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: N/A

This transmittal updates Chapter 32, Home Health Agency Cost Report, (Form CMS-1728-94). This transmittal clarifies and corrects the existing instructions. This transmittal also incorporates recent statutory changes and an Executive order. The effective dates for all changes will vary.

Significant Revisions:

- Worksheet S-4 - Adds column 3, line 16 to capture total visits performed by interns and residents to facilitate the calculation of allowable graduate medical education (GME) pass through costs incurred by a home health agency (HHA) based rural health clinic (RHC) and federally qualified health center (FQHC).
- Worksheet D, Part I - Clarifies the instructions for line 1.
- Worksheets D, Part II; CM-3, Part II; and RF-3 - Added or revised lines or instructions as applicable to accommodate the 2 percent Medicare sequestration adjustment, as indicated in the Office of Management and Budget Report to the Congress on the sequestration required by section 251A of the Balanced Budget and Emergency Deficit Control Act, as amended by the Joint Committee. The sequestration adjustment is effective for portions of cost reporting periods that overlap or begin on or after April 1, 2013.

- Worksheet D, Part II - Revised instructions for line 19. This line is now shaded on the worksheet.
- Worksheets D, Part II; CM-3, Part II; and RF-3 - Adds lines to section 3201(c) of the Middle Class Tax Relief and Job Creation Act of 2012 which reduces bad debts by 12 percent for cost reporting periods that begin on or after October 1, 2012, 24 percent for cost reporting periods that begin on or after October 1, 2013, and 35 percent for cost reporting periods that begin on or after October 1, 2014.
- Worksheet CM-3, Part II - Adds line 17.01 and 17.02, respectively, to accommodate adjusted reimbursable bad debts and allowable bad debts for dual eligible beneficiaries.
- Worksheet RF-1, RF-2 and RF-3 - Revises the worksheets to incorporate the payment of allowable GME costs for HHA based RHCs and FQHCs pursuant to 42 CFR 405.2468(f)(2).
- Worksheet RF-2 - Adds lines 7.01 (Medical Nutrition Therapist) and 7.02 (Diabetes Self-Management Training) as new position categories to facilitate the collection of full time equivalent and visit data for FQHCs.
- Worksheet RF-3 - Adds lines 16.01 through 16.05 to implement section 4104 of the Patient Protection and Affordable Care Act which eliminates coinsurance and deductible for preventive services furnished by HHA based for RHCs and FQHCs, effective for dates of service on or after January 1, 2011.
    - Adds line 22.01 and 22.02 to accommodate adjusted reimbursable bad debts and allowable bad debts for dual eligible beneficiaries, respectively.

REVISED ELECTRONIC SPECIFICATIONS EFFECTIVE DATE: Changes to the electronic reporting specifications are effective for cost reporting periods beginning on or after October 1, 2012.

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.

3200. GENERAL

The Paperwork Reduction Act of 1995 establishes the requirement that the private sector be informed as to why information is collected and what the information is used for by the government. In accordance with §1815(a), 1833(e), and 1861(v)(1)(A) of the Act, providers of service participating in the Medicare program are required to submit annual information to achieve settlement of costs for health care services rendered to Medicare beneficiaries. Also, 42 CFR 413.20 requires cost reports from providers on an annual basis. In accordance with these provisions, all home health agencies (HHAs) must complete Form CMS-1728-94, which provides data used by the fiscal intermediaries *(hereafter referred to as contractor)* in determining program reimbursement. Besides determining program reimbursement, the data submitted on the cost report supports management of the Federal programs, e.g., data extraction in developing cost limits. In completing Form CMS-1728-94, the information reported must conform to the requirements and principles set forth in the Provider Reimbursement Manual, Part *1* (CMS Pub. 15-*1*). The instructions contained in this chapter are effective for cost reporting periods ending on or after December 31, 1994.

NOTE: This form is not used by HHAs that are hospital-based. Instead, they continue to use Form CMS-2552.

HHAs, as the term is used in this chapter, refers to institutions meeting the requirements of §1861(o) of the Act. Refer to *CMS Internet Only Manual (IOM) 100-02, chapter 7* and CMS Pub. 15-*1* for further definition of terms.

For cost reporting periods beginning on or after October 1, 1980, all HHAs must use the cost per visit by type-of-visit method of apportioning costs between Medicare and non-Medicare beneficiaries. Under this method, the total allowable cost of all visits for each type of service is divided by the total number of visits for that type of service. Next, for each type of service, the number of Medicare covered visits is multiplied by the average cost per visit just computed. This represents the cost Medicare will recognize as the cost for that service, subject to the cost limits published by CMS. (See 42 CFR 413.30.)

The cost data reported must be based on the stepdown method of cost finding (see 42 CFR 413.24(d)(1)) and on the accrual basis of accounting. However, where governmental institutions operate on a cash basis of accounting, cost data developed on such basis of accounting are acceptable, subject to appropriate treatment of capital expenditures.

Form CMS-1728-94 must be used by all HHAs which are not provider-based to which payment is made by Medicare and must be submitted to the HHAs Medicare *contractor* in accordance with cost report filing date requirements contained in CMS Pub. 15-*1*, §2413. This form must be used for cost reporting periods ending on or after December 31, 1994.

Small HHAs, as defined in 42 CFR 413.24(d), will not have to complete certain identified worksheets of Form CMS-1728-94, e.g., Worksheets A-1, A-2, and A-3.

An HHA that is not provider-based may be considered a small HHA if:

1. The HHA receives less than $35,000 in Medicare reimbursement for the immediately preceding cost reporting period, and

2. This reimbursement represented less than 50 percent of the total operating cost of the agency.

Supplemental worksheets are provided on an as needed basis depending on the needs of the HHA. Not all supplemental worksheets are needed by all HHAs. The following conditions are examples of situations for which supplemental worksheets are needed:

- Reimbursement is claimed for a HHA-based comprehensive outpatient rehabilitation facility (CORF), HHA-based rural health clinic (RHC), Federally qualified health center (FQHC), or community mental health center (CMHC); or

- The HHA has physical therapy services furnished by outside suppliers.

You may submit computer prepared forms in lieu of the forms provided by CMS. These computer prepared forms are acceptable if the forms are reviewed and accepted for provider use by CMS before being placed into use. (See *CMS Pub. 15-2,* §108 for the use of computer prepared cost reporting forms.)

If computer prepared cost reporting forms have been reviewed and accepted for provider use, they must be revised and resubmitted for review and acceptance whenever changes in the law, regulations, or program instructions are adopted which have an impact on Medicare cost reporting.

These forms include the stepdown method of cost finding which provides for the allocation of the cost of services rendered by each general service cost center to other cost centers which utilize such services. Once the costs of a general service cost center have been allocated, that cost center is considered closed. Once closed, it does not receive any of the costs that are subsequently allocated from the remaining general service cost centers. After all costs of the general service cost centers have been allocated to the remaining cost centers, the total costs of these remaining cost centers are further distributed to the departmental classification to which they pertain, e.g., physical therapy, skilled nursing care, HHA-based CORF.

HHAs that are not hospital-based (freestanding) are required to use the stepdown method of cost finding. (See CMS Pub. 15-*1*, §2308.) However, a freestanding HHA that is considered small may use a simplified version of the stepdown method for HHA cost allocations. (See 42 CFR 413.24(d).)

