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USING COST REPORTS AND PS&R REPORTS TO PROVIDE MEANINGFUL FINANCIAL INFORMATION

Many home health agencies have not developed internal reporting models to appropriately assess the financial impact of Medicare PPS reimbursement. Even so, an appropriately prepared cost report, coupled with the Medicare PS&R report, can provide certain information of value to the agency. The following is an example of the information that can be developed using these two reports.

Medicare Visits and Episodes by Category

Using the PS&R summary reports, the following episodes and visits per-episode are reported on the cost report submission:

	Full w/o Outliers	Full w/ Outliers	LUPA	PEP Only	SCIC w/PEP	SCIC Only	Total
Episodes	613	50	46	5	-	6	720
% of total	85.1%	6.9%	6.4%	0.7%	0.0%	0.8%	100.0%

Medicare Visits Per Category

	Full w/o Outliers	Full w/ Outliers	LUPA	PEP Only	SCIC w/PEP	SCIC Only	Total
Skilled Nursing	4,445	916	101	29	-	77	5,568
Physical Therapy	6,656	991	17	26	-	69	7,759
Occupational Therapy	1,285	639	4	-	-	16	1,944
Speech Therapy	376	265	-	3	-	12	656
Medical Social Services	143	22	1	2	-	6	174
Home Health Aide	5,092	764	1	-	-	71	5,928
Total	17,997	3,597	124	60	-	251	22,029

Average Number of Medicare Visits Per Medicare Episode

The average number of Medicare visits per Medicare episode is determined by dividing the total number of visits per-episode by the number of episodes reported by category. The result is as follows:

	Full w/o Outliers	Full w/ Outliers	LUPA	PEP Only	SCIC w/PEP	SCIC Only	Total
Skilled Nursing	7.3	18.3	2.2	5.8	-	12.8	7.7
Physical Therapy	10.9	19.8	0.4	5.2	-	11.5	10.8
Occupational Therapy	2.1	12.8	0.1	-	-	2.7	2.7
Speech Therapy	0.6	5.3	-	0.6	-	2.0	0.9
Medical Social Services	0.2	0.4	0.0	0.4	-	1.0	0.2
Home Health Aide	8.3	15.3	0.0	-	-	11.8	8.2
Total	29.4	71.9	2.7	12.0	-	41.8	30.6

Reimbursement Per-Episode

The reimbursement per-episode is determined by using total episode reimbursement and dividing by the number of episodes by category. For the year ended December 31, 2005, this results in the following:

	Full w/o Outliers	Full w/ Outliers	LUPA	PEP Only	SCIC w/PEP	SCIC Only	Total
Reimbursement	\$ 1,861,451	\$ 220,522	\$ 11,155	\$ 4,749	\$ -	\$ 18,222	\$ 2,116,100
Reimbursement Per Episode	\$ 3,037	\$ 4,410	\$ 242	\$ 950	\$ -	\$ 3,037	\$ 2,939

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WE HAVE BUYERS AVAILABLE

Is the sale of your home health agency a potential today or in the future? Would you be interested in taking some of the equity out of your agency?

Dixon Hughes works with many entities that are presently acquiring or interested in acquiring your equity interests, either in total or part. Even if you are just beginning to plan for a sale, do not hesitate to contact us. We can assist you in locating a buyer or enhance your operations and financial reporting in anticipation of a future sale to better ensure you receive appropriate consideration for your equity interests.

Contact William T. (Ted) Cuppett, tcuppett@dixon-hughes.com, if you have interests in a current or future equity sell-off.

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Costs of Home Health Services

The costs of home health services are reported below. These costs exclude medical supplies and drugs, which are integrated later in this report. The direct costs are extracted from Worksheet A, column 10 of the cost report submission, meaning that Medicare non-allowable costs are removed.

	Direct Costs	Total Costs
Skilled Nursing	\$ 287,489	\$ 446,853
Physical Therapy	491,937	764,632
Occupational Therapy	141,830	220,451
Speech Therapy	49,173	76,431
Medical Social Services	25,259	39,261
Home Health Aide	138,611	215,448
Total	\$ 1,134,299	\$ 1,763,076

Additionally, non-reimbursable activities are excluded. Total costs are reported, net of drugs and supplies, at amounts presented on Worksheet C, Part I of the cost report submission.

