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# Medicare

## Provider Reimbursement Manual - Part 2, Provider Cost Reporting Forms and Instructions, Chapter 32, Form CMS-1728-94

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Department of Health and  
Human Services (DHHS)  
Centers for Medicare and  
Medicaid Services (CMS)

**Transmittal 15**

**Date: March 2010**

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### **NEW/REVISED MATERIAL--EFFECTIVE DATE:**

This transmittal updates Chapter 32, Home Health Agency Cost Report, (Form CMS-1728-94). The effective date for instructional changes will vary due to various implementation dates.

### **Significant Revisions:**

- This transmittal reflects clarifications to existing instructions and electronic cost reporting (ECR) specifications to insure cost report software date sensitivity and backward compatibility. No new Medicare policy is implemented through this transmittal. For ECR purposes, the effective date of this transmittal is identical to the immediately preceding transmittal 14.

**REVISED ELECTRONIC SPECIFICATIONS EFFECTIVE DATE:** Changes to the electronic reporting specifications are effective for cost reporting periods ending on or after October 1, 2009.

**DISCLAIMER:** The revision date and transmittal number apply to the red *italicized material* only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

to two decimal places, e.g., .04447 is rounded to .04. Compute contract FTEs for column 2 as follows. Add all hours for which contracted and consultant staff worked and divide by 2080 hours.

If employees are paid for unused vacation, unused sick leave, etc., exclude these paid hours from the numerator in the calculations.

### Part III - Metropolitan Statistical Area (MSA) or Core Based Statistical Area (CBSA) Code Data.--

Line 28.--Enter the total number of MSAs and/or CBSAs where Medicare covered services were provided during the cost reporting period. MSA codes identify the geographic area at which Medicare covered service are furnished while CBSA codes are five character numeric codes that also identify the geographic area at which Medicare covered service are furnished. Obtain these codes from your fiscal intermediary. The number of identified MSAs/CBSAs must be between 1 and 30.

Line 29.--List all MSA/CBSA and/or Non-MSA/Non-CBSA codes where Medicare covered home health services was provided. Enter one MSA/CBSA code on each line as necessary. If additional lines are needed, continue subscripting with lines 29.01, 29.02 et cetera, as necessary entering one MSA/CBSA code on each subscripted line. Obtain these codes from your fiscal intermediary. Non-MSA (rural) codes are assembled by placing the digits "99" in front of the two digit State code, e.g., for the state of Maryland the rural MSA code is 9921. For HHA services rendered on or after January 1, 2006, enter the 5 digit CBSA code and Non-CBSA (rural). Non-CBSA codes are assembled by placing the digits "999" in front of the two digit State code, e.g., for the state of Maryland the Non-CBSA code is 99921. This line may only be subscripted through line 29.29.

### Part IV - PPS Activity Data - Applicable for Services Rendered on or After October 1, 2000.--

In accordance with 42 CFR §413.20 and §1895 of the Social Security Act, home health agencies are mandated to transition from a cost based reimbursement system to a prospective payment system (PPS) effective for home health services rendered on or after October 1, 2000.

The statistics required on this worksheet pertain to home health services furnished on or after October 1, 2000. Depending on the services provided by the HHA the data to be maintained for each episode of care payment category for each covered discipline include aggregate program visits, corresponding aggregate program charges, total visits, total charges, total episodes and total outlier episodes, and total non-routine medical supply charges.

All data captured in Part IV of this worksheet must be associated only with episodes of care which terminate during the current fiscal year for payment purposes. Similarly, when an episode of care is initiated in one fiscal year and concludes in the subsequent fiscal year, all data required in Part IV of this worksheet associated with that episode will appear in the fiscal year on the PS&R in which the episode of care terminates.

HHA Visits.--See the second paragraph of this section for the definition of an HHA visit.

Episode of Care.--Under home health PPS the 60 day episode is the basic unit of payment where the episode payment is specific to one individual beneficiary. Beneficiaries are covered for an unlimited number of non-overlapping episodes. The duration of a full length episode will be 60 days. An episode begins with the start of care date and must end by the 60<sup>th</sup> day from the start of care.

**Less than a full Episode of Care.--**

When 4 or fewer visits are provided by the HHA in a 60 day episode period, the result is a low utilization payment adjustment (LUPA). In this instance the HHA will be reimbursed based on a standardized per visit payment.

An episode may end before the 60<sup>th</sup> day in the case of a beneficiary elected transfer, or a discharge and readmission to the same HHA (including for an intervening inpatient stay). This type of situation results in a partial episode payment (PEP) adjustment.

When a beneficiary experiences a significant change in condition (SCIC) and subsequently, but within the same 60 day episode, elects to transfer to another provider, a SCIC within a PEP occurs. Effective for episodes of care ending on or after January 1, 2008, do not complete column 5 for SCIC within PEP episodes.

A significant change in condition (SCIC) adjustment occurs when a beneficiary experiences a significant change in condition, either improving or deteriorating, during the 60 day episode that was not envisioned in the original plan of care. The SCIC adjustment reflects the proportional payment adjustment for the time both prior and after the beneficiary experienced the significant change in condition during the 60 day episode. Effective for episodes of care ending on or after January 1, 2008, do not complete column 6 for SCIC-only episodes.

Use lines 30 through 41 to identify the number of visits and the corresponding visit charges for each discipline for each episode payment category. Lines 42 and 44 identify the total number of visits and the total corresponding charges, respectively, for each episode payment category. Line 45 identifies the total number of episodes completed for each episode payment category. Line 46 identifies the total number of outlier episodes completed for each episode payment category. Outlier episodes do not apply to 1) Full Episodes without Outliers and 2) LUPA Episodes. Line 47 identifies the total medical supply charges incurred for each episode payment category. Column 7 displays the sum total of data for columns 1 through 6. The statistics and data required on this worksheet are obtained from the provider statistical and reimbursement (PS&R) report and only pertain to services rendered on or after October 1, 2000.

Columns 1 through 6.--Enter data pertaining to Title XVIII patients only for services furnished on or after October 1, 2000. Enter, as applicable, in the appropriate columns 1 through 6, lines 30 through 41, the number of aggregate program visits furnished in each episode of care payment category for each covered discipline and the corresponding aggregate program visit charges imposed for each covered discipline for each episode of care payment category. The visit counts and corresponding charge data are mutually exclusive for all episode of care payment categories. For example, visit counts and the corresponding charges that appear in column 4 (PEP only Episodes) do not include any visit counts and corresponding charges that appear in column 5 (SCIC within a PEP) and vice versa. This is true for all episode of care payment categories in columns 1 through 6.

Line 42.--Enter in columns 1 through 6 for each episode of care payment category, respectively, the sum total of visits from lines 30, 32, 34, 36, 38 and 40.

Line 43.-- Enter in columns 1 through 6 for each episode of care payment category, respectively, the sum total of other charges for all other unspecified services reimbursed under PPS.

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. Also enter the cost and administration of pneumococcal and influenza vaccines to Medicare beneficiaries receiving services on or after January 1, 1998 in an HHA-based RHC and/or an HHA-based FQHC. 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 would be 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 would be entitled to separate payment for the vaccine and its administration under the Part B vaccine benefit.

Some of the expenses includable in this cost center would be 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.

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 osteoporosis vaccines and the cost of administering the osteoporosis vaccines on this line.

Line 13.20.--Enter the cost incurred to administer pneumococcal, influenza, and hepatitis B vaccines. Use cost center code 1320 in accordance with table 5 of the electronic reporting specifications for the appropriate cost center code.

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.

Line 15.--Enter the cost of home dialysis aide services furnished in connection with a home dialysis program.

Line 16.--These are services for the assessment, diagnostic evaluation, treatment, management, and monitoring of patients with deficiencies or abnormalities of cardiopulmonary function.

Line 23.--Enter the direct costs of all other non-reimbursable services. Enter the direct costs associated with TeleMedicine on line 23.20. See table 5 of the electronic reporting specifications for the appropriate cost center code.

Line 24.--Enter the direct costs of the HHA-based CORF.

Line 25.--Enter the direct costs associated with the HHA-based hospice.

Line 26.--Enter the direct costs associated with the HHA-based CMHC.

Line 27.--Enter the direct costs associated with the HHA-based RHC. \*

Column 4.--Compute the average cost per visit for each type of discipline. Divide the number of visits (column 3) into the cost (column 2) for each discipline.

