STATE OF INDIANA
Office of Medicaid Policy and Planning
Instructions for the Home Health Agencies Medicaid Cost Reporting Form

GENERAL INSTRUCTIONS
Applicable For Cost Report Revision October 1, 2014
Required for Fiscal Year Ends October 31, 2014 and After

These instructions are for use under the provisions of the home health agency rate-setting criteria (405 IAC 1-4.2). These instructions are not intended to be comprehensive. In completing the forms, providers shall rely on the criteria, Medicare cost reporting requirements, and other relevant rules and regulations. In addition, the results of compliance reviews or inquiry by the Office of Medicaid Policy and Planning (OMPP) or its designee should be considered in the preparation of the annual reports.

Forms and Information - Forms are available on the website of Myers and Stauffer LC at in.mslc.com. Information may be obtained by calling (317) 846-9521 or (800) 877-6927. Completed forms containing original signatures must be mailed by the due date and filed with:

Myers and Stauffer LC,
Certified Public Accountants, Attn: HHA
9265 Counselors Row, Suite 100
Indianapolis, Indiana 46240

For Cost Reporting fiscal years ending October 31, 2014 and after, the new Cost Reporting Form must be used.

For your convenience, the new forms on the Myers and Stauffer LC website include two versions. One version is in Excel and the other version is in PDF format. Whichever format is used, it must be completed, signed, and mailed to Myers and Stauffer LC at the above address. Submission of the annual report electronically is not a valid submission.

Annual Rate Reviews - Providers must file an annual report within one hundred fifty (150) days of their fiscal (reporting) year-end. The OMPP may designate alternative reporting dates as permitted by 405 IAC 1-4.2-3.1. Extensions of the 150-day filing period may be granted for good cause if requested in writing by the provider prior to the reporting due date. For Medicare certified agencies, the cost reporting period should coincide with the Medicare fiscal reporting period. For Non-Medicare agencies, the cost reporting period should coincide with the agency’s fiscal year. All financial data, except hourly and visit rates, should be rounded to the nearest whole number or dollar amount.

Required Attachments to the Medicaid Cost Report - Medicare-certified agencies are required to submit with the Medicaid cost report a complete copy of their most recently filed Medicare cost report. Medicare-certified agencies that are exempt from filing a Medicare cost report are required to disclose their exempt status. All agencies are required to submit a complete set of financial statements coinciding with the cost reporting period.

Full Disclosure Required - The home health agency cost report form requires the full disclosure of cost and statistical information. Full disclosure requires that a knowledgeable financial reader, after reviewing the completed forms and attachments, would not be misled. In completing the forms, attach additional schedules and explanations, where necessary, to accomplish full disclosure (e.g. attach a reconciliation clarifying...
differences between an agency’s Medicaid and Medicare cost reports or disclose that actual hours are not available for physical therapists and estimates were used). Report all data on appropriate lines and schedules of the form.

Attach Explanations Instead of Altering Forms - If there are circumstances in which the form does not seem appropriate to report the data, or if more space is needed, attach a separate schedule. Do not make two listings on a line or change the name of a line (except for lines marked “other”). Column headers may not be modified nor should boxes that have been crossed out or shaded on the form be utilized in submitting data. Lengthy or detailed workpapers involving several pages normally should not be submitted with the report, but should be retained by the provider for future reference and should be made available when requested by the OMPP or its designee.

Cover Letter - A cover letter outlining the nature of the filing or request should accompany all cost reports. Other relevant information that should be provided in the cover letter, when applicable, includes but is not limited to the following information:

- A listing of the documents submitted;
- A complete explanation of all adjustments reported on the Medicaid cost report;
- An explanation of disciplines for which there are total salaries and wages reported in Column (7) that do not receive vacation, sick, and holiday pay;
- If the required time records are not maintained for any specific discipline or for all disciplines; and,
- Other relevant information to support the filing;
- Complete set of financial statements

Agencies NOT Receiving Medicaid Claims Payment During the Current Reporting Period - Agencies that did not receive Medicaid claims payment during the current reporting period are not required to file a Medicaid cost report for that period. If an agency has an active home health agency Indiana AIM number but did not provide Medicaid services during the current reporting period, a cover letter should be sent each reporting period which states that NO Medicaid services were provided during the period. Agencies that provide Waiver services only are exempt from the Medicaid cost report filing requirement.
Sources of Information - The following table presents the common sources of information for the Medicaid cost report form. Any variance between total Medicare cost and total Medicaid cost should be documented in a separate attachment.

