HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
Table of Contents, Chapter 32	32-3 (1 p.)	32-3 (1 p.)
3202 (Cont.) - 3204	32-9 - 32-10.1 (3 pp.)	32-9 - 32-10 (2 pp.)
3205 - 3206 (Cont.)	32-13 - 31-18 (8 pp.)	32-13 - 31-18 (6 pp.)
3213 - 3214	32-27 - 31-28 (2 pp.)	32-27 - 31-28 (2 pp.)
3214 (Cont.) - 3222	32-31 - 32-48 (21 pp.)	32-31 - 32-48 (20 pp.)
3225.3 - 3228	32-53 - 32-58 (6 pp.)	32-53 - 32-58 (6 pp.)
3238 - 3246 (Cont.)	32-73 - 32-89 (16 pp.)	32-73 (1 p.)
3290 - 3290 (Cont.)	32-301 - 32-302 (2 p.)	32-301 (1 p.)
	32-303 - 32-306 (6 pp.)	32-303 - 32-306 (4 pp.)
	32-319 - 32-322 (4 pp.)	32-319 - 32-322 (4 pp.)
	32-331 - 32-336 (16 pp.)	32-331 - 32-336 (6 pp.)
3295 (Cont.) - 3295 (Cont.)	32-503 - 32-506.2 (6 pp.)	32-503 - 32-506.2 (4 pp.)
	32-509 - 32-512 (5 pp.)	32-509 - 32-512 (6 pp.)
	32-515 - 32-516.1 (3 pp.)	32-515 - 32-516 (2 pp.)
	32-519 - 32-522 (4 pp.)	32-519 - 32-522 (4 pp.)
	32-527 - 32-528 (2 pp.)	32-527 - 32-528 (2 pp.)
	32-530.3 - 32-532.1 (5 pp.)	32-530.3 - 32-532 (3 pp.)
	32-535 - 32-542 (8 pp.)	32-535 - 32-542 (8 pp.)

NEW/REVISED COST REPORTING FORMS AND INSTRUCTIONS--EFFECTIVE DATE: SEE BELOW

This transmittal revises Chapter 32, Home Health Agency Cost Reporting Form HCFA-1728-94 for implementation of a Prospective Payment System (PPS) in accordance with §1895 of the Social Security Act effective for home health services rendered on or after October 1, 2000. This transmittal also revises chapter 32 by incorporating hospice worksheets (K series worksheets) into the chapter and is effective for cost reporting periods ending on or after October 31, 2000.

NEW/REVISED COST REPORTING FORMS--EFFECTIVE DATE: Changes effective for services rendered on or after October 1, 2000.

The following is a list of the revised cost reporting forms:

Form HCFA 1728-94 Wkst.:	Summary of Changes:
S-2	Line 3.5 for HHA based Hospice identification data is added.
S-3, Part I	Line 10 (Unduplicated Census Count) is subscripted to capture counts before and on or after October 1, 2000.

S-3, Part IV	This part is established to capture visit, charge and episode data for the various payment categories under home health PPS for services rendered on or after October 1, 2000.
S-5	This new worksheet captures hospice statistical data.
A, A-1, A-2, A-3	Effective for cost reporting periods beginning on or after October 1, 2000, do not complete Worksheets A-1, A-2, and A-3. Enter the total direct expense on directly on Worksheet A in the appropriate column.
C, Parts II	Lines 1-6 and column 11 are subscripted to capture visit and cost data before and on or after October 1, 2000.
C, Part III	Line 15 (Cost of Medical Supplies) and line 16 (Drugs) are subscripted to capture cost and charge data before and on or after October 1, 2000.
C, Part IV	Column 5.02 is added to capture outpatient therapy visit counts for services rendered on or after October 1, 2000. Line references for line 17, 18 and 21 are revised.
D, Part I	Line 4 (Total Charges for Title XVIII) is subscripted to capture charges before and on or after October 1, 2000. Revised the calculation instructions for line 8, column 3.
D, Part II	Lines 12.01-12.14 are added to capture total PPS reimbursement amounts for the various payment categories for services rendered on or after October 1, 2000.
J Series	If all services rendered by CORFs and OPT, OOT, and OSP providers are paid under established fee schedules do not complete these worksheets for cost reporting periods ending on or after June 30, 2001. CMHCs must continue to complete these worksheets.
CM-2	Columns 3.01, 3.02 and 6 as well as lines 16 and 17, columns 2, 4, 5 and 6 are added to facilitate CMHC PPS for services rendered on or after August 1, 2000.
CM-3	Column 1 and line 1 are subscripted to facilitate CMHC PPS.
K-1, K-2, K-3, K-4 K-5, K-6	These new worksheets are added to capture hospice statistical data.

NEW/REVISED ELECTRONIC REPORTING SPECIFICATIONS--EFFECTIVE DATE: Changes to the Electronic Reporting Specifications Are Effective for Cost Reporting Periods Ending on or after October 31, 2000.

The following is a summary of some of the more significant revisions to the electronic reporting specifications to the cost report. Table 2 reflects the additional worksheet indicators for Worksheets S-5, K-1, K-2, K-3, K-4, K-5, K-6. Table 3 reflects the additional data requirements for Worksheets S-3, S-5, C, D, CM-2, CM-3, K-1, K-2, K-3, K-4, K-5 and K-6. Table 3C reflects revisions to subscriptable lines. Table 5 reflects additional nonstandard cost center coding. Table 6 reflects revisions to level I edits. 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.

Step	Worksheet	Instructions
26	Supp. J-2	Read §3222. Complete entire worksheet.
27	Supp. J-3	Read §3223. Complete lines 1-22.
28	Supp. J-4	Read §3224. Complete lines 1-4.
29	Supp. J-3	Read §3223. Complete lines 23-26.
	CMHC	
30	Supp. CM-1, Pt I	Read §3225.1. Complete column 0, lines 1-12.
31	Supp. CM-1, Pt III	Read §3225.3. Fully complete.
32	Supp. CM-1, Pt I	Read §3225.3. Complete columns 1-6, lines 1-12.
33	Supp. CM-1, Pt II	Read §3225.2. Fully complete.
34	Supp. CM-1, Pt I	Read §3225.3. Fully complete.
35	Supp. CM-2	Read §3226. Complete entire worksheet.
36	Supp. CM-3	Read §3227. Complete lines 1-24.
37	Supp. CM-4	Read §3228. Complete lines 25-28.
38	Supp. CM-3	Read §3227. Complete lines 23-26.
	RHC/FQHC	
39	S-4	Read §3233. Complete entire worksheet.
40	RF-1	Read §3234. Complete entire worksheet.
41	RF-2	Read §3235. Complete entire worksheet.
42	RF-4	Read §3237. Complete entire worksheet.
43	RF-5	Read §3238. Complete entire worksheet.
44	RF-3	Read §3236. Complete entire worksheet.

Step	Worksheet	Instructions
45	S-5	Read §3239. Complete entire worksheet.
46	K-1, K-2, K-3	Read §§3241-3243. Complete all worksheets.
47	K	Read §3240. Complete entire worksheet.
48	K-4, Parts I and II	Read §3244. Complete entire worksheets.
49	K-5, Parts I - III	Read §§3245-3245.3. Complete entire worksheets.
50	K-6	Read §3246. Complete entire worksheet.
51	S	Read §3203. Complete Part II entirely. Then complete Part I.

3203. WORKSHEET S - HOME HEALTH AGENCY COST REPORT

The intermediary indicates in the appropriate box whether this is the initial cost report (first cost report filed for the period), final report due to termination, or if this is a reopening. If it is a reopening, indicate the number of times the cost report has been reopened.

3203.1 Part I - Certification by Officer or Administrator of Provider(s).-- This certification is read, prepared, and signed after the cost report has been completed in its entirety. The cost report is not accepted by the fiscal intermediary unless it contains an original signature.

3203.2 Part II - Settlement Summary.--Enter the balance due to or from for each component of the complex. Transfer the settlement amounts as follows:

- Home health agency from Worksheet D, Part II, line 29 (Part A from column 1 and Part B from column 2).
- HHA-based CORF from Worksheet J-3, line 24.
- HHA-based CMHC from Worksheet CM-3, line 26.
- HHA-based RHC or FQHC from Worksheet RF-3, line 26. Specify the provider type.

3204. WORKSHEET S-2 - HOME HEALTH AGENCY COMPLEX IDENTIFICATION DATA

The information required on this worksheet is needed to properly identify the provider.

Line 1--Enter the street address and P.O. Box (if applicable) of the HHA.

Line 1.01--Enter the city, state, and zip code of the HHA.

Lines 2 through 6--On the appropriate lines and columns indicated, enter the names, provider identification numbers, and certification dates of the HHA and its various components, if any.

Line 2--This is an institution which meets the requirements of §§1861(o) and 1891 of the Act and participates in the Medicare program.

Line 3--This is a distinct part CORF that has been issued a CORF identification number and which meets the requirements of §1861(cc) of the Act. If you have more than one HHA-based CORF, subscript this line and report the required information for each CORF.

Line 3.50--This is a distinct part Hospice that has been issued a Hospice identification number and which meets the requirements of §1861(dd) of the Act. If you have more than one HHA-based Hospice, subscript this line and report the required information for each Hospice.

Line 4--This is a distinct part CMHC that has been issued a CMHC identification number and which meets the requirements of §1861(ff) of the Act. If you have more than one HHA-based CMHC, subscript this line and report the required information for each CMHC.

Line 5--This is a distinct part RHC that has been issued a RHC identification number and which meets the requirements of §1861(aa) of the Act. If you have more than one HHA-based RHC, subscript this line and report the required information for each RHC.

