, the general format of Worksheet H-5, Parts I and II, is identical.

The statistical basis shown at the top of each column on Worksheet H-5, Part II, is the recommended basis of allocation of the cost center indicated.

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

Except for non-PPS providers, unless there is a change in ownership, the hospital must continue the same cost finding methods (including its cost finding bases) in effect in the hospital's last cost reporting period ending on or before October 1, 1991. (See 42 CFR 412.302(d).) If there is a change in ownership, the new owners may request that the intermediary approve a change in order to be consistent with their established cost finding practices. (See HCFA Pub. 15-I, §2313.)

Lines 1 through 19--On Worksheet H-5, Part II, for all cost centers to which the general service cost center is being allocated, enter that portion of the total statistical base applicable to each.

Line 20--Enter the total of lines 1 through 19 for each column. The total in each column must be the same as shown for the corresponding column on Worksheet B-1, line 71.

Line 21--Enter the total expenses for the cost center allocated. Obtain this amount from Worksheet B, Part I, line 71, from the same column used to enter the statistical base on Worksheet H-5, Part II (e.g., in the case of capital-related cost buildings and fixtures, this amount is on Worksheet B, Part I, column 1, line 71).

Line 22--Enter the unit cost multiplier which is obtained by dividing the cost entered on line 21 by the total statistic entered in the same column on line 20. Round the unit cost multiplier to six decimal places.

Multiply the unit cost multiplier by that portion of the total statistics applicable to each cost center receiving the services. Enter the result of each computation on Worksheet H-5, Part I, in the corresponding column and line.

After the unit cost multiplier has been applied to all the cost centers receiving the services, the total cost (line 20, Part I) must equal the total cost on line 21, Part II.

Perform the preceding procedures for each general service cost center.

In column 25, Part I, enter the total of columns 5A through 24.

In column 28, Part I, for lines 2 through 19, multiply the amount in column 27 by the unit cost multiplier on line 21, Part I, and enter the result in this column. On line 20, enter the total of the amounts on lines 2 through 19. The total on line 20 equals the amount in column 27, line 1.

In column 29, Part I, enter on lines 2 through 19 the sum of columns 27 and 28. The total on line 20 equals the total in column 28, line 20.

3647. WORKSHEET H-6 - APPORTIONMENT OF PATIENT SERVICE COSTS

This worksheet provides for the apportionment of home health patient service costs to titles V, XVIII, and XIX. Titles V and XIX use the columns identified as Part A for each program.

3647.1 Part I - Computation of Lesser of Aggregate Program Cost, Aggregate of Program Limitation Cost, or Per Beneficiary Cost Limitation--This part provides for the computation of the reasonable cost limitation to designated program patient care visits and is required by 42 CFR 413.30 and 42 CFR 413.53. For cost reporting periods beginning on or after October 1, 1997, §4601 of the Balanced Budget Act requires a home health agency to be paid based on the lesser of aggregate Medicare cost, aggregate Medicare limitation or the agency specific per beneficiary annual cost limit applied to the unduplicated census count.

Cost Per Visit Computation

Column Descriptions

Column 1--Enter the cost for each discipline from Worksheet H-5, Part I, column 29, lines as indicated. Enter the total on line 7.

Column 2--Where the hospital complex maintains a separate department for any of the cost centers listed on this worksheet, and the departments provide services to patients of the hospital's HHA, complete the amounts entered on lines 2 through 4 in accordance with the instructions contained in §3647.2. Enter the total on line 7.

Column 3--Enter the sum of columns 1 and 2.

Column 4--Enter the total agency visits from your records for each type of discipline on lines 1 through 6. Total visits reported in column 4 reflect visits rendered for the entire fiscal year and equal the visits reported on S-3, Part I, regardless of when the episode was completed.

Column 5--Compute the average cost per visit for each type of discipline. Divide the number of visits (column 4) into the cost (column 3) for each discipline.

Columns 6 and 9--To determine title XVIII, Part A, V, and XIX cost of service, multiply the number of covered visits in completed episodes made to beneficiaries (column 6) (from your records) by the average cost per visit amount in column 5 for each discipline. Enter the product in column 9.

NOTE: Statistics in column 7, lines 1 through 16, reflect statistics for services that are part of a home health plan, and thus not subject to deductibles and coinsurance. OBRA 1990 provides for the limited coverage of injectable drugs for osteoporosis. While covered as a home health benefit under Part B, these services are subject to deductibles and coinsurance. Report charges for osteoporosis injections in column 8, line 16, in addition to statistics for services that are not part of a home health plan.