<table>
<thead>
<tr>
<th>Medicaid Cost Report</th>
<th>Description</th>
<th>Source</th>
<th>Medicare Cost Report</th>
</tr>
</thead>
</table>
| Schedule 1 Columns 1 - 3 Lines 1-10 | Total Visits | Internal Visit Records and Billing Records | Freestanding: Worksheet S-3, Part 1 Column 5  
Hospital based: Worksheet H-3 Parts I & II, Column 4 |
| Schedule 1 Columns 4-6 Lines 1-10 | Medicaid Visits | Internal Visit Records and Billing Records |  |
| Schedule 1 Columns 1-2& Columns 4-5 Lines 11-19 | Private Pay Hourly & Visit Rates | Billing Registers |  |
Hospital based: Worksheet H, salaries column |
Hospital based: Worksheet H, contract svs column |
| Schedule 2 Column 9, Lines 17-18 | Expenses- Semi-Variable | General Ledger | For transportation:Freestanding : Worksheet A  
transportation column less non-direct care. Hospital based: Worksheet H  
transportation column less non-direct care |
Hospital based: Worksheet H-2 Part I, Employee benefits column |
| Schedule 2 Column 9, Lines 26-46 | Expenses- Overhead | General Ledger |  |
| Schedule 2 Columns 7-9 Lines 47-63 | Expenses- Non Allowable | Payroll Journal and General Ledger |  |
| Schedule 2,Column 10 Lines 1-64 | Expenses- Agency Adjustments | Medicare A-6 and A-8; other non-allowable items as determined by the General Ledger | Freestanding: Worksheets A-4, A-5 and A-6  
Hospital based: Worksheets H-2, Part I; H-3, Parts I & II |
| Schedule 3 Columns 12-17 Lines 1-26 | Hours Paid | Payroll Journal for salaries and PTO; Invoices for contract |  |
Reporting Format - All statistical, salaries and wages, hours paid, and cost data should be reported by specific discipline on the respective cost report line. In addition, total visits, Medicaid visits, and private pay hourly and visit rates should be reported in the appropriate category of In Home Visits or Telehealth “visits” (Telehealth visits are each day that is billed for a patient for telehealth services).

Services which do not result in Medicaid encounters or its equivalent (e.g. staffing services for other agencies, facilities or hospital departments, hospice care, industrial or clinic staffing, etc.), should not be reported on Schedule 1 (Statistics). Additionally, the salaries and benefits associated with these services should be reported on Schedule 2, Column 7-9 with an adjustment in Column (10), or reported on Lines 47-62, Non-Allowable. Corresponding hours for non-Medicaid equivalent encounters should be reported on Schedule 3 in the same manner that expenses were reported as either an adjustment to Column (14) or reported as non-allowable on Lines 15-25.

Examples of costs which should be reported on the non-reimbursable lines are: Home Dialysis Aides Services, Respiratory Therapy, Health Promotion Activities, Day Care Programs, Home Delivered Meals Program, Hospice Services (not provided at the patient’s residence), Private Duty Nursing, and Clinic Services that are not consistent with Medicaid encounters or their equivalents.

For every discipline-specific Medicaid encounter, or its equivalent, there should be a visit, salaries and wages, hours paid, vacation, sick and holiday pay (if applicable), and total cost reported.