Line 6--This is a distinct part FQHC that has been issued a FQHC identification number and which meets the requirements of §1861(aa) of the Act. If you have more than one HHA-based FQHC, subscript this line and report the required information for each FQHC.

Line 7--Enter the inclusive dates covered by this cost report. In accordance with 42 CFR 413.24(f), you are required to submit periodic reports of your operations which generally cover a consecutive

3205. WORKSHEET S-3 - HOME HEALTH AGENCY STATISTICAL DATA

In accordance with 42 CFR 413.20(a), 42 CFR 413.24(a), and 42 CFR 413.24(c), you are required to maintain statistical records for proper determination of costs payable under the Medicare program. The statistics required on this worksheet pertain to a home health agency. The data to be maintained, depending on the services provided by the agency, includes the number of program visits, total number of agency visits, number of program home health aide hours, total agency home health aide hours, program unduplicated census count and total unduplicated census count, program patient count, and total agency patient count. In addition, FTE data are required by employee staff, contracted staff, and total staff.

HHA Visits.--A visit is an episode of personal contact with the beneficiary by staff of the HHA or others under arrangements with the HHA for the purpose of providing Medicare-type services. A Medicare-type service is a service which satisfies the definition of a home health service in HCFA Pub. 13-3, §§3118 and 3119, HCFA Pub. 11, §§205 and 206, and 42 CFR 409.40. In preparing the cost report, recognize only the costs associated with Medicare-type like-kind visits in reimbursable cost centers. Medicare like-kind visits generally fall under the definition of Medicare visits as described in 42 CFR 409.45 (b) through (g). In counting like-kind visits, it is critical that non-Medicare visits are of the same type as those that would be covered by Medicare. This insures that costs of services are comparable across insurers and that providers are reimbursed equitably for home health services provided. A visit is initiated with the delivery of Medicare-type home health service and ends at the conclusion of delivery of Medicare-type home health services. (See 42 CFR 409.48(c).) Use lines 1 through 7 to identify the number of service visits and corresponding number of patients. The patient count in columns 2, 4, and 6 includes each individual who received each type of service. The sum of the patient count in columns 2 and 4 may not equal the amount in column 6 for each line. Also, the total of all of the lines may not equal line 10, unduplicated census count, since many patients receive more than one type of service. Beneficiaries who experience multiple spells of illnesses (multiple visits and/or multiple discharges and admissions) within a cost reporting period must be counted only once in the unduplicated census count.

Part I - Statistical Data.--

Columns 1 and 2.--Enter data pertaining to Title XVIII patients only. Enter in column 1 the Title XVIII visits for each discipline for services rendered through September 30, 2000 for reporting periods which overlap October 1, 2000. For reporting periods which begin on or after October 1, 2000 enter in column 1 all visits rendered during the entire cost reporting period. Enter in column 2 the patient count applicable to the Title XVIII visits in column 1 for each line description. See HCFA Pub. 11 for patient count determination. Enter the sum of lines 1 through 7 in column 1 on line 8 (total visits). The sum of lines 1 through 7 in column 2 do not equal the unduplicated census count on line 10 because a beneficiary could be receiving more than one type of service.

Columns 3 and 4.--Enter data pertaining to all other patients for the entire reporting period. Enter in column 3 the count of all the agency visits except Title XVIII visits for each discipline. Enter in column 4 the total agency patient count, except Title XVIII, applicable to the agency visits entered in column 3. Enter the sum of lines 1 through 7 in column 3 on line 8 (total visits). The sum of lines 1 through 7 in column 4 may not equal the unduplicated census count on line 10 because a patient could be receiving more than one type of service.

Columns 5 and 6.--The amounts entered in column 5 are the sum of columns 1 and 3 for each discipline for cost reporting periods ending on or before September 30, 2000. For reporting periods which overlap October 1, 2000, enter in column 5 the total visits rendered during the entire reporting period. For reporting periods which overlap October 1, 2000, the amounts entered in column 5 may not equal the sum of columns 1 and 3 for each discipline. For reporting periods beginning on or after October 1, 2000, column 5 will again equal the sum of columns 1 and 3. The amounts entered in column 6 may not be the sum of columns 2 and 4 for each discipline. The unduplicated census count

on line 10, column 6, may not necessarily equal the sum of the unduplicated census count, line 10, columns 2 and 4.

For example, if a patient receives both covered services and noncovered services, he or she is counted once as Title XVIII (for covered services), once as other (for noncovered services), and only once as total.

Lines 1 through 6.--These lines identify the type of home health services rendered to patients. The entries reflect the number of visits furnished and the number of patients receiving a particular type of service.

Line 7.--Enter in columns 3 and 5 the total of all other visits. Enter in columns 4 and 6 the patient count applicable to visits furnished by the agency but which are not reimbursable by Title XVIII.

Line 8.--Enter the sum of lines 1 through 7 for all columns as appropriate.

Line 9.--Enter the number of hours applicable to home health aide services.

Line 10, 10.01 and 10.02.--Enter on line 10 in the appropriate column the unduplicated count of all patients receiving home visits or other care provided by employees of the agency or under contracted services for the entire the reporting period. Enter on line 10.01 in the appropriate column the unduplicated count of all patients receiving home visits or other care provided prior to October 1, 2000 by employees of the agency or under contracted services during the reporting period. Enter on line 10.02 in the appropriate column the unduplicated count of all patients receiving home visits or other care provided on or after October 1, 2000 by employees of the agency or under contracted services during the reporting period. Beneficiaries who receive services before and after October 1, 2000 must be included in both unduplicated census counts before and after October 1, 2000. The sum of lines 10.01 and 10.02 may not necessarily equal line 10. For cost reporting periods beginning on or after October 1, 2000, do not subscript line 10 as all unduplicated census count data is entered on line 10. Count each individual only once. However, because a patient may be covered under more than one health insurance program, the total census count may not equal the sum of the Title XVIII and all other census counts. For purposes of calculating the unduplicated census count, if a beneficiary has received health care in more than one MSA, you must prorate the unduplicated census count based on the ratio of visits provided in an MSA to the total visits furnished to the beneficiary so as to not exceed a total of (1). For example, if an HHA furnishes 100 visits to an individual beneficiary in one MSA during the cost reporting period and the same individual received a total of 400 visits (the other 300 visits were furnished in other MSAs during the cost reporting period), the reporting HHA would count the beneficiary as a .25 (100 divided by 400) in the unduplicated census count for Medicare patients for the cost reporting period. Round the result to two decimal places, e.g., .2543 is rounded to .25. **A provider is also to query the beneficiary to determine if he or she has received health care from another provider during the year, i.e., Maryland versus Florida for beneficiaries with seasonal residence**.

Part II - Employment Data (Full Time Equivalent).--

Lines 11 through 27--Lines 11 through 27 provide statistical data related to the human resources of the HHA. The human resources statistics are required for each of the job categories specified in lines 11 through 25. Enter any additional categories needed on lines 26 and 27.

Enter the number of hours in your normal work week.

Report in column 1 the full time equivalent (FTE) employees on the HHA'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 HHA. Compute staff FTEs for column 1 as follows. Total all hours for which employees worked and divide by 2080 hours. Round

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

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

Part III - Metropolitan Statistical Area (MSA) Code Data.--

Line 28.--Enter the total number of MSAs where Medicare covered services were provided during the cost reporting period. MSA codes are four character numeric

codes that identify the geographic area at which Medicare covered service are furnished. Obtain these codes from your fiscal intermediary.

Line 29.--List all MSA and/or Non-MSA codes where Medicare covered home health services were provided. Enter one MSA code on each line as necessary. If additional lines are needed, continue subscripting with lines 29.01, 29.02 et cetera, as necessary entering one MSA code on each subscripted line. Obtain these codes from your fiscal intermediary. Non-MSA (rural) codes are assembled by placing the digits "99" in front of the two digit State code, e.g., for the state of Maryland the rural MSA code is 9921.

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

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

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

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

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

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

Less that a full Episode of Care.--

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

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

When a beneficiary experiences a significant change in condition (SCIC) and subsequently, but within the same 60 day episode, elects to transfer to another provider a SCIC within a PEP occurs.

A significant change in condition (SCIC) adjustment occurs when a beneficiary experiences a significant change in condition, either improving or deteriorating, during the 60 day episode that was not envisioned in the original plan of care. The SCIC adjustment reflects the proportional payment adjustment for the time both prior and after the beneficiary experienced the significant change in condition during the 60 day episode.

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

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

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

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

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

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

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

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

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

3206. WORKSHEET A - RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

Worksheet A provides for recording the trial balance of expense accounts from your accounting books and records. It also provides for the necessary reclassifications and adjustments to certain accounts prior to the cost finding calculations. Also include on Worksheets A, A-1, A-2, and A-3 all expenses incurred for only those visits completed in the current reporting period when the episode of care overlaps the cost report year end. For cost reporting periods beginning on or after October 1, 2000, do not complete Worksheets A-1, A-2 and A-3. Enter directly on Worksheet A the total expenses for Salaries and Wages (column 1), Employee Benefits (column 2) and Contracted/Purchased Services (column 4) in the appropriate cost center.

The cost centers on this worksheet are listed in a manner which facilitates the transfer of the various cost center data to the cost finding worksheets. Each of the cost centers listed does not apply to all providers using these forms. Therefore, use those cost centers applicable to your type of HHA.

Under certain conditions, a provider may elect to use different cost centers for allocation purposes. These conditions are stated in HCFA Pub. 15-I, §2313.