3215.2 Part II - Computation of the Aggregate Medicare Cost and the Aggregate of the Medicare Limitation.--This part provides for the computation of the cost of Medicare patient care visits and the corresponding reasonable cost limitation for Medicare services provided in the MSA/CBSA/CBSA identified. Complete this part one time for each MSA/CBSA where Medicare beneficiary visits were provided during the cost reporting period. Lines 1 through 6 and column 11 are subscripted to isolate pre October 1, 2000 costs to facilitate the application of the lesser of aggregate costs or aggregate visit limits. Effective for cost reporting periods beginning on or after October 1, 2000, do not complete lines 8 through 14 as all HHAs are reimbursed under PPS and no longer subject to per visit cost limitations; but continue to complete lines 1 through 7.

Column 4.--Transfer the average cost per visit from Worksheet C, Part I, column 4, lines as indicated. The average cost per visit for each discipline is identical for all MSAs/CBSAs.

Columns 5 and 8.--To determine the Medicare Part A cost of services, multiply the number of covered Part A visits made to beneficiaries prior to October 1, 2000 (column 5, lines 1 through 6, excluding subscripts) from your records by the average cost per visit amount in column 4 for each discipline. Enter the product in column 8.

Columns 6 and 9.--To determine the Medicare Part B cost of services not subject to deductibles and coinsurance, multiply the number of visits made to Part B beneficiaries prior to October 1, 2000 (column 6, lines 1 through 6, excluding subscripts) from your records by the average cost per visit amount in column 4 for each discipline. Enter the product in column 9.

Columns 5 and 6, lines 1.01, 2.01, 3.01, 4.01, 5.01, 6.01.--Enter in column 5 the Medicare Part A visits furnished to program beneficiaries on or after October 1, 2000, for episodes completed during the fiscal year. Multiply the number of covered Part A visits from your records by the average cost per visit amount in column 4 for each discipline. Enter the product in column 8. Enter in column 6 the Medicare Part B visits not subject to deductibles and coinsurance furnished to program beneficiaries on or after October 1, 2000, for episodes completed during the fiscal year. Multiply the number of visits made to Part B beneficiaries by the average cost per visit amount in column 4 for each discipline. Enter the product in column 9.

**NOTE:** For cost reporting periods which overlap October 1, 2000, the sum of Worksheets C, Part II, columns 5 and 6, lines 1.01, 2.01, 3.01, 4.01, 5.01 and 6.01, respectively, must equal the corresponding amounts on Worksheet S-3, Part IV, column 7, lines 30, 32, 34, 36, 38 and 40, respectively. For cost reporting periods which begin on or after October 1, 2000, the sum of Worksheets C, Part II, columns 5 and 6, lines 1 through 6, respectively, must equal the corresponding amounts on Worksheet S-3, Part IV, column 7, lines 30, 32, 34, 36, 38 and 40.

Columns 7 and 10.--**DO NOT USE THESE COLUMNS.** See §3215.5.

**NOTE:** For reporting periods overlapping October 1, 2000, the sum of all Worksheets C, Part II, Medicare program visits, sum of lines 1-6 (excluding subscripts) for columns 5 and 6 must be equal to or less than the sum of the visits shown on Worksheet S-3, Part I, column 1, lines 1 through 6.

Column 11.--Enter the total Medicare cost for each discipline (sum of columns 8 and 9) for visits rendered prior to October 1, 2000. Add the amounts on lines 1 through 6 (exclusive of subscripts). Enter this total on line 7. Enter in column 11.01 the total Medicare cost for each discipline (sum of columns 8 and 9, lines 1.01, 2.01, 3.01, 4.01, 5.01, 6.01) for visits rendered on or after October 1, 2000. Enter this total on line 7.

Column Descriptions for Cost Limitation Computation

Column 4.--Enter the Medicare limitation (see § 1861(v)(1)(L) of the Act) for the applicable MSA for each discipline on lines 8 through 13. The intermediary furnishes these limits to the provider.

Columns 5 and 8.--To determine the Medicare limitation cost for Part A cost of services, multiply the number of covered Part A visits made to beneficiaries prior to October 1, 2000 (column 5) from your records by the Medicare cost limit amount in column 4 for each discipline. Enter the product in column 8.

Columns 6 and 9.--To determine the Medicare limitation cost for Part B cost of services, multiply the number of visits made to Part B beneficiaries not subject to deductibles and coinsurance prior to October 1, 2000 (column 6) from your records by the Medicare cost limit amount in column 4 for each discipline. Enter the product in column 9.

**NOTE:** Column 5, line 7 may not equal column 5, line 14; Column 6, line 7 may not equal Column 6, line 14. Columns 5 and 6, respectively, lines 1-6 (excluding subscripts) must equal columns 5 and 6, lines 8-13.

Columns 7 and 10.--**DO NOT USE THESE COLUMNS.** See §3215.5.

Column 11.--Enter the total Medicare limitation cost for each discipline (sum of columns 8 and 9). Add the amounts on lines 8 through 13. Enter this total on line 14.

3215.3 Part III - Supplies and Drugs Cost Computation.--Certain items covered by Medicare and furnished by an HHA are not included in the visit for apportionment purposes. Since an average cost per visit and the cost limit per visit do not apply to these items, the ratio of total cost to total charges is developed and applied to Medicare charges to arrive at the Medicare cost for these items. Enteral/parenteral nutrition therapy (EPNT) items which are considered prosthetic devices furnished by an HHA on or after March 14, 1986, are reimbursed on a reasonable charge basis through billings submitted to the Part B specialty carrier. (As a prosthetic device, such items are reimbursable under Part B only.) Charges for these items must be included in the total charges, but excluded from Title XVIII charge statistics in the apportionment of medical supply costs on Worksheet C, Part III, line 15. Lines 15 and 16 are subscripted to isolate pre 10/1/2000 costs to facilitate the flow of these costs to Worksheet D in order to apply LCC.

**NOTE:** For services furnished on or after January 1, 1989, the HHA Part A reimbursement for DME, prosthetics, and orthotics was changed from cost reimbursement to a fee schedule reimbursement.

Additionally, certain items furnished by an HHA on or after January 1, 1990, are not considered as DME. This includes medical supplies such as catheters, catheter supplies, ostomy bags, and supplies relating to ostomy care.

Lines 15 and 16.--Enter in column 2 the total applicable costs for the entire cost reporting period for each line item from Worksheet B, column 6, lines 12 and 13, respectively (the costs entered on lines 15 and 15.01 must be equal; the costs entered on lines 16 and 16.01 must be equal). Enter in column 3 the total charges for the entire cost reporting period for each line (the charges entered on lines 15 and 15.01 must be equal; the charges entered on lines 16 and 16.01 must be equal). The language in the two preceding parentheticals is only applicable for cost reporting periods which overlap October 1, 2000. *For cost reporting periods ending on or after July 1, 2006, enter in column 2 the total charges for services rendered on lines 15, 16, and 16.20, respectively.* Enter in column 4 the ratio of costs (column 2) to charges (column 3) for each line.

Line 15.--Enter in columns 5, 6, and 7 the charges for medical supplies not paid on a fee schedule for services rendered prior to October 1, 2000. 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.

Line 15.01.--For reporting periods which overlap October 1, 2000, enter in columns 5, 6, and 7 the charges for medical supplies not paid on a fee schedule for services rendered from October 1, 2000 through the fiscal year end. For reporting periods that begin on or after October 1, 2000, eliminate line 15.01 and record all charge and resulting cost data on line 15.

Line 16.--Enter in column 6 the charges for pneumococcal vaccine and its administration, influenza vaccine and its administration, and hepatitis B vaccine and its administration for services rendered prior to April 1, 2001. Enter in column 7 the charge for covered osteoporosis drugs for services rendered prior to October 1, 2000.

For services rendered on or after April 1, 2001 through December 31, 2002, do not enter any amounts in column 6 as pneumococcal vaccine and its administration, influenza vaccine and its administration, and hepatitis B vaccine and its administration are reimbursed under OPPS, but continue to enter in column 7 the charge for covered osteoporosis drugs as they remain cost reimbursed. (See §1833(m)(5) of the Act.)

Effective for services rendered on or after January 1, 2003 through June 30, 2006, pneumococcal vaccines and its administration and influenza vaccine and its administration are cost reimbursed not subject to deductibles and coinsurance. For services rendered on and after January 1, 2003 through June 30, 2006, enter in column 6 program charges for hepatitis vaccines and its administration (OPPS reimbursed). Enter in column 6.01 program charges for pneumococcal vaccines and its administration and influenza vaccine and its administration. Continue to enter in column 7 the program charges for covered injectable osteoporosis drugs as they remain cost reimbursed.

