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)

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NEW/REVISED MATERIAL--EFFECTIVE DATE:

This transmittal updates Chapter 32, Home Health Agency Cost Report, (Form CMS 1728-94) to reflect further clarification to existing instructions and incorporates the transition from metropolitan statistical areas (MSAs) to core based statistical areas (CBSAs). The effective date for instructional changes will vary due to various implementation dates.

Additional, 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). However, the actual vaccines cost will continue to be cost reimbursed.

Other Note Worthy Revisions to Worksheets:

- Worksheet S - Updated the disclosure statement at the bottom of the worksheet.
- Worksheet S-3, Part III - Added column 1.01 to capture CBSA codes.
- Worksheet C, Part II - Revised label to add from "MSA Code" to "MSA/CBSA Code".
- Worksheets K; K-1; K-2; K-3; K-4, Part I; K-4, Part II; K-5, Part I; and K-5, Part II - Added the following cost centers: line 10.20 - Nursing Care - Continuous Home Care; 18.20 - Home Health Aide and Homemaker - Continuous Home Care; 20.30 - Analgesics; 20.31 - Sedatives/Hypnotics; and 20.32 - Other Specify.

REVISED ELECTRONIC SPECIFICATIONS EFFECTIVE DATE: Changes to the electronic reporting specifications are effective for cost reporting periods ending on or after January 31, 2007.

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 name, home office number, FI/contractor number, and address of the home office; 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.

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.

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 44.--Enter in columns 1 through 6 for each episode of care payment category, respectively, the sum total of visit charges from lines 31, 33, 35, 37, 39, 41 and 43.

NOTE: *The standard episodes entered on line 9 and outlier episodes entered on line 46 are mutually exclusive.*

Line 45.--Enter in columns 1 and 3 through 6 for each episode of care payment category, respectively, the total number of episodes of *standard episodes of* care rendered and concluded in the provider's fiscal year.

Line 46.--Enter in columns 2 and 4 through 6 for each episode of care payment category identified, respectively, the total number of outlier episodes of care rendered and concluded in the provider's fiscal year. Outlier episodes do not apply to columns 1 and 3 (Full Episodes without Outliers and LUPA Episodes, respectively).

Line 47.-- Enter in columns 1 through 6 for each episode of care payment category, respectively, the total non-routine medical supply charges for services rendered and concluded in the provider's fiscal year.

Column 7.-- Enter on lines 30 through 47, respectively, the sum total of amounts from columns 1 through 6.

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 that overlap 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. Also, continue to include the cost of osteoporosis vaccines and the cost of administering the osteoporosis vaccines on this line. 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. *

Line 28.--Enter the direct costs associated with the HHA-based FQHC. *

Line 29.--Enter the total of lines 1 through 28.

* For cost reporting periods overlapping the January 1, 1998 effective date for the new RF worksheet series, enter the direct costs associated with the HHA-based RHC and/or FQHC as applicable for the entire cost reporting period. The A worksheet series will reflect costs for the entire cost reporting period, not just the costs for services rendered exclusively before or exclusively after the effective date. Sections 3229 and 3230 implement the methodology to segregate costs before and after the effective date for proper input of data in the RH and FQ worksheet series.

3207. WORKSHEET A-1 - COMPENSATION ANALYSIS - SALARIES AND WAGES

A small HHA, as defined in 42 CFR 413.24(d), does not have to complete Worksheet A-1.

Enter all salaries and wages for the HHA on this worksheet for the actual work performed within the specific area or cost center in accordance with the column headings. For example, if the administrator also performs skilled nursing care which accounts for 25 percent of that person's time, then enter 75 percent of the administrator's salary on line 5 (A&G) and 25 percent of the administrator's salary enter on line 6 (skilled nursing care).

The records necessary to determine the split in salary between two or more cost centers must be maintained by the HHA and must adequately substantiate the method used to split the salary. These records must be available for audit by the intermediary and the intermediary can accept or reject the method used to determine the split in salary. When approval of a method has been requested in writing and this approval has been received prior to the beginning of a cost reporting period, the approved method remains in effect for the requested period and all subsequent periods until you request in writing to change to another method or until the intermediary determines that the method is no longer valid due to changes in your operations.

Definitions

Salary.--This is gross salary paid to the employee before taxes and other items are withheld, including deferred compensation, overtime, incentive pay, and bonuses. (See CMS Pub. 15-I, Chapter 21.)

Administrators (Column 1).--

Possible Titles: President, Chief Executive Officer

Duties: This position is the highest occupational level in the agency. This individual is the chief management official in the agency. The administrator develops and guides the organization by taking responsibility for planning, organizing, implementing, and evaluating. The administrator is responsible for the application and implementation of established policies. The administrator may act as a liaison among the governing body, the medical staff, and any departments. The administrator provides for personnel policies and practices that adequately support sound patient care and maintains accurate and complete personnel records. The administrator implements the control and effective utilization of the physical and financial resources of the provider.

Directors (Column 2).--

Possible Titles: Medical Director, Director of Nursing, or Executive Director

Duties: The medical director is responsible for helping to establish and assure that the quality of

medical care is appraised and maintained. This individual advises the chief executive officer on medical and administrative problems and investigates and studies new developments in medical practices and techniques.

The nursing director is responsible for establishing the objectives for the department of nursing. This individual administers the department of nursing and directs and delegates management of professional and ancillary nursing personnel.

Supervisors (Column 4).--Employees in this classification are primarily involved in the direction, supervision, and coordination of HHA activities.

When a supervisor performs two or more functions, e.g., supervision of nurses and home health aides, the salaries and wages must be split in proportion with the percent of the supervisor's time spent in each cost center providing the HHA maintains the proper records (continuous time records) to support the split. If continuous time records are not maintained by the HHA, enter the entire salary of the supervisor on line 5 (A&G) and allocate to all cost centers through stepdown. However, if the supervisor's salary is all lumped in one cost center, e.g., skilled nursing care, and the supervisor's title coincides with this cost center, e.g., nursing supervisor, no adjustment is required.

Therapists (Column 6).--Include in column 6, on the line indicated, the cost attributable to the following services:

Physical therapy	-	line 7
Occupational therapy	-	line 8
Speech pathology	-	line 9
Medical social services	-	line 10

Physical therapy is the provision of physical or corrective treatment of bodily or mental conditions by the use of physical, chemical, and other properties of heat, light, water, electricity, sound, massage, and therapeutic exercise by or under the direction of a registered physical therapist as prescribed by a physician. The physical therapist provides evaluation, treatment planning, instruction, and consultation. Activities include, but are not limited to, the following: application of muscle tests and other evaluative procedures; formulation and provision of therapeutic exercise and other treatment programs upon physician referral or prescription; instructing and counseling patients, relatives, or other personnel; and consultation with other health workers concerning a patient's total treatment program.

Occupational therapy is the application of purposeful, goal-oriented activity in the evaluation, diagnosis, and/or treatment of persons whose function is impaired by physical illness or injury, emotional disorder, congenital or developmental disability, or the aging process, in order to achieve optimum functioning, to prevent disability, and to maintain health. Specific occupational therapy services include, but are not limited to, education and training in activities of daily living (ADL); the design, fabrication, and application of splints; sensorimotor activities; the use of specifically designed crafts; guidance in the selection and use of adaptive equipment; therapeutic activities to enhance functional performance; prevocational evaluation and training; and consultation concerning the adaptation of physical environments for the handicapped. These services are provided to individuals in their place of residence by or under the direction of an occupational therapist as prescribed by a physician.

HHAs may establish multiple A&G cost centers (referred to as componentized or fragmented) by using one of two possible methodologies. The rationale for allocating the shared A&G service cost center first is that shared A&G cost centers service all other cost centers, while 100 percent of HHA A&G reimbursable and 100 percent of HHA A&G nonreimbursable only service their respective cost centers. That is consistent with 42 CFR 413.24(d)(1), which states, in part, that "the cost of nonrevenue-producing cost centers serving the greatest number of other centers, while receiving benefits from the least number of centers, is apportioned first." Under the first methodology (also referred to as option 1), the HHA must classify all A&G costs as either A&G shared costs, A&G reimbursable costs, or A&G nonreimbursable costs. That is, 100 percent of the componentized A&G costs relate exclusively to either the HHA reimbursable or HHA nonreimbursable cost centers. The remaining costs are classified as A&G shared costs. The componentized A&G costs are allocated through cost finding to their respective cost centers in aggregate. First, allocate A&G shared costs to all applicable cost centers, including to the A&G reimbursable and A&G nonreimbursable cost centers on the basis of accumulated costs. Then allocate HHA A&G reimbursable costs to all applicable HHA reimbursable cost centers (not including special purpose cost centers) on the basis of accumulated costs and allocate HHA A&G nonreimbursable costs to all applicable HHA nonreimbursable cost centers on the basis of accumulated costs. Only A&G shared costs will be allocated to the special purpose cost centers. Accordingly, the total A&G costs in the CORF, Hospice, CMHC, RHC, and FQHC worksheets must equal the corresponding A&G shared costs on Worksheet B. The following three A&G cost center categories will be created: (1) A&G shared costs, (2) 100 percent HHA reimbursable costs, and (3) 100 percent HHA nonreimbursable costs, in this order only. Do not allocate A&G reimbursable costs to the A&G nonreimbursable cost center. Calculate the accumulated cost statistics as follows:

A&G Cost Center	Sum of Worksheet B	Transfer to Worksheet B-1
A&G Shared Costs	Col. 0-4, lines 5.02-28	Col. 5.01, lines 5.02-28
A&G Reimb. Costs	Col. 0-5.01, lines 6-14	Col. 5.02, lines 6-14
A&G Nonreimb. Costs	Col. 0-5.01, lines 15-23	Col. 5.03, lines 15-23

Under the second methodology (also referred to as option 2), unique A&G cost centers may be created (see CMS Pub. 15-I, §2313.1) to further refine the allocation process. The statistical basis upon which to allocate fragmented A&G costs must represent, as accurately as possible, the consumption or usage of A&G services by the benefiting cost centers. HHAs wishing to use an alternative allocation methodology (i.e., a change in allocation basis or the sequence of cost center allocation) must do so in accordance with CMS Pub. 15-I, §2313.

