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# Medicare

Department of Health and  
Human Services (DHHS)

## Provider Reimbursement Manual

HEALTH CARE FINANCING  
ADMINISTRATION (HCFA)

### Part 2 - Provider Cost Reporting Forms and Instructions - Chapter 32 - Form HCFA-1728-94

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Transmittal No. 9

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#### **REVISED COST REPORTING FORMS AND INSTRUCTIONS--EFFECTIVE DATE: SEE BELOW**

This transmittal updates and makes corrections to Chapter 32, Home Health Agency Cost Reporting Form HCFA-1728-94 and is effective for periods ending on or after April 30, 2000, except as otherwise noted.

Effective for reporting periods ending on and after April 30, 2000, do not complete worksheet RF-4 for HHA based RHCs and FQHCs. The costs of pneumococcal and influenza vaccines and the cost of administering these vaccines are now reported on Worksheet A, line 13 (drugs).

Worksheet C, part V, adds column 5.01 (Medicare Program Visits for Services on or after January 1, 1999) for physical, speech and occupational therapy services rendered to non-homebound beneficiaries. These services are reimbursed based on the physician fee schedule. Consequently, the visits associated with these services have no reimbursement impact, but are captured for statistical purposes.

HHAs with cost reporting periods beginning in Federal fiscal year 2000 only (10/1/1999 - 9/30/2000) will be reimbursed for costs associated with the Outcome and Assessment Information Set (OASIS) as required by Program Memorandum A-00-03. Worksheet D, line 25.5 (Other Adjustments) instructions are revised to reflect the reporting of these costs by multiplying the Medicare Unduplicated Census Count on Worksheet S-3, column 2, line 10, times \$10, minus the interim OASIS payment made to the provider on April 1, 2000. This procedure will be undertaken by fiscal intermediaries during final settlement.

Worksheet D, line 27 reflects new instructions regarding the calculation of this line. Worksheet D, line 28 reflects new instructions for the previously existing worksheet D, line 28.5 (tentative settlement) that is for intermediary use only.

For physical, speech and occupational therapy services rendered to non-homebound beneficiaries on or after January 1, 1999, prorated, based on total HHA visits, the amounts paid and/or payable to outside suppliers.

Worksheet J-3, line 23 instructions reflects new instructions for the previously existing worksheet J-3, line 23.5 (tentative settlement) that is for intermediary use only.

Worksheet CM-3, line 25 instructions reflects new instructions for the previously existing worksheet CM, line 25.5 (tentative settlement) that is for intermediary use only.

Worksheet RF-2, column 3, lines 1-3 allow for the input of intermediary-derived productivity standards when an exemption is granted to the default productivity standards of 4200, 2100 and 2100 visits, respectively.

Worksheet RF-3, instructions reflects the addition of line 15.5, Primary Payer amounts. Line 25 instructions reflect the addition of line 25.5 (tentative settlement) that is for intermediary use only.

**REVISED COST REPORTING FORMS--EFFECTIVE DATE: Changes effective for cost reporting periods ending on or after April 30, 2000.**

The following is a summary of the major revisions to the cost reporting forms:

Form HCFA  
1728-94 Wkst.

Summary of changes:

|                    |  |
|--------------------|--|
| C, Part V          | Column 5.01 is added.  |
| D, Part II<br>25.5 | The calculation of line 27 is revised as follows: line 25 plus line minus line 26. |
| J-3                | The line descriptions for lines 1.1, 1.2, 8.1 and 8.2 are clarified.               |
| RF-2               | Revised the footnote addressing the exemption to the productivity standards.       |
| RF-3               | Line 15.5, primary pay amounts, is added.  |
| RF-4               | This worksheet is no longer applicable. See instructions.                          |

**NEW/REVISED ELECTRONIC REPORTING SPECIFICATIONS--EFFECTIVE DATE: Changes to the Electronic Reporting Specifications are Effective for Cost Reporting Periods Ending On or After April 30, 2000.**

The following is a summary of some of the more significant revisions to the electronic reporting specifications to the cost report. Table 3 reflects the additional data requirements for Worksheets C, Part V; F; and RF-3. Table 6 revisions include the revision of edits 1035S, 1000C, 1000R and 1000Q and the addition of edits 1010C, 1000H, 1005H and 1010H. These represent only the highlights of the electronic cost reporting specifications. All changes indicated should be given equal importance, and failure to do so may result in the rejection of a cost report and/or suspension of a software vendor's authority to market the program until such changes are incorporated.

**DISCLAIMER:** The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

Line 3--Enter the direct expenses incurred in the operation and maintenance of the plant and equipment, maintaining general cleanliness and sanitation of the plant, and protecting employees, visitors, and agency property.

Line 4--Enter all of the cost of transportation except those costs previously directly assigned in column 3. This cost is allocated during the cost finding process.

Line 5--Use this cost center to record the expenses of several costs which benefit the entire facility. Examples include fiscal services, legal services, accounting, data processing, taxes, and malpractice costs.

Line 6--Skilled nursing care is a service that must be provided by or under the supervision of a registered nurse. The complexity of the service, as well as the condition of the patient, are factors to be considered when determining whether skilled nursing services are required. Additionally, the skilled nursing services must be required under the plan of treatment.

Line 7--Enter the direct costs of physical therapy services by or under the direction of a registered physical therapist as prescribed by a physician. The therapist provides evaluation, treatment planning, instruction, and consultation.

Line 8--These services include (1) teaching of compensatory techniques to permit an individual with a physical impairment or limitation to engage in daily activities; (2) evaluation of an individual's level of independent functioning; (3) selection and teaching of task-oriented therapeutic activities to restore sensory-integrative function; and (4) assessment of an individual's vocational potential, except when the assessment is related solely to vocational rehabilitation.

Line 9--These are services for the diagnosis and treatment of speech and language disorders that create difficulties in communication.

Line 10--These services include (1) assessment of the social and emotional factors related to the individual's illness, need for care, response to treatment, and adjustment to care furnished by the facility; (2) casework services to assist in resolving social or emotional problems that may have an adverse effect on the beneficiary's ability to respond to treatment; and (3) assessment of the relationship of the individual's medical and nursing requirements to his or her home situation, financial resources, and the community resources available upon discharge from facility care.

Line 11--Enter the cost of home health aide services. The primary function of a home health aide is the personal care of a patient. The services of a home health aide are given under the supervision of a registered professional nurse and, if appropriate, a physical, speech, or occupational therapist. The assignment of a home health aide to a case must be made in accordance with a written plan of treatment established by a physician which indicates the patient's need for personal care services. The specific personal care services to be provided by the home health aide must be determined by a registered professional nurse and not by the home health aide.

Line 12--The cost of medical supplies reported in this cost center are those costs which are directly identifiable supplies furnished to individual patients and for which a separate charge is made. These supplies are generally specified in the patient's plan of treatment and furnished under the specific direction of the patient's physician.

Medical supplies which are not reported on this line are those minor medical and surgical supplies which would not be expected to be specifically identified in the plan of treatment or for which a separate charge is not made. These supplies (e.g., cotton balls, alcohol prep) are items that are frequently furnished to patients in small quantities (even though in certain situations, these items may be used in greater quantity) and are reported in the administrative and general (A&G) cost center.

Line 13--Enter the costs of vaccines and the cost of administering the vaccines. Also enter the cost and administration of pneumococcal and influenza vaccines to Medicare beneficiaries receiving services on or after January 1, 1998 in an HHA-based RHC and/or an HHA-based FQHC. A visit by an HHA nurse for the sole purpose of administering a vaccine is not covered as an HHA visit under the home health benefit, even though the patient may be an eligible home health beneficiary receiving services under a home health plan of treatment. Section 1862(a)(1)(B) of the Act excludes Medicare coverage of vaccines and their administration other than the Part B coverage contained in §1861 of the Act.

If the vaccine is administered in the course of an otherwise covered home health visit, the visit would be covered as usual, but the cost and charges for the vaccine and its administration must be excluded from the cost and charges of the visit. The HHA would be entitled to separate payment for the vaccine and its administration under the Part B vaccine benefit.

Some of the expenses includable in this cost center would be the costs of syringes, cotton balls, bandages, etc., but the cost of travel is not permissible as a cost of administering vaccines, nor is the travel cost includable in the A&G cost center. The travel cost is non-reimbursable. Attach a schedule detailing the methodology employed to develop the administration of these vaccines. These vaccines are reimbursable under Part B only.

Line 14--Enter the direct expenses incurred in renting or selling durable medical equipment (DME) items to the patient for the purpose of carrying out the plan of treatment. Also, include all the direct expenses incurred by you in requisitioning and issuing the DME to patients.

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

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

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

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

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

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

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

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

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

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

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

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

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

#### Column Descriptions for Small HHAs

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

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

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

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

Columns 3, 4, and 5 are not needed.

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

### 3215. WORKSHEET C - APPORTIONMENT OF PATIENT SERVICE COSTS

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

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

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

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

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

#### Column Descriptions for Cost Per Visit Computation

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

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

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

**3215.2 Part II - Computation of the Aggregate Medicare Cost and the Aggregate of the Medicare Limitation.**--This part provides for the computation of the cost of Medicare patient care visits and the corresponding reasonable cost limitation for Medicare services provided in the MSA identified. Complete this part one time for each MSA where Medicare beneficiary visits were provided during the cost reporting period.

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

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

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

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

NOTE: The sum of all Worksheets C, Part II, Medicare program visits, sum of lines 1-6 for columns 5 and 6 plus Worksheet C, Part V, sum of lines 25-27 for columns 3 and 5 must equal the visits shown on Worksheet S-3, column 1, lines 1 through 6. Consequently, the sum of all Worksheets C, Part II, Medicare program visits, line 7, columns 5 and 6, and Worksheet C, Part V, line 28, columns 3 and 5 must equal the sum on Worksheet S-3, line 8, column 1.

Column 11--Enter the total Medicare cost for each discipline (sum of columns 8 and 9). Add the amounts on lines 1 through 6. Enter this total on line 7.

#### Column Descriptions for Cost Limitation Computation

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

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

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

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

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

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

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

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

Lines 15 and 16--Enter in column 2 the applicable costs of each line item from Worksheet B, column 6, lines 12 and 13, respectively. Enter in column 3 the total charges applicable for each line. Enter in column 4 the ratio of costs (column 2) to charges (column 3) for each line.