Effective for cost reporting periods ending on or after July 1, 2006 (see section 3206, line 13), line 16 represents pneumococcal, influenza, and hepatitis B vaccines, *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 which overlap April 1, 2001, enter in column 6 the charges for pneumococcal vaccine and its administration and influenza vaccine and its administration. For hepatitis B vaccine and its administration rendered on or after April 1, 2001 through December 31, 2002, enter the charges in column 6. Enter in column 7 the charges for covered osteoporosis drugs rendered on or after April 1, 2001 through the fiscal year end. (See §1833(m)(5) of the Act.) 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. Osteoporosis drugs will continue to be reimbursed on a cost basis for services rendered on and after April 1, 2001 and will use line 16 to record applicable data.

Line 16.20.--Effective for cost reporting periods ending on or after July 1, 2006 (see section 3206, 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:

### Vaccines Charges

|         | <u>Column 6</u>   | <u>Column 7</u>  |
|---------|---|--|
| Line 16 | Enter charges for 7/1/2006 & subsequent hepatitis B vaccines.                   | Enter charges for the full fiscal year for osteoporosis drugs. |
|         | Enter charges for the full fiscal year for pneumococcal and influenza vaccines. |  |

## Vaccines Charges (Continued)

|            | <u>Column 6</u>  | <u>Column 7</u>   |
|------------|--|---|
| Line 16    | Do not enter charges for pre 7/1/2006 hepatitis B vaccines.  |   |
| Line 16.20 | Enter charges for pre 7/1/2006 pneumococcal and influenza vaccine administration.<br><br>Do not enter charges for the full fiscal Year for hepatitis B vaccine administration.<br><br>Do not enter charges for 7/1/2006 & subsequent pneumococcal and influenza vaccine administration.<br><br>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. |

Column 8--To determine the Medicare Part A cost, multiply the Medicare charges (column 5) by the ratio (column 4) for each line item. Enter the product in column 8.

Column 9-9.01--To determine the Medicare Part B cost, multiply the Medicare charges (column 6) by the ratio (column 4) for each line item. Enter the product in column 9. If applicable, multiply the Medicare charges (column 6.01) by the ratio (column 4) for each line item. Do not subscript column 9 for cost reporting periods ending after June 30, 2006.

Column 10--To determine the Medicare Part B cost (subject to deductibles and coinsurance), multiply the Medicare charges (column 7) by the ratio (column 4). Enter the product in column 10.

3215.4 Part IV - Comparison of the Lesser of the Aggregate Medicare Cost, the Aggregate of the Medicare Per Visit Limitation and the Aggregate Per Beneficiary Cost Limitation--This part provides for the comparison of the reasonable cost limitation applied to each home health agency's total allowable cost attributable to Medicare patient care visits. This comparison is required by 42 CFR 413.30 and 42 CFR 413.53. For cost reporting periods beginning on or after October 1, 1997, §1861(v)(1)(L) of the Social Security Act is amended by §4601 of BBA 1997, requiring home health agency net cost of covered services to be based on the lesser of the aggregate Medicare cost, the aggregate of the Medicare cost per visit limitation or the aggregate per beneficiary cost limitation. The per beneficiary cost limitation is derived by totaling the application of each MSA/non-MSA's unduplicated census count (two decimal places) (see §3205) to the per-beneficiary cost limitation for the corresponding MSA/non-MSA. To accomplish this, the sum of all Worksheets C, Part II amounts in column 11, line 7, plus the applicable cost of medical supplies is compared with the sum of all Worksheets C, Part II amounts in column 11, line 14 plus the applicable cost of medical supplies and with the amount in column 6, line 24.

Line 17--Enter in columns 3, 4, and 6, respectively, the sum of the amounts from each Worksheet C, Part II, columns 8, 9, and 11 (exclusive of subscripts), respectively, lines 1-6 (exclusive of subscripts).

3216. WORKSHEET D - CALCULATION OF REIMBURSEMENT SETTLEMENT - PART A AND PART B SERVICES

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 D consists of the following two parts:

- Part I - Computation of the Lesser of Reasonable Cost or Customary Charges. 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 42 CFR 413.13(e)(1).
- Part II - Computation of Reimbursement Settlement.

3216.1 Part I - Computation of the Lesser of Reasonable Cost or Customary Charges.--Providers are paid the lesser of the reasonable cost of services furnished to beneficiaries or the customary charges 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, 3, and 11 of Part I. Transfer the resulting cost to line 12 of Part II.

Line Descriptions

Line 1--Reporting periods beginning prior to October 1, 2000, enter the cost of services from Worksheet C, Parts III, IV and V based on the following table. If the amount in column 6, line 19 is less than the amount in column 6, line 22, and the amount in column 6, line 24, transfer (aggregate Medicare cost). For cost reporting periods beginning on or after October 1, 2000, transfer the cost of osteoporosis drugs from Worksheet C, Part III, column 10, line 16 to column 3 of this worksheet.

For services rendered on or after January 1, 2003, do not transfer the cost of hepatitis vaccines from Worksheet C, Part III, column 9, line 16, as they are OPPS reimbursed; however, transfer the cost of pneumococcal and influenza vaccines from Worksheet C, Part III, column 9.01, line 16 to column 2 of this worksheet, and the cost of osteoporosis drugs from Worksheet C, Part III, column 10, line 16 to column 3 of this worksheet.

For cost reporting periods ending after July 1, 2006 (see §3206, line 13), transfer the cost of pneumococcal, influenza, and hepatitis vaccines from Worksheet C, Part III, column 9, line 16, to column 2 of this worksheet, and the cost of osteoporosis drugs from Worksheet C, Part III, column 10, line 16 to column 3 of this worksheet. Also transfer the administration of pneumococcal, influenza, and *hepatitis B* vaccines from Worksheet C, Part III, column 9, line 16.20, to column 2, *for the portion of the reporting period before July 1, 2006.*

To Worksheet D, Line 1

From Worksheet C

Col. 1, Part A

Part IV, col. 3, line 19

Col. 2, Part B

Part III, sum of col. 9 line 16 (excluding subscripted lines), and Part IV, col. 4, line 19

Col. 3, Part B

Part III, sum of col. 10, lines 15 (excluding subscripted lines), 16 and 16.01, and Part V, col. 8, line 28

If the amount in column 6, line 22 is less than the amount in column 6, line 19, and the amount in column 6, line 24, transfer (aggregate Medicare limitation):

To Worksheet D, Line 1From Worksheet C

Col. 1, Part A

Part IV, col. 3, line 22

Col. 2, Part B

Part III, sum of col. 9, line 16 (excluding subscripted lines), and Part IV, col. 4, line 22

Col. 3, Part B

Part III, sum of col. 10, lines 15 (excluding subscripted lines), 16 and 16.01, and Part V, col. 8, line 28

If column 6, line 24 is less than the amount in column 6, line 19, and the amount in column 6, line 22, transfer (aggregate agency beneficiary limitation):

To Worksheet D, Line 1From Worksheet C

Col. 1, Part A

Part IV, col. 3, line 24

Col. 2, Part B

Part III, sum of col. 9, line 16 (excluding subscripted lines), and Part IV, col. 4, line 24

Col. 3, Part B

Part III, sum of col. 10, lines 15 (excluding subscripted lines), 16 and 16.01, and Part V, col. 8, line 28

Line 2.--Enter in column 3 the cost of services from the HHA-based RHC (Worksheet RH-2, Part III) plus the cost of services from the HHA-based FQHC (Worksheet FQ-2, Part III). The costs transferred to this location are only the costs associated with RHC/FQHC services rendered prior to January 1, 1998.

Line 3.--In each column, enter the amount on line 1 plus the amount on line 2.

Line 4.--In columns 1, 2 and 3, enter from your records the charges for the applicable Medicare services rendered prior to October 1, 2000. Also, in columns 2 and 3, enter from your records the charges for the applicable Medicare covered drugs (see §3215.3) rendered prior to October 1, 2000. In column 3, also enter the Medicare charges applicable to all RHCs and FQHCs, respectively, for services furnished prior to January 1, 1998.

Line 4.01.--In column 2, enter from your records only the charges for applicable Medicare covered pneumococcal and influenza vaccines (see §3215.3) rendered on or after January 1, 2003 (from Worksheet C, line 16, column 6.01). In column 3, enter from your records only the charges for applicable Medicare covered osteoporosis drugs (see §3215.3) rendered on or after October 1, 2000 (from Worksheet C, line 16, column 7). For all other services rendered on or after October 1, 2000, do not enter any charges in columns 1 and 2.

Effective for cost reporting periods ending after June 30, 2006, in column 2, enter the charges for Medicare covered pneumococcal, influenza, and hepatitis B vaccines (from Worksheet C, Part III, lines 16 and 16.20, column 6). In column 3, enter the charges for Medicare covered osteoporosis drugs (from Worksheet C, Part III, lines 16, column 7).