Standard (i.e., preprinted) HCFA line numbers and cost center descriptions cannot be changed. If a provider needs to use additional or different cost center descriptions, it may do so by adding additional lines to the cost report. Added cost centers must be appropriately coded. Identify the added line as a numeric subscript of the immediately preceding line. That is, if two lines are added between lines 5 and 6, identify them as lines 5.01 and 5.02. If additional lines are added for general services cost centers, corresponding columns must be added to Worksheets B and B-1 for cost finding.

NOTE: Cost centers appearing on Worksheet A, Lines 6 -11 may not be subscripted beyond those which are preprinted. (See HCFA Pub. 15-I §2313.2c)

Also, submit the working trial balance of the facility with the cost report. A working trial balance is a listing of the balances of the accounts in the general ledger to which adjustments are appended in supplementary columns and is used as a basic summary for financial statements.

Cost center coding is a methodology for standardizing the meaning of cost center labels as used by health care providers on the Medicare cost reports. The Form HCFA 1728-94 provides for 27 preprinted cost center descriptions on Worksheet A. In addition, a space is provided for a cost center code. The preprinted cost center labels are automatically coded by HCFA approved cost reporting software. These 27 cost center descriptions are hereafter referred to as the standard cost centers. One additional cost center description with general meaning has been identified. This additional description will hereafter be referred to as a nonstandard label with an "Other..." designation to provide for situations where no match in meaning to the standard cost centers can be found. Refer to Worksheet A, line 23.

The use of this coding methodology allows providers to continue to use labels for cost centers that have meaning within the individual institution. The four digit cost center codes that are associated with each provider label in their electronic file provide standardized meaning for data analysis. The preparer is required to compare any added or changed label to the descriptions offered on the standard or nonstandard cost center tables. A description of cost center coding and the table of cost center codes are in Table 5 of the electronic reporting specifications.

If the cost elements of a cost center are separately maintained on your books, you must maintain a reconciliation of the costs per the accounting books and records to those on this worksheet. The reconciliation is subject to review by the intermediary.

Column 1.--Obtain the expenses listed from Worksheet A-1. The sum of column 1 must equal Worksheet A-1, column 9, line 29.

Column 2.--Obtain the expenses listed from Worksheet A-2. The sum of column 2 must equal Worksheet A-2, column 9, line 29.

Column 3.--If the transportation costs, i.e., owning or renting vehicles, public transportation expenses, or payments to employees for driving their private vehicles can be directly identified to a particular cost center, enter those costs in the appropriate cost center. If these costs are not identifiable to a particular cost center, enter them on line 4.

Column 4.--Obtain the expenses listed in this column from Worksheet A-3. The sum of column 4 must equal Worksheet A-3, column 9, line 29.

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

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

Column 7.--Enter any reclassifications among the cost center expenses in column 6 which are needed to effect proper cost allocation.

Worksheet A-4 reflects the reclassifications affecting the cost center expenses. This worksheet need not be completed by all providers, but is completed only to the extent reclassifications are needed and appropriate in the particular circumstances. Show reductions to expenses in parentheses ( ).

The net total of the entries in column 7 must equal zero on line 29.

Column 8.--Adjust the amounts entered in column 6 by the amounts entered in column 7 (increase or decrease) and extend the net balances to column 8. The total of column 8 must equal the total of column 6 on line 29.

Column 9.--Enter on the appropriate lines the amounts of any adjustments to expenses indicated on Worksheet A-5, column 2. The amount on Worksheet A, column 9, line 29 must equal the amount on Worksheet A-5, column 2, line 21.

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

Transfer the amounts in column 10, lines 1 through 29, to the corresponding lines on Worksheet B, column 0.

Line Descriptions

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

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

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

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

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

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

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

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

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

Column 2.--If the symbol A, D, E, F, or G is entered in column 1, enter the name of the related individual in column 2. If the symbol B or C is entered in column 1, enter the name of the related organization.

Column 3.--Enter the address of the individual or organization listed in column 2.

Column 4.--If the individual in column 2 or the provider has a financial interest in the related organization, enter the percent of ownership in such organization.

Column 5.--If the individual in column 2 or the organization in column 2 has a financial interest in the provider, enter the percent of ownership in the provider.

Column 6.--Enter the type of business in which the related organization engages (e.g., medical drugs and/or supplies, laundry and linen service).

3213. WORKSHEET A-7 - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCE

Columns 1 and 6.--Enter the balance recorded in your books at the beginning of your cost reporting period (column 1) and at the end of your cost reporting period (column 6).

Columns 2 through 4.--Enter the cost of capital assets acquired by purchase in column 2. In column 3, enter the fair market value, at date acquired, for donated assets. Enter the sum of columns 2 and 3 in column 4.

Column 5.--Enter the cost or other basis of all capital assets sold, traded or transferred, retired, or disposed of in any manner during your cost reporting period.

The sum of columns 1 and 4 minus column 5 equals column 6.

3214. WORKSHEET B - COST ALLOCATION - GENERAL SERVICE COSTS AND WORKSHEET B-1 - COST ALLOCATION - STATISTICAL BASIS

Worksheet B provides for the allocation of the expenses of each general service cost center to those cost centers which receive the services. The cost centers serviced by the general service cost centers include all cost centers within the provider organization, i.e., other general service cost centers, reimbursable cost centers, nonreimbursable cost centers, and special purpose cost centers. Obtain the total direct expenses from Worksheet A, column 10. To facilitate transferring amounts from Worksheet A to Worksheet B, the same cost centers with corresponding line numbers (lines 1 through 29) are listed on both worksheets.

Worksheet B-1 provides for the proration of the statistical data needed to equitably allocate the expenses of the general service cost centers on Worksheet B.

To facilitate the allocation process, the general format of Worksheets B and B-1 are identical. The column and line numbers for each general service cost center are identical on the two worksheets. In addition, the line numbers for each general, reimbursable, nonreimbursable, and special purpose cost centers are identical on the two worksheets. The cost centers and line numbers are also consistent with Worksheets A, A-1, A-2, and A-3. If the provider has subscripted any lines on these A worksheets, the provider must subscript the same lines on the B worksheets.

NOTE: General service columns 1 through 5 and subscripts thereof must be consistent on Worksheets B and B-1; J-1, Parts I and III; CM-1, Parts I and III; RH-1, Parts I and III; FQ-1, Parts I and III; and K-5, Parts I and II.

The statistical bases shown at the top of each column on Worksheet B-1 are the recommended bases of allocation of the cost centers indicated. If a different basis of allocation is used, the provider must indicate the basis of allocation actually used at the top of the column.

Most cost centers are allocated on different statistical bases. However, for those cost centers where the basis is the same (e.g., square feet), the total statistical base over which the costs are to be allocated will differ because of the prior elimination of cost centers that have been closed.

Close the general service cost centers in accordance 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. This is further clarified in HCFA Pub. 15-I, §2306.1 which also clarifies the order of allocation for stepdown purposes. Consequently, first close those cost centers that render the most services to and receive the least services from other cost centers. The cost centers are listed in this sequence from left to right on the worksheet. However, the circumstances of an agency may be such that a more accurate result is obtained by allocating to certain cost centers in a sequence different from that followed on these worksheets.

NOTE: A change in order of allocation and/or allocation statistics is appropriate for the current fiscal year cost if received by the intermediary, in writing, within 90 days prior to the end of that fiscal year. The intermediary has 60 days to make a decision or the change is automatically accepted. The change must be shown to more accurately allocate the overhead or, if it is accurate, should be changed due to simplification of maintaining the statistics. If a change in statistics is made, the provider must maintain both sets of statistics until an approval is made. If both sets are not maintained and the request is denied, the provider will revert back to the previously approved methodology. The provider must include with the request all supporting documentation and a thorough explanation of why the alternative approach should be used. (See HCFA Pub. 15-I, §2313.)

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

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

Under the second methodology (also referred to as option 2), unique A&G cost centers may be created (see 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.--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. Lines 1 through 6 and column 11 are subscripted to isolate pre October 1, 2000 costs to facilitate the application of the lesser of aggregate costs or aggregate visit limits.

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 prior to October 1, 2000 (column 5, lines 1 through 6, excluding subscripts) from your records by the average cost per visit amount in column 4 for each discipline. Enter the product in column 8.

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

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

NOTE: The sum of Worksheets C, Part II, columns 5 and 6, lines 1.01, 2.01, 3.01, 4.01, 5.01 and 6.01, respectively, may not necessarily equal the corresponding amounts on Worksheet S-3, Part IV, column 7, lines 30, 32, 34, 36, 38 and 40, respectively due to the difference between visits contained in episodes terminating in the current fiscal year (Worksheet S-3, Part IV) and visits rendered through the fiscal year end (Worksheet C, Part II).

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

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

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

Column Descriptions for Cost Limitation Computation

Column 4.--Enter the Medicare limitation (see §1861(v)(1)(L) of the Act) for the applicable MSA for each discipline on lines 8 through 13. The 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 prior to October 1, 2000 (column 5) from your records by the Medicare cost limit amount in column 4 for each discipline. Enter the product in column 8.

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

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

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

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

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

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

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

Lines 15 and 16.--Enter in column 2 the total applicable costs for the entire cost reporting period for each line item from Worksheet B, column 6, lines 12 and 13, respectively (the costs entered on lines 15 and 15.01 must be equal; the costs entered on lines 16 and 16.01 must be equal). Enter in column 3 the total charges for the entire cost reporting period for each line (the charges entered on lines 15 and 15.01 must be equal; the charges entered on lines 16 and 16.01 must be equal). Enter in column 4 the ratio of costs (column 2) to charges (column 3) for each line.