Personal Care Attendant and Homemaker - The Personal Care Attendant (PCA) and Homemaker (HM) lines are to be used to capture information for non-certified attendants. Certified home health aides who provide PCA or HM services should be reported on the home health aide lines. Do not use the PCA and/or HM lines unless you can fully report all visits, salaries and wages, total hours paid, vacation, sick and holiday pay and hours paid and the total costs for all PCAs and/or HMs.
SPECIFIC INSTRUCTIONS

Most sections and lines of the forms are self-explanatory. For purposes of these instructions, the following definitions apply. Following the definitions section below are specific instructions to the cost report schedules.

Definitions

“Contemporaneous” means occurring at the same time (e.g., time records that are documented at the same time the event occurred. Documentation created at the end of the day based on a recollection of events is not considered contemporaneous).

“Continuous” means an uninterrupted duration.

“Direct care personnel” means the agency’s registered nurses (RN), licensed practical nurses (LPN), physical therapists (PT), occupational therapists (OT), speech pathologists (SP), home health aides (HHA).

“Home health agency” (HHA) means an agency licensed by the Indiana State Department of Health to provide home health care and enrolled as a Medicaid provider.

“Home health care” means health care provided to recipients who are medically confined to their home (residence) as certified by the attending or primary physician.

“Medicaid visit” means one (1) Medicaid occurrence or encounter.

“Medicare cost report” means either HCFA 1728 (Freestanding Agencies) or HCFA 2552 (Hospital-Based Agencies).

“Non-direct personnel” means administrators, directors, supervisors (including direct care personnel performing supervisory functions), clerical and all other employees not included in the direct care personnel definition.

“OMPP” means the Office of Medicaid Policy and Planning.

“Semi-Variable Component” means direct care supervisors, routine non-billable medical supplies, and direct care transportation.

“Telehealth visit” means the total number of billed days for which a patient is receiving telehealth services.
Agency Information

Medicaid & Medicare Agency Numbers - Agencies should accurately fill in their Medicaid Provider Indiana agency number in the spaces provided. The Medicaid Agency number should be the same provider number reported on home health agency claims submitted for Medicaid payment. Agencies that are certified to participate in the Medicare Program should indicate their Medicare provider number in the appropriate box. Agencies that are not Medicare certified should indicate “N/A” as the Medicare Provider number.

Cost report period - Indicates the period of the report as Month, Day, and Year (i.e. MM/DD/YYYY). Calendar year-end providers (with 12 months of data) would indicate their cost report period as 01/01/XXXX through 12/31/XXXX. Providers with other than a calendar year end would indicate the appropriate date in the same format.

FYE - Is the agency’s Fiscal Year End indicated as the Month and Day (i.e. MM/DD).

County Name - The County Name should be the county of the Agency’s physical address.

Type of Agency - Check the box that best describes your agency. All agencies should check either Freestanding (F) or Hospital-Based (H).

Type of Control - The type of agency: For-profit, non-profit, or Government (state or county) owned.

Schedule 1 – Statistics

Questions -
1) Enter the number of employees at the fiscal year end using the last payroll journal of the year.
2) Enter the percentage of Home Health business that is conducted in Indiana.

Total Visits - The number of total in home visits should include a count for Medicare, Medicaid, Private Pay, Waiver and all other reimbursement payers, regardless of whether paid on an hourly or visit basis (column 1). Column 2 includes the number of days that service was provided as telehealth. The total visits reported should represent all Medicaid equivalent encounters (occurrences) performed during the reporting period, including private duty nursing encounters. Provide an explanation for variances from the Medicare Cost Report.

Medicaid Visits - The Medicaid visits reported should represent only Medicaid encounters (occurrences) performed during the reporting period, including Medicaid private duty nursing encounters. The Medicaid visits are a subset of the Total Visits. Accordingly, Medicaid visits should always be equal to or less than Total visits.