Lines 5 through 8.--These lines provide for the accumulation of charges which relate to the reasonable cost on line 3.

3233. WORKSHEET S-4 - HHA-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER PROVIDER STATISTICAL DATA

**COMPLETE THE S-4 AND RF SERIES WORKSHEETS FOR SERVICES RENDERED ON OR AFTER JANUARY 1, 1998.**

In accordance with 42 CFR 413.20(a), 42 CFR 413.24(a), and 42 CFR 413.24(c), you are required to maintain statistical records for proper determination of costs payable under the Medicare program. The statistics reported on this worksheet pertain to provider-based rural health clinics (RHCs) and provider-based Federally qualified health centers (FQHCs). If you have more than one of these clinics, complete a separate worksheet for each facility.

Lines 1 and 1.01.--Enter the full address of the RHC/FQHC.

Line 2.--For FQHCs only, enter your appropriate designation (urban or rural). See §505.2 of the RHC/FQHC Manual for information regarding urban and rural designations. If you are uncertain of your designation, contact your intermediary. RHCs do not complete this line.

Lines 3 through 8.--In column 1, enter the applicable grant award number(s). In column 2, enter the date(s) awarded.

Line 9.--Subscript line 9 as needed to list all physicians furnishing services at the RHC/FQHC. Enter the physician name in column 1, and the physician's Medicare billing number in column 2.

Line 10.--Subscript line 10 as needed to list all supervisory physicians. Enter the physician name in column 1, and the number of hours the physician spent in supervision in column 2.

Line 11.--If the facility provides other than RHC or FQHC services (e.g., laboratory or physician services), answer Y (yes) *in column 1, then indicate the number of other operations in column 2*, and enter the type(s) of operation(s) and hour(s) on subscripts of line 12. If the facility does not provide other services, enter N (no) on line *11*, and do not complete subscripts of line 12.

Lines 12.--Enter the starting and ending hours in the applicable columns 1 through 14 for the days that the clinic is available to provide RHC/FQHC services. For facilities providing other than RHC or FQHC services, enter on subscripts of line 12, columns 1 through 14 the starting and ending hours in the applicable columns for the days that the facility is available to provide RHC/FQHC services.

Line 13.--If the facility has been approved for an exception to the productivity standard, enter Y (yes) or N (no).

Line 14.--If this facility is filing a consolidated cost report, as defined in CMS Pub. 27, §508(D), enter Y (yes) or N (no). If the response is yes, enter in column 2 the number of providers included in this report.

Line 15.--If the response to question 14 is yes, list all associated provider names and the corresponding provider numbers included in this report.

Line 16.--If this facility is claiming allowable and/or non-allowable Graduate Medical Education (GME) costs as a result of substantial payment for interns and residents, enter Y (yes) or N (no) and enter the number of Medicare visits in column 2 performed by interns and residents. Complete Worksheet RF-1, lines 20 and 27 as applicable.

3234. WORKSHEET RF-1 - ANALYSIS OF HHA-BASED RURAL HEALTH CLINIC/  
FEDERALLY QUALIFIED HEALTH CENTER COSTS

Effective for services rendered on or after January 1, 1998, use this worksheet only if you operate a certified rural health clinic (RHC) or Federally qualified health center (FQHC). Only those cost centers that represent services for which the facility is certified are used. If you have more than one provider-based RHC and/or FQHC, complete a separate worksheet for each facility.

This worksheet is for the recording of direct RHC and FQHC 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.

Column Descriptions

Columns 1 through 6.--The expenses listed in these columns must be in accordance with your accounting books and records. If the cost elements of a cost center are maintained separately on your books, a reconciliation of costs per the accounting books and records to those on this worksheet must be maintained by you and are subject to review by your intermediary.

Enter on the appropriate lines in columns 1 through 6 the total expenses incurred during the reporting period. Detail the expenses as Compensation (column 1), Employee Benefits (column 2), Contracted Services (column 3), Transportation (column 4) and Other (column 5). The sum of columns 1 through 5 must equal 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. (See §3210 for examples of reclassifications that may be needed.) Submit with the cost report copies of any workpapers used to compute the reclassifications reported in this column. Show reductions to expenses in parentheses ( ).

The net total of the entries in column 7 must equal zero on line 30.

Column 8.--Add column 6 to column 7, and extend the net balances to column 8. The total of column 8 must equal the total of column 6 on line 30.

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 §3211.) Submit with the cost report copies of any workpapers used to compute the adjustments reported in this column.

NOTE: The allowable cost of the services furnished by National Health Service Corp (NHSC) personnel may be included in your facility's costs. Obtain this amount from your intermediary, and include this as an adjustment to the appropriate lines on column 9.

Column 10.--Adjust the amounts in column 8 by the amounts in column 9, and extend the net balance to column 10. The total facility costs on line 30 must equal the net expenses for cost allocation on Worksheet A for the RHC/FQHC cost center.

Line Descriptions

Lines 1 through 9.--Enter the costs of your health care staff .

Line 10.--Enter the sum of the amounts on lines 1 through 9.

Line 11.--Enter the cost of physician medical services furnished under agreement.

Line 12.--Enter the expenses of physician supervisory services furnished under agreement.

Line 14.--Enter the sum of the amounts on lines 11 through 13.

Lines 15 through 20.--Enter the expenses of other health care costs.

Line 20.--If the clinic incurred all or substantially all training costs (Graduate Medical Education (GME)), enter the total allowable direct and indirect GME cost. **DO NOT USE THIS LINE.**

Line 21.--Enter the sum of the amounts on lines 15 through 20.

Line 22.--Enter the sum of the amounts on lines 10, 14, and 21. Transfer this amount to Worksheet RF-2, line 10.

Lines 23 through 26.--Enter the expenses applicable to services that are not reimbursable under the RHC/FQHC benefit.

Line 27.--If the clinic does not provide all or substantially all training costs, enter the total non-allowable direct and indirect GME cost.

Line 28.--Enter the sum of the amounts on lines 23 through 27. Transfer the total amount in column 7 to Worksheet RF-2, line 11.

Line 29.--Enter the overhead expenses directly costed to the facility. These expenses may include rent, insurance, interest on mortgage or loans, utilities, depreciation of buildings and fixtures, depreciation of equipment, housekeeping and maintenance expenses, and property taxes. Submit with the cost report supporting documentation to detail and compute the facility costs reported on this line.

Line 30.--Enter the expenses related to the administration and management of the RHC/FQHC that are directly costed to the facility. These expenses may include office salaries, depreciation of office equipment, office supplies, legal fees, accounting fees, insurance, telephone service, fringe benefits, and payroll taxes. Submit with the cost report supporting documentation to detail and compute the administrative costs reported on this line.

Line 31.--Enter the sum of the amounts on lines 29 and 30. Transfer the total amount in column 7 to Worksheet RF-2, line 14.

Line 32.--Enter the sum of the amounts on lines 22, 28 and 31. This is the total facility cost.

### 3235. WORKSHEET RF-2 - ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Use this worksheet only if you operate a certified provider-based RHC or FQHC as part of your complex. If you have more than one provider-based RHC and/or FQHC, complete a separate worksheet for each facility.

**3235.1 Visits and Productivity.**--This section summarizes the number of facility visits furnished by the health care staff and calculates the number of visits to be used in the rate determination. Lines 1 through 9 list the types of practitioners (positions) for whom facility visits must be counted and reported.

Column descriptions

Column 1.--Record the number of all full time equivalent (FTE) personnel in each of the applicable staff positions in the facility's practice. (See CMS Pub. 27, §503 for a definition of FTEs.)

Column 2.--Record the total visits actually furnished to all patients by all personnel in each of the applicable staff positions in the reporting period. Count visits in accordance with instructions in 42 CFR 405.2401(b) defining a visit.

Column 3.--Productivity standards established by CMS are applied as a guideline that reflects the total combined services of the staff. Apply a level of 4200 visits for each physician and a level of 2100 visits for each nonphysician practitioner. If you *were* granted an exception to the productivity standards (answered yes to question 13 of Worksheet S-4), enter the number of productivity visits approved by the intermediary on lines 1-3.

Intermediaries have the authority to waive the productivity guideline in cases where you have demonstrated reasonable justification for not meeting the standard. In such cases, the intermediary could set any number of visits as reasonable (not just your actual visits) if an exception is granted. For example, if the guideline number is 4200 visits and you have only furnished 1000 visits, the intermediary need not accept the 1000 visits but could permit 2500 visits to be used in the calculation.

Column 4.--For lines 1 through 3, enter the product of column 1 and column 3. This is the minimum number of facility visits the personnel in each staff position are expected to furnish.