In completing the worksheets, reductions in expenses must always be shown in parentheses ( ).

12 month period of your operations. (See *CMS Pub. 15-2,* §§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 *contractor* 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
2 = voluntary non-profit, other
3 = proprietary, sole proprietor
4 = proprietary, partnership
5 = proprietary, corporation
6 = private non-profit
7 = governmental & private combined
8 = governmental, federal
9 = governmental, state
10 = governmental, city
11 = governmental, city-county
12 = governmental, county
13 = governmental, health district

- 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.

- 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.

- 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.

- 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.

- 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. *If "L" is selected you must meet your contractor's criteria for filing a low Medicare utilization cost report. (See 42 CFR 413.24 (h)).*

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-*1*, 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-*1*, 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-*1*, 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 HHA 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 HHA contract with outside suppliers for physical therapy services? (See CMS Pub. 15-*1*, chapter 14.) Enter "Y" for yes or "N" for no.

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

Line 22.02--Does the HHA 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 HHA componentized (or fragmented) its administrative and general service costs, enter 1 for option one and 2 for option two. Do not respond if A&G services are not fragmented. (See §3214 for an explanation of the A&G componentization options.)

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

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

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

(has no reimbursement impact) as all medical supplies are covered under the PPS benefit for this period.

Line 15.01.--For *cost* reporting periods *that* 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*s* and resulting cost data on line 15.

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

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

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

Effective for cost reporting periods ending on or after July 1, 2006 (see section 3206, line 13), line 16 represents pneumococcal, influenza, and hepatitis B vaccines, and osteoporosis drugs, but not the administration of these vaccines. See the chart below for proper placement of charges.

Line 16.01.--For reporting periods which overlap April 1, 2001, enter in column 6 the charges for pneumococcal vaccine and its administration and influenza vaccine and its administration. For hepatitis B vaccine and its administration rendered on or after April 1, 2001 through December 31, 2002, enter the charges in column 6. Enter in column 7 the charges for covered osteoporosis drugs rendered on or after April 1, 2001 through the fiscal year end. (See §1833(m)(5) of the Act.) For reporting periods that begin on or after April 1, 2001, eliminate line 16.01 and record all charge and resulting cost data on line 16. Osteoporosis drugs will continue to be reimbursed on a cost basis for services rendered on and after April 1, 2001 and will use line 16 to record applicable data.

Line 16.20.--Effective for cost reporting periods ending on or after July 1, 2006 (see section 3206, line 13), line 16.20 represents the administration of pneumococcal, influenza, and hepatitis B vaccines. See the chart below for proper placement of charges.

Effective for cost reporting periods ending on or after July 1, 2006, enter vaccine charges according to the chart below:

Vaccines Charges

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

Vaccines Charges (Continued)

	Column 6	Column 7
Line 16	Enter charges for the full fiscal year for pneumococcal and influenza vaccines. 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 *CBSA/non-CBSA's* unduplicated census count (two decimal places) (see §3205) to the per-beneficiary cost limitation for the corresponding *CBSA*/non-*CBSA*. To accomplish this, the sum of all Worksheets C, Part II amounts in column 11, line 7, plus the applicable cost of medical supplies is compared with the sum of all Worksheets C, Part II amounts in column 11, line 14 plus the applicable cost of medical supplies and with the amount in column 6, line 24.

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

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

This worksheet applies to Title XVIII only and provides for the reimbursement calculation of Part A and Part B. This computation is required by 42 CFR 413.9, 42 CFR 413.13, and 42 CFR 413.30.

Worksheet D consists of the following two parts:

Part I - Computation of the Lesser of Reasonable Cost or Customary Charges. This part provides for the computation of the lesser of reasonable cost as defined in 42 CFR 413.13(b) or customary charges as defined in 42 CFR 413.13(e)(1).

Part II - Computation of Reimbursement Settlement.

3216.1 Part I - Computation of the Lesser of Reasonable Cost or Customary Charges.--Providers are paid the lesser of the reasonable cost of services furnished to beneficiaries or the customary charges for the same services. This part provides for the computation of the lesser of reasonable cost as defined in 42 CFR 413.13(b) or customary charges as defined in the 42 CFR 413.13(e).

NOTE: Nominal charge providers are not subject to the lesser of cost or charges (LCC). Therefore, a nominal charge provider only completes lines 1, 2, 3, and 11 of Part I. Transfer the resulting cost to line 12 of Part II.

Line Descriptions

Line 1--Reporting periods beginning prior to October 1, 2000, enter the cost of services from Worksheet C, Parts III, IV and V based on the following table. If the amount in column 6, line 19 is less than the amount in column 6, line 22, and the amount in column 6, line 24, transfer *the* aggregate Medicare cost. *For cost reporting periods beginning on or after October 1, 2000, do not transfer any costs to line 1, column 1 of this worksheet.* For cost reporting periods beginning on or after October 1, 2000, transfer the cost of osteoporosis drugs from Worksheet C, Part III, column 10, line 16 to column 3 of this worksheet.

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

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

To Worksheet D, Line 1	From Worksheet C
Col. 1, Part A	Part IV, col. 3, line 19
Col. 2, Part B	Part III, sum of col. 9 line 16 (excluding subscripted lines), and Part IV, col. 4, line 19
Col. 3, Part B	Part III, sum of col. 10, lines 15 (excluding subscripted lines), 16 and 16.01, and Part V, col. 8, line 28

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

To Worksheet D, Line 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.

Do not include on these lines (1) the portion of charges applicable to the excess costs of luxury items or services (see CMS Pub. 15-*1*, §2104.3) and (2) provider charges to beneficiaries for excess costs as described in CMS Pub. 15-*1*, §2570. When provider operating costs include amounts that flow from the provision of luxury items or services, such amounts are not allowable in computing reimbursable costs.

Lines 5, 6, 7, and 8.--These lines provide for the reduction of Medicare charges where the provider does not actually impose such charges (in the case of most patients liable for payment for services on a charge basis) or fails to make reasonable efforts to collect such charges from those patients. Enter on line 8 the product of multiplying the ratio on line 7 by line 4 for each column. For column 3, lines 5 and 6, prorate, based on the ratio derived in line 4, all amounts applicable to RHC/FQHCs. Providers which do impose these charges and make reasonable efforts to collect the charges from patients liable for payment for services on a charge basis are not required to complete lines 5, 6, and 7, but enter on line 8 the amount from line 4 for column 1 (excluding subscripted lines) and enter on line 8, columns 2 and 3 the sum of the amounts from lines 4 and 4.01. (See 42 CFR 413.13(b).) In no instance may the customary charges on line 8 exceed the actual charges on line 4.

Line 9.--Enter in each applicable column on line 9 the excess of total customary charges (line 8) over the total reasonable cost (line 3). In situations when in any column the total charges on line 8 are less than the total cost on line 3 of the applicable column, enter zero (0) on line 9.

Line 10.--Enter in each applicable column on line 10 the excess of total reasonable cost (line 3) over total customary charges (line 8). In situations when in any column the total cost on line 3 is less than the customary charges on line 8 of the applicable column, enter zero (0) on line 10.