The fragmentation of A&G costs may constitute a direct assignment of A&G costs and as such must follow the policy established under §2307 of CMS Pub. 15-I.

Column Descriptions for Small HHAs

Small home health agencies, as defined in 42 CFR 413.24(d), may use the following procedures for completing Worksheet B. Certain alterations must be made to the worksheets to accommodate these procedures and not all of the columns are used. Worksheet B-1 is not used in these procedures.

Column 0.--Enter the costs on each line from the corresponding line on Worksheet A, column 10.

Column 1.--Disregard the column title. Enter on line 5 the sum of lines 1 through 5 of column 0. Enter on lines 6 through 28 the amounts from column 0 for the corresponding lines. Divide the total on line 5 by the total of lines 6 through 28. This results in the unit cost multiplier (UCM). Round the UCM to six places.

Column 2.--Multiply the cost on each of the lines 6 through 28 in column 1 by the UCM and enter the result in column 2 for each line.

Columns 3, 4, and 5.--Not needed.

Column 6.--For lines 6 through 28, add the amounts on each line in columns 1 and 2, and enter the result for each line.

3215. WORKSHEET C - APPORTIONMENT OF PATIENT SERVICE COSTS

This worksheet provides for the apportionment of home health patient service costs to Title XVIII only.

NOTE: Certain services may be rendered by an HHA that are not covered under the home health provision of §1832(a)(2)(A) of the Act. These services are covered under a different provision, i.e., §1832(a)(2)(B) of the Act. Under §1832(a)(2)(B) of the Act, any provider may render the services authorized under that section. An HHA is a provider. Therefore, an HHA may render medical and other health services. These services are reimbursed in accordance with §1833(a)(2)(B) of the Act. If a beneficiary receives any of these services, the beneficiary is liable for coinsurance, i.e., 20 percent of reasonable charges. The reimbursement for these services is subject to the lesser of reasonable cost or customary charges (LCC), and such reimbursement cannot exceed 80 percent of the reasonable cost of these services. These services are considered as Medicare services reimbursable under Title XVIII of the Act and are includable as Medicare visits for statistical purposes. However, the costs associated with the visits are not subject to the cost per visit limit. (See 42 CFR 413.30.) The provider must maintain auditable records of the number of visits, charges, deductibles and coinsurance applicable to those visits. A separate reimbursement computation and a separate LCC computation is required.

These services are reimbursable under Part B only and will be entered in lines 15 and 16, columns 7 and 10 and lines 25 through 27, columns 3 through 8.

Payment on Basis of Location of Service.--Section 4604 of the Balanced Budget Act (BBA) of 1997, appends §1891(g) of the Social Security Act, effective for cost reporting periods beginning on or after October 1, 1997, requiring home health agencies to submit claims for payment for home health services under Title XVIII on the basis of the geographic location at which the service is furnished. This requires home health agencies to make Medicare program cost limitation comparisons based on the geographic location (MSA/CBSA) or Non-MSA/*Non-CBSA*) of services furnished to program beneficiaries. To accomplish this, Worksheet C, Part I, the aggregate cost per visit computation is completed one time for the entire home health agency. Worksheet C, Part II, computes the aggregate Medicare cost and the aggregate Medicare cost per visit limitation. Worksheet C, Part II is performed once for each MSA/*CBSA* and/or Non-MSA/*Non-CBSA* where Medicare covered services were furnished during the cost reporting period. Section 4601 of BBA 1997 (See §3215.4) requires HHA 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.

3215.1 Part I - Aggregate Agency Cost Per Visit Computation.--This part provides for the computation of the average home health agency cost per visit used to derive each MSA/CBSA's total allowable cost attributable to Medicare patient care visits. Complete this part once for the entire home health agency. This computation is required by 42 CFR 413.30 and 42 CFR 413.53.

Column Descriptions for Cost Per Visit Computation

Column 2.--Enter in column 2 the amount for each discipline from Worksheet B, column 6, lines as indicated.

Column 3.--Enter the total agency visits from statistical data (Worksheet S-3, column 5, lines 1. through 6) for each type of discipline on lines 1 through 6.

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.* 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, 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, 2001through 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

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

Vaccines Charges (Continued)

	Column 6	*Column 7*
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.* *Do not enter charges for the full fiscal Year for hepatitis B vaccine administration.* *Do not enter charges for 7/1/2006 & subsequent pneumococcal and influenza vaccine administration.* *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).

Line 18.--Enter in columns 3 and 4, respectively, the cost of medical supplies from Part III, columns 8 and 9, respectively, line 15 (excluding subscripted lines). Enter in column 6 the sum of columns 3 and 4.

Line 19.--Enter the sum of lines 17 and 18 for columns 3 and 4. Enter in column 6 the sum of columns 3 and 4.

Effective for cost reporting periods beginning on or after October 1, 2000, do not complete lines 20 through 24 as all HHAs are reimbursed under PPS and no longer subject to cost per visit limitations or annual beneficiary limitations.

Line 20.--Enter in columns 3, 4 and 6, respectively, the sum the amounts from each Worksheet C, Part II, columns 8, 9 and 11, respectively, line 14.

Line 21.--Enter in columns 3 and 4, respectively, the cost of medical supplies from Part III, columns 8 and 9, respectively, line 15 (excluding subscripted lines). Enter in column 6 the sum of columns 3 and 4.

Line 22.--Enter the sum of lines 20 and 21 for columns 3 and 4. Enter in column 6 the sum of columns 3 and 4.

Line 23 and applicable subscripts.--For each MSA/non-MSA enter the following:

Column 0.--Enter the MSA/non-MSA code from Worksheet S-3, Part III, line 29, the corresponding subscripts thereof.

Column 1.--Enter the corresponding Medicare program (Title XVIII) unduplicated census count (two decimal places) from your records associated with services rendered prior to October 1, 2000. (See §3205.)

Column 2.--Enter the applicable per beneficiary annual limitation. Obtain this amount from your intermediary.

Column 6.--For each MSA/non-MSA determine the beneficiary cost limitation by multiplying the unduplicated census count (column 1) by the per beneficiary annual cost limitation (column 2). Enter the result in column 6.

Line 24.--In columns 1 (two decimal places) and 6, respectively, enter the sum of lines 23 through 23.24. Enter in column 3 the result of column 3, line 19 divided by column 6, line 19 multiplied by column 6, line 24. Enter in column 4 the result of column 4, line 19 divided by column 6, line 19 multiplied by column 6, line 24. (The sum of columns 3 and 4 must equal column 6.)

NOTE: The Medicare (Title XVIII) unduplicated census count (Worksheet S-3, Part I, column 2, line 10.01 (Pre 10/1/2000 Unduplicated Census Count)) 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).

3215.5 Part V - Outpatient Therapy Reduction Computation.--This section computes the reduction in the reasonable costs of outpatient physical therapy services (which includes outpatient speech language pathology) and outpatient occupational therapy provided under arrangement for beneficiaries who are not homebound and are not covered by a physician's plan of care as required by §1834(k) of the Act and enacted by §4541 of BBA 1997. The amount of the reduction is 10 percent for services rendered on or after January 1, 1998. For outpatient therapy services rendered on or after January 1, 1999, §4541 of BBA 1997 mandates a fee schedule payment basis for

outpatient physical therapy, outpatient occupational therapy, and outpatient speech pathology. Therefore, any outpatient therapy services furnished on or after January 1, 1999 **must not be included** in this section due to the application of a fee schedule for these services, but the corresponding visits must be recorded in column 5.01. These outpatient therapy services are reimbursed the lesser of the fee scheduled amount or the statutory limitation which is applied on a beneficiary specific basis through the Medicare claims system. This requires no provider input on the cost report. Columns 7 (visits) and 10 (costs) of Worksheet C, Part II represent data subject to deductible and coinsurance which should never have been subject to per visit cost limitations. This section (Worksheet C, Part V) was introduced in transmittal 6 (November 1998) to separately compile such visit and cost data not subject to deductible and coinsurance. As such, columns 7 and 10 of Worksheet C, Part II should not be used. Instead, such data should be captured in this section.

Column 2.--Enter in column 2 the average cost per visit amount for each discipline from Worksheet C, Part I, column 4, lines as indicated.

Columns 3 and 4.--To determine the Medicare Part B cost of services subject to deductibles and coinsurance, multiply the number of covered Part B visits made before January 1, 1998 by non-homebound program beneficiaries to rehabilitation facilities under arrangement (column 3) from your records by the average cost per visit amount in column 2 for each discipline. Enter the result in column 4.

Columns 5, 5.01, 5.02 and 6.--Enter in column 5 the number of Medicare covered Part B visits from your records made by non-homebound (not covered by a physician's plan of care) program beneficiaries to rehabilitation facilities under arrangement for services furnished January 1, 1998 thru December 31, 1998 only. Enter in column 5.01 the number of Medicare covered Part B visits from your records made by non-homebound program beneficiaries to rehabilitation facilities under arrangement for services furnished from January 1, 1999 through September 30, 2000. Outpatient therapy service visits rendered between January 1, 1999 and September 30, 2000 are reimbursed based on a fee schedule as described above. Determine the Medicare cost of services subject to deductibles and coinsurance by multiplying the amount in column 5 by the average cost per visit amount in column 2 for each discipline. Enter the result in column 6. Enter in column 5.02 the number of Medicare covered Part B visits from your records made by non-homebound program beneficiaries to rehabilitation facilities under arrangement for services furnished on or after October 1, 2000. Outpatient therapy services furnished to non-homebound program beneficiaries not covered by a physician's plan of care on or after October 1, 2000 are reimbursed under outpatient PPS. The non-homebound visits captured in columns 5.01 and 5.02 are for statistical purposes only and do not impact the settlement.

Column 7.--Compute the reasonable cost reduction by multiplying the cost of Medicare services in column 6 by 90 percent (.90). This is the application of the 10 percent reasonable cost reduction. Enter the result in column 7.