Column 5.--On line 4, enter the greater of the subtotal of the actual visits in column 2 or the minimum visits in column 4 .

On lines 5 through 7 and 9, enter the actual number of visits for each type of position.

Line Descriptions

Line 8.--Enter the total of lines 4 through 7.

Line 9.--Enter the number of visits furnished to facility patients by physicians under agreement with you. Physicians services under agreements with you are (1) all medical services performed at your site by a physician who is not the owner or an employee of the facility, and (2) medical services performed at a location other than your site by such a physician for which the physician is compensated by you. While all physician services at your site are included in RHC/FQHC services, physician services furnished in other locations by physicians who are not on your full time staff are paid to you only if your agreement with the physician provides for compensation for such services.

3235.2 Determination of Total Allowable Cost Applicable To RHC/FQHC Services.--This section determines the amount of the overhead costs incurred by both the parent provider and the facility which apply to RHC/FQHC services.

Line 10.--Enter the cost of health care services from Worksheet RF-1, column 10, line 22 less the amount on Worksheet RF-1, column 10, line 20.

Line 11.--Enter the total nonreimbursable costs from Worksheet RF-1, column 10, line 28.

Line 12.--Enter the sum of lines 10 and 11 for the cost of all services (excluding overhead).

Line 13.--Enter the percentage of RHC/FQHC services. This percentage is determined by dividing the amount on line 10 (the cost of health care services) by the amount on line 12 (the cost of all services, excluding overhead).

Line 14.--Enter the total facility overhead costs incurred from Worksheet RF-1, column 10, line 31.

Line 15.--Enter the amount of GME overhead costs. To determine the amount of GME overhead multiply the amount of facility overhead (from line 14) by the ratio of Intern and Resident visits (from Worksheet S-4, column 2, line 16) over total visits (from Worksheet RF-3, line 6). **DO NOT USE THIS LINE.**

Line 16.--Enter the net facility overhead costs by subtracting line 15 from line 14. **DO NOT USE THIS LINE.**

Line 17.--Enter the overhead cost incurred by the parent provider allocated to the RHC/FQHC. This amount is the difference between the total costs after allocation from the corresponding RHC/FQHC cost center on the B worksheet, column 6 and Worksheet B, column 0.

Line 18.--Enter the sum of lines **14** and 17 to determine the total overhead costs related to the RHC/FQHC.

Line 19.--Enter the overhead amount applicable to RHC/FQHC services. It is determined by multiplying the amount on line 13 (the ratio of RHC/FQHC services to total services) by the amount on line 18 (total overhead costs).

Line 20.--Enter the total allowable cost of RHC/FQHC services. It is the sum of line 10 (cost of RHC/FQHC health care services) and line 19 (total overhead costs).

### 3236. WORKSHEET RF-3 - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

This worksheet applies to title XVIII only and provides for the reimbursement calculation. Use this worksheet to determine the interim all inclusive rate of payment and the total Medicare payment due you for the reporting period.

3236.1 Determination of Rate For RHC/FQHC Services.--This section calculates the cost per visit for RHC/FQHC services and applies the screening guideline established by CMS on your health care staff productivity.

#### Line Descriptions

Line 1.--Enter the total allowable cost from Worksheet RF-2, line 20.

Line 2.--Enter the total cost of pneumococcal and influenza vaccine from Worksheet RF-4, line 15.

Line 3.--Subtract the amount on line 2 from the amount on line 1 and enter the result.

Line 4.--Enter the greater of the minimum or actual visits by the health care staff from Worksheet RF-2, column 5, line 8.

Line 5.--Enter the visits made by physicians under agreement from Worksheet RF-2, column 5, line 9.

Line 6.--Enter the total adjusted visits (sum of lines 4 and 5).

Line 7.--Enter the adjusted cost per visit. This is determined by dividing the amount on line 3 by the visits on line 6.

Lines 8 and 9.--Per visit payment limits are revised each January 1, (except calendar year 2003 updates that occurred January 1 and March 1 (see PM A-03-21)). Complete columns 1, 2 and 3, if

applicable (add column 3 for lines 8-14 if the cost reporting period overlaps 3 limit update periods) for lines 8 and 9 to identify costs and visits affected by different payment limits during a cost reporting period. Enter the rates and the corresponding data chronologically in the appropriate column as they occur during the cost reporting period.

For services rendered from January 1, 2010, through December 31, 2013, the maximum rate per visit entered on line 8 and the outpatient mental health treatment service limitation applied on line 14 both correspond to the same time period (calendar year). Consequently, both are entered in the same column, and no subscripting of the columns are necessary.

Line 8.--Enter your applicable per visit payment limit. Obtain this amount from CMS Pub. 27, §505 or from your intermediary.

Line 9.--Enter the lesser of the amount on line 7 or line 8.

**NOTE:** If only one payment limit is applicable during the cost reporting period, or the cost per visit (line 7) is less than both payment limits (line 8), complete column 2 only.

3236.2 Calculation of Settlement.--Use this section to determine the total Medicare payment due you for covered RHC/FQHC services furnished to Medicare beneficiaries during the reporting period.

Complete columns 1 and 2 of lines 10 through 14 to identify costs and visits affected by different payment limits during a cost reporting period.

#### Line Descriptions

Line 10.--Enter the number of Medicare covered visits excluding visits subject to the outpatient mental health services limitation from your intermediary records.

Line 11.--Enter the subtotal of Medicare cost. This cost is determined by multiplying the rate per visit on line 9 by the number of visits on line 10 (the total number of covered Medicare beneficiary visits for RHC/FQHC services during the reporting period).

Line 12.--Enter the number of Medicare covered visits subject to the outpatient mental health services limitation from your intermediary records.

Line 13.--Enter the Medicare covered cost for outpatient mental health services by multiplying the rate per visit on line 9 by the number of visits on line 12.

Line 14.--Enter the limit adjustment. In accordance with MIPPA 2008, section 102, the outpatient mental health treatment service limitation applies as follows: For services rendered through December 31, 2009, the limitation is 62.50 percent; services from January 1, 2010, through December 31, 2011, the limitation is 68.75 percent; services from January 1, 2012, through December 31, 2012, the limitation is 75 percent; services from January 1, 2013, through December 31, 2013 the limitation is 81.25 percent; and services on or after January 1, 2014, the limitation is 100 percent. This is computed by multiplying the amount on line 13 by the corresponding outpatient mental health service limit percent. This limit applies only to therapeutic services, not initial diagnostic services.

Line 15.--Enter the total allowable GME pass-through costs determined by dividing Medicare visits performed by Interns and Residents (from Worksheet S-4, column 2, line 16) by the total visits (from Worksheet RF-2, column 2, sum of lines 8 and 9) and multiply that result by the total allowable GME cost reported on Worksheet RF-1, column 10, line 20. Add the applicable overhead costs associated with GME (from line 15 of Worksheet RF-2) and enter that result on this line. (Note: If there are no allowable GME pass-through costs, this line will be zero.) **DO NOT USE THIS LINE.**

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-1728-94  
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

| <u>DESCRIPTION</u>  | <u>LINE(S)</u> | <u>COLUMN(S)</u> | <u>FIELD SIZE</u> | <u>USAGE</u> |
|---|----------------|------------------|-------------------|--------------|
| WORKSHEET S-4 (Continued)   |                |                  |                   |              |
| Physician(s) furnishing services at the clinic or under arrangement |                |                  |                   |              |
| Physician name  | 9              | 1                | 36                | X            |
| Billing number  | 9              | 2                | 36                | X            |
| Supervision (see instructions)                                      |                |                  |                   |              |
| Supervisory physician name  | 10             | 1                | 36                | X            |
| Number of hours of supervision during period                        | 10             | 2                | 11                | 9(8).99      |
| Does this facility operate as other than an RHC or FQHC? (Y/N)      | 11             | 1                | 1                 | X            |
| If yes, indicate number of other operations.                        | 11             | 2                | 2                 | 9            |
| Facility hours of operation *:                                      |                |                  |                   |              |
| Clinic hours from/to:   | 12             | 1-14             | 4                 | 9            |
| Other facility type:  | 12.01-12.10    | 0                | 36                | X            |
| Other facility hours from/to:                                       | 12.01-12.10    | 1-14             | 4                 | 9            |
| Is this clinic exempt from the productivity standard? (Y/N)         | 13             | 1                | 1                 | X            |
| Is this a consolidated cost report? (Y/N)                           | 14             | 1                | 1                 | X            |
| If yes, indicate the number of providers included in this report.   | 14             | 2                | 2                 | 9            |
| List all provider names:  | 15             | 1                | 36                | X            |
| List all provider numbers:  | 15             | 2                | 6                 | X            |
| Is the provider claiming allowable GME costs? (Y/N)                 | 16             | 1                | 1                 | X            |
| If yes, enter the number of Medicare visits.                        | 16             | 2                | 5                 | 9            |

