1725. SUPPLEMENTAL WORKSHEET K - HOME HEALTH AGENCY (HHA)-BASED HOSPICE COST AND DATA REPORT

The data entered on Worksheet S-1 relates only to home health agency patients. All statistical and employment data relating to hospice services provided by a home health agency-based hospice under a hospice plan of care are to be entered on Supplemental Worksheets K and K-1. All patients receiving either hospice or home health services must be placed into one of the following four categories upon admission. The categories determine which worksheets are to be used to record the statistical data for that patient.

Home Health - Patient is receiving services under a home health plan of treatment (enter on Worksheet S-1)

1. Medicare Home Health (patient is Medicare but is not currently under a Medicare hospice election)

2. Other (non-Medicare) Home Health

Hospice - Patient is receiving services under a hospice interdisciplinary team plan of care (enter on Supplemental Worksheets K and K-1)

3. Medicare Hospice (patient is currently under a valid Medicare hospice election)

4. Other (non-Medicare) hospice

The preceding four categories are mutually exclusive and a patient can never be in more than one category at any one time. In addition, any time a patient switches from one category to another, it is considered a discharge from the initial category and an admission to the subsequent category. This could occur, for example, when a Medicare patient is initially admitted to the HHA under a home health plan of treatment and, subsequent to this, makes a valid Medicare hospice election. In this situation, the patient is considered discharged from the home health agency (Category 1) and admitted to the Home Health Agency-Based Hospice (Category 3). Switching of categories could also occur as a result of revocation of hospice election or exhaustion of hospice benefits.

These categories are also to be used in determining the portion of salaries and fringe benefits to be reported in the hospice cost center on Worksheet A for employees whose time is split (or shared) between hospice activities (treating hospice patients) and home health agency activities (treating home health agency patients).

ITEM 1. HOSPICE INFORMATION

Enter the requested information in the spaces provided. Include the name and address including county of the hospice, the HCFA provider number and the beginning and ending dates of the cost reporting period.

ITEM 2. DATE HOSPICE BEGAN OPERATIONS

Indicate the date the hospice first began operations.

ITEM 3. BEDS PROVIDED

If the hospice directly furnishes inpatient care and maintains distinct part units for "general" and "respite" care, enter the number of beds in each unit. If the hospice directly furnishes only "general" or "respite" care, enter the number of beds in the appropriate space. If the hospice directly furnishes both inpatient "general" and "respite" care, but does not maintain distinct units, enter the total number of beds in the space for "general" beds. If the hospice does not directly furnish inpatient care, enter "None."

ITEM 4. DATE CERTIFIED

Indicate the date the hospice was certified to participate in the Medicare program.

ITEM 5. TYPE OF CONTROL

Indicate the type of ownership or auspices under which the hospice is operated.

a. Voluntary - A voluntary hospice is one which is usually financed by earnings and contributions and governed by a community-based board of directors. The primary function is the care of the terminally ill in the home. Some voluntary hospices are operated under church auspices.

b. Proprietary - A proprietary hospice is one which is owned and operated by an individual or business corporation. The organization may be a sole proprietorship (individual), a partnership (including limited partnership and joint stock company) or a corporation. Indicate the type of operation.

c. Government - A government hospice is administered by a State, county, city or other local unit of government and having as major responsibility the health care and safety of its patients.

ITEM 6. HEALTH CARE PROGRAMS

Check the title(s) under which reimbursement is being claimed for services rendered to beneficiaries, or where "grant" money has been provided under titles III or XX.

ENROLLMENT DAYS

Enter on lines 7 through 12 the enrollment days applicable to each type of care. Enrollment days are unduplicated days of care received by a hospice patient. A day is recorded for each day a hospice patient receives one of the four types of care. Where a patient moves from one type of care to another, count only one day of care for that patient. The day of care for the type of care the patient moved into should be counted. The day of care for the type of care the patient moved from should not be counted. Enter on line 13 the total unduplicated days.

COLUMN DESCRIPTIONS

COLUMN 1--Enter in column 1, only the unduplicated Medicare days applicable to the four types of care. Enter on line 13, the total unduplicated Medicare days.

COLUMN 2--Enter in column 2, only the unduplicated days for Medicare patients who have exhausted their Medicare benefits. Record the days by type of care and enter the total on line 13.