Line 11.--Enter the amounts paid or payable by workers' compensation and other primary payers where program liability is secondary to that of the primary payer. Primary payer amounts relating to services paid under PPS are included on this line, which may result in line 12 being negative. There are several situations under which Medicare payment is secondary to a primary payer. Prorate, based on the ratio derived in line 4 (including subscripts), all amounts applicable to RHC/FQHCs. Some of the most frequent situations in which the

Medicare program in a secondary payer include:

1. Workers' compensation,
2. No fault coverage,
3. General liability coverage,
4. Working aged provisions,
5. Disability provisions, and
6. Working ESRD beneficiary provisions.

Generally, when payment by the primary payer satisfies the total liability of the program beneficiary, for cost reporting purposes only, the services are considered to be nonprogram services. (The primary payment satisfies the beneficiary's liability when the provider accepts that payment as payment in full. The provider notes this on no-pay bills submitted in these situations.) The patient visits and charges are included in total patient visits and charges, but are not included in program patient visits and charges. In this situation, no primary payer payment is entered on line 11.

However, when the payment by the primary payer does not satisfy the beneficiary's obligation, the program pays the lesser of (a) the amount it would otherwise pay (without regard to the primary payer payment or deductible and coinsurance) less the primary payer payment or (b) the amount it would otherwise pay (without regard to primary payer payment or deductibles and coinsurance) less applicable deductible and coinsurance. Primary payer payment is credited toward the beneficiary's deductible and coinsurance and are not entered on line 11.

When the primary payment does not satisfy the beneficiary's liability, include the covered visits and charges in program visits and charges, and include the total visits and charges in total visits and charges for cost apportionment purposes. Enter the primary payer payment on line 11 to the extent that primary payer payment is not credited toward the beneficiary's deductible and coinsurance. Primary payer payments that are credited toward the beneficiary's deductible and coinsurance are not entered on line 11. The primary payer rules are more fully explained in 42 CFR 411.

3216.2 Part II - Computation of Reimbursement Settlement.--

NOTE: For Part II, where applicable and not specifically instructed to do so, prorate, based on the ratio derived in Part I, line 4, all amounts applicable to RHCs and FQHCs, respectively.

Line 12.--Enter in column 1 the amount on line 3, column 1, minus the amount on line 11, column 1. Enter in column 2 the sum of the amounts on line 3, columns 2 and 3, minus the sum of the amounts on line 11, columns 2 and 3.

Lines 12.01 through 12.14.--Under PPS enter only payment amounts associated with episodes completed in the current cost reporting period. Payments for episodes of care which overlap fiscal years must be recorded in the fiscal year in which the episode was completed. Enter in columns 1 and 2 for lines 12.01 through 12.06, as applicable, the appropriate PPS payment for each episode of care payment category indicated on the worksheet. Enter in columns 1 and 2 for lines 12.07 through 12.10, as applicable, the appropriate PPS outlier payment for each episode of care payment category indicated on the worksheet. Enter in columns 1 and 2, line 12.11 the sum total of other payments. Enter in columns 1 and 2, lines 12.12 through 12.14, the gross payments for DME, oxygen, and prosthetics and orthotics payments, respectively associated with home health PPS services (bill types 32 and 33 only).

For lines 12.12 through 12.14 do not include any amounts associated with services billed on bill type 34. Obtain these amounts from your records or PS&R report.

Line 13.--Enter in column 2 the applicable Part B deductibles billed to Medicare patients. Exclude coinsurance amounts. Include any amounts of deductibles satisfied by primary payer payments. Prorate, based on the ratio derived in line 4, all amounts applicable to RHCs/FQHCs, respectively. Do not enter deductibles for DME, oxygen, and prosthetics and orthotics.

Line 15.--If there is an excess of reasonable cost over customary charges, enter the Part A excess (line 10, column 1) in column 1 and the Part B excess (sum of line 10, columns 2 and 3) in column 2. If you are a nominal charge provider (response of “Y” to S-2, line 21), enter zero on this line.

Line 17.--Enter in column 2 all coinsurance billable to Medicare beneficiaries including amounts satisfied by primary payer payments. Coinsurance is applicable for services reimbursable under §1832(a)(2) of the Act and is entered in column 2. Prorate, based on the ratio derived in line 4, all amounts applicable to RHCs/FQHCs, respectively. Do not enter coinsurance for DME, oxygen, and prosthetics and orthotics.

NOTE: If the component qualifies as a nominal charge provider, enter 20 percent of costs subject to coinsurance on this line. Compute this amount by subtracting Part B deductibles on line 13 and Part B primary payment amounts in column 3, line 11 from Part B costs subject to coinsurance in column 3, line 1. Multiply the resulting amount by 20 percent and enter it on this line.

Line 19.--Enter the reimbursable bad debts, net of recoveries, in the appropriate columns. *Columns 1 and 2 are shaded as HHAs cannot generate bad debts.*

Line 20.--Column 2 amount is the combined amount from Worksheets RH-2, column 5, line 10 and FQ-2, column 5, line 11. *For pneumococcal vaccines (and their administration) rendered after December 31, 2002, this line must be zero.*

Line 21.--For column 1, enter the sum of lines 18 and 19, column 1. For column 2, enter the sum of lines 18, 19, and 20, column 2.

Line 22.--Enter the program's share of any net depreciation adjustment applicable to prior years resulting from the gain or loss on the disposition of depreciable assets. (See CMS Pub. 15-*1*, §132.) Enter the amount of any excess depreciation taken as a negative amount.

NOTE: Effective for changes in ownership that occur on or after December 1, 1997, §4404 of BBA 1997 amends §1861(v)(1)(O) of the Act which states, in part, that "...a provider of services which has undergone a change of ownership, such regulations provide that the valuation of the asset after such change of ownership shall be the historical cost of the asset, as recognized under this title, less depreciation allowed, to the owner of record...." That is, no gain or loss is recognized for such transactions on or after December 1, 1997.

Line 23.--Enter the program's share of any recovery of excess depreciation applicable to prior years resulting from provider termination or a decrease in Medicare utilization. Submit the workpapers which have developed this amount. (See CMS Pub. 15-*1*, §136ff.)

Line 24.--Where a provider's cost limit is raised as a result of its request for review, amounts which were erroneously collected on the basis of the initial cost limit are required to be refunded to the beneficiary. Enter any amounts which are not refunded either because they are less than $5 collected from a beneficiary or because the provider is unable to locate the beneficiary. (See CMS Pub. 15-*1*, §2577.)

Line 25.--Enter in each column the amount on line 21, plus line 22 minus the sum of lines 23 and 24.

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Line 25.5*0*.--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 *contractor* use only during final settlement.)

Line 26.--*Enter the sequestration adjustment amount from the PS&R report.*

Line 27.--Enter the amount on line 25 plus line 25.5*0 and subscripts* minus line 26.

Line 28.--Enter the interim payment from Worksheet D-1, line 4. For *contractor* 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 *by entering the result of line 27 minus line 28*. Indicate overpayments by parentheses ( ). Transfer the amount in column 1 to Worksheet S, Part II, line 1, and column 1. Transfer the amount in column 2 to Worksheet S, Part II, line 1, and 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 contractor .