\* List hours of operation based on a 24 hour clock. For example, 8:30am is 0830 and 12 midnight is 2400

WORKSHEET RF-1

|                     |                                   |                 |   |    |
|---------------------|-----------------------------------|-----------------|---|----|
| Provider based cost | 1-9, 11-13, 15-19, 23-27, & 29-30 | 1-5, 7, 9, & 10 | 9 | -9 |
|---------------------|-----------------------------------|-----------------|---|----|

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-1728-94  
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

| <u>DESCRIPTION</u>   | <u>LINE(S)</u> | <u>COLUMN(S)</u>      | <u>FIELD SIZE</u> | <u>USAGE</u> |
|--|----------------|-----------------------|-------------------|--------------|
| <b>WORKSHEET RF-2</b>  |                |                       |                   |              |
| Number of FTE Personnel  | 1-3 & 5-7      | 1                     | 6                 | 9(3).99      |
| Total Visits   | 1-3, 5-7 & 9   | 2                     | 9                 | 9            |
| Productivity standard *  | 1-3            | 3                     | 9                 | 9            |
| Greater of columns 2 or 4  | 4              | 5                     | 9                 | 9            |
| Parent provider overhead allocated to facility (see instructions)  | 17             | 1                     | 9                 | 9            |
| * Use the standard visits per the instructions as the default. Those standards may change if an approved exception is granted. (See Worksheet S-4 for response to approved exception to the standard productivity visits.) |                |                       |                   |              |
| <b>WORKSHEET RF-3</b>  |                |                       |                   |              |
| Adjusted cost per visit  | 7              | 1                     | 6                 | 9(3).99      |
| Maximum rate per visit (from your intermediary)  | 8              | 1, 2 & 3              | 6                 | 9(3).99      |
| Rate for Program covered visits  | 9              | 1, 2 & 3              | 6                 | 9(3).99      |
| Medicare covered visits excluding mental health services (from your intermediary)  | 10             | 1, 2 & 3              | 9                 | 9            |
| Medicare covered visits for mental health services (from your intermediary)  | 12             | 1, 2 & 3              | 9                 | 9            |
| Primary payer amounts  | 15.5           | 1                     | 9                 | 9            |
| Beneficiary deductible (from your intermediary)  | 17             | 1                     | 9                 | 9            |
| Reimbursable bad debts   | 22             | 1                     | 9                 | 9            |
| Text as needed for blank line  | 23             | 0                     | 36                | X            |
| Other adjustments  | 23             | 1                     | 9                 | -9           |
| Interim payments   | 25             | 1                     | 9                 | 9            |
| Protested amounts  | 27             | 1                     | 9                 | 9            |
| <b>WORKSHEET RF-4</b>  |                |                       |                   |              |
| Ratio of pneumococcal and vaccine staff time to total health care staff time   | 2              | 1,2, <b>2.01,2.02</b> | 8                 | 9.9(6)       |
| Medical supplies cost-pneumococcal and influenza vaccine (from your records)   | 4              | 1,2, <b>2.02</b>      | 9                 | 9            |

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-1728-94  
 TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

| <u>DESCRIPTION</u>   | <u>LINE(S)</u> | <u>COLUMN(S)</u> | <u>FIELD SIZE</u> | <u>USAGE</u> |
|--|----------------|------------------|-------------------|--------------|
| WORKSHEET RF-4 (Continued)   |                |                  |                   |              |
| Total number of pneumococcal and influenza vaccine injections (from your records)              | 11             | 1,2,2.01,2.02    | 9                 | 9            |
| Number of pneumococcal and influenza vaccine injections administered to Medicare beneficiaries | 13             | 1,2,2.01,2.02    | 9                 | 9            |
| WORKSHEET RF-5   |                |                  |                   |              |
| Total interim payments paid to provider  | 1              | 2                | 9                 | 9            |
| Interim payments payable   | 2              | 2                | 9                 | 9            |
| Date of each retroactive lump sum adjustment (MM/DD/YYYY)                                      | 3.01-3.98      | 1                | 10                | X            |
| Amount of each lump sum adjustment   |                |                  |                   |              |
| Program to provider  | 3.01-3.49      | 2                | 9                 | 9            |
| Provider to program  | 3.50-3.98      | 2                | 9                 | 9            |
| WORKSHEET S-5  |                |                  |                   |              |
| Continuous Home Care Days  | 1              | 1-4              | 9                 | 9            |
| Routine Home Care Days   | 2              | 1-4              | 9                 | 9            |
| Inpatient Respite Care Days  | 3              | 1-4              | 9                 | 9            |
| General Inpatient Care Days  | 4              | 1-4              | 9                 | 9            |
| Total Hospice Days   | 5              | 1-4              | 9                 | 9            |
| Number of patients Receiving Hospice Care  | 6              | 1-4              | 9                 | 9            |
| Total number of unduplicated continuous care hours billable to Medicare                        | 7              | 1 & 2            | 9                 | 9(4).99      |
| Average length of stay   | 8              | 1-4              | 6                 | 9(3).99      |
| Unduplicated Census Count  | 9              | 1-4              | 9                 | 9            |
| WORKSHEET K  |                |                  |                   |              |
| Transportation   | 1-33           | 3                | 11                | 9            |
| Other Cost   | 1-33           | 5                | 11                | 9            |
| Reclassification   | 1-33           | 7                | 11                | 9            |
| Adjustment   | 1-33           | 9                | 11                | -9           |
| WORKSHEET K-1  |                |                  |                   |              |
| Salaries and wages   | 3-33           | 1-7              | 11                | 9            |
| All other  | 3-33           | 8                | 11                | 9            |
| WORKSHEET K-2  |                |                  |                   |              |
| Employee benefits  | 3-33           | 1-7              | 11                | 9            |
| All other  | 3-33           | 8                | 11                | 9            |

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-1728-94  
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

| <u>DESCRIPTION</u>                     | <u>LINE(S)</u> | <u>COLUMN(S)</u> | <u>FIELD SIZE</u> | <u>USAGE</u> |
|--|----------------|------------------|-------------------|--------------|
| WORKSHEET K-3                          |                |                  |                   |              |
| Contracted services/purchased services | 3-33           | 1-7              | 11                | 9            |
| All others                             | 3-33           | 8                | 11                | 9            |

WORKSHEET K-4, PARTS I & II COLUMN HEADINGS

|                                   |        |        |    |   |
|-----------------------------------|--------|--------|----|---|
| Column heading (cost center name) | 1-3 +  | 1-5, 6 | 10 | X |
| Statistical basis                 | 4, 5 + | 1-5, 6 | 10 | X |

+ Refer to Table 1 for specifications and Table 2 for the worksheet identifier for column headings. There may be up to five type 2 records (3 for cost center name and 2 for the statistical basis) for each column. However, for any column that has less than five type 2 record entries, blank records or the word blank is not required to maximize each column record count.

WORKSHEET K-4, PARTS I & II

Part I:

|                 |      |     |    |    |
|-----------------|------|-----|----|----|
| Cost allocation | 7-33 | 7   | 11 | -9 |
| Total           | 34   | 1-5 | 11 | 9  |

Part II:

|                                |      |      |    |    |
|--------------------------------|------|------|----|----|
| All cost allocation statistics | 1-33 | 1-5* | 11 | 9  |
| reconciliation                 | 6-33 | 6A   | 11 | -9 |

\* See note to Worksheet B-1 for treatment of administrative and general accumulated cost column.

WORKSHEET K-5 PARTS I, II and III

Part I:

|                               |      |         |    |   |
|-------------------------------|------|---------|----|---|
| Total cost after cost finding | 2-28 | 8       | 11 | 9 |
| Total cost                    | 29   | 0-4 & 5 | 11 | 9 |

Part II:

|  |      |         |    |    |
|--|------|---------|----|----|
| All cost allocation statistics             | 1-28 | 1-4, 5* | 11 | 9  |
| Centers - Statistical Basis Reconciliation | 1-28 | 5A      | 11 | -9 |

• See note to Worksheet B-1 for treatment of administrative and general accumulated cost column. Do not include X on line zero [0] of the accumulated cost column since this is a replica of Worksheet B-1.