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

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

Line 16.--Enter in column 6 the charges for pneumococcal vaccine and its administration, influenza vaccine and its administration, and hepatitis B vaccine and its administration for services rendered prior to October 1, 2000. Enter in column 7 the charge for covered osteoporosis drugs for services rendered prior to October 1, 2000. (See §1833(m)(5) of the Act.)

Line 16.01.--For reporting periods which overlap October 1, 2000, enter in column 6 the charges for pneumococcal vaccine and its administration, influenza vaccine and its administration, and hepatitis B vaccine and its administration rendered on or after October 1, 2000 through the fiscal year end. Enter in column 7 the charges for covered osteoporosis drugs rendered on or after October 1, 2000 through the fiscal year end. (See §1833(m)(5) of the Act.) For reporting periods that begin on or after October 1, 2000, eliminate line 16.01 and record all charge and resulting cost data on line 16. Osteoporosis drugs will continue to be reimbursed on a cost basis for services rendered on and after October 1, 2000.

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 (exclusive of subscripts), respectively, lines 1-6 (exclusive of subscripts).

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

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

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

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

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

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

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

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

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

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

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

NOTE: The Medicare (Title XVIII) unduplicated census count (Worksheet S-3, Part I, column 2, line 10.01 (Pre 10/1/2000 Unduplicated Census Count)) must be equal to or greater than the sum of the unduplicated census count for all MSAs (Worksheet C, Part IV, column 1, line 24).

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

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

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

Columns 5, 5.01, 5.02 and 6.--Enter in column 5 the number of Medicare covered Part B visits from your records made by non-homebound (not covered by a physician's plan of care) program

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

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

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

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

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

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

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

Worksheet D consists of the following two parts:

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

Part II - Computation of Reimbursement Settlement.

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

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

Line Descriptions

Line 1--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 (excluding subscripted lines), and Part IV, col. 4, line 19
Col. 3, Part B	Part III, sum of col. 10, lines 15 (excluding subscripted lines), 16 and 16.01, and Part V, col. 8, line 28

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

To Worksheet D, Line 1	From Worksheet C
Col. 1, Part A	Part IV, col. 3, line 22
Col. 2, Part B	Part III, sum of col. 9, line 16 (excluding subscripted lines), and Part IV, col. 4, line 22
Col. 3, Part B	Part III, sum of col. 10, lines 15 (excluding subscripted lines), 16 and 16.01, and Part V, col. 8, line 28

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

To Worksheet D, Line 1	From Worksheet C
Col. 1, Part A	Part IV, col. 3, line 24
Col. 2, Part B	Part III, sum of col. 9, line 16 (excluding subscripted lines), and Part IV, col. 4, line 24
Col. 3, Part B	Part III, sum of col. 10, lines 15 (excluding subscripted lines), 16 and 16.01, and Part V, col. 8, line 28

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

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

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

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

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 for columns 1 and 2 (excluding subscripted lines) and enter on line 8, column 3 the sum of the amounts from lines 4 and 4.01. (See 42 CFR 413.13(b).) In no instance may the customary charges on line 8 exceed the actual charges on line 4.

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

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

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

Medicare program in a secondary payer include:

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

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

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

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

3216.2 Part II - Computation of Reimbursement Settlement.--

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

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

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

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

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

Line 15.--If there is an excess of reasonable cost over customary charges, enter the Part A excess (line 10, column 1) in column 1 and the Part B excess (sum of line 10, columns 2 and 3) in column 2.

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

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

Line 19.--Enter the reimbursable bad debts, net of recoveries, in the appropriate columns.

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 (excluding subscripts), times $10, minus the interim OASIS payment made to the provider on April 1, 2000. Do not include this interim OASIS payment on Worksheet D-1, but rather attach documentation supporting the payment(s). (For intermediary use only during final settlement.)

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

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

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

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

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

Line 31.--Do not use this line.

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

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

The column headings designate two categories of payments:

Category 1 - Part A
Category 2 - Part B

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

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

Line Descriptions

Line 1.--Enter the total Medicare interim payments paid to the HHA for all covered services rendered prior to October 1, 2000. Additionally, for services rendered on or after October 1, 2000, enter the total Medicare interim payments paid to the HHA for applicable covered osteoporosis drugs. The amount entered reflects the sum of all interim payments paid on individual bills (net of adjustment bills) for services rendered in this cost reporting period and includes amounts withheld from the

HHA's interim payments due to an offset against overpayments to the HHA applicable to prior cost reporting periods. It does not include any retroactive lump sum adjustment amounts based on a subsequent revision of the interim rate, or tentative or net settlement amounts; nor does it include interim amounts; nor does it include interim payments payable. If the HHA is reimbursed under the periodic interim payment method of reimbursement, enter the periodic interim payments received for this cost reporting period. Do not include payments received for services reimbursed on a fee schedule basis.

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

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

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

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

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

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

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

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

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

3218. WORKSHEETS F, F-1, AND F-2 - FINANCIAL STATEMENTS

These worksheets are prepared from your accounting books and records. Additional worksheets may be submitted if necessary.

Complete all worksheets in the "F" series. Worksheets F and F-2 are completed by all providers maintaining fund-type accounting records. Providers not maintaining fund-type accounting records should only complete the General Fund columns of these worksheet. Cost reports received with incomplete "F" worksheets are returned to the provider for completion and the provider is considered as having failed to file a cost report.

3219. WORKSHEET A-8-3 - REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

This worksheet provides for the computation of any needed adjustments to costs applicable to physical therapy, occupational therapy, and speech pathology services furnished by outside suppliers. The information required on this worksheet provides, in the aggregate, all data for therapy services furnished by all outside suppliers in determining the reasonableness of therapy costs. (See HCFA Pub.15-I, chapter 14.)

Complete this worksheet for cost reporting periods beginning prior to October 1, 2000 for physical therapy, occupational therapy, or speech pathology services rendered prior to October 1, 2000. Do not complete this worksheet for cost reporting periods beginning on or after October 1, 2000.

NOTE: If you furnish physical therapy services under arrangement with outside suppliers, complete a separate worksheet A-8-3 for physical therapy services rendered before April 10, 1998 and a separate worksheet A-8-3 for physical therapy services rendered on or after April 10, 1998. In additional to physical therapy services, if you furnish either occupational therapy and/or speech pathology services on or after April 10, 1998, under arrangement with outside suppliers, complete a separate worksheet for each discipline. For physical therapy, occupational therapy, and speech pathology services that overlap April 10, 1998, prorate, based on total charges, any statistics and costs for purposes of calculating standards, allowances, or the actual reasonable cost determination, e.g., overtime hours. (See 42 CFR § 413.106.)

Complete this worksheet once for each type of therapy service furnished by an outside supplier.

If you contract with an outside supplier for therapy services, the potential for limitation and the amount of payment you receive depends on several factors:

- An initial test to determine whether these services are categorized as intermittent part time or full time services;
- The location where the services are rendered, i.e, HHA home visit;
- For HHA services, whether detailed time and mileage records are maintained by the contractor and HHA;
- Add-ons for supervisory functions, aides, overtime, equipment, and supplies; and
- Intermediary determinations of reasonableness of rates charged by the supplier compared with the going rates in the area.

3219.1 Part I - General Information.--This part provides for furnishing certain information concerning therapy services furnished by outside suppliers.

Line 1.--For services performed at the patient's residence, count only those weeks during which services were rendered by supervisors, therapists, or assistants to patients of the HHA. (See HCFA Pub. 15-I, chapter 14.)

Line 2.--Multiply the amount on line 1 by 15 hours per week. This calculation is used to determine whether services are full time or intermittent part time.

Line 3.--Enter the number of unduplicated HHA visits made by the supervisor or therapist. Only count one visit when both the supervisor and therapist were present during the same visit.

Line 4.--Enter the number of unduplicated HHA visits made by the therapy assistant. Do not include in the count the visits when either the supervisor or therapist were present during the same visit.

Line 5.--Enter the standard travel expense rate applicable. (See HCFA Pub. 15-I, chapter 14.)

Line 6.--Enter the optional travel expense rate applicable. (See HCFA Pub. 15-I, chapter 14.) Use this rate only for home health patient services for which time records are available.

Line 7.--Enter in the appropriate columns the total number of hours worked for therapy supervisors, therapists, therapy assistants, and aides furnished by outside suppliers.

Line 8.--Enter in each column the appropriate adjusted hourly salary equivalency amount (AHSEA). This amount is the prevailing hourly salary rate plus the fringe benefit and expense factor described in HCFA Pub. 15-I, chapter 14. This amount is determined on a periodic basis for appropriate geographical areas and is published as an exhibit at the end of HCFA Pub. 15-I, chapter 14. Use the appropriate exhibit for the period of this cost report.

Enter in column 1 the supervisory AHSEA, adjusted for administrative and supervisory responsibilities. Determine this amount in accordance with the provisions of HCFA Pub. 15-I, §1412.5. Enter in columns 2, 3, and 4 (for therapists, assistants, and aides respectively) the AHSEA from either the appropriate exhibit found in HCFA Pub. 15-I, chapter 14 or from the latest publication of rates. If the going hourly rate for assistants in the area is unobtainable, use no more than 75 percent of the therapist AHSEA. The cost of services of a therapy aide or trainee is evaluated at the hourly rate, not to exceed the hourly rate paid to your employees of comparable classification and/or qualification, e.g., nurses' aides. (See HCFA Pub. 15-I, §1412.2.)