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 *CONTRACTOR*.

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 ( ).

For services rendered January 1, 2003 through December 31, 2003:
a. If line 1.04 is => 90% but < 100% enter 60% of line 1.03 minus line 1.01.
b. If line 1.04 is < 90% enter 6% of line 1.03.

Do not use lines 2 through 8, 12 and 14, columns as applicable for a) any part of the cost reporting period on or after August 1, 2000 when the reporting period overlaps August 1, 2000; and b) for all cost reporting periods beginning on or after August 1, 2000 as these lines are not applicable for the previously mentioned periods.

Line 2.--For cost reporting periods ending prior to August 1, 2000, enter in column 1 the charges from Worksheet CM-2, column 3.01, line 17. For cost reporting periods that overlap August 1, 2000, enter in column 1 the pre-transition Medicare charges. For cost reporting periods which overlap August 1, 2000, January 1, 2002, January 1, 2003, or January 1, 2004, do not enter charge data for services rendered on or after August 1, 2000, as services are 100 percent OPPS reimbursed and not subject to LCC.

Lines 3 through 6.--These lines provide for the reduction of program charges when you do not actually impose such charges (in the case of most patients liable for payment for services on a charge basis) or when you fail to make reasonable efforts to collect such charges from the patients. Enter on line 6 the product of line 5 times line 2. In no instance may the customary charges on line 6 exceed the actual charges on line 2. This line is not applicable for services rendered on or after August 1, 2000.

If you impose these charges and make reasonable efforts to collect the charges from patients liable for payment for services on a charge basis, you are not required to complete lines 3, 4, and 5, but enter on line 6 the amount on line 2. (See 42 CFR 413.13(b).)

Line 7.--If line 6 is greater than line 1, column 1, enter the excess of customary charges over reasonable cost. This line is not applicable for services rendered on or after August 1, 2000.

Line 8.--If line 1, column 1 is greater than line 6, enter the excess of reasonable cost over customary charges. This line is not applicable for services rendered on or after August 1, 2000.

Line 9.--Enter the amounts paid and payable by Workers' Compensation and other primary payers (from your records).

3227.2 Part II - Computation of Reimbursement Settlement.--

Line 10.--For cost reporting periods overlapping August 1, 2000, enter in column 1 the cost of CMHC services from Part I, line 1, column 1 minus line 9, column 1 and enter in column 1.01 the cost of CMHC services from Part I, line 1.01, column 1.01 plus line 1.05, column 1.01 minus line 9, column 1.01.

For cost reporting periods beginning on or after August 1, 2000, enter in column 1 the cost of CMHC services from Part I, line 1.01, column 1, plus line 1.05, column 1 minus line 9, column 1. Follow the same procedures for column 1.01.

Line 11.--Enter the Part B deductibles billed to CMHC patients (from your records) excluding any coinsurance amounts.

Line 12.--Enter excess reasonable cost from line 8. This line is not applicable for services rendered on or after August 1, 2000 as PPS reimbursed services are not subject to LCC.

Line 13.--Enter the result of line 10 minus lines 11 and 12.

Line 14.--Enter in the applicable column 80 percent of the amount shown on line 13. CMHCs enter 0 (zero) for services on or after August 1, 2000 reimbursed under OPPS.

Line 15.--For services rendered prior to August 1, 2000, enter in the appropriate column the actual coinsurance billed program patients from your records. For services rendered on or after August 1, 2000, enter in the appropriate column the gross coinsurance amount billed to Medicare beneficiaries.

Line 17.--For services rendered prior to August 1, 2000, enter reimbursable bad debts, net of recoveries, for CMHC services. The amount entered for services rendered on or after August 1, 2000 must not exceed the discounted coinsurance applicable to Medicare beneficiaries.

Line 17.01.--Enter in column 1 the result of line 17 (including negative amounts) times 88 percent for cost reporting periods that begin on or after October 1, 2012, 76 percent for cost reporting periods that begin on or after October 1, 2013, and 65 percent for cost reporting periods that begin on or after October 1, 2014.

Line 17.02.--Enter the gross allowable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. These amounts must also be reported on line 17.

Line 18.--For services rendered prior to August 1, 2000, enter in the appropriate column the result of line 17 plus the lesser of lines 14 or 16. For services rendered on or after August 1, 2000, enter in the appropriate column the result of line 16 plus line 17. *For cost reporting periods that begin on or after October 1, 2012, enter in column 1 the result of line 16 plus line 17.01.*

Line 19.--Enter the program's share of any net depreciation adjustment applicable to prior years resulting from the gain or loss on the disposition of depreciable assets. (See CMS Pub. 15-*1*, §132ff.) Enter the amount of any excess depreciation taken in parenthesis ( ).

NOTE: Effective for changes in ownership that occur on or after December 1, 1997, §4404 of BBA 1997 amends §1861(v)(1)(O) of the Act which states, in part, that "...a provider of services which has undergone a change of ownership, such regulations provide that the valuation of the asset after such change of ownership shall be the historical cost of the asset, as recognized under this title, less depreciation allowed, to the owner of record...." That is, no gain or loss is recognized for such transactions on or after December 1, 1997.

Line 20.--Enter the program's share of any recovery of excess depreciation applicable to prior years resulting from your termination or a decrease in Medicare utilization. (See CMS Pub. 15-*1*, §136ff.)

Line 21.--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-*1*, §2146.4.) Specify the adjustment in the space provided.

Line 22.--Enter the total cost (sum of line 18, columns 1 and 2, minus lines 19 and 20, plus or minus line 21).

Line 23.--*For cost reporting periods that overlap or begin on or after April 1, 2013, enter the sequestration adjustment amount as [(2 percent times (total days in the cost reporting period that occur during the sequestration period beginning on or after April 1, 2013, divided by total days in the entire cost reporting period, rounded to four decimal places)) times line 22].*

Line 24.--Enter the amount due the provider (line 22 minus line 23).

Line 25.--Enter the total interim payments from Worksheet CM-4, column 2, line 4. For *contractor* final settlement, report on line 25.5 the amount from Worksheet CM-4, line 5.99.

Line 26.--Enter the balance due provider/program *(line 24 minus line 25)* and transfer the amount to Worksheet S, Part II, column 2, and line 3.

Line 27.--Enter the program reimbursable effect of nonallowable cost report items which you are disputing. Compute the reimbursement effect in accordance with *CMS Pub. 15-2,* §115.2. Attach a schedule showing the supporting details and computation.

Line 28.--Do not use this line for periods beginning on or after October 1, 1997.

3228. WORKSHEET CM-4 - ANALYSIS OF PAYMENTS TO PROVIDER FOR CMHC 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 CMHC, 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 *contractor*.

Line Descriptions

Line 1.--Enter the total Medicare interim payments paid to the HHA-based CMHC. 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 CMHC's interim payments due to an offset against overpayments to the CMHC 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 CMHC 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 CM-3, line 25.

DO NOT COMPLETE THE REMAINDER OF WORKSHEET CM-4. THE REMAINDER OF THE WORKSHEET IS COMPLETED BY YOUR *CONTRACTOR*.

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 CM-3, line 24.