Line 15--Enter in columns 5, 6, and 7 the charges for medical supplies not paid on a fee schedule.

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. Enter in column 7 the charge for covered osteoporosis drugs. (See §1833(m)(5) of the Act.)

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--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.

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

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



Line 17--Enter in columns 3, 4, and 6, respectively, the sum of the amounts from each Worksheet C, Part II, columns 8, 9 and 11, respectively, line 7.

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

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

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

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

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

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

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

Column 1--Enter the corresponding Medicare program (title XVIII) unduplicated census count (two decimal places) from your records. (See §3205.)

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

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

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

**NOTE:** The 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 MSAs (Worksheet C, Part IV, column 1, line 24).

3215.5 Part V - Outpatient Therapy Reduction Computation--This section computes the reduction in the reasonable costs of outpatient physical therapy services (which includes outpatient speech language pathology) and outpatient occupational therapy provided under arrangement for beneficiaries who are not homebound as required by §1834(k) of the Act and enacted by §4541 of BBA 1997. The amount of the reduction is 10 percent for services rendered on or after January 1, 1998. For outpatient therapy services rendered on or after January 1, 1999, §4541 of BBA 1997 mandates a fee schedule payment basis for outpatient physical therapy, outpatient occupational therapy, and outpatient speech pathology. Therefore, any outpatient therapy services furnished on or after January 1, 1999 **must not be included** in this section due to the application of a fee schedule for these services, but the corresponding visits must be recorded in column 5.01. These outpatient therapy services are reimbursed the lesser of the fee scheduled amount or the statutory limitation which is applied on a beneficiary specific basis through the Medicare claims system. This requires no provider input on the cost report

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

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

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

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

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

Line 20--For columns 3 through 8, respectively, enter the sum of lines 25 through 27.

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 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--Enter the cost of services from Worksheet C, Parts III, IV and V as follows. If the amount in column 6, line 19 is less than the amount in column 6, line 22, and the amount in column 6, line 24, transfer (aggregate Medicare cost):

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 and Part IV, col. 4, line 19

Col. 3, Part B

Part III, sum of col. 10, lines 15 and 16 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 and Part IV, col. 4, line 22

Col. 3, Part B

Part III, sum of col. 10, lines 15 and 16 and Part V, col. 8, line 28

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

To Worksheet D, Line 1From Worksheet C

Col. 1, Part A

Part IV, col. 3, line 24

Col. 2, Part B

Part III, sum of col. 9, line 16 and Part IV, col. 4, line 24

Col. 3, Part B

Part III, sum of col. 10, lines 15 and 16 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. In column 3, also enter the Medicare charges applicable to all RHCs and FQHCs, respectively, for services furnished prior to January 1, 1998.

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 HCFA Pub. 15-I, §2104.3) and (2) provider charges to beneficiaries for excess costs as described in HCFA Pub. 15-I, §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. (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. There are several situations under which Medicare payment is secondary to a primary payer. Prorate, based on the ratio derived in line 4, 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.

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.

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.

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.

**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.

Line 20--Column 2 amount is the combined amount from Worksheets RH-2, column 5, line 10 and FQ-2, column 5, line 11.

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 HCFA Pub. 15-I, §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 HCFA Pub. 15-I, §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 HCFA Pub. 15-I, §2577.)

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

Line 25.5--Enter any other adjustments. For example, enter an adjustment resulting from changing the recording of vacation pay from cash basis to accrual basis. (See HCFA 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, times \$10, minus the interim OASIS payment made to the provider on April 1, 2000. (For fiscal intermediary use only during final settlement).

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

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

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

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

Line 30--Enter the Medicare reimbursement effect of protested items. The reimbursement effect of the nonallowable items is estimated by applying reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost

finding process. (See §115.2.) A schedule showing the supporting details and computations for this line must be attached.

Line 31--Do not use this line.

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

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

The column headings designate two categories of payments:

- Category 1 - Part A
- Category 2 - Part B

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

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

Line Descriptions

Line 1--Enter the total Medicare interim payments paid to the HHA. 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 on this line 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 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.

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

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

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

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

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

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

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

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



3219.5 Part V - Computation of Therapy Limitation and Excess Cost Adjustment--This part provides for the calculation of the adjustment to therapy service costs in determining the reasonableness of therapy cost.

Lines 45 and 46--When the outside supplier provides the equipment and supplies used in furnishing direct services to your patients, the actual cost of the equipment and supplies incurred by the outside supplier (as specified in HCFA Pub. 15-I, §1412.1) is considered an additional allowance in computing the limitation.

Line 48--Enter the amounts paid and/or payable to the outside suppliers for therapy services rendered during the period as reported in the cost report. This includes any payments for supplies, equipment use, overtime, or any other expenses related to supplying therapy services for you. For physical therapy, occupational therapy, and speech pathology services rendered to non-homebound beneficiaries on or after January 1, 1999, prorate, based on total HHA visits, the amounts paid and/or payable to outside suppliers, e.g., multiply the amount paid and/or payable to outside suppliers by the ratio of visits made by non-homebound beneficiaries to CORFs (and/or OPTs) to total HHA visits. The result is the amount of the reduction.

Line 49--Enter the excess cost over the limitation, i.e., line 48 minus line 47. Transfer this amount to Worksheet A-5, line 10 for physical therapy services, line 10.1 for occupational therapy services and line 10.2 for speech pathology services. If the amount is negative, enter a zero.

## 3220. WORKSHEET S-6 - HHA-BASED CORF STATISTICAL DATA

In accordance with 42 CFR 413.20(a), 42 CFR 413.24(a) and 42 CFR 413.24(c), maintain statistical records for proper determination of costs payable under the Medicare program. The statistics reported on this worksheet pertain to an HHA-based CORF. If you have more than one provider-based CORF, complete a separate worksheet for each facility. The data maintained, depending on the services provided by the CORF, include number of program treatments, total number of treatments, number of program patients, and total number of patients. In addition, FTE data is required by employee staff, contracted staff, and total.

CORF Treatments--Use lines 1 through 8 to identify the number of service treatments and corresponding number of patients. The patient count in columns 2 and 4 includes each individual who received each type of service. The sum of the patient count in columns 2 and 4 equals the total in column 6 for each line.

Columns 1 and 3--Enter the number of treatments for title XVIII and other, respectively, for each discipline. Enter the total for each column on line 9.

Columns 2 and 4--Enter the number of patients corresponding to the number of treatments in columns 1 and 3 for title XVIII and other, respectively, for each discipline.

Columns 5 and 6--Enter in column 5 the total of columns 1 and 3. Enter in column 6 the total of columns 2 and 4.

Line Descriptions

Lines 1 through 7--These lines identify the type of CORF services which are reimbursable by the program. These lines reflect the number of times a person was a patient receiving a particular service.

Line 8--This line identifies other services not listed on lines 1 through 7 which are not reimbursable by the program.

Line 9--Enter in column 1 the total of the amounts on lines 1 through 7. Enter in columns 3 and 5 the total of the amounts on lines 1 through 8.

Lines 10 through 28--These lines provide statistical data related to the human resources of the CORF. The human resources statistics are required for each of the job categories specified on lines 10 through 26. Enter any additional categories needed on lines 27 and 28.

Enter the number of hours in your normal work week in the space provided.

Report in column 1 the full time equivalent (FTE) employees on the CORF's payroll. These are staff for which an IRS Form W-2 is used.

Report in column 2 the FTE contracted and consultant staff of the CORF.

Compute FTEs as follows. Add hours for which employees or contractors were paid, divide by 2080 hours, and round to two decimal places.

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

**3221. WORKSHEET J-1 - ALLOCATION OF GENERAL SERVICE COSTS TO CORF COST CENTERS**

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

**3221.1 Part I - Allocation of General Service Costs to CORF Cost Centers.--Worksheet J-1, Part I** provides for the allocation of the expenses of each general service cost center to those cost centers which receive the services. Obtain the total direct expenses (column 0, line 15) from Worksheet A, column 10, line 24. Obtain the cost center allocation (column 0, lines 1 through 14) from your records. The amounts on line 15, columns 0 through 6, must agree with the corresponding amounts on Worksheet B, columns 0 through 6, line 24. Complete the amounts entered on lines 1 through 15, columns 1 through 8, in accordance with the instructions contained in §3221.3.

**3221.2 Part II - Computation of Unit Cost Multiplier for Allocation of CORF Administrative and General Costs.--Use this part to compute the unit cost multiplier used to allocate CORF administrative and general costs to the revenue producing CORF cost centers.**

Line 1--Enter the amount from Part I, column 6, line 15.

Line 2--Enter the amount from Part I, column 6, line 1.

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

Line 4--Divide line 2 by line 3 and enter the result. Multiply each amount in column 6, lines 2 through 15, by the unit cost multiplier and enter the result on the corresponding line of column 7.

**3221.3 Part III - Allocation of General Service Costs to CORF Cost Centers - Statistical Basis.--Worksheet J-1, Parts II and III** provide for the proration of the statistical data needed to equitably allocate the expenses of the general service cost centers on Worksheet J-1, Part I. If there is a difference between the total accumulated costs reported on the Part III statistics and the total accumulated costs calculated on Part I, use the reconciliation column on Part III for reporting any adjustments. See §3214 for the appropriate usage of the reconciliation columns. For componentized A&G cost centers, the accumulated cost center line must match the reconciliation column number.

To facilitate the allocation process, the general format of Worksheet J-1, Parts I and III, is identical.

The statistical basis shown at the top of each column on Worksheet J-1, Part III is the recommended basis of allocation of the cost center indicated.

**NOTE:** If you wish to change your allocation basis for a particular cost center, you must make a written request to your intermediary for approval of the change and submit reasonable justification for such change prior to the beginning of the cost reporting period for which the change is to apply. The effective date of the change is the beginning of the cost reporting period for which the request has been made. (See HCFA Pub. 15-I, §2313.)

Lines 1 through 14--On Worksheet J-1, Part III, for all cost centers to which the general service cost center is being allocated, enter that portion of the total statistical base applicable to each.

Line 15--Enter the total of lines 1 through 14 for each column. The total in each column must be the same as shown for the corresponding column on Worksheet B-1, line 24.

