Medicare

Provider Reimbursement Manual -

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

Department of Health and Human Services (DHHS)

Centers for Medicare and Medicaid Services (CMS)

Transmittal 14 **Date: January 2010**

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NEW/REVISED MATERIAL--EFFECTIVE DATE:

This transmittal updates Chapter 32, Home Health Agency Cost Report, (Form CMS-1728-94). This transmittal also reflects further clarification to existing instructions and incorporates select legislative and other provisions. The effective date for instructional changes will vary due to various implementation dates.

Significant Revisions:

- Worksheet RF-3 - Line 14 is revised to implement section 102 of the Medicare Improvement for Patients and Providers Act (MIPPA) of 2008 for rural health clinics (RHCs) and Federally qualified Health centers (FQHCs), to phase out the outpatient mental health treatment limitation over the 5 year period from 2010 through 2014.
- Worksheet RF-4 - Columns 2.01 and 2.02 are added to capture relevant data and calculate the costs of H1N1 influenza vaccines; and the simultaneous administration of H1N1 influenza and seasonal influenza vaccines and administration under the authority of section 1861(s)(10)(A) of the Social Security Act.

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.

12 month period of your operations. (See §§102.1-102.3 for situations where you may file a short period cost report.)

Cost reports are due on or before the last day of the fifth month following the close of the period covered by the report. A 30 day extension of the due date may be granted by the intermediary only when a provider's operations are significantly adversely affected due to extraordinary circumstances over which the provider has no control. (See 42 CFR 413.24 (f)(2)(ii).)

When you voluntarily or involuntarily cease to participate in the health insurance program or experience a change of ownership, a cost report is due no later than 150 days following the effective date of the termination of your agreement or change of ownership. There are no provisions for an extension of the cost report due date for termination or change of ownership.

Line 8--Enter the type of ownership or auspices under which the provider is conducted.

1 = voluntary non-profit, church	7 = governmental & private combined
2 = voluntary non-profit, other	8 = governmental, federal
3 = proprietary, sole proprietor	9 = governmental, state
4 = proprietary, partnership	10 = governmental, city
5 = proprietary, corporation	11 = governmental, city-county
6 = private non-profit	12 = governmental, county
	13 = governmental, health district

o Combined Governmental and Private.--This is an HHA administered jointly by a private organization and a governmental agency, supported by tax funds, public funds, earnings, and contributions, which provides nursing and therapeutic services.

o Governmental Agency.--This is an HHA administered by a state, county, city, or other local unit of government and having as a major responsibility prevention of disease and community education. It must offer nursing care of the sick in their homes.

o Voluntary Non-Profit.--This is an HHA which is governed by a community-based board of directors and is usually financed by earnings and contributions. The primary function is the care of the sick in their homes. Some voluntary agencies are operated under church auspices.

o Private Not-for-Profit.--This is an HHA that is a privately developed and governed non-profit organization which provides care of the sick in the home. This agency must qualify as a tax exempt organization under title 26 USC 5018 of the Internal Revenue Code.

o Proprietary Organization.--This is an HHA that is owned and operated by non-governmental interests and is not a non-profit organization.

Line 9--Indicate whether this is a low or no Medicare utilization cost report. Enter an "L" for low Medicare utilization or "N" for no Medicare utilization. Refer to 42 CFR 413.24(h) for a definition of low Medicare utilization.

Lines 10 through 12--Enter on the appropriate lines the amount of depreciation claimed under each method of depreciation used by the HHA during the cost reporting period.

Line 13--Enter the sum of lines 10 through 12. This amount must equal the amount of depreciation included in costs on Worksheet A.

Line 14--Were there any disposals of capital assets during the cost reporting period? Enter "Y" for yes or "N" for no.

Line 15--Was accelerated depreciation claimed on any asset in the current or any prior cost reporting period? Enter "Y" for yes or "N" for no.

Line 16--Was accelerated depreciation claimed on assets acquired on or after August 1, 1970? (See CMS Pub. 15-I, Chapter 1.) Enter "Y" for yes or "N" for no.

Line 17--If depreciation is funded, enter the fund balance at the end of the cost reporting period.