Part III:

|                                      |     |   |    |   |
|--------------------------------------|-----|---|----|---|
| Total HHA charges                    | 1-6 | 3 | 11 | 9 |
| Total hospice charges                | 1-6 | 5 | 11 | 9 |
| Total hospice shared ancillary costs | 1-6 | 6 | 11 | 9 |

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-1728-94  
TABLE 6 - EDITS

| <u>Reject Code</u> | <u>Condition</u>   |
|--------------------|--|
| 1035               | The vendor code (record #1, positions 38-40) must be a valid code (HCRIS #2050). [3/31/1997]   |
| 1040               | All calendar format dates must be edited for 10 character format, e.g., 01/01/1996 (MM/DD/YYYY) (HCRIS #2100). [1/31/2007]   |
| 1050               | The type 1 record #1 must be correct and the first record in the file. [3/31/1997]   |
| 1055               | All record identifiers (positions 1-20) must be unique (HCRIS #2000). [3/31/1997]  |
| 1060               | Only a Y or N is valid for fields which require a Yes/No response (HCRIS #2015). [3/31/1997]   |
| 1065               | Variable column (Worksheet B and Worksheet B-1) must have a corresponding type 2 record (Worksheet A label) with a matching line number. [3/31/1997]   |
| 1070               | All line, subtitle, column, and subcolumn numbers (positions 11-13, 14-15, 16-18, and 19-20, respectively) must be numeric, except for any cost center with accumulated cost as its statistic, which must have its Worksheet B-1 reconciliation column numbered the same as its Worksheet A line number followed by an "A" as part of the line number followed by the subtitle number. [3/31/1997] |
| 1075               | Cost center integrity must be maintained throughout the cost report. For subscripted lines, the relative position must be consistent throughout the cost report. [3/31/1997]   |
| 1080               | For every line used on Worksheets A, B, and C, there must be a corresponding type 2 record. [3/31/1997]  |
| 1090               | Fields requiring numeric data (charges, visits, costs, FTEs, etc.) may not contain any alpha character (HCRIS #2125). [3/31/1997]  |
| 1100               | In all cases where the file includes both a total and the parts that comprise that total, each total must equal the sum of its parts. [3/31/1997]  |
| 1005S              | The cost report ending date (Worksheet S-2, column 2, line 7) must be on or after September 30, 1996. [9/30/1996]  |
| 1010S              | All provider and component numbers displayed on Worksheet S-2, column 2, lines 2-6, must contain six (6) alphanumeric characters. [3/31/1997]  |
| 1015S              | The cost report period beginning date (Worksheet S-2, column 1, line 7) must precede the cost report ending date (Worksheet S-2, column 2, line 7). [3/31/1997]  |
| 1020S              | The home health agency name, provider number, and certification date (Worksheet S-2, line 2, columns 1, 2, and 3, respectively) must be present and valid. [3/31/1997]   |
| 1030S              | For each provider name reported (Worksheet S-2, column 1, lines 2-6), there must be corresponding entries made on Worksheet S-2, lines 2-6, for the provider number (column 2) and the certification date (column 3). If there is no component name entered in column 1, then columns 2 and 3 for that line must also be blank. [3/31/1997]  |
| 1035S              | On Worksheet S-2, there must be a response in every file in column 1, lines 8, 14-16, 18-23, and in column 2 for line 23. If the HHA does not contain a CORF or CMHC, then no response is required in the file in column 2, line 24 (CORF) or column 2, line 25 (CMHC), respectively. [9/30/1998]  |

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| <u>Reject Code</u> | <u>Condition</u>  |
|--------------------|---|
| 1040S              | On Worksheet S-2, if the response to column 1, line 29 is "Y", then there must be a response on line 29.01, columns <i>1, 2 and 3</i> ; line 29.02, columns <i>1 or 2, and 3</i> ; line 29.03, columns 1, 2 and 3 and conversely, if the response to column 1, line 29 is "N", then there must be no response on line 29.01, columns <i>1, 2 and 3</i> ; line 29.02, columns <i>1 or 2 and 3</i> ; line 29.03, columns 1, 2 and 3. [1/31/2007]  |
| 1075S              | All amounts reported on Worksheet S-3, Part I must not be less than zero. [3/31/1997]   |
| 1080S              | Total visits on Worksheet S-3, Part I, column 5, line 8 must be greater than or equal to the unduplicated census count on Worksheet S-3, Part I, sum of columns 2 and 4, line 10. [FYs ending through 9/30/2000]  |
| 1081S              | Total visits on Worksheet S-3, Part I, column 5, line 8 must be greater than or equal to the unduplicated census count on Worksheet S-3, Part I, column 6, line 10. [10/1/2000s]  |
| 1085S              | If Worksheet S-3, Part III, column 1, line 29 has data then it must be a four character alpha numeric, or if column 1.01, line 29 has data then it must be a five character alpha numeric. [1/1/2006s]  |
| 1090S              | The following three items must be equal: Worksheet S-3, Part III, line 28, sum of columns 1 and 1.01 (number of MSAs/CBSAs); the number of worksheets C, part II; and Worksheet S-3, Part III, columns 1 and 1.01, line 29 and subscripts (number of MSAs/CBSAs codes identified). [1/31/2007]  |
| 1000A              | All amounts reported on Worksheet A, columns 1-5, line 29, must be greater than or equal to zero. [3/31/1997]   |
| 1020A              | For reclassifications reported on Worksheet A-4, the sum of all increases (column 4) must equal the sum of all decreases (column 7). [3/31/1997]  |
| 1025A              | For each line on Worksheet A-4, if there is an entry in columns 3, 4, 6, or 7, there must be an entry in column 1. There must be an entry on each line of column 4 for each entry in column 3 (and vice versa), and there must be an entry on each line of column 7 for each entry in column 6 (and vice versa). [3/31/1997]  |
| 1040A              | For Worksheet A-5 adjustments on lines 1-4, 6-9, and 11-12, if either columns 2 or 4 has an entry, then both columns 2 and 4 must have entries, and if any one of columns 0, 1, 2, or 4 for lines 13-20 and subscripts thereof has an entry, then all columns 0, 1, 2, and 4 must have entries. Only valid line numbers may be used in column 4. [3/31/1997]  |
| 1045A              | If there are any transactions with related organizations or home offices as defined in CMS Pub. 15-I, chapter 10 (Worksheet A-6, Part A, column 1, line 1 is "Y"), Worksheet A-6, Part B, columns 4 or 5, sum of lines 1-3 must be greater than zero; and Part C, column 1, any one of lines 1-5 must contain any one of alpha characters A through G. Conversely, if Worksheet A-6, Part A, column 1, line 1 is "N", Worksheet A-6, Parts B and C must not be completed. [3/31/1997] |
| 1050A              | If Worksheet A-8-3, sum of columns 1-3, line 32 is greater than zero, column 4, line 36 must be greater than the sum of columns 1-3, line 32 and equal to or less than 2080 hours. The sum of Worksheet A-8-3 for physical therapy services provided prior to 4/10/1998, column 4, line 36 and Worksheet A-8-3 for physical therapy services provided on or after 4/10/1998, column 4, line 36, must be equal to or less than 2080 hours. [9/30/1998]                                 |
| 1000B              | On Worksheet B-1, all statistical amounts must be greater than or equal to zero, except for reconciliation columns. [3/31/1997]   |
| 1005B              | Worksheet B, column 6, line 29 must be greater than zero. [3/31/1997]   |