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

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

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

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

Line 2.--For FQHCs only, enter your appropriate designation (urban or rural). *See IOM 100-02, Chapter 13, section 70.2* for information regarding urban and rural designations. If you are uncertain of your designation, contact your *contractor*. RHCs do not complete this line.

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

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

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

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

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

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

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

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

Line 16.--If this facility is claiming *allowable* Graduate Medical Education (GME) costs as a result of substantial payment for interns and residents, enter "Y" for yes or "N" for no *in column 1. If yes,* enter the number of Medicare visits *performed by interns and residents* in column 2 *and total visits performed by interns and residents in column 3*. Complete Worksheet RF-1, lines 20 and 27 as applicable. *(See 42 CFR 405.2468 (f)(2).)*

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

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

This worksheet is for the recording of direct RHC and FQHC costs from your accounting books and records to arrive at the identifiable agency cost. This data is required by 42 CFR 413.20. It also provides for the necessary reclassifications and adjustments to certain accounts prior to the cost finding calculations.

Column Descriptions

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

Enter on the appropriate lines in columns 1 through 6 the total expenses incurred during the reporting period. Detail the expenses as Compensation (column 1), Employee Benefits (column 2), Contracted Services (column 3), Transportation (column 4) and Other (column 5). The sum of columns 1 through 5 must equal column 6.

Column 7.--Enter any reclassifications among the cost center expenses listed in column 6 which are needed to effect proper cost allocation. This column need not be completed by all providers, but is completed only to the extent reclassifications are needed and appropriate in the particular circumstances. (See §3210 for examples of reclassifications that may be needed.) Submit with the cost report copies of any workpapers used to compute the reclassifications reported in this column. Show reductions to expenses in parentheses ( ).

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

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

Column 9.--In accordance with 42 CFR 413ff, enter on the appropriate lines the amounts of any adjustments to expenses required under the Medicare principles of reimbursement. (See §3211.) Submit with the cost report copies of any workpapers used to compute the adjustments reported in this column.

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

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

Line Descriptions

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

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

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

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

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

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

Line 20.--*If the clinic incurred all or substantially all training costs for interns and residents, enter the total allowable direct GME cost. (See 42 CFR 405.2468 (f)(2).)*

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

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

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

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

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

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

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

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

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

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

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

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

Column descriptions

Column 1.--Record the number of all full time equivalent (FTE) personnel in each of the applicable staff positions in the facility's practice. (*See IOM 100-02, chapter 13, section 70.4* for a definition of FTEs.)

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

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

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

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

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

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

Line Descriptions

Line 1.--Enter in column 1 the number of staff physician FTEs and in column 2 the total visits furnished to facility patients by staff physicians working at the facility on a regular ongoing basis. Include on this line, physician data (FTEs and visits) for services furnished to facility patients by staff physicians working under contractual agreement with you on a regular ongoing basis in the RHC facility. These physicians are subject to productivity standards. (See 42 CFR 405.2468(d)(2)(v).)

Line 7.01.--For medical nutrition therapy services performed by a registered dietitian, enter the corresponding FTE count in column 1 and total visits performed in column 2. (See IOM 100-02, chapter 13, section 210.2.4.) For FQHC only.

Line 7.02.--For diabetes self-management training performed by a registered dietitian, enter the corresponding FTE count in column 1 and total visits performed in column 2. (See IOM 100-02, chapter 13, section 210.2.4.) For FQHC only.

Line 8.--Enter the total of lines 4 through 7 *(and subscripts)*.

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

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

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

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

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

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

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

Line 15.--*If you are claiming allowable GME cost (line 20 of Worksheet RF-1 completed), enter the amount of GME overhead costs. To determine the amount of GME overhead, multiply the amount of facility overhead (from line 14) by the ratio of Intern and Resident visits (from Worksheet S-4, column 3, line 16) over total visits (from Worksheet RF-3, line 6). If you are not claiming GME enter zero.*

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

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

Line 18.--Enter the sum of lines *16* and 17 to determine the total overhead costs related to the RHC/FQHC.

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

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

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

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

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

Line Descriptions

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

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

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

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

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

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

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

Lines 8 and 9.--Per visit payment limits are revised each January 1, (except calendar year 2003 updates that occurred January 1 and March 1 (see PM A-03-21)). Complete columns 1, 2 and 3, if applicable (add column 3 for lines 8-14 if the cost reporting period overlaps 3 limit update periods) for lines 8 and 9 to identify costs and visits affected by different payment limits during a cost reporting period. Enter the rates and the corresponding data chronologically in the appropriate column as they occur during the cost reporting period.

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

Line 8.--Enter your applicable per visit payment limit. Obtain this amount from your *contractor or IOM 100-02, chapter 13, sections 70.1 for RHCs or 70.2 for FQHCs*.

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

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

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

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

Line Descriptions

Line 10.--Enter the number of Medicare covered visits excluding visits subject to the outpatient mental health services limitation from *the PS&R*.

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

Line 12.--Enter the number of Medicare covered visits subject to the outpatient mental health services limitation from *the PS&R*.

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

Line 14.--Enter the limit adjustment. In accordance with MIPPA 2008, section 102, the outpatient mental health treatment service limitation applies as follows: For services rendered through December 31, 2009, the limitation is 62.50 percent; services from January 1, 2010, through December 31, 2011, the limitation is 68.75 percent; services from January 1, 2012, through December 31, 2012, the limitation is 75 percent; services from January 1, 2013, through December 31, 2013 the limitation is 81.25 percent; and services on or after January 1, 2014, the limitation is

100 percent. This is computed by multiplying the amount on line 13 by the corresponding outpatient mental health service limit percent. This limit applies only to therapeutic services, not initial diagnostic services.

Line 15.--Enter the total allowable GME pass-through costs determined by dividing Medicare visits performed by Interns and Residents (from Worksheet S-4, column 2, line 16) by the total visits (from Worksheet *S-4, column 3, line 16,*) and multiply that result by the *(sum of* total allowable GME cost reported on Worksheet RF-1, column 10, line 20 *and allowable GME overhead costs from Worksheet RF-2, line 15) and enter that result on this line. For cost reporting periods that overlap January 1, 2011, prorate the result using a ratio of days before January 1, 2011, to days on and after January 1, 2011, for the applicable columns. For cost reporting periods beginning on or after January 1, 2011, do not use column 1; instead enter the result in column 2.*

NOTE: If there are no allowable GME pass-through costs, this line is zero.)

Line 15.5.--Enter the primary payers (from *the PS&R*). *For cost reporting periods that overlap January 1, 2011, prorate the result using a ratio of days before January 1, 2011, to days on and after January 1, 2011, for the applicable columns. For cost reporting periods beginning on or after January 1, 2011, do not use column 1; instead enter the result in column 2.*

Line 16.--Enter the total Medicare cost. This is equal to the sum of the amounts on line 11, columns 1 *and* 2, plus line 14, columns 1 and *2,* plus *line 15, column 1 minus line 15.5. For cost reporting period that overlap January 1, 2011, enter in column 1 the sum of the amounts on lines 11, 14, and 15, column 1, minus line 15.5. Enter in column 2 the sum of the amounts on lines 11, 14, and 15, column 2, minus line 15.5. For cost reporting periods that begin on or after January 1, 2011, enter the sum of lines 11, 14, and 15, columns 1 and 2, minus line 15.5 in column 2.*

NOTE: *Section 4104 of ACA eliminates coinsurance and deductible for preventive services, effective for dates of service on or after January 1, 2011. RHCs and FQHCs must provide detailed HCPCS coding for preventive services to ensure that coinsurance and deductible are not applied. Providers must maintain this documentation to apply the appropriate reductions on lines 16.03 and 16.04.*

Line 16.01.--Enter the total program charges from the contractor's records (PS&R). For cost reporting periods that overlap January 1, 2011, do not complete column 1 and enter total program charges for services rendered on or after January 1, 2011 in column 2. For cost reporting periods beginning on or after January 1, 2011, enter total program charges in column 2.