Column 8.--Compute the reasonable costs net of the reduction by adding column 7 to column 4. Enter the result in column 8.

Line 28.--For columns 3 through 8, respectively, enter the sum of lines 25 through 27.

NOTE: For cost reporting periods beginning on or after October 1, 2000, the following lines and/or columns revert back to the standard lines or columns (eliminate the subscript(s)): lines 1-1.01, 2-2.01, 3-3.01, 4-4.01, 5-5.01, 6-6.01, respectively, revert to lines 1, 2, 3, 4, 5, 6, respectively; column 11-11.01, lines 1-6 reverts to column 11, lines 1-6; line 15-15.01 reverts to line 15; line 16-16.01 reverts to line 16.

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 and influenza vaccines from Worksheet C, Part III, column 9, line 16.20, to column 2.

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 1	From 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 1	From 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.

Line 25.5.--Enter any other adjustments. For example, enter an adjustment resulting from changing the recording of vacation pay from cash basis to accrual basis. (See CMS Pub. 15-I, §2146.4.) For purposes of reimbursing costs associated with the Outcome and Assessment Information Set (OASIS) as required by Program Memorandum A-00-03 (cost reporting periods beginning in Federal fiscal year 2000 only), report on this line, in column 1, the result of multiplying the Medicare unduplicated census count on Worksheet S-3, column 2, line 10 (excluding subscripts), times $10, minus the interim OASIS payment made to the provider on April 1, 2000. Do not include this interim OASIS payment on Worksheet D-1, but rather attach documentation supporting the payment(s). (For intermediary use only during final settlement.)

Line 26.--Using the methodology explained in §120, enter the sequestration adjustment.

Line 27.--Enter the amount on line 25 plus line 25.5 minus line 26.

Line 28.--Enter the interim payment from Worksheet D-1, line 4. For intermediary final settlement, report on line 28.5 the amount from Worksheet D-1, line 5.99.

Line 29.--Enter the balance due the provider or the program. Indicate overpayments by parentheses ( ). Transfer the amount in column 1 to Worksheet S, Part II, line 1, column 1. Transfer the amount in column 2 to Worksheet S, Part II, line 1, column 2.

Line 30.--Enter the Medicare reimbursement effect of protested items. The reimbursement effect of the nonallowable items is estimated by applying reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See §115.2.) A schedule showing the supporting details and computations for this line must be attached.

Line 31.--Do not use this line.

3217. WORKSHEET D-1 - ANALYSIS OF PAYMENTS TO HOME HEALTH AGENCIES FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Complete this worksheet for Medicare interim payments only. (See 42 CFR 413.64.)

The column headings designate two categories of payments:

Category 1 - Part A
Category 2 - Part B

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 Provider Statistical and Reimbursement Report (PS&R) was not also adjusted.

Line Descriptions

Line 1.--Enter the total Medicare interim payments paid to the HHA for all covered services rendered prior to October 1, 2000. Additionally, for services rendered on or after October 1, 2000, enter the total Medicare interim payments paid to the HHA for applicable covered osteoporosis drugs *and any other vaccines paid on a cost reimbursement basis*. 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 and includes amounts withheld from the

HHA's interim payments due to an offset against overpayments to the HHA 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 amounts; nor does it include interim payments payable. If the HHA is reimbursed under the periodic interim payment method of reimbursement, enter the periodic interim payments received for this cost reporting period. Do not include payments received for services reimbursed on a fee schedule basis.

Also enter in columns 2 and 4, as applicable for HHA services furnished on or after October 1, 2000, the total Medicare PPS payments and the total Medicare PPS outlier payments paid to the HHA for all episode payment categories for related episodes completed during the current cost reporting period. The amounts entered reflect the sum of all interim PPS payments paid on individual claims (net of adjustments) for episodes completed in the current cost reporting period. Enter gross payments for total DME, oxygen, and prosthetics and orthotics, associated with home health PPS services only (bill types 32 and 33). Do not include any payment information associated with services recorded on bill type 34.

Line 2.--Enter the total Medicare interim payments payable on individual bills. Since the cost in the cost report is on an accrual basis, this line represents the amount of services rendered in the cost reporting period but not paid as of the end of the cost reporting period and does not include payments reported on line 1.

Line 3.--Enter the amount of each retroactive lump sum adjustment and the applicable date.

Line 4.--Enter the total amount of the interim payments (sum of lines 1, 2, and 3.99). Transfer these totals to the appropriate column on Worksheet D, Part II, line 28.

DO NOT COMPLETE THE REMAINDER OF WORKSHEET D-1. THE REMAINDER OF THE WORKSHEET IS COMPLETED BY YOUR FISCAL INTERMEDIARY.

Line 5.--List separately each tentative settlement payment after desk review together with the date of payment. If the cost report is reopened after the Notice of Program Reimbursement (NPR) has been issued, all settlement payments prior to the current reopening settlement are reported on line 5.

Line 6.--Enter the net settlement amount from Worksheet D, Part II, line 29, transferring the Part A amount to column 2 and Part B amount to column 4.

NOTE: On lines 3, 5, and 6, when an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment, even though total repayment is not accomplished until a later date.

Line 7.--Enter the total Medicare program liability. Enter the sum of the amounts on lines 4, 5.99, and 6.01 or 6.02 in columns 2 and 4, as appropriate. Enter amounts due the program in parentheses ( ).

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 from April 1, 2001 through December 31, 2002. Except for these dates, all vaccines are reimbursed through the parent provider and cannot be claimed by the RHC and FQHC.

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 by entering the sum of the amount in column 1, line 10 and the amount in column 2, 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. This is equal to the sum of the amount in column 1, line 14 and column 2, 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.

Line 2--Enter the total Medicare interim payments payable on individual bills. Since the cost in the cost report is on an accrual basis, this line represents the amount of services rendered in the cost reporting period, but not paid as of the end of the cost reporting period, and does not include payments reported on line 1.

Line 3--Enter the amount of each retroactive lump sum adjustment and the applicable date.

Line 4--Enter the total amount of the interim payments (sum of lines 1, 2, and 3.99). Transfer these totals to Worksheet RF-3, line 25.

DO NOT COMPLETE THE REMAINDER OF WORKSHEET RF-5. THE REMAINDER OF THE WORKSHEET IS COMPLETED BY YOUR FISCAL INTERMEDIARY.

Line 5--List separately each tentative settlement payment after desk review together with the date of payment. If the cost report is reopened after the Notice of Program Reimbursement (NPR) has been issued, report all settlement payments prior to the current reopening settlement on line 5.

Line 6--Enter the net settlement amount (balance due to the provider or balance due to the program) for the NPR, or, if this settlement is after a reopening of the NPR, for this reopening.

NOTE: On lines 3, 5, and 6, when an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment, even though total repayment is not accomplished until a later date.

Line 7--Enter the sum of the amounts on lines 4 and 5.99. The amount must equal Worksheet RF-3, line 24.

3239. WORKSHEET S-5 - HOSPICE IDENTIFICATION DATA

In accordance with 42 CFR 418.310 hospice providers of service participating in the Medicare program are required to submit annual information for health care services rendered to Medicare beneficiaries. Also, 42 CFR 413.24 requires cost reports from providers on an annual basis. The data submitted on the cost reports supports management of Federal programs. The statistics required on this worksheet pertain to a HHA-based hospice. Complete a separate S-5 for each HHA-based hospice.

3239.1 Part I - Enrollment Days.--Based on level of care.

Lines 1-4.--Enter on lines 1 through 4 the enrollment days applicable to each type of care. Enrollment days are unduplicated days of care received by a hospice patient. A day is recorded for each day a hospice patient receives one of four types of care. Where a patient moves from one type of care to another, count only one day of care for that patient for the last type of care rendered. For line 4, an inpatient care day should be reported only where the hospice provides or arranges to provide the inpatient care.

Line 5.--Enter the total of lines 1 through 4 for columns 1 through 4.

For the purposes of the Medicare and Medicaid hospice programs, a patient electing hospice can receive only one of the following four types of care per day:

Continuous Home Care Day - A continuous home care day is a day on which the hospice patient is not in an inpatient facility. A day consists of a minimum of 8 hours and a maximum of 24 hours of predominantly nursing care. **Convert continuous home care hours into days so that a true accountability can be made of days provided by the hospice.**

Routine Home Care Day - A routine home care day is a day on which the hospice patient is at home and not receiving continuous home care.

Inpatient Respite Care Day - An inpatient respite care day is a day on which the hospice patient receives care in an inpatient facility for respite care.

General Inpatient Care Day - A general inpatient care day is a day on which the hospice patient receives care in an inpatient facility for pain control or acute or chronic symptom management which cannot be managed in other settings.

Column Descriptions

Column 1.--Enter only the unduplicated Medicare days applicable to the four types of care. Enter on line 5 the total unduplicated Medicare days.

Column 2.-- Enter only the unduplicated Medicare days applicable to the four types of care for all Medicare hospice patients residing in a skilled nursing facility. Enter on line 5 the total unduplicated days.

Column 3.-- Enter in column 3 only the days applicable to the four types of care for all non-Medicare or other hospice patients. Enter on line 5 the total unduplicated days.

Column 4.--Enter the total days for each type of care, (i.e., sum of columns 1 and 3). The amount entered in column 4, line 5 should represent the total days provided by the hospice.

NOTE: Convert continuous home care hours into days so that column 4, line 5 reflects the actual total number of days provided by the hospice.

3239.2 Part II - Census Data.--

Line 6.--Enter on line 6 the total number of patients receiving hospice care within the cost reporting period for the appropriate payer source. Do not include the number of patients receiving care under subsequent election periods. (See CMS Pub. 21 §204.)

The total under this line should equal the actual number of patients served during the cost reporting period for each program. Thus, if a patient's total stay overlapped two reporting periods, the stay should be counted once in each reporting period. The patient who initially elects the hospice benefit, is discharged or revokes the benefit, and then elects the benefit again within a reporting period is considered to be a new admission with a new election and is counted twice.