Columns 7 and 10--To determine the Medicare Part B cost of service, not subject to deductibles and coinsurance, multiply the number of visits made in completed episodes to Part B beneficiaries (column 7) (from your records) by the average cost per visit amount in column 5 for each discipline. Enter the product in column 10. Note if the PS&R reports Part B services separately as "subject to and not subject to" deductibles and coinsurance, add the two reports together for each discipline.

For cost reporting periods that overlap October 1, 2000:

Columns 6, 7, 9, 10 and 12--Subscript these columns and report visits and cost for services rendered prior to October 1, 2000 in columns 6, 7, 8, 9, 10, and 12. For services rendered on and after October 1, 2000 enter visits and costs in columns 6.01, 7.01, 9.01, 10.01, and 12.01. No subscripting

is required for cost reporting periods beginning on or after October 1, 2000.

NOTE: For cost reporting periods which overlap October 1, 2000, the sum of visits reported in columns 6 and 7 and subscripts (if applicable) may not equal the corresponding amounts on Worksheet S-4, column 7, lines 21, 23, 25, 27, 29 and 31, respectively since those visits are reported based upon the completion of the episode during the fiscal year. However, for cost reporting period beginning on or after October 1, 2000, sum of visits reported in columns 6 and 7 must equal the corresponding amounts on Worksheet S-4, column 7, lines 21, 23, 25, 27, 29 and 31, respectively. These visits are reported for episodes completed during the fiscal year.

Columns 8 and 11--Do not use these columns.

Column 12 and 12.01--Enter the total program cost for each discipline (sum of columns 9 and 10). Add the amounts on lines 1 through 6, and enter this total on line 7.

Cost Limitation Computation--Enter for each Metropolitan Statistical Area (MSA) the payment limitation for each discipline for lines 8 through 13. This is supplied by your intermediary. Subscript each discipline line to accommodate multiple MSAs serviced by your home health agency. For cost reporting periods beginning on and after October 1, 2000, the completion of the cost limitation section is no longer required.

Column Descriptions

Column 5--Enter the program limitation (see §1814(b)(1) of the Act) for each discipline on lines 8 through 13. Your fiscal intermediary furnishes these limits to you.

Columns 6 and 9--To determine the program cost limitation for title XVIII, Part A, V, and XIX cost of services, multiply the number of covered visits made to beneficiaries (column 6, lines 1 through 6) (from your records) by the program cost limit amount in column 5 for each discipline. Enter the product in column 9.

Columns 7 and 10--To determine the Medicare cost limitation for Part B cost of services, not subject to deductibles and coinsurance, multiply the number of visits to Part B beneficiaries (column 7, lines 1 through 6) (from your records) by the Medicare cost limit amount in column 5 for each discipline. Enter the product in column 10.

NOTE: Enter in columns 6, 7, 9, and 10 only, the visits rendered through September 30, 2000.

Columns 8 and 11--Do not use these columns for lines 1 through 14.

Column 12--Enter the total program cost limitation for each discipline and subscripts (sum of columns 9 and 10). Add lines 8 through 13 and subscripts, and enter this total on line 14.

Supplies and Drugs Cost Computation.--Certain services covered by the program and furnished by a home health agency are not included in the cost per visit for apportionment purposes. Since an average cost per visit and the cost limit per visit do not apply to these items, develop and apply the ratio of total cost to total charges to program charges to arrive at the program cost for these services.

Column 1--Enter the facility costs in column 1, lines 15 and 16, from Worksheet H-5, Part I, column 29, lines 8 and 9, respectively. For cost reports that overlap October 1, 2000 subscript lines 15 and 16. For cost reporting periods beginning on or after October 1, 2000, do not subscript lines 15 and 16.

Column 2--Enter the shared ancillary costs from Worksheet H-6, Part II, column 3, lines 4 and 5, respectively.

Columns 3 through 5--In column 3, enter the total for lines *15, 16, and 16.20* of columns 1 and 2. *For cost reporting periods ending on or after July 1, 2006, enter in column 4 the total charges for lines 15, 16, and 16.20, respectively, in accordance with the chart under instructions for line 16.20. Refer to §3641, lines 13 and 13.20.* Develop a ratio of total cost (column 3) to total charges (column 4) (from your records), and enter this ratio in column 5.