Average Cost Per-Visit

The average cost per-visit is determined using the costs reported above and the total visits as reported on Worksheet S-3, Part 1.

These averages are as follows:

	Direct Costs/Visit	Total Costs/Visit
Skilled Nursing	\$ 43	\$ 67
Physical Therapy	59	91
Occupational Therapy	68	105
Speech Therapy	73	113
Medical Social Services	127	197
Home Health Aide	22	35

Average Direct Cost Per-Episode

The average cost per-episode, excluding drugs and supplies, is determined using the average cost-per-visit, reported above and multiplying those amounts by the average number of visits provided in each category. The result is as follows:

	Full w/o Outliers	Full w/ Outliers	LUPA	PEP Only	SCIC w/PEP	SCIC Only	Total
SN	\$ 313.34	\$ 791.64	\$ 94.88	\$ 250.63	\$ -	\$ 554.55	\$ 334.17
PT	635.29	1,159.63	21.62	304.24	-	672.84	630.51
OT	141.78	864.37	5.88	-	-	180.36	182.61
ST	44.55	384.96	-	43.58	-	145.27	66.18
MSS	29.61	55.85	2.76	50.77	-	126.93	30.67
HHA	184.87	340.07	0.48	-	-	263.36	183.24
Total	\$ 1,349.44	\$ 3,596.53	\$ 125.63	\$ 649.22	\$ -	\$ 1,943.32	\$ 1,427.39

Average Total Cost Per Episode

	Full w/o Outliers	Full w/ Outliers	LUPA	PEP Only	SCIC w/PEP	SCIC Only	Total
SN	\$ 487.06	\$ 1,230.55	\$ 147.48	\$ 389.59	\$ -	\$ 862.02	\$ 519.45
PT	987.43	1,802.43	33.61	472.89	-	1,045.81	980.00
OT	220.38	1,343.56	9.14	-	-	280.35	283.85
ST	69.25	598.37	-	67.74	-	225.80	102.86
MSS	46.02	86.81	4.29	78.92	-	197.29	47.68
HHA	287.33	528.54	0.75	-	-	409.32	284.79
Total	\$ 2,097.48	\$ 5,590.26	\$ 195.27	\$ 1,009.13	\$ -	\$ 3,020.58	\$ 2,218.64

Margins Per-Episode

Using the reimbursement per-episode and costs per-episode, the following margin per-episode (reimbursement less direct costs) and income per-episode (reimbursement less total costs) result. These exclude medical supplies and drugs.

	Total
Reimbursement per episode	\$ 2,939.03
Direct cost per episode	\$ 1,427.39
Margin per episode	\$ 1,511.64
Total cost per episode	\$ 2,218.64
Income per episode	\$ 720.39

ACCOUNTING AND FINANCIAL REPORTING FOR MEDICARE HOME HEALTH EPISODES OF CARE

Many home health agencies understate Medicare revenues and receivables in their financial statements. This understatement is the result of failure to design accounting and financial reporting procedures that address the billing and receivable systems in use by the agency. Unfortunately, many CPAs inexperienced with Medicare PPS reimbursement to home health agencies do not recognize the revenue recognition inadequacies of most home health billing and receivable software systems and, accordingly, are not in an appropriate position to advise their clients.

The Medicare program reimburses home health agencies for home health services based on an episode of care, except for certain circumstances described later in this article. These episodes of care extend for a period of time not exceeding sixty days from the start of care date. Accordingly, revenues relating to the episode (a single flat payment) must be appropriately recognized over the period of care or estimated period of care.

Episodes that begin and end within the same reporting period do not pose a problem for home health agencies inasmuch as the revenues and expenses associated with the episode are both reported in that period. The accounting and financial reporting difficulties relate to those episodes that overlap accounting and financial reporting periods. The following is a simplified explanation of the accounting and financial reporting methodology that should be employed under general conditions. Depending on the computer software being used for Medicare billing and reporting, modifications to this approach may be necessary.

(1) Most home health billing software systems recognize the entire HHRG (PPS Payment) as a receivable at the start of care date. Accordingly, revenues and receivables are technically overstated to the extent that the episode has not been completed.

(2) Additionally, most systems produce a "Deferred Revenue" report. This report reflects the total anticipated PPS payment and, depending on the date of the report, separate that portion of the revenue earned from that unearned on the basis that every episode will have a duration of sixty days.