Line 9.--Enter the standard travel allowance equal to one half of the AHSEA. Enter in columns 1 and 2 one half of the amount in column 2, line 8. Enter in column 3 one half of the amount in column 3, line 8. (See HCFA Pub. 15-I, §1402.4.)

Lines 10 and 11.--Enter the number of travel hours and number of miles driven, respectively, if time records of visits are kept. (See HCFA Pub. 15-I, §§1402.5 and 1412.6.)

NOTE: There is no travel allowance for aides employed by outside suppliers.

3219.2 Part II - Salary Equivalency Computation.--This part provides for the computation of the full time or intermittent part time salary equivalency.

When you furnish therapy services from outside suppliers to Medicare patients but simply arrange for such services for non health care program patients and do not pay the other Medicare portion of such services, your books reflect only the cost of the health care program portion. Where you can gross up costs and charges in accordance with provisions of HCFA Pub. 15-I, §2314, complete Part II, lines 12 through 17 and 20 in all cases and lines 18 and 19, where appropriate. However, where you cannot gross up costs and charges, complete lines 12 through 17 and 20.

Lines 12 through 17.--To compute the total salary equivalency allowance amounts, multiply the total hours worked (line 7) by the adjusted hourly salary equivalency amount for supervisors, therapists, assistants, and aides.

Lines 18 and 19.--If the sum of hours in columns 1 through 3, line 7, is less than or equal to the product found on line 2, complete these lines. (See the exception above where you cannot gross up costs and charges, and services are provided to program patients only.)

Line 20.--If there are no entries on lines 18 and 19, enter the amount on line 17. Otherwise, enter the sum of the amounts on lines 16 and 19.

3219.3 Part III - Travel Allowance and Travel Expense Computation - HHA Services.--This part provides for the computation of the standard travel allowance, the standard travel expense, the optional travel allowance, and the optional travel expense. (See HCFA Pub. 15-I, §§1402ff, 1403.1 and 1412.6.)

Lines 21 through 24.--Complete these lines for the computation of the standard travel allowance and standard travel expense for therapy services performed in conjunction with HHA visits. Use these lines only if you do not use the optional method of computing travel. A standard travel allowance is recognized for each visit to a patient's residence. If services are furnished to more than one patient at the same location, only one standard travel allowance is permitted, regardless of the number of patients treated.

Lines 25 through 28.--Complete the optional travel allowance and optional travel expense computations for therapy services in conjunction with home health services only. Compute the optional travel allowance on lines 25 through 27. Compute the optional travel expense on line 28.

Lines 29 through 31.--Choose and complete only one of the options on lines 29 through 31. However, use lines 30 and 31 only if you maintain time records of visits. (See HCFA Pub. 15-I, §1402.5.)

3219.4 Part IV - Overtime Computation.--This part provides for the computation of an overtime allowance when an individual employee of the outside supplier performs services for you in excess of your standard work week. No overtime allowance is given to a therapist who receives an additional allowance for supervisory or administrative duties. (See HCFA Pub. 15-I, §1412.4.)

Line 32.--Enter in the appropriate columns the total overtime hours worked. Where the total hours in column 4 are either zero or equal to or greater than 2080, the overtime computation is not applicable. Make no further entries on lines 33 through 40. Enter zero in each column of line 41. Enter the sum of the hours recorded in columns 1 through 3 in column 4.

Line 33.--Enter in the appropriate column the overtime rate (the AHSEA from line 8, column as appropriate, multiplied by 1.5).

Line 35.--Enter the percentage of overtime hours by class of employee. Determine this amount by dividing each column on line 32 by the total overtime hours in column 4, line 32.

Line 36.--Use this line to allocate your standard work year for one full time employee. Enter the numbers of hours in your standard work year for one full time employee in column 4. Multiply the standard work year in column 4 by the percentage on line 35 and enter the result in the corresponding columns.

Line 37.--Enter in columns 1 through 3 the AHSEA from Part I, line 10, columns 2 through 4, as appropriate.

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. For other than CMHCs if all services are paid under established fee schedules for CORF, OPT, OOT, and OSP providers these worksheets no longer need to be completed for cost reporting periods ending on or after June 30, 2001.

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 all CORF services. Drugs, biologicals (and the applicable Part B deductible and coinsurance for both) and supplies rendered on or after July 1, 2000, are also reimbursed based on the fee schedule. Vaccines are reimbursed under the outpatient prospective payment system (OPPS). Medicare (Title XVIII) charges for services based on the fee schedule or OPPS must **not** be included 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 render 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.

3225. WORKSHEET CM-1 - ALLOCATION OF GENERAL SERVICE COSTS TO CMHC COST CENTERS

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

3225.1 Part I - Allocation of General Service Costs to CMHC Cost Centers.--Worksheet CM-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 12) from Worksheet A, column 10, line 26. Obtain the cost center allocation (column 0, lines 1 through 11) from your records. The amounts on line 12, columns 0 through 5, must agree with the corresponding amounts on Worksheet B, columns 0 through 5, line 26. Complete the amounts entered on lines 1 through 11, columns 1 through 8, in accordance with the instructions contained in §3225.3.

NOTE: There is no revenue code specifically entitled "Diagnostic Services." Therefore, use revenue code 918 (testing) when billing for these services.

3225.2 Part II - Computation of Unit Cost Multiplier for Allocation of CMHC Administrative and General Costs.--Use this part to compute the unit cost multiplier used to allocate CMHC administrative and general costs to the revenue producing CMHC cost centers.

Line 1.--Enter the amount from Part I, column 6, line 12.

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 Part I, column 6, lines 2 through 11, by the unit cost multiplier and enter the result on the corresponding line of column 7.

3225.3 Part III - Allocation of General Service Costs to CMHC Cost Centers - Statistical Basis.--Worksheet CM-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 CM-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 CM-1, Parts I and III, is identical.

The statistical basis shown at the top of each column on Worksheet CM-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 11.--On Worksheet CM-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 12.--Enter the total of lines 1 through 11 for each column. The total in each column must be the same as shown for the corresponding column on Worksheet B-1, line 26.

Line 13.--Enter the total expenses for the cost center allocated. Obtain this amount from Worksheet B, line 26, from the same column used to enter the statistical base on Worksheet CM-1, Part III (e.g., in the case of capital-related cost buildings and fixtures, this amount is on Worksheet B, column 1, line 26).

Line 14.--Enter the unit cost multiplier which is obtained by dividing the cost entered on line 13 by the total statistic entered in the same column on line 12. 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 CM-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 12, Part I) must equal the total cost on line 13, 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 11, 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 12, enter the total of the amounts on lines 2 through 11. The total on line 12 equals the amount in column 6, line 1.

In column 8, Part I, enter on lines 2 through 11 the sum of the amounts in columns 6 and 7. The total on line 12 equals the total in column 6, line 12.

3226. WORKSHEET CM-2 - COMPUTATION OF CMHC COSTS

Use this worksheet only if you operate an HHA-based CMHC. If you have more than one provider-based CMHC, complete a separate worksheet for each facility. Partial hospitalization services provided by CMHCs are reimbursed based on a Prospective Payment System (PPS).

All CMHC services rendered on or after August 1, 2000 are reimbursed based on a PPS subject to a transitional corridor payment. Vaccines furnished CMHCs are reimbursed based on outpatient PPS.

3226.1 Part I - Apportionment of CMHC Cost Centers.--

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

Column 2.--Enter the 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 3.01.-- For each cost center, enter the corresponding charges from your records for total Title XVIII CMHC services rendered during the entire cost reporting period.

Column 3.02.--For each cost center, enter the total Title XVIII CMHC costs by multiplying the charges in column 3.1 by the ratio in column 3.

Column 4.--For each cost center, enter the corresponding charges from your records for Title XVIII CMHC services rendered on or after August 1, 2000.

Column 5.--For each cost center, enter the costs on or after 8/1/2000 by multiplying the charges in column 4 by the ratio in column 3.

Column 6.-- For each cost center, enter the costs associated with services rendered prior to August 1, 2000 by subtracting the amount in column 5 from the amount in column 3.2.

Line 12.--Enter the totals for columns 1, 2, 3.01, 3.02, 4, 5 and 6.

3226.2 Part II - Apportionment of Cost of CMHC Services Furnished by 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 CMHC.

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 only when CHMC services are furnished by shared HHA departments.

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 3.01.-- For each cost center, enter the corresponding charges from your records for total Title XVIII CMHC services rendered during the entire cost reporting period.

Column 3.02.--For each cost center, enter the total Title XVIII CMHC costs by multiplying the charges in column 3.01 by the ratio in column 3.

Column 4.--For each cost center, enter the charges from your records for Title XVIII CMHC services rendered on or after August 1, 2000.

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

Column 6.-- For each cost center, enter the costs associated with services rendered prior to August 1, 2000 by subtracting the amount in column 5 from the amount in column 3.02.

Line 16.--Enter the sum lines 13 through 15 for columns 1, 2, 3.01, 3.02, 4, 5 and 6.

3226.3 Part III - Total CMHC Costs.--

Columns 3.01, 3.02 and 4-6.--Enter the sum total of Part I, line 12 plus Part II, line 16 for each column, respectively.

Column 6.--Enter the total costs from Part I, column 6, line 12 plus Part II, column 6, line 16. Transfer this amount to Worksheet CM-3, line 1, column 1.