Line 16.02.--Enter the total program preventive charges from the provider's records. For cost reporting periods that overlap January 1, 2011, do not complete column 1 and enter total program preventive charges for services rendered on or after January 1, 2011 in column 2. For cost reporting periods beginning on or after January 1, 2011, enter total program preventive charges in column 2.

Line 16.03.--Enter the total program preventive costs. For cost reporting periods that overlap January 1, 2011, do not complete column 1 and enter the total program preventive costs ((line 16.02 divided by line 16.01) times line 16) for services rendered on or after January 1, 2011, in column 2. For cost reporting periods beginning on or after January 1, 2011, enter the total program preventive costs ((line 16.02 divided by line 16.01) times line 16, colum1`n 2).

Line 16.04.--Enter the total program non-preventive costs. For cost reporting periods that overlap January 1, 2011, do not complete column 1 and enter the total program non- preventive costs ((line 16 minus lines 16.03 and 17) times .80) for services rendered on or after January 1, 2011, in column 2. For cost reporting periods beginning on or after January 1, 2011, enter the total program non-preventive costs ((line 16, column 2, minus lines 16.03 and 17, column 2) times .80) in column 2.

Line 16.05.--Enter the total program costs. For cost reporting periods that overlap January 1, 2011, enter total program costs (line 16 times .80) for services rendered prior to January 1, 2011, in column 1, and enter the sum of lines 16.03 and 16.04, in column 2. For cost reporting periods beginning on or after January 1, 2011, enter the sum of lines 16.03 and 16.04, in column 2.

Line 17.--Enter the amount credited to the RHC's Medicare patients, to satisfy their deductible liabilities on the visits on lines 10 and 12 as recorded by the *contractors* from clinic bills processed during the reporting period. RHCs determine this amount from *their PS&R.* FQHCs enter zero on this line as deductibles do not apply.

Line 17.5--Enter the coinsurance amount applicable to the RHC or FQHC for program patient visits on lines 10 and 12 as recorded by the contractor from clinic bills processed during the reporting period. This line captures data for informational and statistical purposes only. This line does not impact the settlement calculation.

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. *Do not complete this line for cost reporting periods ending on or after January 1, 2011.*

Line 19.--*Enter the net program costs, excluding vaccines. For cost reporting periods ending prior to January 1, 2011, e*nter 80% of the amount on line 18. *Do not complete this line for cost reporting periods ending on or after January 1, 2011.*

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. *For cost reporting periods ending on or after January 1, 2011, enter the sum of line 16.05, columns 1 and 2, plus line 20.*

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

Line 22.01.--Enter the result of line 22 (including negative amounts) times 88 percent for cost reporting periods that begin on or after October 1, 2012, 76 percent for cost reporting periods that begin on or after October 1, 2013, and 65 percent for cost reporting periods that begin on or after October 1, 2014.

Line 22.02.--Enter the gross allowable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. These amounts must also be reported on line 22.

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-*1*, §2146.4.) Specify the adjustment in the space provided.

Line 24.--This is the sum of lines 21 *and* 22, *plus or minus line* 23. *For cost reporting periods that begin on or after October 1, 2012, enter the sum of lines 21 and 22.01, plus or minus line 23.*

Line 24.01.--For cost reporting periods that overlap or begin on or after April 1, 2013, enter the sequestration adjustment amount as [(2 percent times (total days in the cost reporting period that occur during the sequestration period beginning on or after April 1, 2013, divided by total days in the entire cost reporting period, rounded to four decimal places)) times line 24].

Line 25--Enter the interim payments from Worksheet RF-5, line 4. For *contractor* 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 (line 24 minus lines *24.01 and* 25.) Transfer this amount to Worksheet S, Part II, column 2, line:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Line Descriptions

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

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 1728-94
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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 *contractors* is 3½" diskette, *compact diskette or flash drive. The file* must be in IBM format. The character set must be ASCII. You must seek approval from your *contractor* regarding alternate methods of submission to ensure that the method of transmission is acceptable.

The following are requirements for all records:

1. All alpha characters must be in upper case.

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

3. No record may exceed 60 characters.

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

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

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

FILE NAMING CONVENTION

Name each cost report file in the following manner:
HHNNNNNN.YYL, where
1. HH (Home Health Agency Electronic Cost Report) is constant;
2. NNNNNN is the 6 digit *CMS Certification 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.

Name each cost report Print Image (PI) file in the following manner:
PINNNNNN.YYL, where
1. PI is constant;
2. NNNNNN is the 6 digit *CMS Certification 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 *beginning* on or after *2012275 (10/1/2012)*. Prior approval(s) 97090, 1998273, 1999304, 2000121, 2000305, 2001273, 2004031, 2007031, *and 2009274*.

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

Worksheets That Apply to the HHA Complex (Continued)

Worksheet	Worksheet Indicator	
K	K010000	(b)
K-1	K110000	(b)
K-2	K210000	(b)
K-3	K310000	(b)
K-4, Part I	K410001	(b)
K-4, Part II	K410002	(b)
K-5, Part I	K510001	(b)
K-5, Part II	K510002	(b)
K-5, Part III	K510003	(b)
K-6	K610000	(b)

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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

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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 J-4 (Continued)				
Amount of each lump sum adjustment				
Program to provider	3.01-3.49	2	9	9
Provider to program	3.50-3.98	2	9	9
WORKSHEET CM-1				
Part I:				
Net expenses for cost allocation	1-12	0	9	9
Total allocation	12	1-4, 5	9	9
Part III:				
Reconciliation	1-11	5A	9	-9
Cost allocation statistics	1-11	1-4, 5	9	9
WORKSHEET CM-2				
Part I:				
CMHC charges				
In total	2-11	2	9	9
Total Title XVIII charges	2-11	3.01	9	9
Post 7/31/2000 Title XVIII charges	2-11	4	9	9
Part II:				
HHA charges for CMHC services				
In total	13-15	2	9	9
Total Title XVIII charges	13-15	3.01	9	9
Post 7/31/2000 Title XVIII charges	13-15	4	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 CM-3				
Part I:				
CMHC PPS payments including outlier payments	1.01	1 & 1.01	9	9
CMHC specific payment to cost ratio	1.02	1 & 1.01	5	9.9(3)
CMHC transitional corridor payment	1.05	1 & 1.01	9	9
Total charges for CMHC services	2	1	9	9
Amount collected from patients	3	1	9	9
Amount collectible from patients	4	1	9	9
Primary payment amounts	9	1 & 1.01	9	9
Part II:				
Part B deductibles billed	11	1 & 1.01	9	9
Coinsurance billed	15	1 & 1.01	9	9
Reimbursable bad debts	17	1 & 1.01	9	-9
Adjusted reimbursable bad debts	*17.01*	*1*	*9*	*-9*
Allowable bad debts for dual eligible beneficiaries	*17.02*	*1*	*9*	*-9*
Amount applicable to prior periods resulting from depreciable asset disposal	19	1	9	9
Recovery of excess depreciation	20	1	9	9
Text as needed for blank line	21	0	36	X
Other adjustments	21	1	9	-9
Sequestration adjustment	23	1	9	9
Protested amounts	27	1	9	-9
WORKSHEET CM-4				
Total interim payments paid to provider	1	2	9	9
Interim payments payable	2	2	9	9
Date of each retroactive lump sum adjustment (MM/DD/YYYY)	3.01-3.98	1	10	X