(3) Lastly, most systems recognize the entire episodic revenue and remove the episode revenue from deferred (unearned) at the date the episode ends, if the episode ends prior to the end of the sixty day period.

Based on this billing and receivable system process, the home health agency should maintain the following accounts in their accounting records:

(1) Medicare receivables – the gross amount of the PPS payment to be paid less any payment received and after any adjustments associated with the initially identified PPS payment. This includes any unearned portion.

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ADVANCED COST REPORTING PROGRAM TO BE OFFERED IN CONJUNCTION WITH COMPREHENSIVE HOSPICE COST REPORTING PROGRAM

Health Services Publishing & Management, an activity of Dixon Hughes PLLC, is offering a one-day Advanced Cost Reporting program in conjunction with its annual Hospice Cost Reporting and Reimbursement Management program. These programs are being offered in Las Vegas in December 2007. For additional information on these programs, please visit www.healthspm.com or contact Margie Pringle at mpringle@dixon-hughes.com.

PROPOSED CHANGES TO PPS REIMBURSEMENT

The long-awaited proposed changes to PPS reimbursement for home health agencies have been released by the U.S. Center for Medicare and Medicaid Services (CMS). Dixon Hughes, like everyone else, is working to digest the details behind the obvious changes. The financial impact of the changes, as proposed, can significantly vary from agency to agency. If we can be of assistance to you in assessing the financial impact on your agency, do not hesitate to contact us.

L O C A T I O N S

Alabama

Birmingham205.212.5300

Georgia

Atlanta404.575.8900

North Carolina

Asheville828.254.2254

Boone828.262.0997

Burnsville828.682.2876

Charlotte704.367.7020

Durham919.484.0630

Greensboro336.383.5200

Greenville252.321.0505

Hendersonville828.692.9176

High Point336.889.5156

Raleigh919.876.4546

Salisbury704.636.9090

Southern Pines910.692.8555

Sylva828.586.6200

Winston-Salem336.714.8100

South Carolina

Charleston/East Bay Street843.722.6443

Charleston/Meeting Street843.937.9710

Greenville864.288.5544

Spartanburg864.583.5800

Summerville843.937.9710

Tennessee

Memphis901.684.2277

Brentwood/Nashville615.312.8272

Texas

Dallas/Fort Worth817.276.4100

West Virginia

Charleston304.343.0168

Fairmont304.368.0580

Morgantown304.292.7343

To ensure compliance with requirements imposed by the IRS, we inform you that any tax advice contained in this communication (including any attachments) is not intended or written to be used, and cannot be used, for the purpose of avoiding penalties under the Internal Revenue Code.



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(2) Deferred revenue – This account is a contra-receivable account and represents that portion of the balance in Medicare receivables that is unearned. Accordingly, the net balance of Medicare receivables (above) and the deferred revenue should equal that amount of receivables only relating to revenues earned through the date of the financial reporting period.

(3) Allowance for PPS adjustments – An allowance for modifications to the original PPS payment amounts for LUPAs, SCICs, PEPs, outliers, or other adjustments expected on recorded revenues after the date of the financial reporting period. LUPA and outlier episodes are based on a per-visit basis for reimbursement in lieu of an episodic reimbursement.

(4) Allowance for denied claims – An allowance for denied claims based on historical experience of the agency.

As previously mentioned, most accounting systems track deferred revenue based on a standard sixty day episode period. Unfortunately, most agencies do not average sixty days per-episode and, accordingly, an adjustment for financial reporting may be required to more accurately reflect revenues earned. To accommodate any adjustment, most agencies carry a balance in the deferred revenue account based on the sixty day method and, as necessary, adjust this balance at the end of each reporting period to reflect a more accurate accounting method if substantially different from the sixty day method.

It is important to understand that the sixty day method results in the most conservative estimate of revenue and may not be in accordance with generally accepted accounting principles that require a matching of revenues and expenses in the period being reported. Methods for modification include, but are not limited to:

- Average length of stay method
- Average number of visits method
- 50% completion method

An inability of the home health agency to report Medicare revenues and receivables appropriately for episodes of care in process at the end of any reporting period can significantly distort those receivables actually earned and realizable. The significance of the distortion is largely dependent on the extent that care deviates from a 60-day episode period. Agency accounting staff and the agency's external CPA firm need to focus on the reality of Medicare PPS revenue recognition to ensure the integrity of financial information developed and used by management and external financial statement users.