3227. WORKSHEET CM-3 - CALCULATION OF REIMBURSEMENT SETTLEMENT - CMHC SERVICES

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

NOTE: Column 1 is subscripted for lines 1 through 18 for cost reporting periods which overlap August 1, 2000. Column 1 must also be subscripted for all cost reporting periods which overlap

December 31, 2001, 2002 and 2003 to accommodate the transitional corridor payment calculation associated with the portion of the cost reporting period which overlaps any of the aforementioned dates. Enter in column 1 any data applicable to CMHC services rendered prior to August 1, 2000. Enter in column 1.01 data applicable to CMHC services rendered on or after August 1, 2000.

3227.1 Part I - Computation of Lesser of Reasonable Cost or Customary Charges.--

Line 1.--Enter in column 1 the cost of CMHC services rendered prior to August 1, 2000 from Worksheet CM-2, Part III, column 6, line 17. Enter in column 1.01 the cost of CMHC services rendered on or after August 1, 2000 from Worksheet CM-2, Part III, column 5, line 17.

Lines 1.01 through 1.05 are to be completed by CMHCs for Title XVIII services rendered on or after August 1, 2000.

Line 1.01.--Enter the PPS payments received including outliers.

Line 1.02.--Enter the 1996 CMHC specific payment to cost ratio provided by your intermediary.

Line 1.03.--Line 1, column 1.01 times line 1.02.

Line 1.04.--Line 1.01 divided by line 1.03.

Line 1.05.-- Enter the transitional corridor payment amount calculated based on the following:

For services rendered August 1, 2000 through December 31, 2001:
a. If line 1.04 is => 90% but < 100% enter 80% of line 1.03 minus line 1.01.
b. If line 1.04 is => 80% but < 90% enter the result of .71 times line 1.03 minus .70 times line 1.01.
c. If line 1.04 is => 70% but < 80% enter the result of .63 times line 1.03 minus .60 times line 1.01.
d. If line 1.04 is < 70% enter 21% of line 1.03.

For services rendered January 1, 2002 through December 31, 2002:
a. If line 1.04 is => 90% but < 100% enter 70% of line 1.03 minus line 1.01.
b. If line 1.04 is => 80% but < 90% enter the result of .61 times line 1.03 minus .60 times line 1.01.
c. If line 1.04 is < 80% enter 13% of result line 1.03.

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

Line 2.--Enter in column 1 the total CMHC charges incurred prior to August 1, 2000 by subtracting the amount on Worksheet CM-2, column 4, line 17 from the amount on Worksheet CM-2, column 3.01, line 17.

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

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

Line 7.--If line 6 is greater than line 1, column 1, enter the excess of customary charges over reasonable cost.

Line 8.--If line 1, column 1 is greater than line 6, enter the excess of reasonable cost over customary charges.

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

3227.2 Part II - Computation of Reimbursement Settlement.--

Line 10.--Enter in column 1 the cost of CMHC services from Part I, line 1, column 1 minus line 9, column 1. Enter in column 1.01 the cost of CMHC services from Part I, line 1.01, column 1.01 plus line 1.05, column 1.01 minus line 9, column 1.01.

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

Line 12.--Enter excess reasonable cost from line 8.

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

Line 14.--Enter 80% of line 13 in column 1.

Line 15.--Enter in column 1 the actual coinsurance billed program patients from your records. Enter in column 1.01 the gross coinsurance amount billed to Medicare beneficiaries.

Line 17.--Enter reimbursable bad debts, net of recoveries, for CMHC services. The amount entered in column 1.01 must not exceed the discounted coinsurance applicable to Medicare beneficiaries.

Line 18.--Enter in column 1 the result of line 17 plus the lesser of lines 14 or 16. Enter in column 1.01 the result of line 17 plus the lesser of lines 13 or 16.

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.

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

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

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

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

Line Descriptions

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

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

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

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

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

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

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

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

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

3239. WORKSHEET S-5 - HOSPICE IDENTIFICATION DATA

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

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

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

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

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

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

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

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

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

Column Descriptions

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

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

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

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

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

3239.2 Part II - Census Data.--

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Column 7.--Enter any reclassifications among cost center expenses in column 6 which are needed to effect proper cost allocation. This column need not be completed by all providers, but is completed only to the extent reclassifications are needed and appropriate in the particular circumstances. Show reductions to expenses as negative amounts.

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

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

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

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

Line Descriptions

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

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

Line 3 - Plant Operation and Maintenance.--This cost center contains the direct expenses incurred in the operation and maintenance of the plant and equipment, maintaining general cleanliness and sanitation of the plant, and protecting employees, visitors, and agency property.

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

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

Line 5 - Volunteer Service Coordination.--Enter all of the cost associated with the coordination of service volunteers. This includes recruitment and training costs.

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

Line 7 - Inpatient - General Care.--This cost center includes costs applicable to patients who receive this level of care because their condition is such that they can no longer be maintained at home. Generally, they require pain control or management of acute and severe clinical problems which

cannot be managed in other settings. The costs incurred on this line are those direct costs of furnishing routine and ancillary services associated with inpatient general care for which other provisions are not made on this worksheet.

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

If a hospice does not maintain its own inpatient beds:

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

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

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

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

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

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

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

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

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

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

Line 14 - Medical Social Services.--This cost center includes only direct expenses incurred in providing medical social services. Medical social services consist of counseling and assessment activities which contribute meaningfully to the treatment of a patient's condition. These services must be provided by a qualified social worker under the direction of a physician.

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

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

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

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

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

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

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

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

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

Line 22 - Patient Transportation.--Enter all of the cost of transportation except those costs previously directly assigned in column 3. This cost is allocated during the cost finding process.

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

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

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

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

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

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

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

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

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

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

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

Definitions

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

Administrator (Column 1).--

Possible Titles: President, Chief Executive Officer

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

Director (Column 2).--

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

Duties: The medical director is responsible for helping to establish and assure that the quality of medical care is appraised and maintained. This individual advises the chief executive officer on medical and administrative problems and investigates and studies new developments in medical practices and techniques.

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

Social Worker (Column 3).--The medical social worker is an individual who has at least a bachelor's degree from a school accredited or approved by the council of social work education. These services must be under the direction of a physician and must be provided by a qualified social worker.

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

When a supervisor performs two or more functions, e.g., supervision of nurses and home health aides, the salaries and wages must be split in proportion with the percent of the supervisor's time spent in each cost center, provided the hospice maintains the proper records (continuous time records) to support the split. If continuous time records are not maintained by the hospice, enter the entire salary of the supervisor on line 6 (A&G) and allocate to all cost centers through stepdown. However, if the supervisor's salary is all lumped in one cost center, e.g., nursing care, and the supervisor's title coincides with this cost center, e.g., nursing supervisor, no adjustment is required.

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

Physical therapy	-	line 11
Occupational therapy	-	line 12
Speech/language pathology	-	line 13

Therapy and speech/language pathology may be provided for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skill.

Physical therapy is the provision of corrective treatment of bodily or mental conditions by the use of physical, chemical, and other properties of heat, light, water, electricity, sound, massage, and therapeutic exercise by or under the direction of a registered physical therapist as prescribed by a physician.

Occupational therapy is the application of purposeful, goal-oriented activity in the evaluation, diagnosis, and/or treatment of persons whose ability to work is impaired by physical illness or injury, emotional disorder, congenital or developmental disability, or the aging process, in order to achieve optimum functioning, to prevent disability, and to maintain health.

Speech/language pathology provides services to persons with impaired functional communications skills by or under the direction of a qualified speech-language pathologist as prescribed by a physician. This includes the evaluation and management of any existing disorders of the communication process centering entirely, or in part, on the reception and production of speech and language related to organic and/or nonorganic factors.

Aides (Column 7).--Included in this classification are specially trained personnel employed for providing personal care services to patients. These employees are subject to Federal wage and hour laws. This function is performed by specially trained personnel who assist individuals in carrying out physician instructions and established plans of care. The reason for the home health aide services must be to provide hands-on, personal care services under the supervision of a registered professional nurse.

Aides may provide personal care services and household services to maintain a safe and sanitary environment in areas of the home used by the patient, such as changing the bed or light cleaning and laundering essential to the comfort and cleanliness of the patient. Additional services include, but are not limited to, assisting the patient with activities of daily living.

All Other (Column 8).--Employees in this classification are those not included in columns 1-7, e.g., dietary, spiritual, and other counseling services provided while the individual is enrolled in the hospice. Counseling Services must be available to both the terminally ill individual and the family members or other persons caring for the individual at home. Counseling, including dietary counseling, may be provided both for the purpose of training the individual's family or other care giver to provide care, and for the purpose of helping the individual and those caring for him or her to adjust to the individual's approaching death.

Total (Column 9).--Add the amounts of each cost center, columns 1 through 8, and enter the total in column 9. Transfer these totals to Worksheet K, column 1, lines as applicable. To facilitate transferring amounts from Worksheet K-1 to Worksheet K, the same cost centers with corresponding line numbers are listed on both worksheets. Not all of the cost centers are applicable to all agencies. Therefore, use only those cost centers applicable to your hospice.

3242. WORKSHEET K-2 - COMPENSATION ANALYSIS - EMPLOYEE BENEFITS (PAYROLL RELATED)

Enter all payroll-related employee benefits for the hospice on this worksheet. See HCFA Pub. 15-I, Chapter 20, for a definition of fringe benefits. Use the same basis as that used for reporting salaries and wages on Worksheet K-1. Therefore, using the same example as given for Worksheet K-1, enter 75 percent of the administrator's payroll-related fringe benefits on line 6 (A&G) and enter 25 percent of the administrator's payroll-related fringe benefits on line 10 (nursing care). Payroll-related employee benefits must be reported in the cost center in which the applicable employee's compensation is reported. Complete a separate worksheet K-2 for each HHA-based hospice.