COLUMN 3--Enter in column 3, the unduplicated days for hospice patients which are not counted in either column 1 or 2.

COLUMN 4--Enter the total days for each type of care (i.e., sum of columns 1, 2 and 3). The amount entered in column 4, line 13, should represent the total days of care provided by the hospice.

Line 14--Enter on line 14 for "Title XVIII" and "All Other" the number of patients initially filing an election statement with the hospice within this reporting period. Do not include in the count the number of patients electing subsequent election periods. See HCFA Pub. 21,§204.

Line 15--Enter on line 15, the total title XVIII number of Unduplicated Continuous Care hours which are billed or billable to Medicare. When computing the Unduplicated Continuous Care hours, count only one hour regardless of number of services or therapies provided simultaneously within that hour.

Line 16--Enter the average length of treatment for both "Title XVIII" and "All Other". The average length of treatment includes the number of days of care in the normal election periods of hospice care, (two 90-day periods and one 30-day period). Do not include the number of days in the "Medicare Benefits Exhausted" periods.

Line 17--Enter the Unduplicated Census Count of the hospice for title XVIII patients and all other patients within the reporting period. This amount may not agree with the amount on line 14 because of patients electing subsequent election periods in subsequent reporting periods.

1726. SUPPLEMENTAL WORKSHEET K-1 - PATIENT CARE SERVICE UTILIZATION ANALYSIS

Providers are required to maintain statistical records for proper determination of costs under the Medicare program. The data needed to be maintained depends on the services provided by the hospice. For each of the cost centers or services listed on lines 1 through 14, include the number of direct hours of service. Paid hours include hours of service by employees as well as contracted services. Also provide the number of hours of services applicable to volunteers.

This supplemental worksheet provides for recording visiting service data applicable to the four levels of hospice care. The line descriptions and column headings are repeated for each of the four levels of care.

Routine Home Care hours and Continuous Home Care hours applicable to visiting service are to be reported in Part I. Inpatient Respite Care hours and General Inpatient Care hours applicable to visiting service are to be reported in Part II. In addition, all other visiting service hours applicable to all other patient services (i.e., non-Medicare) should be reported in column 5. Generally, visiting service data are entered in Part II, columns 1 through 4 only where hospice patients receive inpatient services under a contractual arrangement in an inpatient facility not operated by the hospice. Statistics should be recorded in each of the four rate categories in accordance with the level of care actually provided (rather than what rate was paid for that day). In most cases, the level of care actually provided will correspond with the HCFA classification and payment for that day. In some cases, however, the level of care provided by the hospice will differ from HCFA's ultimate determination of the proper classification category and payment rate for that day. For example, a hospice may provide general inpatient care for a patient for a particular day, and later find that HCFA reclassified the day to the routine home care category and payment level because the service provided was not reasonable and necessary for the palliation and management of the terminal illness. In a case such as this, for cost reporting purposes, the statistics must be recorded in the general inpatient care category, even though payment was made at the routine home care rate.

All statistics reported on this supplemental worksheet are for visiting services provided by staff, contracted or volunteer hospice personnel, and should correspond to costs reported under "visiting services" in Supplemental Worksheet K-2. Costs recorded in a patient care service center on Supplemental Worksheet K-2 must have statistics for that center on this supplemental worksheet.

PART I --

Enter the indicated patient care services data applicable to services furnished to hospice patients in their homes.

COLUMN DESCRIPTIONS

COLUMNS 1 and 3--Enter the Medicare service hours applicable to the hospice for each applicable line description which were provided by employees of the hospice or by contractors of the hospice. Hours of patient care made after Medicare benefits are exhausted should be reported in the non-Medicare column (Part II, column 5) and not included in the Medicare columns. The Medicare column data is truncated at 210 days.

Line 16--Enter on line 16 bereavement counseling statistics for deceased hospice patients. Note that this line is not added to routine home care since bereavement counseling is not care provided to the patient.

COLUMNS 2 and 4--Enter the Medicare service hours applicable to the hospice for each applicable line description which were provided by volunteer help of the hospice.