Columns 6 through 8--Enter in the appropriate column the program charges for drugs and medical supplies charged to patients and not subject to reimbursement on the basis of a fee schedule.

Line Descriptions for Columns 6 through 8

Line 15--Enter the program covered charges for services rendered prior to October 1, 2000, for medical supplies charged to patients for items not reimbursed on the basis of a fee schedule.

Line 15.01-- Enter the program covered charges for services rendered on or after October 1, 2000, for medical supplies charged to patients for items not reimbursed on the basis of a fee schedule. For cost reporting periods beginning on or after October 1, 2000, continue to capture medical supply charges in columns 5, 6, and 7 for statistical purposes (has no reimbursement impact) as all medical supplies are covered under the PPS benefit for this period. Report charges only for the services rendered in that fiscal year end regardless of when the episode is concluded. For reporting periods that begin on or after April 1, 2001, eliminate line 15.01 and record all charge and resulting cost data on line 15.

Line 16--Enter the program covered charges for services rendered prior to April 1, 2001, for drugs charged to patients for items not reimbursed on the basis of a fee schedule. Enter in column 7 the charges for pneumococcal vaccine and its administration and influenza vaccine and its administration. Do not enter the charges for hepatitis B vaccine and its administration for services rendered on or after April 1, 2001. For cost reporting periods which overlap April 1, 2001, enter in column 8 the total charges for covered osteoporosis drugs for services rendered prior to April 1, 2001.

For services rendered on or after April 1, 2001 through December 31, 2002, do not enter any amounts in column 7 as pneumococcal vaccine and its administration, influenza vaccine and its administration, and hepatitis B vaccine and its administration are reimbursed on a fee basis, but continue to enter in column 8 the charges for covered osteoporosis drugs as they remain cost reimbursed. (See §1833(m)(5) of the Act.)

For services rendered on and after January 1, 2003, do not enter in column 7 program charges for hepatitis vaccines and its administration as it is fee reimbursed. Enter in column 7 program charges for pneumococcal vaccines and its administration and influenza vaccine and its administration (cost reimbursed) for services rendered on or after January 1, 2003 through June 30, 2006 (for cost reporting periods ending on or after April 30, 2005 (T14) complete only column 7, not column 7.01 (eliminated)). Enter in column 8 the program charges for injectable osteoporosis drugs (cost reimbursed).

Effective for cost reporting periods ending on or after July 1, 2006 (see *§*3641, line 13), line 16 represents*:* pneumococcal, influenza, *and* hepatitis B vaccine *costs* and osteoporosis drugs, but not the administration of these vaccines. See the chart below for proper placement of charges.

Line 16.01-- For reporting periods that overlap April 1, 2001, enter the covered program charges for services rendered on or after April 1, 2001 for drugs charged to patients for items not reimbursed on the basis of a fee schedule in the applicable column. Report program charges for injectable drugs for osteoporosis only in column 8 for services rendered on or after April 1, 2001 through the fiscal year end. For reporting periods that begin on or after April 1, 2001, eliminate line 16.01 and record all charge and resulting cost data on line 16.

NOTE: For lines 15.01 and 16.01 use the same cost to charge ratio reported for lines 15 and 16 respectively.

Line 16.20.--Effective for cost reporting periods ending on or after July 1, 2006 (see §3641, line 13), line 16.20 represents the administration of pneumococcal, influenza, and hepatitis B vaccines. See the chart below for proper placement of charges.

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

Vaccine Charges

	Column 7	Column 8
Line 16	Enter charges for services on or after 7/1/2006 for hepatitis B vaccines. Enter charges for the full fiscal year for pneumococcal and influenza vaccines. Do not enter charges for pre 7/1/2006 hepatitis B vaccines.	Enter charges for the full fiscal year for osteoporosis drugs.
Line 16.20	Enter charges for pre 7/1/2006 pneumococcal and influenza vaccine administration. Do not enter charges for the full fiscal year for hepatitis B vaccine administration. Do not enter charges for services on or after 7/1/2006 for pneumococcal and influenza vaccine administration. For fiscal years beginning on or after 7/1/2006 enter 0 (zero).	This location is shaded as the administration of the osteoporosis drugs is included in the skilled nursing visit.

Columns 6 and 9--To determine the program cost, multiply the program charges (column 6) by the ratio (column 5) for each line. Enter the product in column 9.