A patient transferring from another hospice is considered to be a new admission and is included in the count. If a patient entered a hospice under a payer source other than Medicare and then subsequently elects Medicare hospice benefit, count the patient once for each pay source.

The difference between line 6 and line 9 is that line 6 equals the actual number of patients served during the reporting period for each program, whereas under line 9, patients are counted once, even if their stay overlaps more than one reporting period.

Line 7.--Enter the total Title XVIII Unduplicated Continuous Care hours billable to Medicare. When computing the Unduplicated Continuous Care hours, count only one hour regardless of number of services or therapies provided simultaneously within that hour.

Line 8.-- Enter the average length of stay for the reporting period by dividing the amount on line 5 by the amount on line 6. Include only the days for which a hospice election was in effect. The average length of stay for patients with a payer source other than Medicare and Medicaid is not limited to the number of days under a hospice election.

The statistics for a patient who had periods of stay with the hospice under more than one program is included in the respective columns. For example, patient A enters the hospice under Medicare hospice benefit, stays 90 days, revokes the election for 70 days (and thus goes back into regular Medicare coverage), then reelects the Medicare hospice benefits for an additional 45 days, under a new benefit period and dies (patient B). Medicare patient C was in the program on the first day of the year and died on January 29 for a total length of stay of 29 days. Patient D was admitted with private insurance for 27 days, then their private insurance ended and Medicaid covered an additional 92 days. Patient E, with private insurance, received hospice care for 87 days. The average length of stay (LOS) (assuming these are the only patients the hospice served during the cost reporting period) is computed as follows:

Medicare Days (90 & 45 & 29) Patient (A, B & C)	135 days
Medicare Patients	/3

Average LOS Medicare	54.67 Days
Medicaid Days Patient D (92)	92 Days
Medicaid Patient	1
Average LOS Medicaid	92 Days
Other (Insurance) Days (87 & 27)	114 Days
Other Payments (D & E)	2
Average LOS (Other)	54 Days
All Patients (90+45+29+92+87+27)	370 Days
Total number of patients	6
Average LOS for all patients	61.67 Days

Enter the hospice's average length of stay, without regard to payer source, in column 4, line 8.

Line 9.--Enter the unduplicated census count of the hospice for all patients initially admitted and filing an election statement with the hospice within a reporting period for the appropriate payer source. Do not include the number of patients receiving care under subsequent election periods (see CMS Pub. 21 §204). However, the patient who initially elects the hospice benefit, is discharged or revokes the benefits, and elects the benefit again within the reporting period is considered a new admission with each new election and is counted twice.

The total under this line equals the unduplicated number of patients served during the reporting period for each program. Thus, you do not include a patient if their stay was counted in a previous cost reporting period. If a patient enters a hospice source other than Medicare and subsequently becomes eligible for Medicare and elects the Medicare hospice benefit, then count that patient only once in the Medicare column, even though he/she may have had a period in another payer source prior to the Medicare election. A patient transferring from another hospice is considered a new admission and included in the count.

3240. WORKSHEET K - RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

In accordance with 42 CFR 413.20, the methods of determining costs payable under Title XVIII involve making use of data available from the institution's basic accounts, as usually maintained to arrive at equitable and proper payment for services. This worksheet provides for recording the trial balance of expense accounts from your accounting books and records. It also provides for reclassification and adjustments to certain accounts. The cost centers on this worksheet are listed in a manner which facilitates the transfer of the various cost center data to the cost finding worksheets (e.g., on Worksheets K, K-4, Parts I & II, the line numbers are consistent, and the total line is set at 34). Not all of the cost centers listed apply to all providers using these forms. Complete a separate worksheet K for each HHA-based hospice.

Column 1.--Obtain salaries to be reported from Worksheet K-1, col. 9, lines 3-34.

Column 2.--Obtain employee benefits to be reported from Worksheet K-2 col. 9 lines 3-34.

Column 3.--If the transportation costs, i.e., owning or renting vehicles, public transportation expenses, or payments to employees for driving their private vehicles can be directly identified to a particular cost center, enter those costs in the appropriate cost center. If these costs are not identified to a particular cost center enter them on line 22.

Column 4.--Obtain the contracted services to be reported from Worksheet K-3, col. 9 lines 3-34.

Column 5.--Enter in the applicable lines in column 5 all costs which have not been reported in columns 1 through 4.

Column 6.--Add the amounts in columns 1 through 5 for each cost center and enter the total in column 6.

Column 7.--Enter any reclassifications among cost center expenses 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. Show reductions to expenses as negative amounts.

Column 8.--Adjust the amounts entered in column 6 by the amounts in column 7 (increases and decreases) and extend the net balances to column 8. The total of column 8 must equal the total of column 6 on line 34.

Column 9.--In accordance with 42 CFR 413ff, enter on the appropriate lines the amounts of any adjustments to expenses required under Medicare principles of reimbursements. (See §3613.)

Column 10.--Adjust the amounts in column 8 by the amounts in column 9, (increases or decreases) and extend the net balances to column 10.

Transfer the amounts in column 10, lines 1 through 34, to the corresponding lines on worksheet K-4, Part I, column 0.

Line Descriptions

Lines 1 and 2 - Capital Related Cost - Buildings and Fixtures and Capital Related Cost -Movable Equipment.--These cost centers include depreciation, leases and rentals for the use of the facilities and/or equipment, interest incurred in acquiring land and depreciable assets used for patient care, insurance on depreciable assets used for patient care, and taxes on land or depreciable assets used for patient care.

Do not include in these cost centers the following costs: costs incurred for the repair or maintenance of equipment or facilities; amounts included in the rentals or lease or lease payments for repair and/or maintenance agreements; interest expense incurred to borrow working capital or for any purpose other than the acquisition of land or depreciable assets used for patient care; general liability insurance or any other form of insurance to provide protection other than the replacement of depreciable assets; or taxes other than those assessed on the basis of some valuation of land or depreciable assets used for patient care.

Line 3 - Plant Operation and Maintenance.--This cost center contains 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.

Plant Operation and Maintenance include the maintenance and service of utility systems such as heat, light, water, air conditioning and air treatment This cost center also includes the cost of maintenance and repair of buildings, parking facilities and equipment, painting, elevator maintenance, performance of minor renovation of buildings, and equipment. The maintenance of grounds such as landscape and paved areas, streets on the property, sidewalks, fenced areas, fencing, external recreation areas and parking facilities are part of this cost center. The care or cleaning of the interior physical plant, including the care of floors, walls, ceilings, partitions, windows (inside and outside), fixtures and furnishings, and emptying of trash containers, as well as the costs of similar services purchased from an outside organization which maintains the safety and well-being of personnel, visitors and the provider's facilities, are all included in this cost center.

Line 4 - Transportation - Staff.--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 - Volunteer Service Coordination.--Enter all of the cost associated with the coordination of service volunteers. This includes recruitment and training costs.

Line 6 - Administrative and General.--Use this cost center to record expenses of several costs which benefit the entire facility. Examples include fiscal services, legal services, accounting, data processing, taxes, and malpractice costs. If the option to componentize administrative and general costs into more than one cost center is elected, eliminate line 6. Componentized A&G lines must begin with subscripted line 6.01 and continue in sequential order (e.g., 6.01 A&G shared costs). (See §3820 for complete instructions.)

Line 7 - Inpatient - General Care.--This cost center includes costs applicable to patients who receive this level of care because their condition is such that they can no longer be maintained at home. Generally, they require pain control or management of acute and severe clinical problems which cannot be managed in other settings. The costs incurred on this line are those direct costs of furnishing routine and ancillary services associated with inpatient general care for which other provisions are not made on this worksheet.

If a hospice maintains its own inpatient beds, direct patient care costs include 24-hour nursing care within the facility, patient meals, laundry and linen services, and housekeeping. (Plant operation and maintenance costs are recorded on line 3.)

If a hospice does not maintain its own inpatient beds:

Show any costs for furnishing direct patient care services in the Visiting Services section, and;

Show any costs for furnishing inpatient general care services through a contract with another facility on Worksheet K-3.

Line 8 - Inpatient - Respite Care.--This cost center includes costs applicable to patients who receive this level of care on an intermittent, nonroutine, and occasional basis. The costs included on this line are those direct costs of furnishing routine and ancillary services associated with inpatient respite care for which other provisions are not made on this worksheet. Costs incurred by the hospice in furnishing direct patient care services to patients receiving inpatient respite care either directly by the hospice or under a contractual arrangement in an inpatient facility are to be included in visiting service costs section.

For a hospice that maintains its own inpatient beds, these costs include (but are not limited to) the costs of furnishing 24-hour nursing care within the facility, patient meals, laundry and linen services and housekeeping. Plant operation and maintenance costs would be recorded on line 3.

For a hospice that does not maintain its own inpatient beds, but furnishes inpatient respite care through a contractual arrangement with another facility, record contracted/purchased costs on Worksheet K-3. Do not include any costs associated with providing direct patient care. These costs are recorded in the visiting service costs section**.**

Line 9 - Physician Services.--In addition to the palliation and management of terminal illness and related conditions, hospice physician services also include meeting the general medical needs of the patients to the extent that these needs are not met by the attending physician. The amount entered on this line includes costs incurred by the hospice or amounts billed through the hospice for physicians' direct patient care services.

Line 10 - Nursing Care .--Generally, nursing services are provided as specified in the plan of care by or under the supervision of a registered nurse at the patient's residence.

Line 10.20 - Nursing Care–Continuous Home Care.--Enter the continuous home care portion of costs for nursing services provided by a registered nurse, licensed practical nurse or licensed vocational nurse as specified in the plan of care by or under the supervision of a registered nurse at the patient's residence.