Line 18--Did the provider cease to participate in the Medicare program at the end of the period to which this cost report applies? (See CMS Pub. 15-I, chapter 1.) Enter "Y" for yes or "N" for no.

Line 19--Was there a substantial decrease in the health insurance proportion of allowable costs from prior cost reporting periods? (See CMS Pub. 15-I, chapter 1.) Enter "Y" for yes or "N" for no.

Line 20--Does the provider qualify as a small HHA (as explained in 42 CFR 413.24 (d))? Enter "Y" for yes or "N" for no.

Line 21--Does the home health agency qualify as a nominal charge provider (as explained in 42 CFR 409.3)? Enter "Y" for yes or "N" for no.

Line 22--Does the home health agency contract with outside suppliers for physical therapy services? (See CMS Pub. 15-I, chapter 14.) Enter "Y" for yes or "N" for no.

Line 22.01--Does the home health agency contract with outside suppliers for occupational therapy services? Enter "Y" for yes or "N" for no.

Line 22.02--Does the home health agency contract with outside suppliers for speech therapy services? Enter "Y" for yes or "N" for no.

Lines 23 through 25--If the facility is a non-public provider that qualifies for an exemption from the application of the lower of cost or charges (as explained in 42 CFR 413.13(f)) indicate the component and services that qualify for this exemption with a "Y".

Line 26--If the home health agency componentized (or fragmented) its administrative and general service costs, enter 1 for option one and 2 for option two. Do not respond if A&G services are not fragmented. (See §3214 for an explanation of the A&G componentization options.)

Line 27.01-27.03--Enter the amount of malpractice insurance premiums, paid losses and/or self insurance premiums, respectively.

Line 28--If malpractice premiums are reported in other than the A&G cost center, enter Y (yes) or N (no). If yes, submit a supporting schedule listing the cost centers and amounts contained therein.

Line 29-29.03--If this provider is part of a chain organization, enter “Y” for yes and enter the *home office* name, home office number, address of the home office, and FI/contractor name and *identifying* number *of the FI/contractor who receives the Home Office cost statement*; otherwise, enter “N” for no.

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/CBSA/CBSA 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 60th 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 60th 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 6 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 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).

Line 16.--Enter the net facility overhead costs by subtracting line 15 from line 14.

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 16 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.)

Line 15.5--Enter the amounts paid and payable by Workers' Compensation and other primary payers (from your records).

Line 16.--Enter the total Medicare cost. This is equal to the sum of the amounts on line 11, columns 1, 2, and 3 plus line 14, columns 1, 2 and 3 plus line 15 minus line 15.5.

Line 17.--Enter the amount credited to the RHC's Medicare patients to satisfy their deductible liabilities on the visits on lines 10 and 12 as recorded by the intermediary from clinic bills processed during the reporting period. RHCs determine this amount from the interim payment lists provided by the intermediaries. FQHCs enter zero on this line as deductibles do not apply.

Line 18.--Enter the net Medicare cost, excluding vaccines. This is equal to the result of subtracting the amount on line 17 from the amount on line 16.

Line 19.--Enter 80 percent of the amount on line 18.

Line 20.--Enter the Medicare cost of pneumococcal and influenza vaccines and their administration from Worksheet RF-4, line 16.

Line 21.--Enter the total reimbursable Medicare cost. This is equal to the sum of the amounts on lines 19 and 20.

Line 22.--Enter your total reimbursable bad debts, net of recoveries, from your records.

Line 23.--Enter any other adjustment. For example, if you change the recording of vacation pay from the cash basis to the accrual basis, enter the adjustment. (See CMS Pub. 15-I, §2146.4.) Specify the adjustment in the space provided.

Line 24.--This is the sum of lines 21, 22 and 23.

Line 25--Enter the interim payments from Worksheet RF-5, line 4. For intermediary final settlement, report on line 25.5 the amount from Worksheet RF-5, line 5.99.