Line 16--Enter the total expenses for the cost center allocated. Obtain this amount from Worksheet B, line 24, from the same column used to enter the statistical base on Worksheet J-1, Part III (e.g., in the case of capital-related cost buildings and fixtures, this amount is on Worksheet B, column 1, line 24).

Line 17--Enter the unit cost multiplier which is obtained by dividing the cost entered on line 16 by the total statistic entered in the same column on line 15. Round the unit cost multiplier to six decimal places.

Multiply the unit cost multiplier by that portion of the total statistics applicable to each cost center receiving the services. Enter the result of each computation on Worksheet J-1, Part I, in the corresponding column and line.

After the unit cost multiplier has been applied to all the cost centers receiving the services, the total cost (line 15, Part I) must equal the total cost on line 16, Part III.

Perform the preceding procedures for each general service cost center.

In column 6, Part I, enter the total of columns 4A through 5.

In column 7, Part I, for lines 2 through 14, multiply the amount in column 6 by the unit cost multiplier on line 4, Part II, and enter the result in this column. On line 15, enter the total of the amounts on lines 2 through 14. The total on line 15 equals the amount in column 6, line 1.

In column 8, Part I, enter on lines 2 through 14 the sum of the amounts in columns 6 and 7. The total on line 15 equals the total in column 6, line 15.

### 3222. WORKSHEET J-2 - COMPUTATION OF CORF COSTS

Use this worksheet only if you operate an HHA-based CORF. If you have more than one provider-based CORF, complete a separate worksheet for each facility. For CORF services rendered on or after January 1, 1999, §4541 of BBA 1997 mandates a fee schedule payment basis for outpatient physical therapy, outpatient occupational therapy, and outpatient speech pathology as well as for a preponderance of other CORF services. Therefore, the Medicare (title XVIII) charges for these services (based on the fee schedule) must **not** be included in column 4. However, the Medicare (title XVIII) charges applicable to those remaining services reimbursed on a reasonable cost basis are still required in column 4. Contact your intermediary for specific services reimbursed on a fee schedule.

#### 3222.1 Part I - Apportionment of CORF Cost Centers--

Column 1--Enter on each line the total cost for the cost center as previously computed on Worksheet J-1, Part I, column 8, corresponding cost center. To facilitate the apportionment process, the line numbers are the same on both worksheets.

**NOTE:** Do not transfer prosthetic and orthotic devices (line 9) or DME costs (lines 12 and 13) from Worksheet J-1. The DME costs are paid based on a fee schedule and are therefore not reimbursable through the cost report.

Column 2--Enter the total charges for each cost center. Obtain the charges from your records.

Column 3--For each cost center, enter the ratio derived by dividing the cost in column 1 by the charges in column 2.

Column 4--For each cost center, enter the charges from your records for title XVIII CORF patients for CORF services rendered on or before December 31, 1998. For services rendered on or after January 1, 1999, enter only those charges applicable to services reimbursed on a reasonable cost basis. Do not enter charges for services reimbursed based on a fee schedule. Note: For cost reporting periods beginning on or after January 1, 1999, column 4 must equal column 6.

Column 5--For each cost center, enter the costs obtained by multiplying the charges in column 4 by the ratio in column 3.

Reasonable Cost Reduction for Outpatient Therapy.--Columns 6 through 8 compute the reduction in the reasonable costs of CORF services including services provided under arrangement for beneficiaries who are not homebound as required by §1834(k) of the Act and enacted by §4541 of BBA 1997. The amount of the reduction is 10 percent for services rendered on or after January 1, 1998.

Column 6--For each cost center, enter the title XVIII CORF charges (from your records) for services rendered January 1, 1998 through December 31, 1998. For services rendered on or after January 1, 1999, enter only those charges applicable to services reimbursed on a reasonable cost basis. Do not enter charges for services reimbursed based on a fee schedule. That is, the amounts entered in this column must be associated with the amounts entered in column 4.

Column 7--Determine the title XVIII CORF cost for services rendered on or after January 1, 1998 by multiplying the charges in column 6 by the ratio in column 3, and enter the result.

Column 8--Determine the reduction amount by multiplying the cost in column 7 by 10 percent (.10), and enter the result.

Column 9--Determine the title XVIII cost net of the applicable cost reduction by subtracting the amount in column 8 from the amount in column 5. Enter the result in column 9.

Line 15--Enter the totals for columns 1, 2, and 4 through 9.

3222.2 Part II - Apportionment of Cost of CORF Services Furnished by Shared HHA Departments.--Use this part only when the provider complex maintains a separate department for any of the cost centers listed on this worksheet, and the department provides services to patients of the HHA's CORF.

Column 1--Enter on each line the total cost for the HHA cost center as previously computed on Worksheet B, column 6, for the corresponding cost centers.

Column 2--Enter the total facility charges for each cost center. Obtain the charges from your records.

Column 3--For each of the cost centers listed, enter the ratio of cost to charges (column 1 divided by column 2).

Column 4--For each cost center, enter the charges from your records for title XVIII CORF patients.

Column 5--For each cost center, enter the costs obtained by multiplying the charges in column 4 by the ratio in column 3.

Columns 6-8--Follow the instructions for worksheet J-2, Part I, columns 6 through 8, respectively.

Column 9--Determine the title XVIII cost net of the applicable cost reduction by subtracting the amount in column 8 from the amount in column 5. Enter the result in column 9.

Line 23--Enter in columns 4 through 9 the sum of lines 16 through 21.

3222.3 Part III - Total CORF Costs.--

Columns 4-8--Enter the sum of the total cost from Part I, line 15 and Part II, line 23 for each column 4 through 8, respectively.

Column 9--Enter the total cost from Part I, column 9, line 15 plus Part II, column 9, line 23. Transfer this amount to Worksheet J-3, line 1.

3223. WORKSHEET J-3 - CALCULATION OF REIMBURSEMENT SETTLEMENT - CORF SERVICES

Submit a Worksheet J-3 only if you operate an HHA-based CORF. If you have more than one provider-based CORF, complete a separate worksheet for each facility.

3223.1 Part I - Computation of Customary Charges for CORF Services.--

Computation of the Lesser of Reasonable Costs or Customary Charges for CORF Services Rendered in Calendar Year 1998.--Pursuant to §4541 of BBA 1997, §1834(k) of the Act is appended to require that payment for CORF services be subject to the lesser of the charges imposed for CORF services or the adjusted reasonable costs.

Line 1--Enter the cost of CORF services from Worksheet J-2, Part III, column 9, line 24.

Line 1.1--Enter the cost of CORF services rendered prior to January 1, 1998 (services reimbursed on a reasonable cost basis) by subtracting the amount on Worksheet J-2, Part III, column 7, line 24 from the amount on Worksheet J-2, Part III, column 5, line 24.

Line 1.2--Enter the cost of CORF services rendered on or after January 1, 1998 (services reimbursed on a cost basis subject to LCC) by subtracting the amount on Worksheet J-2, Part III, column 8, line 24 from the amount on Worksheet J-2, Part III, column 7, line 24.

Line 2--Enter (from your records) the amounts paid and payable by Workers' Compensation and other primary payers.

Line 3--Enter the amount obtained by subtracting line 2 from line 1.

Line 4--Enter the total CORF charges from Worksheet J-2, Part III, column 4, line 24.

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. In no instance may the customary charges on line 8 exceed the actual charges on line 4.

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. (See 42 CFR 413.13(b).)

Line 8.1--Enter the customary charges for CORF services rendered prior to January 1, 1998 (services reimbursed on a reasonable cost basis) by subtracting the amount on Worksheet J-2, Part III, column 6, line 24 from the amount on Worksheet J-2, Part III, column 4, line 24. If lines 5 and 6 have been completed, multiply the result of line 8.1 by line 7 and enter the result.

Line 8.2--Enter the customary charges for CORF services rendered on or after January 1, 1998 (services reimbursed on a cost basis subject to LCC) from Worksheet J-2, Part III, column 6, line 24. If lines 5 and 6 have been completed, multiply the result of line 8.2 by line 7 and enter the result.

**NOTE:** Line 1 must equal the sum of lines 1.1 and 1.2; line 8 must equal the sum of lines 8.1 and 8.2.

Line 8.3--Enter the excess of total customary charges (line 8.2) over the total reasonable cost (line 1.2). That is, line 8.2 minus line 1.2. When the total charges on line 8.2 are less than the total cost on line 1.2, enter zero (0).

Line 8.4--Enter the excess of total reasonable cost (line 1.2) over total customary charges (line 8.2).

That is, line 1.2 minus line 8.2. When the total cost on line 1.2 is less than the customary charges on line 8.2, enter zero (0).

3223.2 Part II - Computation of Reimbursement Settlement.--

Payment to CORFs is based on the reasonable cost of the services. (See 42 CFR 413.13(c).)

Line 9--Enter the cost of CORF services from line 3.

Line 10--Enter the Part B deductibles billed to program patients (from your records) excluding any coinsurance amounts.

Line 11--Enter the amount obtained by subtracting line 10 from line 9.

Line 11.1--Enter the amount from Part I, line 8.4.

Line 12--Enter 80 percent of line 11.2.

Line 13--Enter the actual coinsurance billed program patients from your records.

Line 14--Enter the amount obtained by subtracting line 13 from line 11.

Line 15--Enter (from your records) reimbursable bad debts, net of recoveries, applicable to any deductibles and coinsurance.

Line 16--Enter the lesser of the amounts on line 12 or 14 plus the amount on line 15.

Line 17--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 HCFA Pub. 15-I, §132ff.) Enter the amount of any excess depreciation taken in parentheses ( ).

**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 18--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 HCFA Pub. 15-I, §§136ff.)

Line 19--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 HCFA Pub. 15-I, §2146.4.) Specify the adjustment in the space provided.

Line 20--Enter the amount on line 16 minus the amounts on lines 17 and 18 plus the amount on line 19.

Line 21--Enter any applicable sequestration adjustment. (See §120.)

Line 23--Enter the total interim payments from Worksheet J-4, line 4. For intermediary final settlement, report on line 23.5 the amount from Worksheet J-4, column 2, line 5.99.

Line 24--Enter the balance due provider/program and transfer this amount to Worksheet S, Part II, column 2, line 2.

Line 25--Enter the program reimbursement effect of nonallowable cost report items which you are

disputing. Compute the reimbursement effect in accordance with §115.2. Attach a schedule showing the supporting details and computation.

Line 26--Do not use this line for periods beginning on or after October 1, 1997.