Line 11 - Physical Therapy.--Physical therapy is the corrective treatment of bodily or mental conditions by the use of physical, chemical, and other properties of heat, light, water, electricity, sound massage, and therapeutic exercise by or under the direction of a registered physical therapist as prescribed by a physician. Therapy and speech-language pathology services may be provided for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

Line 12 - Occupational Therapy.--Occupational therapy is the application of purposeful goal-oriented activity in the evaluation and diagnosis for the persons whose function is impaired by physical illness or injury, emotional disorder, congenital or developmental disability, and to maintain health. Therapy and speech-language pathology services may be provided for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

Line 13 - Speech/Language Pathology .--These are physician-prescribed services provided by or under the direction of a qualified speech-language pathologist to those with functionally impaired communications skills. This includes the evaluation and management of any existing disorders of the communication process centering entirely, or in part, on the reception and production of speech and language related to organic and/or nonorganic factors. Speech-language pathology services may be provided for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

Line 14 - Medical Social Services.--This cost center includes only direct expenses incurred in providing medical social services. Medical social services consist of counseling and assessment

activities which contribute meaningfully to the treatment of a patient's condition. These services must be provided by a qualified social worker under the direction of a physician.

Lines 15-16 - Counseling.--Counseling services must be available to both the terminally ill individual and family members or other persons caring for the individual at home. Counseling, including dietary counseling, may be provided both for the purpose of training the individual's family or other care giver to provide care, and for the purpose of helping the individual and those caring for him or her to adjust to the individual's approaching death. This includes dietary, spiritual, and other counseling services provided while the individual is enrolled in the hospice. Costs associated with the provision of such counseling are accumulated in the appropriate counseling cost center. (Costs associated with bereavement counseling are recorded on line 30.)

Line 18 - Home Health Aide and Homemaker.--Enter the cost of a home health aide and homemaker services. Home health aide services are provided under the general supervision of a registered professional nurse and may be provided only by individuals who have successfully completed a home health aide training and competency evaluation program or competency evaluation program as required in 42 CFR 484.36.

Home health aides may provide personal care services. Aides may also perform household services to maintain a safe and sanitary environment in areas of the home used by the patient, such as changing the bed or light cleaning and laundering essential to the comfort and cleanliness of the patient.

Homemaker services may include assistance in personal care, maintenance of a safe and healthy environment and services to enable the individual to carry out the plan of care.

Line 18.20 - Home Health Aide and Homemaker-Continuous Home Care.--Enter the continuous care portion of cost for home health aide and/or homemaker services provided as specified in the plan of care and under the supervision of a registered nurse.

Line 19 - Other.--Enter on this line any other visiting cost which cannot be appropriately identified in the services already listed.

Line 20 - Drugs, Biological and Infusion Therapy.--Only drugs as defined in §1861(t) of the Act and which are used primarily for the relief of pain and symptom control related to the individual's terminal illness are covered. The amount entered on this line includes costs incurred for drugs or biologicals provided to the patients while at home. If a pharmacist dispenses prescriptions and provides other services to patients while the patient is both at home and in an inpatient unit, a reasonable allocation of the pharmacist cost must be made and reported respectively on line 20 (drugs and biologicals) and on line 7 (Inpatient General Care) or line 8 (Inpatient Respite Care) of worksheet K.

A hospice may, for example, use the number of prescriptions provided in each setting to make that allocation, or may use any other method that results in a reasonable allocation of the pharmacist's cost in relation to the service rendered.

Infusion therapy may be used for palliative purposes if you determine that these services are needed for palliation. For the purposes of a hospice, infusion therapy is considered to be the therapeutic introduction of a fluid other than blood, such as saline solution, into a vein.

Line 20.30 - Analgesics.--Enter the cost of analgesics.

Line 20.31 - Sedatives/Hypnotics.--Enter the cost of sedatives/hypnotics.

Line 20.32 - Other Specify.—Specify the type and enter the cost of any other drugs which cannot be appropriately identified in the drug cost center already listed.

Line 21 - Durable Medical Equipment/Oxygen.--Durable medical equipment as defined in 42 CFR 410.38 as well as other self-help and personal comfort items related to the palliation or management of the patient's terminal illness are covered. Equipment is provided by the hospice for use in the patient's home while he or she is under hospice care.

Line 22 - Patient Transportation.--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 23 - Imaging Services.--Enter the cost of imaging services including MRI.

Line 24 - Labs and Diagnostics.--Enter the cost of laboratory and diagnostic tests.

Line 25 - Medical Supplies.--The cost of medical supplies reported in this cost center are those costs which are directly identifiable supplies furnished to individual patients.

These supplies are generally specified in the patient's plan of treatment and furnished under the specific direction of the patient's physician.

Line 26 - Outpatient Services.--Use this line for any outpatient services costs not captured elsewhere. This cost may include the cost of an emergency room department.

Lines 27-28 - Radiation Therapy and Chemotherapy.--Radiation, chemotherapy and other modalities may be used for palliative purposes if you determine that these services are needed for palliation. This determination is based on the patient's condition and your care giving philosophy.

Line 29 - Other.--Enter any additional costs involved in providing visiting services which has not been provided for in the previous lines.

Lines 30-33 - Non Reimbursable Costs.--Enter in the appropriate lines the applicable costs. Bereavement program costs consist of counseling services provided to the individual's family after the individual's death. In accordance with §1814 (i)(1)(A) of the Act, bereavement counseling is a required hospice service, but it is not reimbursable.

3241. WORKSHEET K-1 - COMPENSATION ANALYSIS - SALARIES AND WAGES

Enter all salaries and wages for the hospice on this worksheet for the actual work performed within the specific area or cost center in accordance with the column headings. For example, if the administrator also performs visiting services which account for 25 percent of that person's time, then enter 75 percent of the administrator's salary on line 6 (A&G) and 25 percent of the administrator's salary enter on line 10 (nursing care). Complete a separate worksheet K-1 for each HHA-based hospice.

The records necessary to determine the split in salary between two or more cost centers must be maintained by the hospice and must adequately substantiate the method used to split the salary. These records must be available for audit by the intermediary, and the intermediary can accept or reject the method used to determine the split in salary. When approval of a method has been requested in writing and this approval has been received prior to the beginning of a cost reporting period, the approved method remains in effect for the requested period and all subsequent periods until you request in writing to change to another method or until the intermediary determines that the method is no longer valid due to changes in your operations.

Definitions

Salary.--This is gross salary paid to the employee before taxes and other items are withheld, includes deferred compensation, overtime, incentive pay, and bonuses. (See CMS Pub. 15-I, Chapter 21.)

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
1234567890123456789012345678901234567890123456789012345678901234567890
1              1   14710019993342000305 8A99P00120000312000305
```

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 *2007031 (1/31/2007).* Prior approval(s) 97090, 1998273, 1999304, 2000121, 2000305, 2001273, *and 2004031*.

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

RECORD NAME: Type 1 Records - Record Numbers 2 - 99

		Size	Usage	Loc.	Remarks
1.	Record Type	1	9	1	Constant "1"
2.	Spaces	10	X	2-11	
3.	Record Number	2	9	12-13	*#2 – The time that the ECR file is created. This is represented in military time as alpha numeric. Use positions 21-25. Example 2:30PM is expressed as 14:30.* *#3-99 – Reserved for future use.*
4.	Spaces	7	X	14-20	Spaces (optional)
5.	ID Information	40	X	21-60	Left justified to position 21.

RECORD NAME: Type 2 Records for Labels

		Size	Usage	Loc.	Remarks
1.	Record Type	1	9	1	Constant "2"
2.	Wkst. Indicator	7	X	2-8	Alphanumeric. Refer to Table 2.
3.	Spaces	2	X	9-10	
4.	Line Number	3	9	11-13	Numeric
5.	Subline Number	2	9	14-15	Numeric
6.	Column Number	3	X	16-18	Alphanumeric
7.	Subcolumn Number	2	9	19-20	Numeric
8.	Cost Center Code	4	9	21-24	Numeric. Refer to Table 5 for appropriate cost center codes.
9.	Labels/Headings				
	a. Line Labels	36	X	25-60	Alphanumeric, left justified
	b. Column Headings Statistical Basis & Code	10	X	21-30	Alphanumeric, left justified

The type 2 records contain both the text that appears on the pre-printed cost report and any labels added by the preparer. Of these, there are three groups: (1) Worksheet A cost center names (labels); (2) column headings for stepdown entries; and (3) other text appearing in various places throughout the cost report.

A Worksheet A cost center label must be furnished for every cost center with cost or charge data anywhere in the cost report. The line and subline numbers for each label must be the same as the line and subline numbers of the corresponding cost center on Worksheet A. The columns and subcolumn numbers are always set to zero.

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

Column headings for the General Service cost centers on Worksheets B and B-1 and Worksheets J-1 (Part III), K-5 (Part II), CM-1 (Part III), FQ-1 (Part III), and RH-1 (Part III) (lines 1-3), are supplied once. They consist of one to three records. Each statistical basis shown on Worksheet B-1 and Worksheets J-1 (Part III), CM-1 (Part III), FQ-1 (Part III), and RH-1 (Part III) is also to be reported. The statistical basis consists of one or two records (lines 4-5). Statistical basis code is supplied only to Worksheet B-1 columns and is recorded as line 6. The statistical code must agree with the statistical bases indicated on lines 4 and 5, i.e., code 1 = square footage, code 2 = dollar value, and code 3 = all others. For transportation costs, use 4 as the code for mileage. Refer to Table 2 for the special worksheet identifier to be used with column headings and statistical basis and to Table 3 for line and column references.

The following type 2 cost center descriptions are to be used for all Worksheet A standard cost center lines.

Line	Description
1	CAP REL COSTS-BLDG & FIXT
2	CAP REL COSTS-MVBLE EQUIP
3	PLANT OPERATION AND MAINTENANCE
4	TRANSPORTATION
5	ADMINISTRATIVE & GENERAL
5.01	A&G SHARED COSTS ▲
5.02	A&G REIMBURSABLE COSTS ▲
5.03	A&G NONREIMBURSABLE COSTS ▲
6	SKILLED NURSING CARE
7	PHYSICAL THERAPY
8	OCCUPATIONAL THERAPY
9	SPEECH PATHOLOGY
10	MEDICAL SOCIAL SERVICES
11	HOME HEALTH AIDE
12	SUPPLIES
13	DRUGS
14	DME
15	HOME DIALYSIS AIDE SERVICES
16	RESPIRATORY THERAPY
17	PRIVATE DUTY NURSING
18	CLINIC
19	HEALTH PROMOTION ACTIVITIES
20	DAY CARE PROGRAM
21	HOME DELIVERED MEALS PROGRAM
22	HOMEMAKER SERVICE
24	CORF
25	HOSPICE
26	CMHC
27	RHC
28	FQHC

▲ Use these standard cost center descriptions when administrative and general fragmentation option 1 is elected.

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

RECORD NAME: Type 3 Records for Nonlabel Data

		Size	Usage	Loc.	Remarks
1.	Record Type	1	9	1	Constant "3"
2.	Wkst. Indicator	7	X	2-8	Alphanumeric. Refer to Table 2.
3.	Spaces	2	X	9-10	
4.	Line Number	3	9	11-13	Numeric
5.	Subline Number	2	9	14-15	Numeric
6.	Column Number	3	X	16-18	Alphanumeric
7.	Subcolumn Number	2	9	19-20	Numeric
8.	Field Data				
	a. Alpha Data	36	X	21-56	Left justified. (Y or N for yes/no answers; dates must use MM/DD/YYYY format - slashes, no hyphens.) Refer to Table 6 for additional requirements for alpha data.
		4	X	57-60	Spaces (optional).
	b. Numeric Data	16	9	21-36	Right justified. May contain embedded decimal point. Leading zeros are suppressed; trailing zeros to the right of the decimal point are not. Positive values are presumed; no A+@ signs are allowed. Use leading minus to specify negative values. Express percentages as decimal equivalents, i.e., 8.75% is expressed as .087500. All records with zero values are dropped. Refer to Table 6 for additional requirements regarding numeric data.

A sample of type 3 records are below.