Line 26.--Enter the total amount due to/from the Medicare program (lines 24 minus line 25.) Transfer this amount to Worksheet S, Part II, column 2, line:

- o 3.50 - 3.58 for RHCs
- o 3.60 - 3.68 for FQHCs

3237. WORKSHEET RF-4 - COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

The cost and administration of pneumococcal and influenza vaccines to Medicare beneficiaries is 100 percent reimbursable by Medicare. This worksheet provides for the computation of these vaccines for services rendered *on or after* April 1, 2001. *Use this worksheet only for vaccines rendered to patients who, at the time of receiving the vaccine(s), are not also receiving services under HHA PPS. If a patient simultaneously received vaccine(s) with any Medicare covered services under HHA PPS, those vaccine costs are* reimbursed through the parent provider *under HHA PPS,* and cannot be claimed by the RHC and FQHC.

Effective for services rendered on or after September 1, 2009, the administration of influenza H1N1 vaccines furnished by RHCs and FQHCs are cost reimbursed. However, no cost will be incurred for the H1N1 vaccine as this is provided free of charge to providers/suppliers.

To account for the cost of administering seasonal influenza vaccines, influenza H1N1 vaccines, and/or both vaccines administered during the same patient visit, column 2 is subscripted adding column 2.01 (administration of only H1N1 vaccines) and 2.02 (administration of both the seasonal influenza and H1N1 vaccines during the same patient visit). The data entered in all columns (1, 2, and applicable subscripts) for lines 4, 11, and 13 are mutually exclusive. That is, the vaccine costs, the total number of vaccines administered, and the total number of Medicare covered vaccines shall be represented only one time in the appropriate column. Columns 2.01 and 2.02 will not reflect the cost of H1N1 vaccines as it is furnished at no cost to the provider. However, the cost of seasonal influenza vaccines is required in columns 2 and 2.02, line 4.

Line 1.--Enter the health care staff cost from Worksheet RF-1, column 10, line 10.

Line 2.--Enter the ratio of the estimated percentage of time involved in administering pneumococcal and influenza vaccine injections to the total health care staff time. Do not include physician service under agreement time in this calculation.

Line 3.--Multiply the amount on line 1 by the amount on line 2 and enter the result.

Line 4.--Enter the cost of pneumococcal and influenza vaccine medical supplies from your records.

Line 5.--Enter the sum of lines 3 and 4.

Line 6.--Enter the amount on Worksheet RF-1, column 10, line 22. This is your total direct cost of the facility.

Line 7.--Enter the amount from Worksheet RF-2, line 18.

Line 8.--Divide the amount on line 5 by the amount on line 6 and enter the result.

Line 9.--Multiply the amount on line 7 by the amount on line 8 and enter the result.

Line 10.--Enter the sum of the amounts on lines 5 and 9.

Line 11.--Enter the total number of pneumococcal and influenza vaccine injections from your records.

Line 12.--Enter the cost per pneumococcal and influenza vaccine injection by dividing the amount on line 10 by the number on line 11 and entering the result.

Line 13.--Enter the number of pneumococcal and influenza vaccine injections from your records.

Line 14--Enter the Medicare cost for vaccine injections by multiplying the amount on line 12 by the amount on line 13.

Line 15--Enter the total cost of pneumococcal and influenza vaccine and its (their) administration *and the administration of H1N1 vaccines* by entering the sum of the amount in column 1, line 10 and the amount in column 2 *(and applicable subscripts)*, line 10. Transfer this amount to Worksheet RF-3, line 2.

Line 16--Enter the Medicare cost of pneumococcal and influenza vaccine and its (their) administration *and the administration of H1N1 vaccines*. This is equal to the sum of the amount in column 1, line 14 and column 2 *(and applicable subscripts)*, line 14. Transfer the result to Worksheet RF-3, line 20.

3238. WORKSHEET RF-5 - ANALYSIS OF PAYMENTS TO PROVIDER-BASED RHC/FQHC FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Complete this worksheet for Medicare interim payments only. (See 42 CFR 413.64.) If there is more than one HHA-based RHC/FQHC, complete a separate worksheet for each facility.

Complete the identifying information on lines 1 through 4. The remainder of the worksheet is completed by your fiscal intermediary.

NOTE: DO NOT reduce any interim payments by recoveries as a result of medical review adjustments where the recoveries were based on a sample percent applied to the universe of claims reviewed, and the PS&R was not also adjusted.