3224. WORKSHEET J-4 - ANALYSIS OF PAYMENTS TO PROVIDER-BASED CORF 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 CORF, complete a separate worksheet for each facility.

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

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

Line Descriptions

Line 1--Enter the total Medicare interim payments paid to the HHA-based CORF. 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 CORF's interim payments due to an offset against overpayments to the CORF 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 CORF 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 J-3, line 23.

**DO NOT COMPLETE THE REMAINDER OF WORKSHEET J-4. THE REMAINDER OF THE WORKSHEET IS COMPLETED BY YOUR FISCAL INTERMEDIARY.**

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

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

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

Line 7--Enter the sum of the amounts on lines 4 and 5.99. The amount must equal Worksheet J-3, line 22.



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 HCFA Pub. 15-I, §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 HCFA Pub. 15-I, §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 HCFA Pub. 15-I, §2146.4.) Specify the adjustment in the space provided.

Line 23--Enter any applicable sequestration adjustment. (See §120.)

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

Line 26--Enter the balance due provider/program and transfer the amount to Worksheet S, Part II, column 2, 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 §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 fiscal intermediary.

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 FISCAL INTERMEDIARY.**

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

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

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

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

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

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

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

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

Line 20.--If the clinic incurred all or substantially all training costs (Graduate Medical Education (GME)), enter the total allowable direct and indirect GME cost.

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

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

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

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

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

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

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

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

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

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

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

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

Column descriptions

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

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

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

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

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

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

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

Line Descriptions

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

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

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

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

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

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

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

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

Line 15.--Enter the amount of GME overhead costs. To determine the amount of GME overhead multiply the amount of facility overhead (from line 14) by the ratio of Intern and Resident visits (from Worksheet S-4, column 2, line 16) over total visits (from Worksheet RF-3, line 6).

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 HCFA 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.--Complete columns 1 and 2 of lines 8 and 9 to identify costs and visits affected by different payment limits during a cost reporting period. Per visit payment limits are revised each January 1. If you are a calendar year provider, complete column 2 only.

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

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

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

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

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

#### Line Descriptions

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

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

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

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

Line 14.--Enter the limit adjustment. This is computed by multiplying the amount on line 13 by the outpatient mental health service limit of 62 ½ percent. This limit applies only to therapeutic services, not initial diagnostic services.

Line 15.--Enter the total allowable GME pass-through costs determined by dividing Medicare visits performed by Interns and Residents (from Worksheet S-4, column 2, line 16) by the total visits (from Worksheet RF-2, column 2, sum of lines 8 and 9) and multiply that result by the total allowable GME cost reported on Worksheet RF-1, column 10, line 20. Add the applicable overhead costs associated with GME (from line 15 of Worksheet RF-2) and enter that result on this line. (Note: If there are no allowable GME pass-through costs, this line will be zero.)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Effective for cost reporting periods ending on or after April 30, 2000, the cost of pneumococcal and influenza vaccines and the cost of administering these vaccines to Medicare beneficiaries is 100 percent reimbursable by Medicare through the parent provider; therefore, this worksheet is no longer completed.

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 17.

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

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

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

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

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

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

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

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

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



## EXHIBIT 1 - Form HCFA-1728-94

The following is a listing of the Form HCFA-1728-94 worksheets and the page number location.

| <u>Worksheets</u>                               | <u>Page(s)</u> |
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| Wkst. S-2                                       | 32-304         |
| Wkst. S-3, Parts I-III                          | 32-305         |
| Wkst. S-4                                       | 32-306         |
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| Wkst. A   | 32-308         |
| Wkst. A-1                                       | 32-309         |
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| Wkst. A-3                                       | 32-311         |
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| Wkst. A-6                                       | 32-314         |
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| Wkst. A-8-3, Parts I-III                        | 32-316         |
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| Wkst. F-1                                       | 32-325         |
| Wkst. F-2                                       | 32-326         |
| Wkst. J-1, Parts I & II                         | 32-327         |
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| Wkst. RF-1                                      | 32-343         |
| Wkst. RF-2                                      | 32-344         |
| Wkst. RF-3                                      | 32-345         |
| Wkst. RF-4 (Do not complete. See Instructions.) | 32-346         |
| Wkst. RF-5                                      | 32-347         |

|  |                     |                                     |                                  |
|--|---------------------|-------------------------------------|----------------------------------|
| APPORTIONMENT OF PATIENT SERVICE COSTS | PROVIDER NO.: _____ | PERIOD:<br>From: _____<br>To: _____ | WORKSHEET C<br>PARTS III, IV & V |
|--|---------------------|-------------------------------------|----------------------------------|

**PART III - SUPPLIES AND DRUGS COST COMPUTATION**

| Other Patient Services | From Wkst B, Col. 6, Line: | Total Cost | Total Charges from HHA Record | Ratio (Col 2 ÷ 3) | Medicare Covered Charges                 |                                      |        | Cost of Services                         |                                      |        |
|------------------------|----------------------------|------------|-------------------------------|-------------------|--|--------------------------------------|--------|--|--------------------------------------|--------|
|                        |                            |            |                               |                   | Part B                                   |                                      | Part A | Part B                                   |                                      | Part A |
|                        |                            |            |                               |                   | Not Subject to Deductibles & Coinsurance | Subject to Deductibles & Coinsurance |        | Not Subject to Deductibles & Coinsurance | Subject to Deductibles & Coinsurance |        |
| 1                      | 2                          | 3          | 4                             | 5                 | 6  | 7                                    | 8      | 9  | 10                                   |        |
| 15                     | Cost of Medical Supplies   | 12         |                               |                   |  |                                      |        |  |                                      | 15     |
| 16                     | Cost of Drugs              | 13         |                               |                   |  |                                      |        |  |                                      | 16     |

**PART IV - COMPARISON OF THE LESSER OF THE AGGREGATE MEDICARE COST, THE AGGREGATE OF THE MEDICARE COST PER VISIT LIMITATION AND THE AGGREGATE PER BENEFICIARY COST LIMITATION**

| Total Cost of Medicare Services (Sum of the amounts from each Wkst. C, Pt. II, cols. 8, 9 & 11, respectively, line 7) | Medicare Program Unduplicated Census Count For Each MSA (4)  | Per Beneficiary Annual Limitation Per MSA/Non-MSA (From Your Intermediary) | Cost of Medicare Services                |                                      |        | Total (Sum of Cols 3 & 4) |
|---|--|--|--|--------------------------------------|--------|---------------------------|
|   |  |  | Part B                                   |                                      | Part A |                           |
|   |  |  | Not Subject to Deductibles & Coinsurance | Subject to Deductibles & Coinsurance |        |                           |
| 1   | 2  | 3  | 4  | 5                                    | 6      |                           |
| 17  | Cost of Medical Supplies (from Part III, columns 8 and 9, line 15)   |  |  |                                      |        | 17                        |
| 18  | Total (Sum of lines 17 and 18)   |  |  |                                      |        | 18                        |
| 20  | Total Cost Per Visit Limitation for Medicare Services (Sum of the amounts from each Wkst. C, Pt. II, cols. 8, 9 & 11, respectively, line 14) |  |  |                                      |        | 20                        |
| 21  | Cost of Medical Supplies (from Part III, columns 8 and 9, line 15)   |  |  |                                      |        | 21                        |
| 22  | Total (Sum of lines 20 and 21)   |  |  |                                      |        | 22                        |

| Per Beneficiary Cost Limitation for MSA: | MSA Code (3)   |   |   |   |   |   | (Col 1 x 2) |
|--|--|---|---|---|---|---|-------------|
|  | 0  | 1 | 2 | 3 | 4 | 5 |             |
| 23                                       |  |   |   |   |   |   | 23          |
| 23.01                                    |  |   |   |   |   |   | 23.01       |
| 23.02                                    |  |   |   |   |   |   | 23.02       |
| 23.03                                    |  |   |   |   |   |   | 23.03       |
| 23.04                                    |  |   |   |   |   |   | 23.04       |
| 23.05                                    |  |   |   |   |   |   | 23.05       |
| 23.06                                    |  |   |   |   |   |   | 23.06       |
| 23.07                                    |  |   |   |   |   |   | 23.07       |
| 23.08                                    |  |   |   |   |   |   | 23.08       |
| 23.09                                    |  |   |   |   |   |   | 23.09       |
| 24                                       | Aggregate Per Beneficiary Cost Limitation (Sum of lines 23 and subscripts thereof) |   |   |   |   |   | 24          |

**PART V - OUTPATIENT THERAPY REDUCTION COMPUTATION**

| Patient Services | From Wkst. C, Part I, Col. 4, Line: | Average Cost Per Visit | Part B<br>Subject to Deductibles and Coinsurance   |   |   |   |  |  |                                     |    |
|------------------|-------------------------------------|------------------------|--|---|---|---|--|--|-------------------------------------|----|
|                  |                                     |                        | Medicare Program Visits for Services Before 1/1/98 | Medicare Program Costs for Services Before 1/1/98 | Medicare Program Visits for Services on 1/1/98-12/31/98 | Medicare Program Visits for Services on or after 1/1/99 | Medicare Program Costs for Services on 1/1/98-12/31/98 | Application of the Reasonable Cost Reduction | Reasonable Costs Net of Adjustments |    |
|                  |                                     |                        | 3  | 4   | 5   | 5.01  | 6  | 7  | 8                                   |    |
| 25               | Physical Therapy                    | 2                      |  |   |   |   |  |  |                                     | 25 |
| 26               | Occupational Therapy                | 3                      |  |   |   |   |  |  |                                     | 26 |
| 27               | Speech Pathology                    | 4                      |  |   |   |   |  |  |                                     | 27 |
| 28               | Total (Sum of lines 25-27)          |                        |  |   |   |   |  |  |                                     | 28 |

(3) The MSA codes flow from Worksheet S-3, Part III, line 29 and subscripts as indicated.