PART II --

Enter the indicated patient care service data applicable to services furnished to hospice patients who are inpatients of facilities furnishing inpatient care to hospice patients under contractual arrangements with the hospice. Do not record inpatient services of physicians or other health care personnel in this part unless they perform a visiting service.

NOTE: Part II of Supplemental Worksheet K-1 is to be used to record statistics for hospice personnel in conjunction with visits made by such personnel to contracted facilities. For example, a hospice may have a contract with a local area hospital to provide general inpatient care and inpatient respite care when needed. On occasion, the hospice may, for example, send one of its counselors to the contracted inpatient facility to provide hospice counseling services, or one of its nurses to check on a patient's progress. Part II of Supplemental Worksheet K-1 is to be used to record this type of activity. Part II of Supplemental Worksheet K-1 is not to be used to record any activity of the contracted inpatient facilities personnel.

COLUMN DESCRIPTIONS

COLUMNS 1 and 3--These columns provide for recording direct service hours applicable to title XVIII patients for Inpatient Respite Care and General Inpatient Care. Enter for each applicable line description, the number of direct hours of service that were provided by the hospice.

COLUMNS 2 and 4--Enter the total volunteer service hours applicable to the hospice for each applicable line description. Hours of patient care made after Medicare benefits are exhausted should be reported in the total column but not included in the Medicare column. The Medicare column data is truncated at 210 days.

EXAMPLE: The amount of time furnished by hospice nurses (i.e., nurses that are either employed by the hospice or whose services are furnished to hospice patients under a contractual arrangement) to patients in their homes are entered in Part I, line 2. The amount of time furnished to hospice patients in inpatient facilities not operated by the hospice, but furnishing inpatient care to hospice patients under a contractual arrangement are entered in Part II, line 2. However, no entries are made in Part II, line 2, with respect to the services of hospice services furnished to hospice inpatients in an inpatient facility operated by the hospice.

1727. SUPPLEMENTAL WORKSHEET K-2 - ANALYSIS OF DIRECT COSTS

The methods of determining costs payable under title XVIII involve making use of data available from the institution basic accounts, as usually maintained, to arrive at equitable and proper payment for services. Supplemental Worksheet K-2 provides for recording the expense accounts from the provider accounting books and records. The cost centers listed on Supplemental Worksheet K-2 are those hospice cost centers for which no separate provision is made on Worksheet A. Generally, the total costs of these cost centers would be included in a single "hospice" cost center on Worksheet A.

Where the cost elements of a cost center are separately maintained on the provider books, a reconciliation of the costs per the accounting books and records to those on this worksheet must be maintained by the provider and is subject to review by the intermediary.

In addition, Supplemental Worksheet K-2 provides for the necessary reclassifications and adjustments to the various cost centers to arrive at the hospice costs to be used by the program for rate setting purposes.

COLUMNS 1 THROUGH 4 - TRIAL BALANCE OF DIRECT EXPENSE (SALARIES-CONTRACTED SERVICES-OTHER-TOTAL)

The expenses listed in these columns must be in accordance with the provider accounting books and records. List on the appropriate lines in columns 1, 2 and 3, the total expenses incurred during the cost reporting period. The expense must be detailed between salaries (column 1), contracted services (column 2) and other than salaries (column 3). The sum of columns 1, 2 and 3 must equal column 4. Any needed reclassifications and/or adjustments must be recorded in columns 5 and 7, as appropriate. The hospice cost on line 25, column 4 must equal the amount shown on Worksheet A, column 6, line 23.

COLUMN 5 - RECLASSIFICATIONS

Enter in this column any reclassifications among the cost center expenses in column 4 which are needed to effect proper cost allocation.

This column may not be completed by all providers, but must be completed to the extent that reclassification to the hospice cost center on Worksheet A (column 7, line 23) are made. The total on line 25, column 5, must equal the amount shown on Worksheet A, column 7, line 23.

COLUMN 6 - SUBTOTAL

Adjust the amounts entered in column 4 by the amounts in column 5 (increase and decrease) and extend the net balances to column 6. The total of column 6 must equal the total of column 4 on line 25 as well as the amount shown on Worksheet A, column 8, line 23.

COLUMN 7 - ADJUSTMENTS

Enter on the appropriate lines in column 7, the adjustments to expenses indicated on Worksheet A, column 9, line 23. The detail of these adjustments will be taken from provider records. The total amount reflected on column 7, line 25, must equal the amount of the adjustments as indicated on Worksheet A, column 9, line 23.