Line Descriptions

Line 1--Enter the total Medicare interim payments paid to the HHA-based RHC/FQHC. The amount entered reflects the sum of all interim payments paid on individual bills (net of adjustment bills) for services rendered in this cost reporting period. The amount entered must include amounts withheld from the RHC/FQHC's interim payments due to an offset against overpayments to the RHC/FQHC applicable to prior cost reporting periods. It does not include any retroactive lump sum adjustment amounts based on a subsequent revision of the interim rate or tentative or net settlement amounts; nor does it include interim payments payable. If the RHC/FQHC is reimbursed under the periodic interim payment method of reimbursement, enter the periodic interim payments received for this cost reporting period.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-1728-94
TABLE 1 - RECORD SPECIFICATIONS

Table 1 specifies the standard record format to be used for electronic cost reporting. Each electronic cost report submission (file) has three types of records. The first group (type one records) contains information for identifying, processing, and resolving problems. The text used throughout the cost report for variable line labels (e.g., Worksheet A) and variable column headers (Worksheet B-1) is included in the type two records. Refer to Table 5 for cost center coding. The data detailed in Table 3 are identified as type three records. The encryption coding at the end of the file, records 1, 1.01, and 1.02, are type 4 records.

The medium for transferring cost reports submitted electronically to fiscal intermediaries is 3½" diskette. These disks must be in IBM format. The character set must be ASCII. You must seek approval from your fiscal intermediary regarding alternate methods of submission to ensure that the method of transmission is acceptable.

The following are requirements for all records:

1. All alpha characters must be in upper case.

2. For micro systems, the end of record indicator must be a carriage return and line feed, in that sequence.

3. No record may exceed 60 characters.

Below is an example of a set of type 1 records with a narrative description of their meaning.

```
          1         2         3         4         5         6
12345678901234567890123456789012345678901234567890123456789012345678901234567890
1         1    14710019993342000305 8A99P00120000312000305
1         2    14:30
```

Record #1: This is a cost report file submitted by Provider 147100 for the period from November 1, 1999 (1999305) through October 31, 2000 (2000305). It is filed on FORM CMS-1728-94. It is prepared with vendor number A99's PC based system, version number 1. Position 38 changes with each new test case and/or approval and is alpha. Positions 39 and 40 remain constant for approvals issued after the first test case. This file is prepared by the home health agency on January 31, 2000 (2000031). The electronic cost report specification dated October 31, 2000 (2000305) is used to prepare this file.

FILE NAMING CONVENTION

Name each cost report file in the following manner:
HHNNNNNN.YYL, where
1. HH (Home Health Agency Electronic Cost Report) is constant;
2. NNNNNN is the 6 digit Medicare home health agency provider number;
3. YY is the year in which the provider's cost reporting period ends; and
4. L is a character variable (A-Z) to enable separate identification of files from home health agencies with two or more cost reporting periods ending in the same calendar year.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-1728-94
TABLE 1 - RECORD SPECIFICATIONS

RECORD NAME: Type 1 Records - Record Number 1

		Size	Usage	Loc.	Remarks
1.	Record Type	1	X	1	Constant "1"
2.	NPI	10	9	2-11	Numeric only
3.	Spaces	1	X	12	
4.	Record Number	1	X	13	Constant "1"
5.	Spaces	3	X	14-16	
6.	HHA Provider Number	6	9	17-22	Field must have 6 numeric characters.
7.	Fiscal Year Beginning Date	7	9	23-29	YYYYDDD - Julian date; first day covered by this cost report
8.	Fiscal Year Ending Date	7	9	30-36	YYYYDDD - Julian date; last day covered by this cost report
9.	MCR Version	1	9	37	Constant "8" (for FORM CMS-1728-94)
10.	Vendor Code	3	X	38-40	To be supplied upon approval. Refer to page 32-503.
11.	Vendor Equipment	1	X	41	P = PC; M = Main Frame
12.	Version Number	3	X	42-44	Version of extract software, e.g., 001=1st, 002=2nd, etc. or 101=1st, 102=2nd. The version number must be incremented by 1 with each recompile and release to client(s).
13.	Creation Date	7	9	45-51	YYYYDDD – Julian date; date on which the file was created (extracted from the cost report)
14.	ECR Spec. Date	7	9	52-58	YYYYDDD – Julian date; date of electronic cost report specifications used in producing each file. Valid for cost reporting periods ending on or after *2009274 (10/1/2009)*. Prior approval(s) 97090, 1998273, 1999304, 2000121, 2000305, 2001273, *2004031, and 2007031*.