Private Pay Rate - Report the fee charged at the end of the fiscal report period to a large percentage of the agency’s private pay patients, including all non-governmental reimbursement payers such as private insurance. If the amount routinely accepted as payment is less than the amount charged, report the amount accepted as the private pay rate. Agencies should report the private pay rates in all the columns (visit and hour) for which they have any private pay business. If a range of fees is frequently charged or accepted, report only the average fee received.
Personal Care Attendant and Homemaker - Lines 8, 9, 18 and 19 are for non-certified Personnel Care Attendants (PCAs) and Homemakers (HMs) only. Do not use the PCA and/or HM lines unless all visits, salaries and wages, total hours paid, vacation, sick and holiday pay, and the total costs for all PCAs and/or HMs can be reported.

**Schedule 2 - Expenses**

**Direct Care Salaries/Wages**

Direct Care Salaries and Wages - Report on Lines 1-6 the total salaries and wages paid for direct care personnel including vacation, holiday and sick pay, continuing education, staff training and other non-direct care activities.

Column (7) (Salaries) - Should be used to report total salaries and wages associated with personnel that are employees of the agency.

Column (8) (Contract) - Should be used to report total salaries and wages associated with contracted employees of the agency.

If direct care personnel perform billable visits for a different discipline (e.g., an RN performs an LPN visit), contemporaneous, continuous time records must be maintained to allocate the salary between the appropriate direct care lines. If contemporaneous, continuous time records are not maintained, report total salaries and wages and total hours paid on the line which corresponds to the discipline of the employee performing the service.

**Non-Direct Care Salaries/Wages**

Non-Direct Care Salaries and Wages - Report on Lines 8-14 the total salaries and wages paid for non-direct care positions, including vacation, sick, and holiday pay, continuing education, and staff training.

Column (7) (Salaries) - Should be used to report total salaries and wages associated with personnel that are employees of the agency.

Column (8) (Contract) - Should be used to report total salaries and wages associated with contracted employees of the agency.

Non-direct care personnel include: administrative, clerical, maintenance, and other non-direct care personnel.

Lines 11-14 (Other non-direct care wages) - Should be used to report non-direct care wages not included in Lines 8-10. Include a description of the wages included on these lines (i.e.-maintenance wages).
Semi-Variable Costs

Total salaries and wages related to Direct Care Supervisors - Should be reported on Line 16 and should include total salaries and wages, including vacation, sick, and holiday pay, continuing education, staff training and other non-direct care activities performed by Direct Care Supervisors. Column (7) (Salaries) should be used to report salaries and wages associated with personnel that are employees of the agency. Column (8) (Contract) should be used to report salaries and wages associated with contracted employees of the agency.

If supervisory personnel perform billable visits, contemporaneous and continuous time records must be maintained to allocate the salary between the appropriate direct care Lines (1-6) and the direct care supervisor Line (16). If contemporaneous and continuous time records are not maintained, report all salaries and wages, hours paid and vacation, sick, and holiday pay on the lines for direct care supervisors. Note: All salaries and wages paid for non-billable supervisory visits must be reported on Schedule 2, Line 16 (Direct Care Supervisor). All hours paid for non-billable supervisory visits must be reported on Schedule 3, Line 7 (Direct Care Supervisor).

Routine Medical Supplies and Direct Care Transportation Report - Should be reported on Lines 17 and 18, Column (9). Routine medical supplies are non-billable and without the Medicare overhead allocation. Direct Care Transportation is direct care travel only and should be reported with any Medicare overhead allocations. Both items should agree to the general ledger; an attachment to explain the variance must be included if they do not agree. Direct Care Transportation should also agree to the Medicare Cost Report.

Employee Benefits

Employee Benefits - Should be reported on Lines 20-25, Column (9) and include the total amount of employee benefits paid for employees performing both direct and non-direct care services, including those reimbursed by Medicare, Medicaid, Private Pay and all other reimbursement payers. For Medicare-certified agencies, Total Employee Benefits Line 25, Column (11) should either agree with or be reconciled to the total Employee Benefits on the Medicare Cost Report.