```
3A000000    21    1          36393
3A000000    21 1  1           5599
3A000000     1                147750
3A000000     1    1           67922
```

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

The line numbers are numeric. In several places throughout the cost report (see list below), the line numbers themselves are data. The placement of the line and subline numbers as data must be uniform.

Worksheet A-4, columns 3 and 6
Worksheet A-5, column 4
Worksheet A-6, Part B, column 1

Examples of records (*) with a Worksheet A line number as data are below.

```
     3A400001    13   0   TO SPREAD INTEREST EXPENSE
     3A400001    13   1   G
*    3A400001    13   3   1
     3A400001    13   4              221409
*    3A400001    13   6   51
     3A400001    13   7              225321
     3A400001    14   0   BETWEEN CAPITAL-RELATED COST
     3A400001    14   1   G
*    3A400001    14   3    4
     3A400001    14   4                3912
     3A400001    15   0   BUILDING & FIXTURES AND
     3A400001    16   0   ADMINISTRATIVE AND GENERAL

     3A500000    12   0   IRS PENALTY
     3A500000    12   1   B
     3A500000    12   2                -935
*    3A500000    12   4   5
     3A500000    13 1 0   MISC INCOME
     3A500000    13 1 1   A
     3A500000    13 1 2             -114525
*    3A500000    13 1 4   5