(4) The sum of column 1, line 24 must equal Worksheet S-3, Part I, column 2, line 10.

|   |               |             |             |
|---|---------------|-------------|-------------|
| CALCULATION OF REIMBURSEMENT SETTLEMENT<br>PART A AND PART B SERVICES | PROVIDER NO.: | PERIOD:     | WORKSHEET D |
|   |               | From: _____ |             |
|   |               | To: _____   |             |

**PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES**

| Description   | PART A | PART B                                   |                                      |    |
|---|--------|--|--------------------------------------|----|
|   |        | Not Subject to Deductibles & Coinsurance | Subject to Deductibles & Coinsurance |    |
|   |        | 1  | 2                                    |    |
| Reasonable Cost of Title XVIII - Part A & Part B Services   |        |  |                                      |    |
| 1 Reasonable Cost of Services (See Instructions)  |        |  |                                      | 1  |
| 2 Cost of Services, RHC & FQHC  |        |  |                                      | 2  |
| 3 Sum of Lines 1 and 2  |        |  |                                      | 3  |
| 4 Total charges for title XVIII - Part A and Part B Services  |        |  |                                      | 4  |
| Customary Charges   |        |  |                                      |    |
| 5 Amount actually collected from patients liable for payment for services on a charge basis (From your records)   |        |  |                                      | 5  |
| 6 Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(b) |        |  |                                      | 6  |
| 7 Ratio of line 5 to 6 (Not to exceed 1.000000)   |        |  |                                      | 7  |
| 8 Total customary charges - title XVIII (Multiply line 7 x line 4 each column)  |        |  |                                      | 8  |
| 9 Excess of total customary charges over total reasonable cost (Complete only if line 8 exceeds line 3)   |        |  |                                      | 9  |
| 10 Excess of reasonable cost over customary charges (Complete only if line 3 exceeds line 8)  |        |  |                                      | 10 |
| 11 Primary Payer Amounts  |        |  |                                      | 11 |

**PART II - COMPUTATION OF REIMBURSEMENT SETTLEMENT**

| Description   | PART A Services | Part B Services |      |
|---|-----------------|-----------------|------|
|   | 1               | 2               |      |
| 12 Total reasonable cost (See Instructions)   |                 |                 | 12   |
| 13 Part B deductibles billed to Medicare patients (exclude coinsurance)   |                 |                 | 13   |
| 14 Subtotal (Line 12 minus line 13)   |                 |                 | 14   |
| 15 Excess reasonable cost (from line 10)  |                 |                 | 15   |
| 16 Subtotal (Line 14 minus line 15)   |                 |                 | 16   |
| 17 Coinsurance billed to Medicare patients (From your records)  |                 |                 | 17   |
| 18 Net cost (Line 16 minus line 17)   |                 |                 | 18   |
| 19 Reimbursable bad debts (From your records)   |                 |                 | 19   |
| 20 Pneumococcal Vaccine   |                 |                 | 20   |
| 21 Total Costs - Current cost reporting period (See Instructions)   |                 |                 | 21   |
| 22 Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets              |                 |                 | 22   |
| 23 Recovery of excess depreciation resulting from agencies' termination or decrease in Medicare utilization         |                 |                 | 23   |
| 24 Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit     |                 |                 | 24   |
| 25 Total cost before sequestration and other adjustments- (line 21 plus/minus line 22 minus sum of lines 23 and 24) |                 |                 | 25   |
| 25.5 Other Adjustments (see instructions) (specify)   |                 |                 | 25.5 |
| 26 Sequestration Adjustment (See Instructions)  |                 |                 | 26   |
| 27 Amount reimbursable after sequestration and other adjustments (Line 25 plus line 25.5 minus line 26)             |                 |                 | 27   |
| 28 Total interim payments (From Worksheet D-1, line 4)  |                 |                 | 28   |
| 28.5 Tentative settlement (For intermediary use only)   |                 |                 | 28.5 |
| 29 Balance due HHA/Medicare program (Line 27 minus line 28) (Indicate overpayments in brackets)                     |                 |                 | 29   |
| 30 Protested amounts (nonallowable cost report items) in accordance with HCFA Pub. 15-II, section 115.2             |                 |                 | 30   |
| 31 Balance due HHA/Medicare program (Line 29 minus line 30) (Indicate overpayments in brackets)                     |                 |                 | 31   |

FORM HCFA-1728-94-D (11-1998) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN HCFA PUB. 15-II, SEC. 3216 - 3216.2)

|                           |  |                                     |               |
|---------------------------|--|-------------------------------------|---------------|
| COMPUTATION OF CORF COSTS | PROVIDER NO.: _____<br>CORF NO.: _____ | PERIOD:<br>FROM: _____<br>TO: _____ | WORKSHEET J-2 |
|---------------------------|--|-------------------------------------|---------------|

**PART I - APPORTIONMENT OF CORF COST CENTERS NET OF THE APPLICABLE REASONABLE COST REDUCTION**

| CORF COST CENTER<br>(OMIT CENTS)    | TOTAL COSTS<br>(FROM SUPP.<br>WKST. J-1, PT.<br>I, COL. 8) (1) | TOTAL<br>CORF<br>CHARGES (2) | RATIO OF<br>COSTS TO<br>CHARGES<br>(COL. 1 / COL. 2) | TITLE XVIII<br>CORF<br>CHARGES * | TITLE XVIII<br>CORF COSTS<br>(COL. 3 X<br>COL. 4) | TITLE XVIII<br>CORF<br>CHARGES ON<br>OR AFTER<br>1/1/98 * | TITLE XVIII<br>CORF<br>COSTS ON OR<br>AFTER 1/1/98 | REASONABLE<br>COST<br>REDUCTION<br>AMOUNT | TITLE XVIII<br>COST NET OF<br>REASONABLE<br>COST<br>REDUCTION |
|-------------------------------------|--|------------------------------|--|----------------------------------|---|---|--|---|---|
|                                     | 1  | 2                            | 3  | 4                                | 5   | 6   | 7  | 8   | 9   |
| 1 Administrative and General        |  |                              |  |                                  |   |   |  |   | 1   |
| 2 Skilled Nursing Care              |  |                              |  |                                  |   |   |  |   | 2   |
| 3 Physical Therapy                  |  |                              |  |                                  |   |   |  |   | 3   |
| 4 Occupational Therapy              |  |                              |  |                                  |   |   |  |   | 4   |
| 5 Speech Pathology                  |  |                              |  |                                  |   |   |  |   | 5   |
| 6 Medical Social Services           |  |                              |  |                                  |   |   |  |   | 6   |
| 7 Respiratory Therapy               |  |                              |  |                                  |   |   |  |   | 7   |
| 8 Psychological Services            |  |                              |  |                                  |   |   |  |   | 8   |
| 9 Prosthetic and Orthotic Devices   |  |                              |  |                                  |   |   |  |   | 9   |
| 10 Drugs and Biologicals            |  |                              |  |                                  |   |   |  |   | 10  |
| 11 Medical Supplies                 |  |                              |  |                                  |   |   |  |   | 11  |
| 12 Durable Medical Equipment-Rented |  |                              |  |                                  |   |   |  |   | 12  |
| 13 Durable Medical Equipment-Sold   |  |                              |  |                                  |   |   |  |   | 13  |
| 14 Other Part B Services            |  |                              |  |                                  |   |   |  |   | 14  |
| 15 TOTALS (Sum of lines 2-14)       |  |                              |  |                                  |   |   |  |   | 15  |

**PART II - APPORTIONMENT OF COST OF CORF SERVICES FURNISHED BY HHA DEPARTMENTS**

|                                       | Fr. Wkst. B,<br>Col 6, Line: |  |  |  |  |  |  |  |    |
|---------------------------------------|------------------------------|--|--|--|--|--|--|--|----|
| 16 Respiratory Therapy                | 16                           |  |  |  |  |  |  |  | 16 |
| 17 Physical Therapy                   | 7                            |  |  |  |  |  |  |  | 17 |
| 18 Occupational Therapy               | 8                            |  |  |  |  |  |  |  | 18 |
| 19 Speech Pathology                   | 9                            |  |  |  |  |  |  |  | 19 |
| 20 Supplies                           | 12                           |  |  |  |  |  |  |  | 20 |
| 21 Drugs Charged to Patients          | 13                           |  |  |  |  |  |  |  | 21 |
| 23 Total (Sum of lines 16 through 21) |                              |  |  |  |  |  |  |  | 23 |

- (1) Cost for Part II, lines 16-22 are obtained from Worksheet B, column 6, lines as appropriate
- (2) Charges for Part II, column 2 are total facility charges for each cost center and are obtained from provider records

**PART III- TOTAL CORF COSTS**

|   |   |   |   |   |   |   |    |
|---|---|---|---|---|---|---|----|
| 24 Total CORF costs - Add the amount from Part I, column 9, line 15 and the amount from Part II, column 9, line 23.<br>Add the amounts from Part I, line 15 and Part II, line 23 for columns 4 through 8, respectively. | 4 | 5 | 6 | 7 | 8 | 9 | 24 |
|---|---|---|---|---|---|---|----|

Transfer the amount in Part III, column 9 to Worksheet J-3, line 1.

\* See instructions for fee scheduled payment basis items for services rendered on or after January 1, 1999.

|   |           |           |               |
|---|-----------|-----------|---------------|
| CALCULATION OF REIMBURSEMENT SETTLEMENT - CORF SERVICES | CORF NO.: | FROM:     | WORKSHEET J-3 |
|   | _____     | TO: _____ |               |

## PART I-COMPUTATION OF CUSTOMARY CHARGES FOR CORF SERVICES

|                   |  |  |     |
|-------------------|--|--|-----|
| 1                 | Total reasonable cost of CORF services (See instructions)  |  | 1   |
| 1.1               | Total reasonable cost of CORF services prior to 1/1/1998 (Reasonable cost basis) (See instructions)  |  | 1.1 |
| 1.2               | Total reasonable cost of CORF services on or after 1/1/1998 (Subject to LCC) (See instructions)  |  | 1.2 |
| 2                 | Primary payment amounts (CORF services)  |  | 2   |
| 3                 | Net cost (Line 1 minus line 2)   |  | 3   |
| 4                 | Total CORF charges   |  | 4   |
| Customary Charges |  |  |     |
| 5                 | Amounts actually collected from patients liable for payments for CORF services on a charge basis (From your records)   |  | 5   |
| 6                 | Amount that would have been realized from patients liable for payment for CORF services on a charge basis had such payment been made in accordance with 42 CFR 413.13(b) |  | 6   |
| 7                 | Ratio of line 5 to line 6 (Not to exceed 1.000000)   |  | 7   |
| 8                 | Total customary charges - CORF services (Multiply line 7 x line 4)   |  | 8   |
| 8.1               | Total customary charges - CORF services prior to 1/1/1998 (Reasonable cost basis) (See instructions)   |  | 8.1 |
| 8.2               | Total customary charges - CORF services on or after 1/1/1998 (Subject to LCC) (See instructions)   |  | 8.2 |