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-4 (Continued)				
Physician(s) furnishing services at the clinic or under arrangement				
Physician name	9	1	36	X
Billing number	9	2	36	X
Supervision (see instructions)				
Supervisory physician name	10	1	36	X
Number of hours of supervision during period	10	2	11	9(8).99
Does this facility operate as other than an RHC or FQHC? (Y/N)	11	1	1	X
If yes, indicate number of other operations.	11	2	2	9
Facility hours of operation *:				
Clinic hours from/to:	12	1-14	4	9
Other facility type:	12.01-12.10	0	36	X
Other facility hours from/to:	12.01-12.10	1-14	4	9
Is this clinic exempt from the productivity standard? (Y/N)	13	1	1	X
Is this a consolidated cost report? (Y/N)	14	1	1	X
If yes, indicate the number of providers included in this report.	14	2	2	9
List all provider names:	15	1	36	X
List all provider numbers:	15	2	6	X
Is the provider claiming allowable GME costs? (Y/N)	16	1	1	X
If yes, enter the number of Medicare visits.	16	2	5	9
If yes, enter the number of total visits.	*16*	*3*	*5*	*9*

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

WORKSHEET RF-1				
Provider based cost	1-9, 11-13, 15-*20*, 23-27, & 29-30	1-5, 7 ,9, & 10	9	-9

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

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
WORKSHEET RF-2				
Number of FTE Personnel	1-3, 5-7,*7.01 &7.02*	1	6	9(3).99
Total Visits	1-3, 5-7,*7.01,7.02* & 9	2	9	9
Productivity standard *	1-3	3	9	9
Greater of columns 2 or 4	4	5	9	9
Parent provider overhead allocated to facility (see instructions)	17	1	9	9
WORKSHEET RF-3				
Adjusted cost per visit	7	1	6	9(3).99
Maximum rate per visit (from your *contractor)*	8	1, 2 & 3	6	9(3).99
Rate for Program covered visit	9	1, 2 & 3	6	9(3).99
Medicare covered visits excluding mental health services (from your *contractor*)	10	1, 2 & 3	9	9
Medicare covered visits for mental health services (from your *contractor*)	12	1, 2 & 3	9	9
Primary payer amounts	15.5	1 *& 2*	9	9
Total Medicare cost (sum of lines 11, 14, and 15 minus 15.5)	*16*	*1 & 2*	*9*	*9*
Total Medicare Charges (from contractor records)	*16.01*	*1 & 2*	*9*	*9*
Total Medicare Preventive Charges (from provider's records)	*16.02*	*1 & 2*	*9*	*9*
Total Medicare Cost	*16.05*	*1 & 2*	*9*	*9*
Beneficiary deductible for RHC only (from your *contractor*)	17	1	9	9
Beneficiary coinsurance for RHC/FQHC (from your contractor)	*17.5*	*1*	*9*	*9*
Reimbursable bad debts	22	1	9	9
Adjusted reimbursable bad debts	*22.01*	*1*	*9*	*9*
Allowable bad debts for dual eligible beneficiaries	*22.02*	*1*	*9*	*9*
Text as needed for blank line	23	0	36	X
Other adjustments	23	1	9	9
Sequestration adjustment	*24.01*	*1*	*9*	*9*
Interim payments	25	1	9	9
Protested amounts	27	1	9	9
WORKSHEET RF-4				
Ratio of pneumococcal and vaccine staff time to total health care staff time	2	1,2,2.01,2.02	8	9.9(6)
Medical supplies cost-pneumococcal and influenza vaccine (from your records)	4	1,2,2.02	9	9

* Use the standard visits per the instructions as the default. Those standards may change if an approved exception is granted. (See Worksheet S-4 for response to approved exception to the standard productivity visits.)

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-1728-94

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

Worksheet	Lines
S-5	All
K, K-1, K-2, K-3	All
K-4, Part I	All
K-4, Part II	All
K-5, Part I	All
K-5, Part II	All
K-5, Part III	All (except line 5 and (6*))
K-6	All

* See footnote on page 32-531.

This page is reserved for future use.

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 *contractor* 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 *contractor* 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 *effective* for cost reporting periods beginning on or after the specified date. Dates followed by an "s" are *effective* 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 *street address or P.O box, city, state, and zip code (Worksheet S-2, line 1, column 1 or 2, and line 1.01, columns 1, 2, and 3, respectively) and* 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]
1036S	*If Worksheet S-2, line 9 is "N", then S-3, Part I, column 1, line 8 must be zero, and vice versa. [10/1/2012b]*

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

Reject Code	Condition
1039S	*If Worksheet S-2, line 22, 22.01 or 22.02 is "Y", respectively, then the corresponding line 7, 8 or 9, column 4 on Worksheet A must be greater than zero and vice versa. [10/1/2012b]*
1040S	On Worksheet S-2, if the response to column 1, line 29 is "Y", then there must be a response on line 29.01, columns 1, 2 and 3; line 29.02, columns 1 or 2, and 3; line 29.03, columns 1, 2 and 3 and conversely, if the response to column 1, line 29 is "N", then there must be no response on line 29.01, columns 1, 2 and 3; line 29.02, columns 1 or 2 and 3; 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]
1076S	*If the visits reported on Worksheet S-3, Part I, column 1, lines 1-6, respectively, are greater than zero, than the patient counts reported in column 2 must also be greater than zero, and vice versa. If the visits reported on Worksheet S-3, Part I, column 3, lines 1-6, respectively, are greater than zero, than the patient counts reported in column 4 must also be greater than zero, and vice versa. Apply this edit on a line by line basis. [10/1/2012b]*
1077S	*The patient count on Worksheet S-3, Part I, column 2 must be less than or equal to the visit count in column 1, on a line by line basis for lines 1 through 6. [10/1/2012b]*
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]
1091S	*For each column 1 through 6 on Worksheet S-3, Part IV, if either line 42 or 44 is greater than zero, then both lines 42 and 44 must be greater than zero. Additionally, if lines 42 and 44 are greater than zero, then the sum of lines 45 and 46 must also be greater than zero. [10/1/2012b]*
1092S	*Medical supply charges on Worksheet S-3, Part IV, line 47, column 7 must equal Worksheet C, Part III, line 15, sum of columns 5 and 6. [10/1/2012b]*
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 *(the code in column 1 must be an uppercase alpha character)*. 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]