Columns 7 (and subscripts) and 10 (and subscripts)--To determine the Medicare Part B cost, multiply the Medicare charges (column 7) by the ratio (column 5) for each line. Follow the same procedure for the corresponding subscripts. Enter the product in column 10 (and 10.01 as applicable).

Columns 8 and 11--To determine the Medicare Part B cost, multiply the Medicare charges (column 8) by the ratio (column 5) for each line. Enter the result in column 11.

Per Beneficiary Cost Limitation

Line 17--Enter the Medicare unduplicated census count for services prior to October 1, 2000 only, from Worksheet S-4, column 2, line 2, for Medicare for cost reporting periods that overlap October 1, 2000. Subscript the line for multiple MSAs as they were reported on S-4 line 20. For cost reporting periods beginning on or after October 1, 2000, completion of the per beneficiary cost limitation data (lines 17 through 19) is no longer required.

Line 18--Enter the agency specific per beneficiary annual limitation supplied by your intermediary for each MSA.

Line 19--Multiply line 17 and subscripts by line 18 and subscripts. If there are multiple MSAs and lines 17 and 18 are subscripted, add them together and enter the result.

3647.2 Part II - Apportionment of Cost of HHA Services Furnished by Shared Hospital Departments.--Use this part only where the hospital complex maintains a separate department for any of the cost centers listed on this worksheet, and the departments provide services to patients of the hospital's HHA. Subscript lines 1-5, as applicable, if subscripted on Worksheet C, Part I.

Column 1--Where applicable, enter in column 1 the cost to charge ratio from Worksheet C, Part I, column 9, lines as indicated.

Column 2--Where hospital departments provide services to the HHA, enter on the appropriate lines the charges applicable to the hospital-based home health agency.

Column 3--Multiply the amounts in column 2 by the ratios in column 1, and enter the result in column 3. Transfer the amounts in column 3 to Worksheet H-6, Part I as indicated. If lines 1-5 are subscripted, transfer the aggregate of each line.

3647.3 Part III - Outpatient Therapy Reduction Computation.--Services are subject to deductible and coinsurance net of operating and capital reductions. This section computes the payment and reduction (for services rendered on or after January 1, 1998) for Part B visit costs subject to deductibles and coinsurance for various home health services provided. For cost reporting periods that overlap the January 1, 1998 effective date, subscripting of columns 2 and 3 is required. For cost reporting periods beginning on or after January 1, 1998, no subscripting is required. For services rendered on and after January 1, 1999, these services are paid under a fee schedule. Report the visits incurred for purposes of balancing total visits with the cost report.

Column 2--Enter in column 2 the average cost per visit amount from Part I, column 5, lines 2 through 4 above.

Column 2.01--Enter in this column the number of visits rendered for each service prior to January 1, 1998.

Column 3 --Enter the number of visits applicable to each service on and after January 1, 1998.

Column 3.01--Enter the result of multiplying column 2 by column 2.01.

Column 4--Multiply column 2 by column 3. Enter 90 percent of the result.

Column 5--Enter the number of visits on or after January 1, 1999.

Line 4--Enter the sum of lines 1 through 3.

3648. WORKSHEET H-7 - CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

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

Worksheet H-7 consists of the following two parts:

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

3648.1 Part I - Computation of Lesser of Reasonable Cost or Customary Charges.--Services

not paid based on a fee schedule are paid the lesser of the reasonable cost of services furnished to beneficiaries or the customary charges made by the providers for the same services. This part provides for the computation of the lesser of reasonable cost as defined in 42 CFR 413.13(b) or customary charges as defined in the 42 CFR 413.13(e).

NOTE: Nominal charge providers are not subject to the lesser of cost or charges (LCC). Therefore, a nominal charge provider only completes lines 1, 2, and 9 of Part I. Transfer the resulting cost to line 10 of Part II.