*    3A600000     1   1    21
     3A600000     3   1   KITCHEN
     3A600000     4   1              3352
     3A600000     5   1              1122
```

RECORD NAME: Type 4 Records - File Encryption

This type 4 record consists of 3 records: 1, 1.01, and 1.02. These records are created at the point in which the ECR file has been completed and saved to *diskette, compact disk or PC hard drive* and insures the integrity of the file.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-1728-94
TABLE 2 - WORKSHEET INDICATORS

This table contains the worksheet indicators that are used for electronic cost reporting. A worksheet indicator is provided for only those worksheets for which data are to be provided.

The worksheet indicator consists of seven digits in positions 2-8 of the record identifier. The first two digits of the worksheet indicator (positions 2 and 3 of the record identifier) always show the worksheet. The third digit of the worksheet indicator (position 4 of the record identifier) is used in several ways. First, it may be used to identify worksheets for multiple HHA-based components. Alternatively, it may be used as part of the worksheet, e.g., A83. For Worksheets A-4 and A-5, if there is a need for extra lines on multiple worksheets, the fifth and sixth digits of the worksheet indicator (positions 6 and 7 of the record identifier) identify the page number. An exception is Worksheet C, Part II which is a two digit identifier (positions 5 and 6 of the worksheet indicator (6 and 7 of record identifier)) which corresponds to the two digit subscript of question 29 on Worksheet S-3 identifying the MSA *or CBSA* in which the provider performed services during the cost reporting period. The seventh digit of the worksheet indicator (position 8 of the record identifier) represents the worksheet or worksheet part.

Worksheets That Apply to the HHA Complex

Worksheet	Worksheet Indicator	
S, Part II	S000002	
S-2	S200000	
S-3	S300000	(a)
S-4	S410000	(b,e)
S-5	S510000	(b)
S-6	S610000	(b)
A	A000000	
A-1	A100000	
A-2	A200000	
A-3	A300000	
A-4	A400010	(c)
A-5	A500010	
A-6, Part A	A60000A	
A-6, Part B	A60000B	
A-6, Part C	A60000C	
A-7	A700000	
A-8-3	A830000	(a,f)
B-1 (For use in column headings)	B10000*	
B	B000000	
B-1	B100000	
C, Part II	C000002	(d)

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-1728-94
TABLE 2 - WORKSHEET INDICATORS

Worksheets That Apply to the HHA Complex (Continued)

Worksheet	Worksheet Indicator	
C, Parts III-V	C000003	(a)
D	D000000	(a)
D-1	D100000	
F	F000000	
F-1	F100000	
F-2	F200000	
J-1, Part I	J110001	(b)
J-1, Part III	J110003	(b)
J-2	J210000	(a,b)
J-3	J310000	(a,b)
J-4	J410000	(b)
CM-1, Part I	M110001	(b)
CM-1, Part III	M110003	(b)
CM-2	M210000	(a,b)
CM-3	M310000	(a,b)
CM-4	M410000	(b)
RH-1, Part I	R110001	(b)
RH-1, Part III	R110003	(b)
RH-2	R210000	(a,b)
FQ-1, Part I	Q110001	(b)
FQ-1, Part III	Q110003	(b)
FQ-2	Q210000	(a,b)
RF-1	H11?000	(e)
RF-2	H21?000	(e)
RF-3	H31?000	(e)
RF-4	H41?000	(e)
RF-5	H51?000	(e)

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-1728-94
TABLE 2 - WORKSHEET INDICATORS

FOOTNOTES:

(a) Worksheets With Multiple Parts Using Identical Worksheet Indicator
Although some worksheets have multiple parts, the lines are numbered sequentially. In these instances, the same worksheet identifier is used with all lines from this worksheet regardless of the worksheet part. This differs from the Table 3 presentation, which still identifies each worksheet and part as they appear on the printed cost report. This affects Worksheets S-3 and D and Worksheets A-8-3; C, Parts III, IV and V; J-2; J-3; CM-2; FQ-2; and RH-2.

(b) Multiple Subproviders (CORFs, CMHCs, RHCs, FQHCs, Hospices)
The third digit of the worksheet indicator (position 4 of the record) is numeric from 1 to 9 to accommodate multiple subproviders. If there is only one subprovider of that type, the default is 1. This affects Worksheets S-4; S-5; S-6; J-1, Parts I and III; J-2; J-3; J-4; CM-1, Parts I and III; CM-2; CM-3; CM-4; RH-1, Parts I and III; RH-2; FQ-1, Parts I and III; and FQ-2; K; K-1; K-2; K-3; K-4 Parts I and II; K-5 Parts I - III; K-6.

(c) Multiple Worksheets for Reclassifications and Adjustments Before Stepdown
The fifth and sixth digits of the worksheet indicator (positions 6 and 7 of the record) are numeric from 01-99 to accommodate reports with more lines on Worksheets A-4. For reports that do not need additional worksheets, the default is 01. For reports that do need additional worksheets, the first page is numbered 01. The number for each additional page of the worksheet is incremented by 1.

(d) Multiple Worksheets C, Part II for Cost Limitations Based on the *MSA or CBSA*
The fifth and sixth digits of the worksheet indicator (positions 6 and 7 of the record) are numeric from 00-2*9* and correspond to the two digit subscript of line 29, *column 1* on Worksheet S-3 (i.e., insert the identifier 02 for line 29.02) which identifies the 4 *character* MSA. If services are provided in only one MSA the default is 00. Where an HHA provides services in multiple MSAs, one Worksheet C, Part II must be completed for each MSA.

The fifth and sixth digits of the worksheet indicator (positions 6 and 7 of the record) are numeric from 30-59 and correspond to, but are not identical with, the two digit subscript of line 29, column 1.01 on Worksheet S-3 (i.e., insert the identifier 30 for line 29.00, 31 for line 29.01, and 32 for line 29.02) which identifies the 5 character CBSA. If services are provided in only one CBSA the default is 30. Where an HHA provides services in multiple CBSAs, one Worksheet C, Part II must be completed for each CBSA. (The actual effective date of use for CBSAs is episodes concluding on or after January1, 2006.)

(e) Multiple Health Clinic Providers (RHCs, FQHCs)
The third digit of the worksheet indicator (position 4 of the record) is numeric from 1 to 9 to accommodate multiple subproviders. If there is only one health clinic provider of that type, the default is 1. This affects Worksheets RF-1, RF-2, RF-3, RF-4 and RF-5. The fourth character of the worksheet indicator (position 5 of the record) indicates the health clinic provider. F indicates Federally Qualified Health Center, and R indicates Rural Health Clinic.

(f) Multiple Worksheets A-8-3
This worksheet is used for physical, occupational, or speech pathology therapy services furnished by outside suppliers. The fourth digit of the worksheet indicator (position 5 of the record) is an alpha character of P for physical therapy, O for occupational therapy, and S for speech pathology therapy services. Additionally, the fifth digit of the worksheet indicator (position 6 of the record) for physical therapy services furnished before April 10, 1998 is indicated by a numeric character of 0. Physical therapy services furnished on or after April 10, 1998 are indicated by a numeric character of 1 in this position.

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

This table identifies those data elements necessary to calculate a home health agency cost report. It also identifies some figures from a completed cost report. These calculated fields (e.g., Worksheet B, column 6) are needed to verify the mathematical accuracy of the raw data elements and to isolate differences between the file submitted by the home health agency complex and the report produced by the fiscal intermediary. Where an adjustment is made, that record must be present in the electronic data file. For explanations of the adjustments required, refer to the cost report instructions.

Table 3 "Usage" column is used to specify the format of each data item as follows:

9	Numeric, greater than or equal to zero.
-9	Numeric, may be either greater than, less than, or equal to zero.
9(x).9(y)	Numeric, greater than zero, with x or fewer significant digits to the left of the decimal point, a decimal point, and exactly y digits to the right of the decimal point.
X	Character.

Consistency in line numbering (and column numbering for general service cost centers) for each cost center is essential. The sequence of some cost centers does change among worksheets.

Table 3 refers to the data elements needed from a standard cost report. When a standard line is subscripted, the subscripted lines must be numbered sequentially with the first subline number displayed as "01" or " 1" (with a space preceding the 1) in field locations 14-15. It is unacceptable to format in a series of 10, 20, or skip subline numbers (i.e., 01, 03), except for skipping subline numbers for prior year cost center(s) deleted in the current period or initially created cost center(s) no longer in existence after cost finding. Exceptions are specified in this manual. For Other (specify) lines, i.e., Worksheet settlement series, all subscripted lines should be in sequence and consecutively numbered beginning with subscripted line number 01. Automated systems should reorder these numbers where providers skip or delete a line in the series.

Drop all records with zero values from the file. Any record absent from a file is treated as if it were zero.

All numeric values are presumed positive. Leading minus signs may only appear in data with values less than zero that are specified in Table 3 with a usage of "-9". Amounts that are within preprinted parentheses on the worksheets, indicating the reduction of another number, are reported as positive values.

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*
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 S-3 (Continued)		
Total Charges	44	1-6	9	9
Total Number of Episodes	45	1, 3-6	9	9
Total Number of Outlier Episodes	46	2, 4-6	9	9
Total Non-Routine Medical Supply Charges for each Payment Category	47	1-6	9	9
Total Home Health Visits by Discipline for each Payment Category	30, 32, 34, 36, 38, 40	7	9	9
Total Medical Supply Charges for each Payment Category	31, 33, 35, 37, 39, 41	7	9	9
Total Visits	42	7	9	9
Other Charges	43	7	9	9
Total Charges	44	7	9	9
Total Number of Episodes	45	7	9	9
Total Number of Outlier Episodes	46	7	9	9
Total Medical Supply Charges	47	7	9	9
		WORKSHEET A		
Direct salaries by department	3-28	1	9	-9
Total direct salaries	29	1	9	9
Employee benefits by department	3-28	2	9	-9
Total employee benefits	29	2	9	9
Transportation costs by department	1-28	3	9	-9
Total transportation costs	29	3	9	9
Contracted/purchased services by department	3-28	4	9	-9
Total contracted/purchased services	29	4	9	9
Other direct costs by department	1-28	5	9	-9
Total other direct costs	29	5	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 A-6 (Continued)				
Part C - For each related organization:				
Type of interrelationship (A through G)	1-5	1	1	X
If type is G, specify description of relationship	1-5	0	36	X
Name of related individual or organization	1-5	2	36	X
Address of related individual or organization	1-5	3	36	X
Percent owned by provider	1-5	4	6	9(3).99
Percent ownership of provider	1-5	5	6	9(3).99
Type of business	1-5	6	15	X
WORKSHEET A-7				
Analysis of changes in capital assets balances for land, land improvements, buildings and fixtures, building improvements, fixed and movable equipment, and in total:				
Beginning balances	1-7	1	9	9
Purchases	1-7	2	9	9
Donations	1-7	3	9	9
Disposals and retirements	1-7	5	9	9
WORKSHEETS B and B-1 AND WORKSHEETS J-1, CM-1, RH-1, and FQ-1, PART III; and K-5, Part II HEADINGS				
Column heading (cost center name)	1-3 +	1-5	10	X
Statistical basis	4, 5 +	1-5	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.

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 B				
Adjustment for A&G costs applicable to contracted services	6-28 ▲	0	9	-9
Costs after cost finding by department	6-28	6	9	-9
Total costs after cost finding	29	6	9	9
WORKSHEET B-1				
All cost allocation statistics	1-28	1-5 *	9	9
Reconciliation	5-28	5A	9	-9
For each cost allocation using accumulated costs as the statistic, include a record containing an X.	0	1-5	1	X

* In each column using accumulated costs as the statistical basis for allocating costs, identify each cost center that is to receive no allocation with a negative 1 (-1) placed in the accumulated cost column. Providers may elect to indicate total accumulated cost as a negative amount in the reconciliation column. However, there should never be entries in both the reconciliation column and accumulated column simultaneously. For those cost centers that are to receive partial allocation of costs, provide only the cost to be excluded from the statistic as a negative amount on the appropriate line in the reconciliation column. If line 5 is fragmented, line 5 must be deleted and subscripts of line 5 must be used.

▲ For each cost center with associated A&G service costs applicable to contracted services (see §3214), the amount entered in column 0 reduces the net expenses for allocation dollar for dollar. **After** all general service costs have been allocated on Worksheet B and column 6 totaled, but before any amounts are transferred to from Worksheet B to Worksheet C, add back the contracted A&G service cost adjustment amount to the corresponding cost center.

WORKSHEET C				
Parts I and II:				
Medicare visits – Parts A and B	1-6 (and subscripts)	5-6	9	9
Medicare cost limits by discipline	8-13	4	6	9(3).99
Parts III, IV, and V:				
Total charges for medical supplies and drugs	15, 15.01, 16, 16.01	3	9	9
Charges for medical supplies – Medicare Parts A and B	15, 15.01	5-7	9	9
Charges for drugs – Medicare Part B	16, 16.01, *16.20*	6, 6.01, 7	9	9
Medicare unduplicated census count for each MSA	23-23.24	1	9	9(6).99
Medicare total unduplicated census count	24	1	9	9(6).99

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-1728-94

TABLE 3A - WORKSHEETS REQUIRING NO INPUT

Worksheet S, Part I
Worksheet A-8-3, Part II
Worksheet J-1, Part II