## COMPUTATION OF LESSER OF REASONABLE COSTS OR CUSTOMARY CHARGES FOR CORF SERVICES FURNISHED IN CALENDAR YEAR 1998

|     |   |  |     |
|-----|---|--|-----|
| 8.3 | Excess of customary charges over reasonable costs (Complete only if line 8.2 exceeds line 1.2) (See instructions) |  | 8.3 |
| 8.4 | Excess of reasonable costs over customary charges (Complete only if line 1.2 exceeds line 8.2) (See instructions) |  | 8.4 |

## PART II - COMPUTATION OF REIMBURSEMENT SETTLEMENT

|      |  |  |      |
|------|--|--|------|
| 9    | Cost of CORF services (From line 3)  |  | 9    |
| 10   | Part B deductible billed to Program patients (exclude coinsurance amounts)                                   |  | 10   |
| 11   | Net Cost (Line 9 minus line 10)  |  | 11   |
| 11.1 | Excess of reasonable costs over customary charges for services rendered on or after 1/1/1998 (from line 8.4) |  | 11.1 |
| 11.2 | Subtotal (line 11 minus line 11.1)   |  | 11.2 |
| 12   | 80% of Part B cost (80% x line 11.2)   |  | 12   |
| 13   | Actual coinsurance billed to Program patients (From your records)  |  | 13   |
| 14   | Net cost less actual billed coinsurance (Line 11 minus line 13)  |  | 14   |
| 15   | Reimbursable bad debts (See instructions)  |  | 15   |
| 16   | Net reimbursable amount (Line 15 plus the lesser of line 12 or line 14)                                      |  | 16   |
| 17   | Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets          |  | 17   |
| 18   | Recovery of excess depreciation resulting from facility's termination or a decrease in Program utilization   |  | 18   |
| 19   | Other adjustments (specify)  |  | 19   |
| 20   | Total Cost - reimbursable to provider (Line 16 minus lines 17 and 18 and plus or minus line 19)              |  | 20   |
| 21   | Sequestration Adjustment (See instructions)  |  | 21   |
| 22   | Amount due provider after sequestration adjustment (Amount on line 20 minus line 21)                         |  | 22   |
| 23   | Interim payments   |  | 23   |
| 23.5 | Tentative settlement (For intermediary use only)   |  | 23.5 |
| 24   | Balance due CORF/Program (Line 22 minus line 23) (Indicate overpayments in brackets)                         |  | 24   |
| 25   | Protested amounts (nonallowable cost report items) in accordance with PRM II, Sec. 115.2(B)                  |  | 25   |
| 26   | Balance due CORF/Program (Line 24 minus line 25) (Indicate overpayments in brackets)                         |  | 26   |

FORM HCFA 1728-94-J-3 (5-2000) (INSTRUCTIONS PUBLISHED IN THIS WORKSHEET ARE PUBLISHED IN HCFA PUB. 15-II, SEC. 3223-3223.2)

ANALYSIS OF HHA-BASED RURAL HEALTH CLINIC/  
FEDERALLY QUALIFIED HEALTH CENTER COSTS

PROVIDER NO.:

PERIOD:  
FROM: \_\_\_\_\_

WORKSHEET RF-1

COMPONENT NO.:

TO: \_\_\_\_\_

| Check Applicable Box:                     |  | <input type="checkbox"/> RHC<br><input type="checkbox"/> FQHC |                 |                                |             |                                   |                    |  |             |   |  |
|---|--|---|-----------------|--------------------------------|-------------|-----------------------------------|--------------------|--|-------------|---|--|
|   | SALARIES   | EMPLOYEE BENEFITS   | TRANSPOR-TATION | CONTRACTED/ PURCHASED SERVICES | OTHER COSTS | TOTAL (sum of col. 1 thru col. 5) | RECLASSIFI-CATIONS | RECLASSIFIED TRIAL BALANCE (col. 6 + col. 7) | ADJUSTMENTS | NET EXPENSES FOR ALLOCATION (col. 8 + col. 9) |  |
|   | 1  | 2   | 3               | 4                              | 5           | 6                                 | 7                  | 8  | 9           | 10  |  |
| <b>FACILITY HEALTH CARE STAFF COSTS</b>   |  |   |                 |                                |             |                                   |                    |  |             |   |  |
| 1   | Physician  |   |                 |                                |             |                                   |                    |  |             | 1   |  |
| 2   | Physician Assistant  |   |                 |                                |             |                                   |                    |  |             | 2   |  |
| 3   | Nurse Practitioner   |   |                 |                                |             |                                   |                    |  |             | 3   |  |
| 4   | Visiting Nurse   |   |                 |                                |             |                                   |                    |  |             | 4   |  |
| 5   | Other Nurse  |   |                 |                                |             |                                   |                    |  |             | 5   |  |
| 6   | Clinical Psychologist  |   |                 |                                |             |                                   |                    |  |             | 6   |  |
| 7   | Clinical Social Worker   |   |                 |                                |             |                                   |                    |  |             | 7   |  |
| 8   | Laboratory Technician  |   |                 |                                |             |                                   |                    |  |             | 8   |  |
| 9   | Other Facility Health Care Staff Costs                           |   |                 |                                |             |                                   |                    |  |             | 9   |  |
| 10  | Subtotal (sum of lines 1-9)                                      |   |                 |                                |             |                                   |                    |  |             | 10  |  |
| <b>COSTS UNDER AGREEMENT</b>              |  |   |                 |                                |             |                                   |                    |  |             |   |  |
| 11  | Physician Services Under Agreement                               |   |                 |                                |             |                                   |                    |  |             | 11  |  |
| 12  | Physician Supervision Under Agreement                            |   |                 |                                |             |                                   |                    |  |             | 12  |  |
| 13  | Other Costs Under Agreement                                      |   |                 |                                |             |                                   |                    |  |             | 13  |  |
| 14  | Subtotal (sum of lines 11-13)                                    |   |                 |                                |             |                                   |                    |  |             | 14  |  |
| <b>OTHER HEALTH CARE COSTS</b>            |  |   |                 |                                |             |                                   |                    |  |             |   |  |
| 15  | Medical Supplies   |   |                 |                                |             |                                   |                    |  |             | 15  |  |
| 16  | Transportation (Health Care Staff)                               |   |                 |                                |             |                                   |                    |  |             | 16  |  |
| 17  | Depreciation-Medical Equipment                                   |   |                 |                                |             |                                   |                    |  |             | 17  |  |
| 18  | Professional Liability Insurance                                 |   |                 |                                |             |                                   |                    |  |             | 18  |  |
| 19  | Other Health Care Costs  |   |                 |                                |             |                                   |                    |  |             | 19  |  |
| 20  | Allowable GME Pass Through Costs                                 |   |                 |                                |             |                                   |                    |  |             | 20  |  |
| 21  | Subtotal (sum of lines 15-20)                                    |   |                 |                                |             |                                   |                    |  |             | 21  |  |
| 22  | Total Cost of Health Care Services (sum of lines 10, 14, and 21) |   |                 |                                |             |                                   |                    |  |             | 22  |  |
| <b>COSTS OTHER THAN RHC/FQHC SERVICES</b> |  |   |                 |                                |             |                                   |                    |  |             |   |  |
| 23  | Pharmacy   |   |                 |                                |             |                                   |                    |  |             | 23  |  |
| 24  | Dental   |   |                 |                                |             |                                   |                    |  |             | 24  |  |
| 25  | Optometry  |   |                 |                                |             |                                   |                    |  |             | 25  |  |
| 26  | All other nonreimbursable costs                                  |   |                 |                                |             |                                   |                    |  |             | 26  |  |
| 27  | Non-allowable GME Pass Through Costs                             |   |                 |                                |             |                                   |                    |  |             | 27  |  |
| 28  | Total Nonreimbursable Costs (sum of lines 23-27)                 |   |                 |                                |             |                                   |                    |  |             | 28  |  |
| <b>FACILITY OVERHEAD</b>                  |  |   |                 |                                |             |                                   |                    |  |             |   |  |
| 29  | Facility Costs   |   |                 |                                |             |                                   |                    |  |             | 29  |  |
| 30  | Administrative Costs   |   |                 |                                |             |                                   |                    |  |             | 30  |  |
| 31  | Total Facility Overhead (sum of lines 29 and 30)                 |   |                 |                                |             |                                   |                    |  |             | 31  |  |
| 32  | Total facility costs (sum of lines 22, 28 and 31)                |   |                 |                                |             |                                   |                    |  |             | 32  |  |

The net expenses for cost allocation on Worksheet A for the applicable RHC/FQHC cost center line must equal the total facility costs in column 10, line 30 of this worksheet for cost reporting periods beginning on or after January 1, 1998.

|  |   |                          |                |
|--|---|--------------------------|----------------|
| ALLOCATION OF OVERHEAD<br>TO RHC/FQHC SERVICES | PROVIDER NO.:   | PERIOD:                  | WORKSHEET RF-2 |
|  | COMPONENT NO.:  | FROM: _____<br>TO: _____ |                |
| Check<br>Applicable Box:                       | <input type="checkbox"/> RHC<br><input type="checkbox"/> FQHC |                          |                |

**VISITS AND PRODUCTIVITY**

| Positions                                  | Number<br>of FTE<br>Personnel | Total<br>Visits | Productivity<br>Standard (1) | Minimum<br>Visits<br>(col. 1x col. 3) | Greater of<br>Col. 2 or<br>Col. 4 |   |
|--|-------------------------------|-----------------|------------------------------|---------------------------------------|-----------------------------------|---|
|  | 1                             | 2               | 3                            | 4                                     | 5                                 |   |
| 1 Physicians                               |                               |                 |                              |                                       |                                   | 1 |
| 2 Physician Assistants                     |                               |                 |                              |                                       |                                   | 2 |
| 3 Nurse Practitioners                      |                               |                 |                              |                                       |                                   | 3 |
| 4 Subtotal (sum of lines 1-3)              |                               |                 |                              |                                       |                                   | 4 |
| 5 Visiting Nurse                           |                               |                 |                              |                                       |                                   | 5 |
| 6 Clinical Psychologist                    |                               |                 |                              |                                       |                                   | 6 |
| 7 Clinical Social Worker                   |                               |                 |                              |                                       |                                   | 7 |
| 8 Total FTEs and Visits (sum of lines 4-7) |                               |                 |                              |                                       |                                   | 8 |
| 9 Physician Services Under Agreements      |                               |                 |                              |                                       |                                   | 9 |

(1) Productivity standards established by HCFA are: 4200 visits for each physician and 2100 visits for each nonphysician practitioner. If an exception to the productivity standard has been granted, (Worksheet S-4, line 13 equals "Y"), then input in column 3, lines 1-3, the productivity standards derived by the fiscal intermediary.

**DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES**

|    |   |  |    |
|----|---|--|----|
| 10 | Total costs of health care services (from Worksheet RF-1, column 10, line 22 less the amount from Worksheet RF-1, column 10, line 20) |  | 10 |
| 11 | Total nonreimbursable costs (from Worksheet RF-1, column 10, line 28)   |  | 11 |
| 12 | Cost of all services (excluding overhead) (sum of lines 10 and 11)  |  | 12 |
| 13 | Ratio of RHC/FQHC services (line 10 divided by line 12)   |  | 13 |
| 14 | Total facility overhead - (from Worksheet RF-1, column 10, line 31) (see instructions)  |  | 14 |
| 15 | Allowable GME Overhead (see instructions)   |  | 15 |
| 16 | Net Facility Overhead (line 14 minus line 15)   |  | 16 |
| 17 | Parent provider overhead allocated to facility (see instructions)   |  | 17 |
| 18 | Total overhead (sum of lines 16 and 17)   |  | 18 |
| 19 | Overhead applicable to RHC/FQHC services (line 13 x line 18)  |  | 19 |
| 20 | Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)  |  | 20 |

|   |   |                          |                |
|---|---|--------------------------|----------------|
| CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES | PROVIDER NO.:   | PERIOD:                  | WORKSHEET RF-3 |
|   | COMPONENT NO.:  | FROM: _____<br>TO: _____ |                |
| Check Applicable Box:   | <input type="checkbox"/> RHC<br><input type="checkbox"/> FQHC |                          |                |

**DETERMINATION OF RATE FOR RHC/FQHC SERVICES**

|   |  |                          |                       |   |
|---|--|--------------------------|-----------------------|---|
| 1 | Total Allowable Cost of RHC/FQHC Services (from Worksheet RF-2, line 20)         |                          |                       | 1 |
| 2 | Cost of vaccines and their administration (from Worksheet RF-4, line 15)         |                          |                       | 2 |
| 3 | Total allowable cost excluding vaccine (line 1 minus line 2)                     |                          |                       | 3 |
| 4 | Total FTEs and Visits (from Wkst. RF-2, col. 5, line 8)                          |                          |                       | 4 |
| 5 | Physicians visits under agreement (from Worksheet RF-2, column 5, line 9)        |                          |                       | 5 |
| 6 | Total adjusted visits (line 4 plus line 5)                                       |                          |                       | 6 |
| 7 | Adjusted cost per visit (line 3 divided by line 6)                               |                          |                       | 7 |
|   |  | Calculation of Limit (1) |                       |   |
|   |  | Prior to January 1       | On or after January 1 |   |
|   |  | 1                        | 2                     |   |
| 8 | Per visit payment limit (from your intermediary)                                 |                          |                       | 8 |
| 9 | Rate for Medicare covered visits (lesser of line 7 or line 8) (See instructions) |                          |                       | 9 |

**CALCULATION OF SETTLEMENT**

|      |   |  |  |      |
|------|---|--|--|------|
| 10   | Medicare covered visits excluding mental health services (from intermediary records)                            |  |  | 10   |
| 11   | Medicare cost excluding costs for mental health services (line 9 x line 10)                                     |  |  | 11   |
| 12   | Medicare covered visits for mental health services (from intermediary records)                                  |  |  | 12   |
| 13   | Medicare covered cost from mental health services (line 9 x line 12)  |  |  | 13   |
| 14   | Limit adjustment for mental health services (line 13 x 62.5%)   |  |  | 14   |
| 15   | Graduate Medical Education Pass Through Cost (see instructions)   |  |  | 15   |
| 15.5 | Primary Payer Amounts   |  |  | 15.5 |
| 16   | Total Medicare cost (line 11, columns 1 & 2 plus line 14, columns 1 & 2 plus column 2, line 15 minus line 15.5) |  |  | 16   |
| 17   | Less: Beneficiary deductible (from intermediary records)  |  |  | 17   |
| 18   | Net Medicare cost excluding vaccines (line 16 minus line 17)  |  |  | 18   |
| 19   | Reimbursable cost of RHC/FQHC services, excluding vaccine (80% of line 18)                                      |  |  | 19   |
| 20   | Medicare cost of vaccines and their administration (from Worksheet. RF-4, line 16)                              |  |  | 20   |
| 21   | Total reimbursable medicare cost (line 19 plus line 20)   |  |  | 21   |
| 22   | Reimbursable bad debts  |  |  | 22   |
| 23   | Other adjustments (specify)   |  |  | 23   |
| 24   | Net reimbursable amounts (sum of lines 21, 22 and 23)   |  |  | 24   |
| 25   | Interim payments (From Worksheet RF-5, line 4)  |  |  | 25   |
| 25.5 | Tentative settlement (For intermediary use only)  |  |  | 25.5 |
| 26   | Balance due component/program (line 24 minus line 25)   |  |  | 26   |
| 27   | Protested amounts (nonallowable cost report items) in accordance with HCFA Pub. 15-II, chapter I, section 115.2 |  |  | 27   |

(1) Lines 8 through 14: Fiscal year providers use columns 1 & 2, calendar year providers use column 2 only.

FORM HCFA-1728-94-RF-3 (5-2000) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN HCFA PUB. 15-II, SECTIONS 3236 - 3236.1)



|  |   |                          |                |
|--|---|--------------------------|----------------|
| COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST | PROVIDER NO.:   | PERIOD:                  | WORKSHEET RF-4 |
|  | COMPONENT NO.:  | FROM: _____<br>TO: _____ |                |
| Check<br>Applicable Box:                               | <input type="checkbox"/> RHC<br><input type="checkbox"/> FQHC |                          |                |

**DO NOT COMPLETE THIS WORKSHEET. SEE INSTRUCTIONS.**

|    |  | PNEUMOCOCCAL | INFLUENZA |    |
|----|--|--------------|-----------|----|
|    |  | 1            | 2         |    |
| 1  | Health care staff cost (from Worksheet RF-1, column 10, line 10)   |              |           | 1  |
| 2  | Ratio of pneumococcal and influenza vaccine staff time to total health care staff time   |              |           | 2  |
| 3  | Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)  |              |           | 3  |
| 4  | Medical supplies cost - pneumococcal and influenza vaccine (from your records)   |              |           | 4  |
| 5  | Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)   |              |           | 5  |
| 6  | Total direct cost of the facility (from Worksheet RF-1, column 10, line 22)  |              |           | 6  |
| 7  | Total overhead (from Worksheet RF-2, line 18)  |              |           | 7  |
| 8  | Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)  |              |           | 8  |
| 9  | Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)   |              |           | 9  |
| 10 | Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)  |              |           | 10 |
| 11 | Total number of pneumococcal and influenza vaccine injections (from your records)  |              |           | 11 |
| 12 | Cost per pneumococcal and influenza vaccine injection (line 10/ line 11)   |              |           | 12 |
| 13 | Number of pneumococcal and influenza vaccine injections administered to Medicare beneficiaries   |              |           | 13 |
| 14 | Medicare cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)   |              |           | 14 |
| 15 | Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet RF-3, line 2)           |              |           | 15 |
| 16 | Total Medicare cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet RF-3, line 20) |              |           | 16 |

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

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

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

The following are requirements for all records:

1. All alpha characters must be in upper case.
2. For micro systems, the end of record indicator must be a carriage return and line feed, in that sequence.
3. No record may exceed 60 characters.

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

|  | 1 | 2  | 3 | 4 | 5 | 6 |
|--|---|--|---|---|---|---|
| 123456789012345678901234567890123456789012345678901234567890 |   |  |   |   |   |   |
| 1  | 1 | 010123199912120001218D99P00120002132000121 |   |   |   |   |

Record #1: This is a cost report file submitted by Provider 010123 for the period from May 1, 1999 (1999121) through April 30, 2000 (2000121). It is filed on Form HCFA-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 July 31, 2000 (2000213). The electronic cost report specification dated April 30, 2000 (2000121) is used to prepare this file.

#### FILE NAMING CONVENTION

Name each cost report file in the following manner:

HHNNNNNN.YYL, where

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

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

RECORD NAME: Type 1 Records - Record Number 1

|                               | <u>Size</u> | <u>Usage</u> | <u>Loc.</u> | <u>Remarks</u>   |
|-------------------------------|-------------|--------------|-------------|--|
| 1. Record Type                | 1           | X            | 1           | Constant "1"   |
| 2. NPI                        | 10          | 9            | 2-11        | Numeric only   |
| 3. Spaces                     | 11          | X            | 2-12        |  |
| 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 HCFA-1728-94)   |
| 10. Vendor Code               | 3           | X            | 38-40       | To be supplied upon approval. Refer to page 32-503.  |
| 11. Vendor Equipment          | 1           | X            | 41          | P = PC; M = Main Frame   |
| 12. Version Number            | 3           | X            | 42-44       | Version of extract software, e.g., 001=1st, 002=2nd, etc. or 101=1st, 102=2nd. The version number must be incremented by 1 with each recompile and release to client(s).   |
| 13. Creation Date             | 7           | 9            | 45-51       | YYYYDDD - Julian date; date on which the file was created (extracted from the cost report)   |
| 14. ECR Spec. Date            | 7           | 9            | 52-58       | YYYYDDD - Julian date; date of electronic cost report specifications used in producing each file. Valid for cost reporting periods ending on or after 2000121 (4/30/2000). Prior approval(s) 97090, 1998273 and 1999304. |