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

Reject Code	Condition
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]
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*; and must also equal on a line by line basis*. [FYs beginning on or after 10/1/2000]
1005C	For the home health agency, the total Medicare (Title XVIII) unduplicated census count (Worksheet S-3, Part I, column 2, line 10) must be equal to or greater than the sum of the unduplicated census count for all MSA (Worksheet C, Part IV, column 1, line 24). [FYs ending through 9/30/2000]
1006C	For the home health agency, the total Medicare (Title XVIII) unduplicated census count (Worksheet S-3, Part I, column 2, line 10.01) must be equal to or greater than the sum of the unduplicated census count for all MSAs (Worksheet C, Part IV, column 1, line 24). [FYs which overlap 10/1/2000]
1010C	If Medicare visits on Worksheet S-3, column 1, lines 1-6, respectively, are greater than zero, then the corresponding cost on Worksheet B, column 6, lines 6-11 must also be greater than zero. [FYs ending through 9/30/2000]
1011C	If the sum of Medicare visits on Worksheet S-3, column 1, lines 1-6 and Worksheet S-3, Part IV, column 7, lines 30, 32, 34 ,36, 38, and 40 are greater than zero, respectively (for each discipline), then the corresponding cost on Worksheet B, column 6, lines 6-11 must also be greater than zero and vice versa. [10/1/2000] This edit is downgraded to a level II edit (edit 2011C) and is effective for cost reporting periods ending on or after January 31, 2007.
1015C	Worksheet C, Part III, lines 15, 16, and 16.20 respectively, column 3 (Total Charges) must be greater than, or equal to, lines 15, 16, and 16.20, respectively, sum of columns 5 through 7 (Medicare Charges). [1/31/2007] This edit is downgraded to a level II edit (edit 2015C) and is effective for cost reporting ending periods ending on or after October 31, 2009.
1005D	If Medicare home health agency visits (Worksheet S-3, Part I, column 1, line 8) are greater than zero, then Medicare home health agency costs (Worksheet D, Part II, sum of columns 1 and 2, line 21) must also be greater than zero, and vice versa. [9/30/1998]

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

Reject Code	Condition
1010D	If Worksheet D, line 27, columns 1 and 2, respectively, are greater than 0 (zero), then Worksheet D-1, line 4, columns 2 and 4, respectively, must also be greater than 0 (zero) and vice versa. [1/31/2007]
1015D	The sum of Worksheet D-1, columns 2 and 4, line 4, respectively, and the sum of Worksheet D, Part II, columns 1 and 2, lines 12 through 12.14, respectively, must both be greater than zero. [10/31/2009]
1000F	*Worksheet F, line 51, column 1; and line 52, column 2, respectively, must equal Worksheet F-2, line 17, column 2 and 4, respectively. [10/1/2012b]*
1000J	Worksheet J-1, Part I, sum of columns 0-5, line 15, must equal the corresponding Worksheet B, column 6, line 24 (or its appropriate subscript). [FYs ending through 6/29/2001]
1001J	If the sum of Worksheet S-6, column 1, lines 1-7 plus column 3, lines 1-8 equals zero, then Worksheet B, column 6, line 24 (or its appropriate subscript) and Worksheet J-1, Part I, sum of columns 0-5, line 15, must also equal zero and vice versa. [6/30/2001]
1000K	Worksheet K-5, Part I, sum of columns 0-5, line 29, must equal the corresponding Worksheet B, column 6, line 25 (or its appropriate subscript). [10/31/2000]
1005K	Worksheet K-5 Part I, column 0, line 29 must equal Worksheet A, column 10, line 25. [10/31/2009]
1000M	Worksheet CM-1, Part I, sum of columns 0-5, line 12, must equal the corresponding Worksheet B, column 6, line 26 (or its appropriate subscript). [3/31/1997]
1005M	Worksheet CM-1 Part I, column 0, line 12 must equal worksheet A, column 10, line 26. [10/31/2009]
1000R	Worksheet RH-1, Part I, sum of columns 0-5, line 11, must equal the corresponding Worksheet B, column 6, line 27 (or its appropriate subscript). [Applicable for cost reporting periods beginning prior to 1/1/1998]
1000Q	Worksheet FQ-1, Part I, sum of columns 0-5, line 12, must equal the corresponding Worksheet B, column 6, line 28 (or its appropriate subscript). [Applicable for cost reporting periods beginning prior to 1/1/1998]
1000H	If Worksheet S-4, line 13 equals "Y", Worksheet RF-2, column 3, lines 1, 2, and 3 must each be greater than zero and at least one line must contain a value other than the standard amount. Conversely, if Worksheet S-4, line 13 equals "N", Worksheet RF-2, column 3, lines 1, 2, and 3 must contain the values 4,200, 2,100 and 2,100, respectively. Apply this edit to both RHC and FQHC components. [4/30/2000]
1005H	If Worksheet S-4, line 16 equals "Y", Worksheet RF-1, column 10, line 20 must be greater than zero. [4/30/2000]
1006H	*If the response on Worksheet S-4, line 16, column 1 is "N" for no, Worksheet RF-3, line 15 must be zero. [10/1/2012b]*
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 *contractor*. Failure to clear these errors in a timely fashion, as determined by your *contractor*, 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
DME	14	1400-1409

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

Edit	Condition		
	Cost Center	Line	Code
	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]

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. 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
2110S	*Worksheet S-3, Part I, column 1, line 8 (total Medicare visits) must not equal Worksheet S-3, Part IV, column 7, line 42 (PPS Medicare visits). [10/1/2012b]*
2115S	*If Worksheet S-3, Part I, line 7, column 3, non-Medicare visits for All Other Services is greater than zero, then Worksheet A, column 10, sum of lines 15 through 23 must also be greater than zero, and vice versa. [10/1/2012b]*
2120S	*If the visit counts on Worksheet S-3, Part IV, column 7, lines 30, 32, 34, 36, 38, or 40 are greater than zero, then the corresponding cost center total cost on Worksheet A, column 10, lines 6, 7, 8, 9, 10, or 11, respectively, must also be greater than zero. Apply this edit on a line by line basis. [10/1/2012b]*
2000A	Worksheet A-4, column 1 (reclassification code) must be alpha characters. [3/31/1997]
2005A	*Worksheet A, column 2, line 29 (total employee benefits) must be greater than zero. [10/1/2012b]*
2010A	*Worksheet A, column 1, line 5 (A&G salaries) must be greater than zero. [10/1/2012b]*
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. [10/1/2000]
2015C	Worksheet C, Part III, lines 15, 16, and 16.20 respectively, column 3 (Total Charges) must be greater than, or equal to, lines 15, 16, and 16.20, respectively, sum of columns 5 through 7 (Medicare Charges). [10/31/2009]
2000D	*Worksheet D, sum of lines 12.01 through 12.10, column 1, must equal Worksheet D-1, line 1, column 2. [10/1/2012b]*
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]
2060F	*Beginning fund balance (Worksheet F-2, column as applicable, line 1) must not equal zero. [10/1/2012b]*
2065F	*Worksheet F, line 59, column 1; (and if applicable, columns 2 through 4, respectively), must be greater than zero. [10/1/2012b]*

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.