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

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
WORKSHEET S-2 (Continued)				
If this facility contains a non-public provider that qualifies for an exemption from the lower of costs or charges, enter "Y" for each component and type of service that qualifies, otherwise enter "N":				
Home Health Agency	23	1, 2	1	X
CORF	24	2	1	X
CMHC	25	2	1	X
If the HHA componentized or fragmented its administrative and general service costs, enter "1" or "2" to indicate the method used.	26	1	1	9
List amounts of malpractice premiums and paid losses:				
Premiums:	27.01	1	9	9
Paid losses:	27.02	1	9	9
Self insurance	27.03	1	9	9
Are malpractice premiums and paid losses reported in other than the administrative and general cost center? (Y/N)	28	1	1	X
If you are part of a chain organization indicate "Y" for yes or "N" for no.	29	1	1	X
If you indicated "yes", enter the				
Name	29.01	1	36	X
Chain provider number	29.01	2	6	X
FI/Contractor number	29.01	3	10	X
Street	29.02	1	36	X
P.O. Box	29.02	2	9	X
FI/MAC name	*29.02*	*3*	*36*	*X*
City	29.03	1	36	X
State	29.03	2	2	X
Zip code of the organization	29.03	3	10	X
WORKSHEET S-3				
Part I:				
County	1	0	36	X
Number of HHA visits by discipline:				
Title XVIII	1-6, 8	1	9	9
Other Than Title XVIII	1-8	3	9	9
Visits by discipline	1-7	5	9	9
Total visits	8	5	9	9
Patient count by discipline:				
Title XVIII	1-6	2	9	9

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

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
WORKSHEET S-3 (Continued)				
Other Than Title XVIII	1-7	4	9	9
In Total	1-7	6	9	9
Home health aide hours:				
Title XVIII	9	1	9	9
Other Than Title XVIII	9	3	9	9
Total	9	5	9	9
Unduplicated census count:				
Title XVIII	10-10.02	2	9	9(6).99
Other Than Title XVIII	10-10.02	4	9	9(6).99
In Total	10-10.02	6	9	9(6).99
Part II:				
Number of hours in normal work week	11	0	6	9(3).99
Text as needed for blank lines	26, 27	0	36	X
Number of full-time equivalent employees				
Staff	11-27	1	6	9(3).99
Contract	11-27	2	6	9(3).99
Part III:				
Total number of MSAs and CBSAs where services were provided	28	1-1.01	2	9
Four digit MSA code for each MSA where services were provided	29	1	4	X
Five digit CBSA code for each CBSA where services were provided	29	1.01	5	X
Part IV:				
Covered Home Health Visits by Discipline for each Payment Category	30, 32, 34, 36, 38, 40	1-6	9	9
Home Health Charges by Discipline for each Payment Category	31, 33, 35, 37, 39, 41	1-6	9	9
Total Visits	42	1-6	9	9
Other Charges	43	1-6	9	9

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

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
WORKSHEET RF-4 (Continued)				
Total number of pneumococcal and influenza vaccine injections (from your records)	11	1,2	9	9
Number of pneumococcal and influenza vaccine injections administered to Medicare beneficiaries	13	1,2	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

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
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

Reject Code	Condition
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] **NOTE:** 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]

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

Reject Code	Condition
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 and the sum of worksheet D, Part II, lines 12 through 12.14 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]
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]
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]
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.

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

Edit	Condition
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: a. Total home health agency visits (line 8, sum of columns 1 and 3) [3/31/1997]; and b. Medicare home health agency visits (column 1, sum of lines 1-7). [3/31/1997]
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]
	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. [1/31/2007]
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.