Line Descriptions

Line 1--This line provides for the computation of reasonable cost of program services. Enter the cost of services from Worksheet H-6, Part I as follows:

For cost reporting periods beginning prior to October 1, 1997:

If Worksheet H-6, Part I, column 12, line 7 is less than column 12, line 14, transfer (aggregate program cost):

To Worksheet H-7, Line 1	From Worksheet H-6,
Col. 1, Part A	Part I, col. 9, sum of lines 7, 15, and 16
Col. 2, Part B - Not subject to deductibles and coinsurance	Part I, col. 10, sum of lines 7, 15, and 16
Col. 3, Part B - Subject to deductibles and coinsurance	Part I, col. 11, sum of lines 7, 15, and 16

If column 12, line 14 is less than column 12, line 7, transfer (aggregate program limitation):

To Worksheet H-7, Line 1	From Worksheet H-6
Col. 1, Part A	Part I, col. 9, sum of lines 14, 15, and 16
Col. 2, Part B - Not subject to deductibles and coinsurance	Part I, col. 10, sum of lines 14, 15, and 16
Col. 3, Part B - Subject to deductible and coinsurance	Part I, col. 11, sum of lines 14, 15, and 16

For cost reporting periods beginning on or after October 1, 1997:

If Worksheet H-6, Part I, column 12, line 7 plus the sum of columns 9, 10, and 11, line 15 is less than column 12, line 14 plus the sum of columns 9, 10, and 11, line 15 or column 2, line 19, transfer (aggregate program cost): Do not include in the calculations below the subscripted columns reported on Worksheet H-6 for services rendered on and after October 1, 2000 except for line 16 or 16.01, column 11, osteoporosis drug costs.

For the following vaccines administered on or after January 1, 2003, enter on line 1, only the cost of pneumococcal and influenza vaccines and their administration reported on Worksheet H-6, line 16, column 10.01 (for cost reporting periods ending on or after April 30, 2005 (T14) transfer column 10, not column 10.01 (eliminated)) and osteoporosis drug costs reported on Worksheet H-6, line 16, column 11. Enter no other costs on this line as drugs for hepatitis are fee reimbursed, and all other services are PPS reimbursed.

For cost reporting periods ending on or after July 1, 2006 (see §3647, line 13), transfer the cost of pneumococcal, influenza, and hepatitis vaccines from Worksheet H-6, *Part I,* column 10, line 16, to column 2 of this worksheet, and the cost of osteoporosis drugs from worksheet H-6, column 11, line 16 to column 3 of this worksheet. *Also for cost reporting periods that overlap July 1, 2006 for the portion of the reporting period before July 1, 2006,* transfer the administration of pneumococcal and influenza vaccines from worksheet H-6, *Part I,* column 10, line 16.20, to column 2.

To Worksheet H-7, Line 1	From Worksheet H-6,
Col. 1, Part A	Part I, col. 9, sum of lines 7, 15, and 16
Col. 2, Part B - Not subject to deductibles and coinsurance	Part I, col. 10 & 10.01, sum of lines 7, 15, and 16
Col. 3, Part B - Subject to deductibles and coinsurance	Part I, col. 11, lines 15 and 16 added to Part III, sum of columns 3.01 and 4, line 4 for services rendered prior to January 1, 1999

If column 12, line 14 plus the sum of columns 9, 10, and 11 line 15 is less than column 12, line 7 plus the sum of columns 9, 10, and 11 line 15 or column 2, line 19, transfer (aggregate program limitation):

To Worksheet H-7, Line 1	From Worksheet H-6,
Col. 1, Part A	Part I, col. 9, sum of lines 14, 15, and 16
Col. 2, Part B - Not subject to deductibles and coinsurance	Part I, col. 10, sum of lines 14, 15, and 16
Col. 3, Part B - Subject to deductibles and coinsurance	Part I, col. 11, lines 15 and 16 added to Part III, sum of columns 3.01 and 4, line 4 for services rendered prior to January 1, 1999

If Column 2, line 19 is less than column 12, line 7 or line 14 plus the sum of columns 9, 10, and 11 line 15 apportion the amount to Part A and Part B in proportion to the Part A and Part B costs reported in columns 9 and 10, line 7 of Worksheet H-6, Part I. Add the amount reported in columns 9 and 10, line 16 to Parts A and B (Not subject to deductible and coinsurance). Enter in column 3 (subject to deductible and coinsurance) the sum of Worksheet H-6, Part I, column 11, lines 15 and 16 and Part III, columns 3.01 and 4, line 4.

Lines 2 through 6--These lines provide for the accumulation of charges which relate to the reasonable cost on line 1. Do not include on these lines (1) the portion of charges applicable to the excess costs of luxury items or services (see CMS Pub. 15-I, chapter 21) and (2) provider charges to beneficiaries for excess costs as described in CMS Pub. 15-I, §2570. When provider operating costs include amounts that flow from the provision of luxury items or services, such amounts are not allowable in computing reimbursable costs. For cost reports that overlap October 1, 2000, enter only the charges for services rendered prior to October 1, 2000. For cost reporting periods beginning on or after October 1, 2000, enter only the charges associated with osteoporosis drugs which continue to be cost reimbursed. For services rendered on or after January 1, 2003, enter the charges for applicable Medicare covered pneumococcal and influenza vaccines (from worksheet H-6, Part I, line 16, column 7.01 (column 7 for cost reporting periods ending on or after 4/30/2005 as column 7.01 is eliminated)).

