2022 Home Health Agencies Annual Report

This is a sample of the online form. Print and use this form to gather the information you will need for submitting the online version.

Please complete this report no later than January 31, 2023.

Facility Information

This report is a: ☐ New Report ☐ Corrected Report

Name of Facility _____

Address of Facility

Address Line 1 _____

Address Line 2 _____

City _____ State _____ ZIP _____

Reporting Period

The required reporting period is January 1 through December 31, 2022.

Please note the reporting period for the Financial Data section must coincide with the most current Medicare cost report for the agency.

Was the agency in operation 12 months at the end of the period? ☐ Yes ☐ No

If No, please report the number of days the agency was in operation _____

Classification

The following definitions apply to this section of the report:

- **Not for Profit** - Excess revenue retained by the corporation; exempt from federal income taxation under section 501 of the Internal Revenue Code of 1954.
- **For Profit (Proprietary)** - Excess revenue distributed to owners or shareholders or held as retained earnings, subject to federal taxation.

Classification ☐ Not for Profit ☐ For Profit

Governmental entity (state, city, county or federal), corporation, company, etc., responsible for the ownership and management of the agency. _____

Who manages the facility (corporation/company)? _____

Is the facility operated as part of a chain, whether or profit or not? ☐ Yes ☐ No

If YES, please give the name and address of the PARENT organization

Parent Organization _____

Address of Parent Organization

Address Line 1 _____

Address Line 2 _____

City _____ State _____ ZIP _____

Other Services

Does the agency's owner/organization have programs/departments providing services to clients in addition to, but separate from, the licensed and/or certified home health agency? Data from these programs are not to be included in this report. ☐ Yes ☐ No

If yes, in which of the following categories is that care provided?

- ☐ Certified Hospice
- ☐ Durable Med Equip
- ☐ Licensed Home Infusion
- ☐ Home Oxygen
- ☐ Outpatient Chemotherapy
- ☐ Outpatient Rehabilitation
- ☐ Private Duty Services
- ☐ Public Health
- ☐ Medicaid Personal Assistance Services
- ☐ Other _____

Home Health Agency – General Information

Service Availability - Home health services are available:

Number of hours a day _____ Number of days a week _____

Agency office hours are:

Number of hours a day _____ Number of days a week _____

Population Served

Please approximate, by percentage, the agency's client population according to the following age categories:

Under 1 _____ **Age 1 - 19** _____ **Age 20 - 44** _____

Age 45 - 64 _____ **Age 65 - 74** _____ **Age 75 - 84** _____

Age 85 and over _____

Services and Visits

Note: If your agency provides services to more than one county, please submit this form for the **main** county and then fill out the **HHA Additional County Reporting Form** for each **additional** county served. (This form includes the county name, services, and number of visits and can be accessed from the main report menu.)

This section should include skilled visits, including skilled nursing, physical therapy, occupational therapy, speech therapy, medical social services, and home health aide, provided through the licensed and/or certified home health agency. These visits can be paid through Medicare, Medicaid, self-pay, private health insurance or other sources. However, they should **not** include private duty nursing, homemaking, personal assistance, or public health visits. Please report utilization for the full 12-month period (calendar year).

Utilization Data: To check your information use the following formula:

Number of patients first day
+ Number admissions
- Number readmissions
= Total unduplicated patients served

How many additional counties will you be reporting? (Must report separately for **all** counties where patients were served)_____

Main County Name _____

Total number of patients on first day of reporting period (January 1) _____

"**Total number of patient admissions**" should include those patients admitted during the report **calendar year**. If a patient was admitted, discharged, and later in the year readmitted, that patient would be counted as two admissions.

Total number of patient admissions during year _____

Total number of patient discharges (including deaths) _____

Total number of patients remaining on last day of reporting period _____

"Total number of patient readmissions" should include those patients who were admitted for service, discharged, and later readmitted for service again, regardless of any difference(s) in the diagnosis upon readmission.

Total number of patient readmissions _____

"Total number of unduplicated patients served during calendar year" should include the number of individuals receiving services from the agency for the given calendar year, counted only ONCE, regardless of the number of services, frequency of admission, or payor source. If a patient was admitted, discharged, and later in the year readmitted, that patient should NOT be counted twice. If a patient is evaluated, but not admitted, that patient should not be counted.

Total number of unduplicated patients served during calendar year _____

"Total number of visits made" should not include evaluation visits for patients who are referred but not later admitted.