COLUMN 8 - TOTAL

Adjust the amounts in column 6 by the amounts in column 7 (increases or decreases) and extend the net balance to column 8. The amount on Supplemental Worksheet K-2, column 8, line 23, must equal the amount shown on Worksheet A, column 10, line 23.

LINE DESCRIPTIONS

Line 1 - Inpatient - General Care--This cost center includes costs applicable to patients who receive this level of care because their condition is such that they can no longer be maintained at home. Generally, they require pain control or management of acute and severe clinical problems which cannot be managed in other settings. The costs included on this line are those direct and indirect costs of furnishing routine and ancillary services associated with inpatient general care for which other provision is not made on this worksheet.

For a hospice that maintains its own inpatient beds, these costs include (but are not limited to) the costs of furnishing nursing care, patient meals, laundry and linen services, diagnostic and therapeutic services (other than physicians direct patient care services), direct medical social services, drugs and biologicals.

For a hospice that does not maintain its own inpatient beds, but furnishes inpatient general care through a contractual arrangement with another facility, these costs include the amounts paid or payable to the other facility for furnishing general inpatient care (other than physicians apostrophe direct patient care services). Costs incurred by a hospice in furnishing direct services to inpatients receiving inpatient general care under a contractual arrangement in an inpatient facility should be included in visiting service costs.

Line 2 – Physicians apostrophe Services - Inpatient General Care--This cost center includes costs incurred by the hospice or amounts billed through the hospice for furnishing physicians apostrophe direct patient care services to hospice patients receiving inpatient general care.

A hospice that maintains its own inpatient beds should include all costs or amounts for furnishing physicians apostrophe direct patient care services to patients receiving general inpatient care.

A hospice that does not maintain its own inpatient beds, but furnishes inpatient general care through a contractual arrangement with another facility should include amounts paid or payable to or through such other facility for physicians apostrophe direct patient care services. Costs incurred by the hospice or amounts billed through the hospice for furnishing

physician's apostrophe direct patient care services to hospice patients receiving general inpatient care under a contractual arrangement in an inpatient facility should be included in visiting service costs.

Line 3 - Inpatient - Respite Care--This cost center include costs applicable to patients who receive this level of care on an intermittent, nonroutine and occasional basis. The costs included on this line are those direct and indirect costs of furnishing routine and ancillary services associated with inpatient respite care for which other provisions are not made on this worksheet.

For a hospice that maintains its own inpatient beds, these costs include (but are not limited to) the costs of furnishing nursing care, patient meals, laundry and linen services, diagnostic and therapeutic services (other than physicians apostrophe direct patient care services), direct medical social services, drugs and biologicals.

For a hospice that does not maintain its own inpatient beds, but furnishes inpatient respite care through a contractual arrangement with another facility, these costs include the amounts paid or payable to the other facility for furnishing inpatient respite care (other than physicians apostrophe direct patient care services). Costs incurred by a hospice in furnishing direct services to inpatients receiving inpatient respite care under a contractual arrangement in an inpatient facility should be included in visiting service costs.

Line 4 - Physicians Services - Inpatient Respite Care--This cost center includes costs incurred by the hospice or amounts billed through the hospice for furnishing physicians apostrophe direct patient care services to hospice patients receiving inpatient respite care.

A hospice that maintains its own inpatient beds should include all costs or amounts for furnishing physicians apostrophe direct patient care services to patients receiving inpatient respite care.

A hospice that does not maintain its own inpatient beds but furnishes inpatient respite care through a contractual arrangement with another facility should include amounts paid or payable to or through such other facility for physicians apostrophe direct patient care services.

Costs incurred by the hospice or amounts billed through the hospice for furnishing physicians apostrophe direct patient care services to hospice patients receiving general inpatient care under a contractual arrangement in an inpatient facility should be included in visiting service costs.

Line 5 - Physician Services--The amount entered on this line includes costs incurred by the hospice or amounts billed through the hospice for physicians apostrophe direct patient care services, other than amounts included on lines 2 and 4.