Line 2--Enter from your records in the applicable column the program charges for Part A, Part B not subject to deductibles and coinsurance, and Part B subject to deductibles and coinsurance.

Effective for cost reporting periods ending on or after July 1, 2006, in column 2, enter the charges for Medicare covered pneumococcal, influenza, and hepatitis B vaccines (from worksheet H-6, lines 16 and 16.20, column 7). In column 3, enter the charges for Medicare covered osteoporosis drugs (from worksheet H-6, line 16, column 8).

Lines 3 through 6--These lines provide for the reduction of program charges when 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. If line 5 is greater than zero, multiply line 2 by line 5, and enter the result on line 6. Providers which do impose these charges and make reasonable efforts to collect the charges from patients liable for payment for services on a charge basis are not required to complete lines 3, 4, and 5, but enter on line 6 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 column 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 on line 7.

Line 8--Enter in each column 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 on line 8.

Line 9--Enter the amounts paid or payable by workmens' compensation and other primary payers where program liability is secondary to that of the primary payer. There are several situations under which program payment is secondary to a primary payer. Some of the most frequent situations in which the Medicare program is a secondary payer include:

- Workmens' compensation,
- No fault coverage,
- General liability coverage,
- Working aged provisions,
- Disability provisions, and
- Working ESRD beneficiary provisions.

Generally, when payment by the primary payer satisfies the total liability of the program beneficiary, for cost reporting purposes only, the services are considered to be nonprogram services. (The primary payment satisfies the beneficiary's liability when the provider accepts that payment as payment in full. The provider notes this on no-pay bills submitted in these situations.) The patient visits and charges are included in total patient visits and charges, but are not included in program patient visits and charges. In this situation, no primary payer payment is entered on line 9.

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

When the primary payer payment does not satisfy the beneficiary's liability, include the covered days and charges in both program visits and charges and total visits and charges for cost apportionment purposes. Enter the primary payer payment on line 9 to the extent that primary payer payment is not credited toward the beneficiary's deductible and coinsurance. Do not enter on line 9 the primary payer payments that are credited toward the beneficiary's deductible and coinsurance. The primary payer rules are more fully explained in 42 CFR 411.

3648.2 Part II - Computation of HHA Reimbursement Settlement.--

Line 10--Enter in column 1 the amount in Part I, column 1, line 1 less the amount in column 1, line 9. Enter in column 2 the sum of the amounts from Part I, columns 2 and 3, line 1 less the sum of the amounts in columns 2 and 3 on line 9. For services rendered on or after October 1, 2000 this line will only include the osteoporosis drug reduced by primary payor amounts.

Lines 10.01 through 10.14--Enter in column 1 only for lines 10.01 through 10.06, as applicable, the appropriate PPS reimbursement amount for each episode of care payment category as indicated on the worksheet. Enter in column 1 only on lines 10.07 through 10.10, as applicable, the appropriate PPS outlier reimbursement amount for each episode of care payment category as indicated on the worksheet. Enter on lines 10.12 through 10.14 the total DME, oxygen, prosthetics and orthotics payments, respectively, associated with home health PPS services (bill types 32 and 33). For lines 10.12 through 10.14 do not include any payments associated with services paid under bill type 34X. Obtain these amounts from your PS&R report.

Line 11--Enter in column 2 the Part B deductibles billed to program patients. Include any amounts of deductibles satisfied by primary payer payments.

NOTE: If the component qualifies as a nominal charge provider, enter 20 percent of costs subject to coinsurance on this line. Compute this amount by subtracting Part B deductibles on line 11 and primary payment amounts in column 3, line 9 from Part B costs subject to coinsurance in column 3, line 1. Multiply the resulting amount by 20 percent and enter it on this line.

Line 13--If there is an excess of reasonable cost over customary charges in any column on line 8, enter the amount of the excess in the appropriate column.

Line 15--Enter in column 2 all coinsurance billable to program beneficiaries including amounts satisfied by primary payer payments. Coinsurance is applicable for services reimbursable under §1832(a)(2) of the Act.