Overhead Costs

Overhead Costs - Report the following non-wage overhead/administrative expenses, including hospital allocations, on Lines 26-46:

- Line 26 Rent/Lease Expense
- Line 27 Depreciation Expense
- Line 28 Interest Expense
- Line 29 Property Taxes
- Line 30 Office Supplies
- Line 31 Telephone Expense
- Line 32 Postage Expense
- Line 33 Dues and Subscriptions
- Line 34 Indirect Travel - Report reasonable expenses incurred for non-direct care travel and non-billable, business related travel.
- Line 35 Legal Fees
- Line 36 Accounting Fees
Line 37 Computer Expense  
Line 38 Repairs and Maintenance  
Line 39 Property and Liability Insurance  
Line 40 Miscellaneous A&G  
Line 41 Hospital Allocation  
Lines 42-45 Other - Include a description of the expense included on these lines (i.e. - items not included in above Lines 1-46 and 47-62).

Non-Allowable Expenses

Expenses not covered by this Medicaid program should be included on Lines 47-62. Many of these items are covered by other programs. Non-Allowable items include, but are not limited to: Telehealth expenses (covered under another Medicaid program), DME, Billable Medical Supplies, Private Duty Nursing (non-Medicaid equivalent), Clinic, Hospice, Extended Care, Marketing/Advertising wages and other costs, Bad Debts, and Penalties/Fines/Late Fees.

Line 47, Telehealth, is for reporting all non-salary related expenses for providing telehealth services. This should include the costs of all computers, monitoring equipment, and supplies. Salary should be reported on Schedule 2 Line 1 with the associated hours reported on Schedule 3 Line 1 and with benefits reported on Schedule 3 Line 20-24.

Line 57, Personal Care Attendant (PCA) and Line 58, Homemaker (HM), are for reporting non-certified PCA and HM personnel only. Certified personnel should be reported on the appropriate discipline line. Do not use the PCA and/or HM lines unless you can report visits, salaries and wages, total hours paid, vacation, sick and holiday pay and total costs.

Grand Total of Expenses on Schedule 2

The Grand Total of Expenses on Schedule 2 must agree to the general ledger and trial balance. Documentation and explanations must be provided with the Cost Report if the amounts do not agree.

Column (7) - Should be reconciled to the total of the Federal Income Tax W-2 and Column (8) should be reconciled to the 1099 forms for these disciplines (net of applicable adjustments, e.g., pool nurse services, year-end accruals and reversals, etc.)

Schedule 3 Hours Paid

Report the total number of hours paid associated with the salaries and wages. Total Hours include vacation, sick, holiday, and any other paid time off.

Column (12) (Employee) should be used to report the number of hours paid for personnel who are employees of the agency.  
Column (13) (Contract) should be used to report the number of hours paid for personnel who are contracted employees of the agency.

Paid Time off (PTO) - Any paid time off should be removed in Column (15) and included in Column (12).
Other Items on Schedules 2 and 3

Agency Adjustments - The Agency Adjustment columns should be used to remove costs that are not patient-related. The adjustment columns can also be used to offset revenue items against related expenses. Negative adjustments should be shown in brackets. Adjustments to Salaries and Wages and/or Benefits (Schedule 2) should generally be accompanied by a corresponding adjustment to Hours Paid (Schedule 3). Supporting documentation should be attached via a separate support schedule.

Required Time Records - The following required time records must be maintained for all agencies submitting a Medicaid Cost Report:

a. Total wages and hours paid for ALL home health agency personnel.
b. Total vacation, sick and holiday pay and hours paid for ALL home health agency personnel.
c. Total wages and hours paid in the performance of supervisory functions.

If the required time records are not maintained for any specific discipline or for all disciplines, this fact must be disclosed in the cover letter.

Certification Statement

After adequate review of the completed form, the certification statement must be signed by a responsible person having authorization from the controlling body (board, owner, etc.) of the agency to make such representations. The financial report submitted must contain original signatures. If a preparer is utilized in completing any portion of the forms, the certification statement must contain original signatures of the preparer and the responsible person having authorization from the controlling body.

For Additional Information or Assistance - Please contact Myers and Stauffer LC at (317) 846-9521 or (800) 877-6927 with any question.