Line 6 - Nursing Care--Enter on this line the costs incurred in furnishing nursing care, other than amounts included on lines 1 and 3. Generally, this includes the costs of patient care services furnished by registered nurses, licensed practical nurses and licensed vocational nurses.

Line 7 - Physical Therapy--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; and instructing and counseling patients, relatives, or other personnel and consultation with other health workers concerning a patient apostrophe total treatment program.

Line 8 - Speech/Language Pathology--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: Diagnostic Assessment and Evaluation--including clinical appraisal of speech, voice and language competencies, through standardized and other tasks, to determine need for and types of rehabilitation required; Rehabilitative Treatment--including planning and conducting treatment programs on an individual basis, to develop, restore or improve communicative efficiency of persons disabled in the process of speech, voice and/or language; and Continuing Evaluation/Periodic Re-evaluation--including both standardized and informal procedures to monitor progress and verify current status. Additional activities include, but are not limited to preparation of written diagnostic, evaluative and special reports; provision of extensive counseling and guidance to communicatively-handicapped individuals and their families; and consultation with other health care practitioners concerning a patient apostrophe total treatment program.

Line 9 - Medical Social Services - Direct--This cost center included only the direct expenses incurred in providing Medical Social Services visits. Other expenses of the medical social services department should be recorded on line 1 - Inpatient -General Care or line 3 - Inpatient - Respite Care.

Medical Social Services is the provision of counseling and assessment activities which contribute meaningfully to the treatment of a patient apostrophe 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 apostrophe illness, his/her need for care, response to treatment and adjustment to care; appropriate action to obtain case work services to assist in resolving problems in these areas; and assessment of the relationship of the patient apostrophe medical and nursing requirements to the home situation, financial resources and the community resources available to the patients.

Line 10 - Occupational Therapy--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 funtioning, 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.

Lines 11-14 - Counseling--Counseling services must be available to both the individual and family.This includes bereavement, dietary, spiritual and other counseling services provided while the individual is enrolled in the hospice. Costs associated with the provision of such counseling is accumulted in the appropriate counseling cost center.

Lines 17-18 - Other Visiting Services--Providers will use these lines to record other visiting service costs. The providers will submit a schedule with the cost report detailing expenses included on these lines.

Line 22 - Drugs and Biologicals - Home Care.--The amount entered on this line includes costs incurred for drugs or biologicals provided to the patient while at home. If a pharmacist dispenses prescriptions and provides other services to patients while the patient is both at home or in an inpatient unit, a reasonable allocation of the pharmacist costs must be made and reported respectively on lines 22 (Drugs and Biologicals Home Care) and 1 (Inpatient -General Care) or 3 (Inpatient Respite Care) of Supplemental Worksheet K-2.

A hospice may, for example, use the number of prescriptions provided in each setting to make the allocation, or may use any other method that results in a reasonable allocation of the pharmacists cost in relation to the services rendered.

1728. SUPPLEMENTAL WORKSHEET K-3 - GENERAL SERVICE COST ALLOCATION STATISTICS

The purpose of this worksheet is to furnish the statistical data necessary to compute the allocation of HHA general service costs to hospice cost centers. An HHA with a home health agency-based hospice should have established a "hospice" cost center on Worksheet A. The total costs in the "hospice" cost center should equal the amount entered on Supplemental Worksheet K-2, column 8, line 25. HHA general service costs should be allocated to the "hospice" cost center on Worksheet B, based on statistics entered on Worksheet B-1. Supplemental Worksheet K-3 provides the statistical basis for the distribution of the HHA general service costs allocated to the "hospice" cost center to the various components of the "hospice" cost center.

The columns on Supplemental Worksheet K-3 are identified and numbered to coincide with the columns on Worksheet B-1. Enter in each column on each of lines 1 through 24 the statistics for the applicable general service cost center.

Line 25 - Total Hospice Statistics--In each column enter the sum of the statistics entered on lines 1 through 24. The sum entered in each column on line 25 must equal the amount entered in the corresponding column of the "hospice" cost center line of Worksheet B-1.

Line 26 - Hospice Allocated Cost--Enter the amount allocated to the "hospice" cost center from the corresponding column of Worksheet B, Part I.

Line 27 - Unit Cost Multiplier--Enter the unit cost multiplier from the corresponding column of Worksheet B-1, line 30.