NOTE: If the component qualifies as a nominal charge provider, enter 20 percent of the costs subject to coinsurance on this line. Compute this amount by subtracting Part B deductibles on line 11 and primary payment amounts in column 3, line 9 from Part B costs subject to coinsurance in column 3, line 1. Multiply the resulting amount by 20 percent and enter it on this line.

Line 17--Enter the reimbursable bad debts in the appropriate columns. If recoveries exceed the current year's bad debts, line 17 will be negative.

Line 17.01--Enter the gross reimbursable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. This amount must also be reported on line 17. (4/1/2004b)

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

Line 20--Enter the program's share of any recovery of excess depreciation applicable to prior years resulting from provider termination or a decrease in program utilization. Submit the work papers which have developed this amount. (See CMS Pub. 15-I, §132.)

Line 21--Enter any other adjustments. For example, enter an adjustment from changing the recording of vacation pay from the cash basis to accrual basis. (See CMS Pub. 15-I, §2146.4.)

Include on this line, for cost reporting periods beginning in Federal fiscal year 2000 only, the special payment for Outcome and Assessment Information Set (OASIS) determined by multiplying the Medicare unduplicated census count on Worksheet S-4, column 2, line 2 and subscripts times $10 reduced by the amount received on April 1, 2000. Do not include this interim payment on Worksheet H-8 but attach separate documentation supporting the payment.

Line 22--Enter the result of line 18 plus or minus lines 19 and 21, minus line 20.

Line 23--Using the methodology explained in §120, enter the sequestration adjustment.

Line 24--Enter line 22 minus line 23.

Line 25--Enter the interim payment amount from Worksheet H-8, line 4. For intermediary final settlement, report on line 25.01 the amount from line 5.99. For titles V and XIX, enter the interim payments from your records.

Line 26--The amounts show the balance due the provider or the program. Transfer to Worksheet S, Part II.

Line 27--Enter the program reimbursement effect of protested items. The reimbursement effect of the nonallowable items is estimated by applying reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See §115.2.) A schedule showing the supporting details and computations for this line must be attached.

THIS PAGE IS LEFT BLANK ON PURPOSE

3649. WORKSHEET H-8 - ANALYSIS OF PAYMENTS TO PROVIDER-BASED HOME HEALTH AGENCIES FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

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

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

Complete the identifying information on lines 1 through 4. The remainder of the worksheet is completed by your fiscal intermediary. Do not include on this worksheet any payments made for DME or medical supplies charged to patients that are paid on the basis of a fee schedule.

Line Descriptions

Line 1--Enter the total Medicare interim payments paid to the HHA for cost reimbursement prior to October 1, 2000. For influenza and pneumococcal vaccines and their respective administration rendered on or after January 1, 2003, enter the total Medicare interim payments paid to the HHA. For osteoporosis vaccines and its administration, enter the total Medicare interim payments paid to the HHA and any other vaccines paid on a cost reimbursement basis. Also include the PPS payments received on and after October 1, 2000 for all episodes concluded in this fiscal year as well as any payments received for osteoporosis drugs. Do not include any payments received for fee scheduled services. The amount entered reflects the sum of all interim payments paid on individual bills (net of adjustment bills) for services rendered in this cost reporting period. The amount entered includes amounts withheld from your interim payments due to an offset against overpayments applicable to prior cost reporting periods. It does not include any retroactive lump sum adjustment amounts based on a subsequent revision of the interim rate, or tentative or net settlement amounts, nor does it include interim payments payable. If you are reimbursed under the periodic interim payment method of reimbursement, enter the periodic interim payments received for this cost reporting period.

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

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

Line 4--Enter the total amount of the interim payments (sum of lines 1, 2, and 3.99). Transfer these totals to the appropriate column on Worksheet H-7, Part II, line 25.

DO NOT COMPLETE THE REMAINDER OF WORKSHEET H-8. THE REMAINDER OF THE WORKSHEET IS COMPLETED BY YOUR FISCAL INTERMEDIARY.

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

Line 6--Enter in column 2 the amount on Worksheet H-7, Part II, column 1, line 26. Enter in column 4 the amount on Worksheet H-7, Part II, column 2, line 26.

Line 7--Enter the net settlement amount (balance due to you or balance due to the program) for the NPR, or, if this settlement is after a reopening of the NPR, for this reopening. Enter the total of the amounts on lines 4, 5.99, and 6.

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