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| <u>Reject Code</u> | <u>Condition</u>   |
|--------------------|--|
| 1010B              | For each general service cost center with a net expense for cost allocation greater than zero (Worksheet B-1, columns 1-5, line 30), the corresponding total cost allocation statistics (Worksheet B-1, column 1, line 1; column 2, line 2; etc.) must also be greater than zero. Exclude from this edit any column that uses accumulated cost as its basis for allocation and any reconciliation column. [3/31/1997]<br><b>NOTE:</b> For small HHAs that elect the optional A&G allocation method (see §3214) as defined in 42 CFR 413.24(d), do not apply edits 1000B, 1005B or 1010B. |
| 1000C              | For the home health agency, total Medicare program (Title XVIII) visits reported as the sum of all Worksheets C, Part II (sum of columns 5 and 6, lines 1-6, plus Worksheet C, Part V, columns 3, 5.01 and 5, lines 25-27) must equal the sum of the visits reported on Worksheet S-3 (column 1, sum of lines 1-6). [FYs ending through 9/30/2000]   |
| 1001C              | For the home health agency, total Medicare program (Title XVIII) visits reported as the sum of all Worksheets C, Part II (sum of columns 5 and 6, lines 1-6 which are pre 10/1/2000 visits (excluding subscripts), plus Worksheet C, Part V, columns 5.01 (pre 10/1/2000 visits), lines 25-27 must equal the sum of the visits reported on Worksheet S-3, column 1, sum of lines 1-6. [FYs which overlap 10/1/2000]  |
| 1002C              | For the home health agency, total Medicare program (Title XVIII) visits reported as the sum of all Worksheets C, Part II (sum of columns 5 and 6, lines 1-6), must equal the sum of the visits reported on Worksheet S-3, Part IV, column 7, sum of lines 30, 32, 34, 36, 38 and 40. [FYs beginning on or after 10/1/ 2000]  |
| 1005C              | For the home health agency, the total Medicare (Title XVIII) unduplicated census count (Worksheet S-3, Part I, column 2, line 10) must be equal to or greater than the sum of the unduplicated census count for all MSA (Worksheet C, Part IV, column 1, line 24). [FYs ending through 9/30/2000]  |
| 1006C              | For the home health agency, the total Medicare (Title XVIII) unduplicated census count (Worksheet S-3, Part I, column 2, line 10.01) must be equal to or greater than the sum of the unduplicated census count for all MSAs (Worksheet C, Part IV, column 1, line 24). [FYs which overlap 10/1/2000]   |
| 1010C              | If Medicare visits on Worksheet S-3, column 1, lines 1-6, respectively, are greater than zero, then the corresponding cost on Worksheet B, column 6, lines 6-11 must also be greater than zero. [FYs ending through 9/30/2000]   |
| 1011C              | If the sum of Medicare visits on Worksheet S-3, column 1, lines 1-6 and Worksheet S-3, Part IV, column 7, lines 30, 32, 34 ,36, 38, and 40 are greater than zero, respectively (for each discipline), then the corresponding cost on Worksheet B, column 6, lines 6-11 must also be greater than zero and vice versa. [10/1/2000] This edit is downgraded to a level II edit (edit 2011C) and is effective for cost reporting periods ending on or after January 31, 2007.   |
| 1015C              | Worksheet C, Part III, lines 15, 16, and 16.20 respectively, column 3 (Total Charges) must be greater than, or equal to, lines 15, 16, and 16.20, respectively, sum of columns 5 through 7 (Medicare Charges). [1/31/2007] This edit is downgraded to a level II edit (edit 2015C) and is effective for cost reporting ending periods ending on or after October 31, 2009.   |
| 1005D              | If Medicare home health agency visits (Worksheet S-3, Part I, column 1, line 8) are greater than zero, then Medicare home health agency costs (Worksheet D, Part II, sum of columns 1 and 2, line 21) must also be greater than zero, and vice versa. [9/30/1998]  |

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| <u>Reject Code</u> | <u>Condition</u>   |
|--------------------|--|
| 1010D              | If Worksheet D, line 27, columns 1 and 2, respectively, are greater than 0 (zero), then Worksheet D-1, line 4, columns 2 and 4, respectively, must also be greater than 0 (zero) and vice versa. [1/31/2007]   |
| 1015D              | The sum of Worksheet D-1, columns 2 and 4, line 4, <i>respectively</i> , and the sum of Worksheet D, Part II, <i>columns 1 and 2</i> , lines 12 through 12.14, <i>respectively</i> , must both be greater than zero. [10/31/2009]  |
| 1000J              | Worksheet J-1, Part I, sum of columns 0-5, line 15, must equal the corresponding Worksheet B, column 6, line 24 (or its appropriate subscript). [FYs ending through 6/29/2001]   |
| 1001J              | If the sum of Worksheet S-6, column 1, lines 1-7 plus column 3, lines 1-8 equals zero, then Worksheet B, column 6, line 24 (or its appropriate subscript) and Worksheet J-1, Part I, sum of columns 0-5, line 15, must also equal zero and vice versa. [6/30/2001]   |
| 1000K              | Worksheet K-5, Part I, sum of columns 0-5, line 29, must equal the corresponding Worksheet B, column 6, line 25 (or its appropriate subscript). [10/31/2000]   |
| 1005K              | Worksheet K-5 Part I, column 0, line 29 must equal Worksheet A, column 10, line 25. [10/31/2009]   |
| 1000M              | Worksheet CM-1, Part I, sum of columns 0-5, line 12, must equal the corresponding Worksheet B, column 6, line 26 (or its appropriate subscript). [3/31/1997]   |
| 1005M              | Worksheet CM-1 Part I, column 0, line 12 must equal worksheet A, column 10, line 26. [10/31/2009]  |
| 1000R              | Worksheet RH-1, Part I, sum of columns 0-5, line 11, must equal the corresponding Worksheet B, column 6, line 27 (or its appropriate subscript). [Applicable for cost reporting periods beginning prior to 1/1/1998]   |
| 1000Q              | Worksheet FQ-1, Part I, sum of columns 0-5, line 12, must equal the corresponding Worksheet B, column 6, line 28 (or its appropriate subscript). [Applicable for cost reporting periods beginning prior to 1/1/1998]   |
| 1000H              | If Worksheet S-4, line 13 equals "Y", Worksheet RF-2, column 3, lines 1, 2, and 3 must each be greater than zero and at least one line must contain a value other than the standard amount. Conversely, if Worksheet S-4, line 13 equals "N", Worksheet RF-2, column 3, lines 1, 2, and 3 must contain the values 4,200, 2,100 and 2,100, respectively. Apply this edit to both RHC and FQHC components. [4/30/2000] |
| 1005H              | If Worksheet S-4, line 16 equals "Y", Worksheet RF-1, column 10, line 20 must be greater than zero. [4/30/2000]  |
| 1010H              | The sum of Worksheet RF-1, column 10, lines 1-9, 11-13, 15-19, 23-27, and 29-30 must equal the amount on Worksheet A, column 10, RHC/FQHC lines as appropriate. [4/30/2000]  |

**NOTE:** The RF Worksheet series is identified by the alpha character "H".

\* Effective for fiscal years which overlap July 1, 2006, or that begin on or after July 1, 2006, line 13 can only be 1300.



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| <u>Edit</u> | <u>Condition</u>  |
|-------------|---|
| 2105S       | If Medicare home health agency unduplicated census count of patients (Worksheet S-3, Part I, column 2, line 10) is greater than zero, then the following fields on Worksheet S-3, Part I, should also be greater than zero: <ul style="list-style-type: none"> <li>a. Total home health agency visits (line 8, sum of columns 1 and 3) [3/31/1997]; and</li> <li>b. Medicare home health agency visits (column 1, sum of lines 1-7). [3/31/1997]</li> </ul> |
| 2000A       | Worksheet A-4, column 1 (reclassification code) must be alpha characters. [3/31/1997]   |
| 2020A       | Worksheet A-6, Part A, must contain a "Y" or "N" response. [3/31/1997]  |
| 2035A       | For Worksheet A-7, the sum of columns 1-3, line 7, minus column 5, line 7, must be greater than zero. [3/31/1997]<br><br>Column headings (Worksheets B-1 and B and Worksheets J-1, Part III, CM-1, Part III, RH-1, Part III, and FQ-1, Part III) are required as indicated in codes 2000B and 2005B:  |
| 2000B       | a. At least one cost center description (lines 1-3), at least one statistical basis label (lines 4-5), and one statistical basis code (line 6) must be present for each general service cost center. This edit applies to all general service cost centers required and/or listed. Exclude any reconciliation columns from this edit. [3/31/1997]   |
| 2005B       | b. The column numbering among these worksheets must be consistent. For example, data in capital related costs - buildings and fixtures is identified as coming from column 1 on all applicable worksheets. [3/31/1997]  |
| 2011C       | If the sum of Medicare visits on Worksheet S-3, column 1, lines 1-6 and Worksheet S-3, Part IV, column 7, lines 30, 32, 34, 36, 38, and 40 are greater than zero, respectively (for each discipline), then the corresponding cost on Worksheet B, column 6, lines 6-11 must also be greater than zero and vice versa. <i>[10/1/2000]</i>  |
| 2015C       | Worksheet C, Part III, lines 15, 16, and 16.20 respectively, column 3 (Total Charges) must be greater than, or equal to, lines 15, 16, and 16.20, respectively, sum of columns 5 through 7 (Medicare Charges). [10/31/2009]   |
| 2000F       | Total assets on Worksheet F (line 33, sum of columns 1-4) must equal total liabilities and fund balances (line 59, sum of columns 1-4) (HCRIS #2545). [3/31/1997]   |
| 2005F       | Net income or loss (Worksheet F-1, column 2, line 33) should not equal zero (HCRIS #2560). [3/31/1997]  |
| 2050F       | Total patient revenue (Worksheet F-1, column 1, line 1) should be equal to or greater than Medicare Part B home health agency charges (Worksheet D, line 4, sum of columns 2 and 3). [3/31/1997]  |

**NOTE:** CMS reserves the right to require additional edits to correct deficiencies that become evident after processing the data commences and, as needed, to meet user requirements.