This assignment can be performed on an actual basis or the following basis:

- o FICA - actual expense by cost center;

- o Health insurance (nonunion) and pension and retirement (gross salaries of participating individuals by cost center);

- Union health and welfare (gross salaries of participating union members by cost center); and;

- All other payroll-related benefits (gross salaries by cost center). Include non payroll-related employee benefits in the A&G cost center, e.g., cost for personal education, recreation activities, and day care.

Add the amounts of each cost center, columns 1 through 8, and enter the total in column 9. Transfer these totals to Worksheet K, column 2, corresponding lines. To facilitate transferring amounts from Worksheet K-2 to Worksheet K, the same cost centers with corresponding line numbers are listed on both worksheets.

3243. WORKSHEET K-3 - COMPENSATION ANALYSIS - CONTRACTED SERVICES/ PURCHASED SERVICES

The hospice may contract with another entity to provide non-core hospice services. However, nursing care, medical social services and counseling are core hospice services and must routinely be provided directly by hospice employees. Supplemental services may be contracted in order to meet unusual staffing needs that cannot be anticipated and that occur so infrequently it would not be practical to hire additional staff to fill these needs. You may also contract to obtain physician specialty services. If contracting is used for any services, maintain professional, financial, and administrative responsibility for the services and assure that all staff meet the regulatory qualification requirements. Complete a separate worksheet K-3 for each HHA-based hospice.

Enter on this worksheet all contracted and/or purchased services for the hospice. Enter the contracted/purchased cost on the appropriate cost center line within the column heading which best describes the type of services purchased. Costs associated with contracting for general inpatient or respite care are recorded on this worksheet. For example, where physical therapy services are purchased, enter the contract cost of the therapist in column 6, line 11. If a contracted/purchased service covers more than one cost center, then the amount applicable to each cost center is included on each affected cost center line. Add the amounts of each cost center, columns 1 through 8, and enter the total in column 9. Transfer these totals to Worksheet K, column 4, corresponding lines. To facilitate transferring amounts from Worksheet K-3 to Worksheet K, the same cost centers with corresponding line numbers are listed on both worksheets.

3244. WORKSHEET K-4, PART I - COST ALLOCATION – HOSPICE GENERAL SERVICE COSTS AND WORKSHEET K-4, PART II – HOSPICE COST ALLOCATION - STATISTICAL BASIS

Worksheet K-4 provides for the allocation of the expenses of each hospice general service cost center to those hospice cost centers which receive the services. The cost centers serviced by the general service cost centers include all cost centers within the provider organization, i.e., other general service cost centers, reimbursable cost centers, and nonreimbursable cost centers. Obtain the total direct expenses from Worksheet K, column 10. To facilitate transferring amounts from Worksheet K to Worksheet K-4, part I, the same cost centers with corresponding line numbers (lines 3 through 34) are listed on both worksheets. Complete a separate worksheet K-4, part 1 and 2 for each HHA-based hospice.

Worksheet K-4, part II, provides for the proration of the statistical data needed to equitably allocate the expenses of the general service cost centers on Worksheet K-4, part I.

To facilitate the allocation process, the general format of Worksheets K-4, part I & II are identical. The column and line numbers for each general service cost center are identical on the two worksheets. In addition, the line numbers for each general, reimbursable, nonreimbursable, and special purpose cost centers are identical on the two worksheets. The cost centers and line numbers are also consistent with Worksheets K, K-1, K-2, and K-3.

NOTE: General service columns 1 through 5 and subscripts thereof must be consistent on Worksheets K-4, parts I & II.

The statistical bases shown at the top of each column on Worksheet K-4, Part II are the recommended bases of allocation of the cost centers indicated. If a different basis of allocation is used, the provider must indicate the basis of allocation actually used at the top of the column.

Most cost centers are allocated on different statistical bases. However, for those cost centers where the basis is the same (e.g., square feet), the total statistical base over which the costs are to be allocated will differ because of the prior elimination of cost centers that have been closed.

Close the general service cost centers in accordance 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. This is clarified in HCFA Pub. 15-I, §2306.1 which further clarifies the order of allocation for stepdown purposes. Consequently, first close those cost centers that render the most services to and receive the least services from other cost centers. The cost centers are listed in this sequence from left to right on the worksheet. However, the circumstances of an agency may be such that a more accurate result is obtained by allocating to certain cost centers in a sequence different from that followed on these worksheets.

NOTE: A change in order of allocation and/or allocation statistics is appropriate for the current fiscal year cost if received by the intermediary, in writing, within 90 days prior to the end of that fiscal year. The intermediary has 60 days to make a decision or the change is automatically accepted. The change must be shown to more accurately allocate the overhead or, if the allocation is accurate, to simplify maintaining the statistics. If a change in statistics is made, the provider must maintain both sets of statistics until approved. If both sets are not maintained and the request is denied, the provider reverts back to the previously approved methodology. The provider must include with the request all supporting documentation and a thorough explanation of why the alternative approach should be used. (See HCFA Pub. 15-I, §2313.)

If the amount of any cost center on Worksheet K, column 10, has a credit balance, show this amount as a credit balance on Worksheet K-4, part I, column 0. Allocate the costs from the applicable overhead cost centers in the normal manner to the cost center showing a credit balance. After receiving costs from the applicable overhead cost centers, if a general service cost center has a credit balance at the point it is allocated, do not allocate the general service cost center. Rather, enter the credit balance on the first line of the column and on line 34. This enables column 7, line 34, to crossfoot to columns 0 and 5A, line 34. After receiving costs from the applicable overhead cost centers, if a revenue producing cost center has a credit balance on Worksheet K-4, part I, column 7, do not carry forward a credit balance to any worksheet.

On Worksheet K-4, part II, enter on the first line in the column of the cost center the total statistics applicable to the cost center being allocated (e.g., in column 1, capital-related cost - buildings and fixtures, enter on line 1 the total square feet of the building on which depreciation was taken). Use accumulated cost for allocating administrative and general expenses.

Such statistical base does not include any statistics related to services furnished under arrangements except where both Medicare and non-Medicare costs of arranged-for services are recorded in your records.

For all cost centers (below the cost center being allocated) to which the service rendered is being allocated, enter that portion of the total statistical base applicable to each.

The total sum of the statistical base applied to each cost center receiving the services rendered must equal the total statistics entered on the first line.

Enter on Worksheet K-4, part II line 34, the total expenses of the cost center to be allocated. Obtain this amount from Worksheet K-4, part I from the same column and line number of the same column. In the case of capital-related costs - buildings and fixtures, this amount is on Worksheet K-4, part I, column 1, line 1.

Divide the amount entered on line 34 by the total statistical base entered in the same column on the first line. Enter the resulting unit cost multiplier on line 35. Round the unit cost multiplier to at least the nearest six decimal places.

Multiply the unit cost multiplier by that portion of the total statistical base applicable to each cost center receiving the services rendered. Enter the result of each computation on Worksheet K-4, part I in the corresponding column and line.

After the unit cost multiplier has been applied to all the cost centers receiving costs, the total expenses (line 34) of all of the cost centers receiving the allocation on Worksheet K-4, part I, must equal the amount entered on the first line of the cost center being allocated.

The preceding procedures must be performed for each general service cost center. Each cost center must be completed on both Worksheets K-4, part I & II before proceeding to the next cost center.

After all the costs of the general service cost centers have been allocated on Worksheet K-4, part I, enter in column 7 the sum of the expenses on lines 7 through 33. The total expenses entered in column 7, line 34, must equal the total expenses entered in column 0, line 34.

Column Descriptions

Column 1.--Depreciation on buildings and fixtures and expenses pertaining to buildings and fixtures such as insurance, interest, rent, and real estate taxes are combined in this cost center to facilitate cost allocation.

Allocate all expenses to the cost centers on the basis of square feet of area occupied. The square footage may be weighted if the person who occupies a certain area of space spends their time in more than one function. For example, if a person spends 10 percent of time in one function, 20 percent in another function, and 70 percent in still another function, the square footage may be weighted according to the percentages of 10 percent, 20 percent, and 70 percent to the applicable functions.

Column 2.--Allocate all expenses (e.g., interest or personal property tax) for movable equipment to the appropriate cost centers on the basis of square feet of area occupied or dollar value.

Column 4.--The cost of vehicles owned or rented by the agency and all other transportation costs which were not directly assigned to another cost center on Worksheet K, column 3, is included in this cost center. Allocate this expense to the cost centers to which it applies on the basis of miles applicable to each cost center.

This basis of allocation is not mandatory and a provider may use weighted trips rather than actual miles as a basis of allocation for transportation costs which are not directly assigned. However, a hospice must request the use of the alternative method in accordance with HCFA Pub. 15-I, §2313. The hospice must maintain adequate records to substantiate the use of this allocation.

Column 6.--The A&G expenses are allocated on the basis of accumulated costs after reclassifications and adjustments.

Therefore, obtain the amounts to be entered on Worksheet K-4, part II, column 6, from Worksheet K-4, part I, columns 0 through 5.

A negative cost center balance in the statistics for allocating A&G expenses causes an improper distribution of this overhead cost center. Negative balances are excluded from the allocation statistics when A&G expenses are allocated on the basis of accumulated cost.

A&G costs applicable to contracted services may be excluded from the total cost (Worksheet K-4, part I, column 0) for purposes of determining the basis of allocation (Worksheet K-4, part II, column 5) of the A&G costs. This procedure may be followed when the hospice contracts for services to be performed for the hospice and the contract identifies the A&G costs applicable to the purchased services.