Worksheet J-2, Part III
Worksheet CM-1, Part II
Worksheet CM-2, Part III
Worksheet RH-1, Part II
Worksheet RH-2, Part III
Worksheet FQ-1, Part II
Worksheet FQ-2, Part III
Worksheet K-6

TABLE 3B - TABLES TO WORKSHEET S-2

Type of Control

1 = Voluntary Nonprofit, Church
2 = Voluntary Nonprofit, Other
3 = Proprietary, Sole Proprietor
4 = Proprietary, Partnership
5 = Proprietary, Corporation
6 = Private Nonprofit
7 = Governmental & Private Combination
8 = Governmental, Federal
9 = Governmental, State
10 = Governmental, City
11 = Governmental, City-County
12 = Governmental, County
13 = Governmental, Health District

TABLE 3C - LINES THAT CANNOT BE SUBSCRIPTED (BEYOND THOSE PREPRINTED)

Worksheet	Lines
S, Part II	1, 4
S-2	1, 2, 7-23, 26-28
S-3	1-26, 28, 30-47
S-4	1-7, 11, 13, 14
A, A-1, A-2, A-3	6-11 (12-13, *13.20*)*, 29
B, B-1	6-11 (12-13, *13.20*)*, 29
C	1-14 (15-16, *16.20*)*, 17-22, 24-28
A-4	All
A-5	1-12, 21

* Additionally, lines surrounded by parentheses may not be subscripted beyond those preprinted for reporting periods which overlap October 1, 2000, *July 1, 2006, or cost reporting periods beginning on or after July 1, 2006.*

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-1728-94

TABLE 3C - LINES THAT CANNOT BE SUBSCRIPTED (BEYOND THOSE PREPRINTED) (CONTINUED)

Worksheet	Lines
A-6, Part A	All
A-6, Part B	1-2, 4
A-6, Part C	1-4
A-7	All
D	All (except line 25.5)
D-1	1, 2, 3.01-3.04, 3.50-3.53, 4
F	All (except lines 9, 26, 31, 41, and 48)
F-1	All (except lines 10, 16, and 31)
F-2	All (except lines 8 and 15)
A-8-3	All
S-6	1-27
J-1, J-2	All
J-3	All (except line 19)
J-4	1, 2, 3.01-3.04, 3.50-3.53
CM-1, CM-2	All
CM-3	All (except line 21)
CM-4	1, 2, 3.01-3.04, 3.50-3.53
RH-1, RH-2	All
FQ-1, FQ-2	All
RF-1, RF-2	All
RF-3	All (except line 23)
RF-4	All
RF-5	1, 2, 3.01-3.04, 3.50-3.53

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 1728-94
TABLE 5 - COST CENTER CODING

Home Health Disciplines

Cost centers appearing on Worksheet A, lines 6-11, may not be subscripted beyond those that are preprinted. (See CMS Pub. 15-I, §2313.2C.) Expansion of the home health discipline cost centers is not allowed.

STANDARD COST CENTER DESCRIPTIONS AND CODES

	CODE	USE
GENERAL SERVICE COST CENTERS		
Capital Related - Buildings and Fixtures	0100	(20)
Capital Related - Movable Equipment	0200	(20)
Plant Operation and Maintenance	0300	(20)
Transportation	0400	(10)
Administrative and General	0500	(20)
HHA REIMBURSABLE SERVICES		
Skilled Nursing Care	0600	(01)
Physical Therapy	0700	(01)
Occupational Therapy	0800	(01)
Speech Pathology	0900	(01)
Medical Social Services	1000	(01)
Home Health Aide	1100	(01)
Supplies	1200	(10)
Drugs	1300	(10)
DME	1400	(10)
HHA NONREIMBURSABLE SERVICES		
Home Dialysis Aide Services	1500	(10)
Respiratory Therapy	1600	(10)
Private Duty Nursing	1700	(10)
Clinic	1800	(10)

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 1728-94
TABLE 5 - COST CENTER CODING

STANDARD COST CENTER DESCRIPTIONS AND CODES (CONTINUED)

	CODE	USE
HHA NONREIMBURSABLE SERVICES (Continued)		
Health Promotion Activities	1900	(10)
Day Care Program	2000	(10)
Home Delivered Meals Program	2100	(10)
Homemaker Service	2200	(10)
SPECIAL PURPOSE COST CENTER		
CORF	2400	(09)
Hospice	2500	(09)
CMHC	2600	(09)
RHC	2700	(09)
FQHC	2800	(09)

NONSTANDARD COST CENTER DESCRIPTIONS AND CODES

GENERAL SERVICE COST CENTERS		
Administrative and General - Shared	0523	(01)
Administrative and General 100% Reimbursable	0521	(01)
Administrative and General 100% Nonreimbursable	0522	(01)
HHA REIMBURSABLE SERVICES		
Cost of Administering Vaccines	*1320*	*(01)*
HHA NONREIMBURSABLE SERVICES		
Other Nonreimbursable	2300	*(20)*
Other Nonreimbursable - Tele-Medicine	2320	(01)

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

Medicare cost reports submitted electronically must be subjected to various edits, which are divided into two categories: Level I and level II edits. These include mathematical accuracy edits, certain minimum file requirements, and other data edits. Any vendor software that produces an electronic cost report file for Medicare home health agencies must automate all of these edits. Failure to properly implement these edits may result in the suspension of a vendor's system certification until corrective action is taken. The vendor's software should provide meaningful error messages to notify the home health agency of the cause of every exception. The edit message generated by the vendor systems must contain the related 4 digit and 1 alpha character, where indicated, reject/edit code specified below. Any file containing a level I edit will be rejected by your fiscal intermediary without exception.

Level I edits (1000 series reject codes) test that the file conforms to processing specifications, identifying error conditions that would result in a cost report rejection. These edits also test for the presence of some critical data elements specified in Table 3. Level II edits (2000 series edit codes) identify potential inconsistencies and/or missing data items that may have exceptions and should not automatically cause a cost report rejection. Resolve these items and submit appropriate worksheets and/or data supporting the exceptions with the cost report. Failure to submit the appropriate data with your cost report may result in payments being withheld pending resolution of the issue(s).

The vendor requirements (above) and the edits (below) reduce both intermediary processing time and unnecessary rejections. Vendors should develop their programs to prevent their client home health agencies from generating *the print image (PI), a hard copy substitute cost report and* electronic cost report file where level I edits exist. Ample warnings should be given to the provider where level II edit conditions are violated. *Vendors shall also develop their programs to apply both level I and II edits to ALL data (calculated, input and transfers) contained in the cost report, not just data exported to the ECR file.*

NOTE: Dates in brackets [ ] at the end of an edit indicate the effective date of that edit for cost reporting periods ending on or after that date. Dates followed by a "b" are for cost reporting periods beginning on or after the specified date. Dates followed by an "s" are for services rendered on or after the specified date unless otherwise noted. [10/31/2000]

I. Level I Edits (Minimum File Requirements)

Reject Code	Condition
1000	The first digit of every record must be either 1, 2, 3 (HCRIS #2005), or 4 (encryption code only). [3/31/1997]
1005	No record may exceed 60 characters (HCRIS #2325). [3/31/1997]
1010	All alpha characters must be in upper case (HCRIS #2020). This is exclusive of the encryption code, type 4 record, record numbers 1, 1.01, and 1.02. [3/31/1997]
1015	For micro systems, the end of record indicator must be a carriage return and line feed, in that sequence (HCRIS #2180). [3/31/1997]
1020	The home health agency provider number (record #1, positions 17-22) must be valid and numeric (HCRIS #2025). [3/31/1997]
1025	All dates (record #1, positions 23-29, 30-36, 45-51, and 52-58) must be in Julian format and legitimate (HCRIS #2040). [9/30/1998]
1030	The fiscal year beginning date (record #1, positions 23-29) must be less than or equal to the fiscal year ending date (record #1, positions 30-36) (HCRIS #2045). [9/30/1998]

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

Reject Code	Condition
1031	*The standard and nonstandard cost centers listed below must be reported on the lines as indicated and the corresponding cost center codes may only appear on the lines as indicated. No other cost center codes may be placed on these lines or subscripts of these lines, unless indicated herein. [1/31/2007]*

Cost Center	*Line*	*Code*
Cap Rel-Bldg & Fixt	*1*	*0100-0119*
Cap Rel-Mvble Equip	*2*	*0200-0219*
Plant Operation and Maintenance	*3*	*0300-0319*
Transportation	*4*	*0400-0409*
Skilled Nursing Care	*6*	*0600*
Physical Therapy	*7*	*0700*
Occupational Therapy	*8*	*0800*
Speech Pathology	*9*	*0900*
Medical Social Services	*10*	*1000*
Home Health Aide	*11*	*1100*
Supplies	*12*	*1200-1209*
Drugs	*13*	*1300-1309**
Drugs	*13.20*	*1320*
DME	*14*	*1400-1409*
Home Dialysis Aide Services	*15*	*1500-1509*
Respiratory Therapy	*16*	*1600-1609*
Private Duty Nursing	*17*	*1700-1709*
Clinic	*18*	*1800-1809*
Health Promotion Activities	*19*	*1900-1909*
Day Care Program	*20*	*2000-2009*
Home Delivered Meals Program	*21*	*2100-2109*
Homemaker Service	*22*	*2200-2209*
CORF	*24*	*2400-2408*
Hospice	*25*	*2500-2508*
CMHC	*26*	*2600-2608*
RHC	*27*	*2700-2708*
FQHC	*28*	*2800-2808*

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

Reject Code	Condition
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, subline, 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 subline 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]

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

Reject Code	Condition
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, column 1; line 29.02, column 1 or 2; 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, column 1; line 29.02, column 1 or 2; 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]

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]*
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]
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]*

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

Reject Code	Condition
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]
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]
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

II. Level II Edits (Potential Rejection Errors)

These conditions are usually, but not always, incorrect. These edit errors should be cleared when possible through the cost report. When corrections on the cost report are not feasible, provide additional information in schedules, note form, or any other manner as may be required by your fiscal intermediary (FI). Failure to clear these errors in a timely fashion, as determined by your FI, may be grounds for withholding payments.

Edit	Condition
2000	All type 3 records with numeric fields and a positive usage must have values equal to or greater than zero (supporting documentation may be required for negative amounts). [3/31/1997]
2005	Only elements set forth in Table 3, with subscripts as appropriate, are required in the file (HCRIS #2010). [3/31/1997]
2010	The cost center codes (positions 21-24) (type 2 records) must be a code from Table 5, and each cost center code must be unique. [3/31/1997]
2015	Standard cost center lines, descriptions, and codes should not be changed. (See Table 5.) This edit applies to the standard line only and not subscripts of that code. [3/31/1997]
2020	All standard cost center codes must be entered on the designated standard cost center line and subscripts thereof as indicated in Table 5. [3/31/1997]
2025	Only nonstandard cost center codes within a cost center category may be placed on standard cost center lines of that cost center category. [3/31/1997]
2030	The standard cost centers listed below must be reported on the lines as indicated and the corresponding cost center codes may only appear on the lines as indicated. No other cost center codes may be placed on these lines or subscripts of these lines, unless indicated herein. [3/31/1997] *This edit is upgraded to a level I edit (edit 1031) and is effective for cost reporting periods ending on or after January 31, 2007.*

Cost Center	Line	Code
Cap Rel-Bldg & Fixt	1	0100-0119
Cap Rel-Mvble Equip	2	0200-0219
Plant Operation and Maintenance	3	0300-0319
Transportation	4	0400-0409
Skilled Nursing Care	6	0600
Physical Therapy	7	0700
Occupational Therapy	8	0800
Speech Pathology	9	0900
Medical Social Services	10	1000
Home Health Aide	11	1100
Supplies	12	1200-1209
Drugs	13	1300-1309

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

Edit	Condition		
	Cost Center	Line	Code
	DME	14	1400-1409
	Home Dialysis Aide Services	15	1500-1509
	Respiratory Therapy	16	1600-1609
	Private Duty Nursing	17	1700-1709
	Clinic	18	1800-1809
	Health Promotion Activities	19	1900-1909
	Day Care Program	20	2000-2009
	Home Delivered Meals Program	21	2100-2109
	Homemaker Service	22	2200-2209
	CORF	24	2400-2408
	Hospice	25	2500-2508
	CMHC	26	2600-2608
	RHC	27	2700-2708
	FQHC	28	2800-2808

2035 The administrative and general standard cost center code (0500) may appear only on line 5. [3/31/1997]

2040 All calendar format dates must be edited for 10 character format, e.g., 01/01/1996 (MM/DD/YYYY) (HCRIS #2100). [9/30/1998] *This edit is converted to edit 1040 effective FYE 1/31/2007.*

2045 All dates must be possible, e.g., no "00", no "30", or "31" of February (HCRIS #2105). [3/31/97]

2005S The combined amount due the provider or program (Worksheet S, Part II, line 4, sum of columns 1 and 2) should not equal zero. [3/31/1997]

2015S The home health agency certification date (Worksheet S-2, column 3, line 2) should be on or before the cost report beginning date (Worksheet S-2, column 1, line 7). [3/31/1997]

2020S The length of the cost reporting period should be greater than 27 days and less than 459 days (HCRIS #2062). [3/31/1997]

2045S Worksheet S-2, line 8 (type of control) must have a value of 1 through 13. (See Table 3B.) [3/31/1997]

2050S On Worksheet S-2, a response is required for at least one of the questions on lines 27.01or 27.03. [9/30/1998]

2100S The following statistics from Worksheet S-3, Part I should be greater than zero:

a. Total visits for the home health agency (column 5, line 8) [3/31/1997]; and

b. Unduplicated census count for the home health agency (column 6, line 10). [3/31/1997]

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]*
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.