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

| <u>DESCRIPTION</u>   | <u>LINE(S)</u> | <u>COLUMN(S)</u> | <u>FIELD SIZE</u> | <u>USAGE</u> |
|--|----------------|------------------|-------------------|--------------|
| WORKSHEET C (Continued)  |                |                  |                   |              |
| Per beneficiary annual cost limit for each MSA                       | 23-23.24       | 2                | 9                 | 9(6).99      |
| Medicare visits for services rendered before 1/1/98                  | 25-27          | 3                | 9                 | 9            |
| Medicare visits for services rendered 1/1/98 to 12/31/98             | 25-27          | 5                | 9                 | 9            |
| Medicare visits for services rendered on or after 1/1/99             | 25-27          | 5.01             | 9                 | 9            |
| WORKSHEET D  |                |                  |                   |              |
| <u>Part I:</u> Total charges for Title XVIII - Part A and B services | 4              | 1-3              | 9                 | 9            |
| Amount collected from patients                                       | 5              | 1-3              | 9                 | 9            |
| Amounts collectible from patients                                    | 6              | 1-3              | 9                 | 9            |
| Primary payer amounts  | 11             | 1-3              | 9                 | 9            |
| <u>Part II:</u> Part B deductibles billed to Medicare patients       | 13             | 2                | 9                 | 9            |
| Coinsurance billed to Medicare patients                              | 17             | 2                | 9                 | 9            |
| Reimbursable bad debts   | 19             | 1,2              | 9                 | 9            |
| Total costs  | 21             | 1,2              | 9                 | 9            |
| Amounts applicable to prior periods                                  | 22             | 1,2              | 9                 | -9           |
| Recovery of excess depreciation                                      | 23             | 1,2              | 9                 | 9            |
| Unrefunded excess charges to beneficiaries                           | 24             | 1,2              | 9                 | 9            |
| Text as needed for blank line (specify)                              | 25.5           | 0                | 36                | X            |
| Other adjustments (see instructions)                                 | 25.5           | 1,2              | 9                 | -9           |
| Sequestration adjustment (see instructions)                          | 26             | 1,2              | 9                 | 9            |
| Protested amounts  | 30             | 1,2              | 9                 | 9            |

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

| <u>DESCRIPTION</u>   | <u>LINE(S)</u>                               | <u>COLUMN(S)</u> | <u>FIELD SIZE</u> | <u>USAGE</u> |
|--|--|------------------|-------------------|--------------|
| WORKSHEET D-1  |  |                  |                   |              |
| Total interim payments paid to provider                    | 1  | 2 & 4            | 9                 | 9            |
| Interim payments payable                                   | 2  | 2 & 4            | 9                 | 9            |
| Date of each retroactive lump sum adjustment (MM/DD/YYYY)  | 3.01-3.98                                    | 1 & 3            | 10                | X            |
| Amount of each lump sum adjustment                         |  |                  |                   |              |
| Program to provider  | 3.01-3.49                                    | 2 & 4            | 9                 | 9            |
| Provider to program  | 3.50-3.98                                    | 2 & 4            | 9                 | 9            |
| WORKSHEET F  |  |                  |                   |              |
| For all home health agencies:                              |  |                  |                   |              |
| Balance sheet account balances                             | 1-10, 12-26, 28-31, 33-41, 43-48, 51, 59     | 1                | 9                 | -9           |
| For home health agencies using fund accounting:            |  |                  |                   |              |
| Specific purpose fund account balances                     | 1-10, 12-26, 28-31, 33-41, 43-48, 52, 59     | 2                | 9                 | -9           |
| Endowment fund account balances                            | 1-10, 12-26, 28-31, 33-41, 43-48, 53-55, 59  | 3                | 9                 | -9           |
| Plant fund account balances                                | 1-10, 12-26, 28-31, 33-41, 43-48, 56, 57, 59 | 4                | 9                 | -9           |
| Text as needed for blank lines                             | 9, 26, 31, 41, 48                            | 0                | 36                | X            |
| WORKSHEET F-1  |  |                  |                   |              |
| Total patient revenues                                     | 1  | 1                | 9                 | 9            |
| Contractual allowances and discounts on patients' accounts | 2  | 1                | 9                 | -9           |

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

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

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

WORKSHEET RF-1

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

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

| <u>DESCRIPTION</u>   | <u>LINE(S)</u> | <u>COLUMN(S)</u> | <u>FIELD SIZE</u> | <u>USAGE</u> |
|--|----------------|------------------|-------------------|--------------|
| WORKSHEET RF-2   |                |                  |                   |              |
| Number of FTE Personnel  | 1-3 & 5-7      | 1                | 6                 | 9(3).99      |
| Total Visits   | 1-3, 5-7 & 9   | 2                | 9                 | 9            |
| Productivity standard *  | 1-3            | 3                | 9                 | 9            |
| Greater of columns 2 or 4  | 4              | 5                | 9                 | 9            |
| GME overhead   | 15             | 1                | 9                 | 9            |
| Parent provider overhead allocated to facility (see instructions)  | 17             | 1                | 9                 | 9            |
| * Use the standard visits per the instructions as the default. Those standards may change if an approved exception is granted. (See Worksheet S-4 for response to approved exception to the standard productivity visits.) |                |                  |                   |              |
| WORKSHEET RF-3   |                |                  |                   |              |
| Adjusted cost per visit  | 7              | 1                | 6                 | 9(3).99      |
| Maximum rate per visit (from your intermediary)  | 8              | 1 & 2            | 6                 | 9(3).99      |
| Rate for Program covered visits  | 9              | 1 & 2            | 6                 | 9(3).99      |
| Medicare covered visits excluding mental health services (from your intermediary)  | 10             | 1 & 2            | 9                 | 9            |
| Medicare covered visits for mental health services (from your intermediary)  | 12             | 1 & 2            | 9                 | 9            |
| Primary payer amounts  | 15.5           | 1                | 9                 | 9            |
| Beneficiary deductible (from your intermediary)  | 17             | 1                | 9                 | 9            |
| Reimbursable bad debts   | 22             | 1                | 9                 | 9            |
| Text as needed for blank line  | 23             | 0                | 36                | X            |
| Other adjustments  | 23             | 1                | 9                 | -9           |
| Interim payments   | 25             | 1                | 9                 | 9            |
| Protested amounts  | 27             | 1                | 9                 | 9            |
| WORKSHEET RF-4   |                |                  |                   |              |
| Ratio of pneumococcal and vaccine staff time to total health care staff time   | 2              | 1 & 2            | 8                 | 9.9(6)       |
| Medical supplies cost-pneumococcal and influenza vaccine (from your records)   | 4              | 1 & 2            | 9                 | 9            |

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

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

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

The vendor requirements (above) and the edits (below) reduce both intermediary processing time and unnecessary rejections. Vendors should develop their programs to prevent their client home health agencies from generating either a hard copy substitute cost report or electronic cost report file where level I edits exist. Ample warnings should be given to the provider where level II edit conditions are violated.

**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, unless otherwise noted.

I. Level I Edits (Minimum File Requirements)

| <u>Reject Code</u> | <u>Condition</u>  |
|--------------------|---|
| 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] |
| 1035               | The vendor code (record #1, positions 38-40) must be a valid code (HCRIS #2050). [3/31/1997]  |



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

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

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

| <u>Reject Code</u> | <u>Condition</u>   |
|--------------------|--|
| 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. [9/30/1998]  |
| 1000A              | All amounts reported on Worksheet A, columns 1-5, line 29, must be greater than or equal to zero. [3/31/1997]  |
| 1020A              | For reclassifications reported on Worksheet A-4, the sum of all increases (column 4) must equal the sum of all decreases (column 7). [3/31/1997]   |
| 1025A              | For each line on Worksheet A-4, if there is an entry in columns 3, 4, 6, or 7, there must be an entry in column 1. There must be an entry on each line of column 4 for each entry in column 3 (and vice versa), and there must be an entry on each line of column 7 for each entry in column 6 (and vice versa). [3/31/1997]   |
| 1040A              | For Worksheet A-5 adjustments on lines 1-4, 6-9, and 11-12, if either columns 2 or 4 has an entry, then both columns 2 and 4 must have entries, and if any one of columns 0, 1, 2, or 4 for lines 13-20 and subscripts thereof has an entry, then all columns 0, 1, 2, and 4 must have entries. Only valid line numbers may be used in column 4. [3/31/1997]   |
| 1045A              | If there are any transactions with related organizations or home offices as defined in HCFA Pub. 15-I, chapter 10 (Worksheet A-6, Part A, column 1, line 1 is "Y"), Worksheet A-6, Part B, columns 4 or 5, sum of lines 1-3 must be greater than zero; and Part C, column 1, any one of lines 1-5 must contain any one of alpha characters A through G. Conversely, if Worksheet A-6, Part A, column 1, line 1 is "N", Worksheet A-6, Parts B and C must not be completed. [3/31/1997] |
| 1050A              | If Worksheet A-8-3, sum of columns 1-3, line 32 is greater than zero, column 4, line 36 must be greater than the sum of columns 1-3, line 32 and equal to or less than 2080 hours. The sum of Worksheet A-8-3 for physical therapy services provided prior to 4/10/1998, column 4, line 36 and Worksheet A-8-3 for physical therapy services provided on or after 4/10/1998, column 4, line 36, must be equal to or less than 2080 hours. [9/30/1998]                                  |
| 1000B              | On Worksheet B-1, all statistical amounts must be greater than or equal to zero, except for reconciliation columns. [3/31/1997]  |
| 1005B              | Worksheet B, column 6, line 29 must be greater than zero. [3/31/1997]  |
| 1010B              | For each general service cost center with a net expense for cost allocation greater than zero (Worksheet A, column 10, lines 1-5), 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]  |
|                    | <b>NOTE:</b> For small HHAs that elect the optional A&G allocation method (see §3214) as defined in 42 CFR 413.24(d), do not apply edits 1000B, 1005B or 1010B.  |
| 1000C              | For the home health agency, total Medicare program (title XVIII) visits reported as the sum of all Worksheets C, Part II (sum of columns 5 and 6, lines 1-6, plus Worksheet C, Part V, columns 3, 5.01 and 5, lines 25-27) must equal the sum of the visits reported on Worksheet S-3 (column 1, sum of lines 1-6). [4/30/2000]  |
| 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 MSAs (Worksheet C, Part IV, column 1, line 24). [9/30/1998]  |

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

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

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

## II. Level II Edits (Potential Rejection Errors)

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

| <u>Edit</u> | <u>Condition</u>  |
|-------------|---|
| 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]      |