Total number of visits made _____

By discipline: (No. of people Served)

- "**Number of people served**," as broken down by discipline, should reflect a duplicated count of the number of clients served by the agency.
- "Total Number of Visits by Discipline" **must be the same** as the "Total Number of Visits" made.

Intermittent Skilled Nursing – Served	_____	**Intermittent Skilled Nursing - Visits**	_____
PT – Served	_____	**PT – Visits**	_____
OT – Served	_____	**OT – Visits**	_____
Speech, Hearing Therapy – Served	_____	**Speech, Hearing Therapy – Visits**	_____
Social Services – Served	_____	**Social Services – Visits**	_____
HHA – Served	_____	**HHA – Visits**	_____

By payor Source - Number of Visits

*****The "TOTAL" for all the visits by each payor source should equal the total number of visits.

"No Pay Source" means visits for which the agency received no payment from any source for billable services

Medicare		**Medicaid**	
Private Health Insurance		**Self-Pay**	
Managed Care		**No Pay Source**	
Other		**TOTAL:**	

PERSONNEL DATA

Please indicate the agency's full-time equivalents (FTEs) as of **December 31, 2022**.

The number of full-time equivalents (FTEs) should indicate the sum of annual paid hours for all employees divided by 2,080 hours.

Employee data should exclude private duty nurses, hospice staff, volunteers, and all personnel whose salary is financed by outside research grants.

For combined facilities, report **ONLY** the personnel for the home health agency.

Nurses – RN - Employees (FTEs)		Nurses – RN - Contract (FTEs)	
Nurses – LPN - Employees (FTEs)		Nurses - LPN - Contract (FTEs)	
Physical Therapists - Employees (FTEs)		Physical Therapists - Contract (FTEs)	
Occupational Therapists - Employees (FTEs)		Occupational Therapists - Contract (FTEs)	
Speech Therapists - Employees (FTEs)		Speech Therapists - Contract (FTEs)	
Medical Social Workers - Employees (FTEs)		Medical Social Workers - Contract (FTEs)	
Home Health Aides - Employees (FTEs)		Home Health Aides - Contract (FTEs)	
PTA - Employees (FTEs)		PTA - Contract (FTEs)	
COTA - Employees (FTEs)		COTA - Contract (FTEs)	
Administrative - Employees (FTEs)		Administrative - Contract (FTEs)	
Administrative Support / Clerical - Employees (FTEs)		Administrative Support / Clerical - Contract (FTEs)	
Total All Categories (FTEs)		**Total All Categories (Contract FTEs)**	

Financial Data

Financial data should include licensed and/or certified home health agency services ONLY.

The reporting period must coincide with the most current Medicare cost report for the agency (Data is for the agency's **FISCAL YEAR**).

Month of Agency's cost reports _____ Fiscal year ending date: _____

Please round to nearest whole dollar. Do not use commas. If actual figures are not available, please estimate and indicate which figures have been estimated by checking the box after the amount.

Total gross revenue includes total revenues from direct patient care and all other sources.

Total gross revenue $_____ ☐ Estimated

Payroll expenses: Report salaries for full-time and part-time personnel as reported in Personnel Data Section

Payroll expenses $_____ ☐ Estimated

Non-payroll expenses: Include all costs for goods and services that have been used or consumed during the reporting period.

Non-payroll expenses $_____ ☐ Estimated

Total expenses $_____

What is your average cost per visit for all disciplines combined? (As shown on the agency's most recent Medicare cost report) $_____

Please indicate the **charge per visit** (dollar amount) and the **cost per visit** for each type of service as shown on the agency's most recent Medicare cost report. If there is no charge or cost, please enter "**0**".

Intermittent Skilled Nursing Charge	$_____	Intermittent Skilled Nursing Cost	$_____
Physical Therapy (PT) Charge	$_____	Physical Therapy (PT) Cost	$_____
Occupational Therapy (OT) Charge	$_____	Occupational Therapy (OT) Cost	$_____
Speech Therapy Charge	$_____	Speech Therapy Cost	$_____
Medical Social Worker (MSW) Charge	$_____	Medical Social Worker (MSW) Cost	$_____
Home Health Aid (HHA) Charge	$_____	Home Health Aid (HHA) Cost	$_____

Report Completion Data

Please complete this report for the previous year no later than January 31, 2023.

Date Report Completed_____

Administrator's Name _____ Administrator's Email _____

If there are questions about any of the responses on this report, who should be contacted?

Contact Name _____

Contact Phone Number _____ Contact Email_____

** Please fill out a separate "Home Health Agency Report - Additional Counties Form" for each additional county served by the agency. ** (This is found on the main menu.)

If you have any questions, please contact:

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