The contracted A&G costs must be added back to the applicable cost center after allocation of the hospice A&G cost before the reimbursable costs are transferred to Worksheet K-5, part I. A separate worksheet must be included to display the breakout of the contracted A&G Costs from the applicable cost centers before allocation and the adding back of these costs after allocation. Intermediary approval does not have to be secured in order to use the above described method of cost finding for A&G.

Worksheet K-4, Part II, Column 6A.--Enter the costs attributable to the difference between the total accumulated cost reported on Worksheet K-4, part I, column 5A, line 34 and the accumulated cost reported on Worksheet K-4, part II, column 6, line 6. Enter any amounts reported on Worksheet K-4, part I, column 5A for (1) any service provided under arrangements to program patients that is not grossed up and (2) negative balances. Including these costs in the statistics for allocating administrative and general expenses causes an improper distribution of overhead.

In addition, report on line 6 the administrative and general costs reported on Worksheet K-4, Part I, column 6, line 6 since these costs are not included on Worksheet K-4, Part II, column 6 as an accumulated cost statistic.

Worksheet K-4, Part II, Column 6.--The administrative and general expenses are allocated on the basis of accumulated costs. Therefore, the amount entered on Worksheet K-4, part II, column 6, line 6, is the difference between the amounts entered on Worksheet K-4, part I, column 5A and Worksheet K-4, part II, column 6A. A negative cost center balance in the statistics for allocating administrative and general expenses causes an improper distribution of this overhead cost center. Exclude negative balances from the allocation statistics.

3245. WORKSHEET K-5 - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

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

3245.1 Part I - Allocation of General Service Costs to Hospice Cost Centers.--Worksheet K-5, part I, provides for the allocation of the expenses of each general service cost center of the HHA to those hospice cost centers which receive the services. Worksheet K-5, parts I and II, provide for the proration of the statistical data needed to equitably allocate the expenses of the general service cost centers on Worksheet K-5, part I.

Obtain the total direct expenses (column 0, line 29) from Worksheet A, column 10, line 25. Obtain the cost center allocation (column 0, lines 1 through 28) from Worksheet K-4, part I, lines as indicated. The amounts on line 29, column 0 through column 5 must agree with the corresponding amounts on Worksheet B, part I, column 0 through column 5, line 25. Complete the amounts entered on lines 1 through 28, columns 1 through 4 and column 5.

Line 30.--Enter the unit cost multiplier (column 6, line 1, divided by the sum of column 6, line 29 minus column 6, line 1, rounded to 6 decimal places). Multiply each amount in column 6, lines 2 through 28, by the unit cost multiplier, and enter the result on the corresponding line of column 7.

3245.2 Part II - Allocation of General Service Costs to Hospice Cost Centers -Statistical Basis.--To facilitate the allocation process, the general format of Worksheet K-5, Parts I and II, are identical.

The statistical basis shown at the top of each column on Worksheet K-5, Part II, 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.)

Except for non-PPS providers, unless there is a change in ownership, the hospital must continue the same cost finding methods (including its cost finding bases) in effect in the hospital's last cost reporting period ending on or before October 1, 1991. (See 42 CFR 412.302(d).) If there is a change in ownership, the new owners may request that the intermediary approve a change in order to be consistent with their established cost finding practices. (See HCFA Pub. 15-I, §2313.)

Lines 1 through 28.--On Worksheet K-5, Part II, 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 29.--Enter the total of lines 1 through 28 for each column. The total in each column must be the same as shown for the corresponding column on Worksheet B-1, line 25.

Line 30.--Enter the total expenses for the cost center allocated. Obtain this amount from Worksheet B, line 25 from the same column used to enter the statistical base on Worksheet K-5, Part II (e.g., in the case of capital-related cost buildings and fixtures, this amount is on Worksheet B, column 1, line 25).

Line 31.--Enter the unit cost multiplier, which is obtained by dividing the cost entered on line 30 by the total statistic entered in the same column on line 29. 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 K-5, 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 29, Part I) must equal the total cost on line 30, Part II.

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 28, multiply the amount in column 6 by the unit cost multiplier on line 30, Part I, and enter the result in this column. On line 29, enter the total of the amounts on lines 2 through 28. The total on line 29 equals the amount in column 6, line 1.

In column 8, Part I, enter on lines 2 through 28 the sum of columns 6 and 7. The total on line 29 equals the total in column 6, line 29.

3245.3 Part III- Computation of Total Hospice Shared Costs.--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 hospice. This worksheet provides for the shared therapy, drugs, or medical supplies from the HHA to the hospice.

Column Description

Column 2.--Where HHA departments provides services to the hospice, enter in column 2 the cost for each discipline from Worksheet B, col. 6, lines as indicated.

Column 3.--Where HHA departments provide services to the hospice, enter on the appropriate lines the total HHA charges, from the provider's records, applicable to the HHA-based hospice.

Column 4.--Where applicable, determine the cost to charge ratio by dividing column 2 by column 3. Enter the results in column 4.

Column 5.-- Where HHA departments provides services to the hospice, enter on the appropriate lines the total hospice charges, from the provider's records, applicable to the HHA-based hospice.

Column 6.--Multiply the ratio in column 4 by the amount in column 5. Enter the result in column 6.

Line 7.--Enter the sum of column 6, lines 1 through 6.

3246. WORKSHEET K-6 - CALCULATION OF PER DIEM COST

Worksheet K-6 calculates the average cost per days in providing care for a hospice patient. It is only an average and should not be misconstrued as the absolute. If you have more than one HHA-based Hospice, complete a separate worksheet for each facility.

Line 1.--Total cost from Worksheet K-5, Part I, column 8, line 29 less column 8, line 28, plus Worksheet K-5, Part III, column 6, line 7. This line reflects the true cost without any non-hospice related costs.

Line 2.--Total unduplicated days from Worksheet S-5, line 5, col. 4.

Line 3.--Average cost per day. Divide the total cost from line 1 by the total number of days from line 2.

Line 4.--Unduplicated Medicare days from Worksheet S-5, line 5, column 1.

Line 5.--Aggregate Medicare cost. Multiply the average cost from line 3 by the number of unduplicated Medicare days on line 4 to arrive at the aggregate Medicare cost.

Line 6.--**NOT APPLICABLE**.

Line 7.--**NOT APPLICABLE**.

Line 8.--Unduplicated SNF days from Worksheet S-5, line 5, column 2.

Line 9.--Aggregate SNF cost. Multiply the average cost from line 3 by the number of unduplicated SNF days on line 8 to arrive at the aggregate SNF cost.

Line 10.--**NOT APPLICABLE**.

Line 11.--**NOT APPLICABLE**.

Line 12.--Other Unduplicated days from Worksheet S-5, line 5, column 3.

Line 13.--Aggregate cost for other days. Multiply the average cost from line 3 by the number of Unduplicated Other days on line 12 to arrive at the aggregate cost for other days.

EXHIBIT 1 - Form HCFA-1728-94

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

Worksheets	Page(s)
Wkst. S, Parts I & II	32-303
Wkst. S-2	32-304
Wkst. S-3, Parts I-III	32-305
Wkst. S-3, Part IV	32-305.1
Wkst. S-4	32-305.2
Wkst. S-5	32-306
Wkst. S-6 Parts I & II	32-307
Wkst. A	32-308
Wkst. A-1	32-309
Wkst. A-2	32-310
Wkst. A-3	32-311
Wkst. A-4	32-312
Wkst. A-5	32-313
Wkst. A-6	32-314
Wkst. A-7	32-315
Wkst. A-8-3, Parts I-III	32-316
Wkst. A-8-3, Parts IV & V	32-317
Wkst. B	32-318
Wkst. B-1	32-319
Wkst. C, Parts I & II	32-320
Wkst. C, Parts III, IV & V	32-321
Wkst. D	32-322
Wkst. D-1	32-323
Wkst. F	32-324
Wkst. F-1	32-325
Wkst. F-2	32-326
Wkst. J-1, Parts I & II	32-327
Wkst. J-1, Part III	32-328
Wkst. J-2	32-329
Wkst. J-3	32-330
Wkst. J-4	32-331
Wkst. K	32-331.1
Wkst. K-1	32-331.2
Wkst. K-2	32-331.3
Wkst. K-3	32-331.4
Wkst. K-4, Part I	32-331.5
Wkst. K-4, Part II	32-331.6
Wkst. K-5, Part I	32-331.7
Wkst. K-5, Part II	32-331.8
Wkst. K-5, Part III	32-331.9
Wkst. K-6	32-331.10
Wkst. CM-1, Parts I & II	32-332
Wkst. CM-1, Part III	32-333
Wkst. CM-2	32-334
Wkst. CM-3	32-335
Wkst. CM-4	32-336
Wkst. RH-1, Parts I & II	32-337
Wkst. RH-1, Part III	32-338

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
12345678901234567890123456789012345678901234567890123456789012345678901234567890
1         1    14710019993342000305 8A99P00120000312000305
```

Record #1: This is a cost report file submitted by Provider 147100 for the period from November 1, 1999 (1999305) through October 31, 2000 (2000305). It is filed on Form 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 January 31, 2000 (2000031). The electronic cost report specification dated October 31, 2000 (2000305) is used to prepare this file.

FILE NAMING CONVENTION

Name each cost report file in the following manner:

HHNNNNNN.YYL, where

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

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

RECORD NAME: Type 1 Records - Record Number 1

		Size	Usage	Loc.	Remarks
1.	Record Type	1	X	1	Constant "1"
2.	NPI	10	9	2-11	Numeric only
3.	Spaces	1	X	12	
4.	Record Number	1	X	13	Constant "1"
5.	Spaces	3	X	14-16	
6.	HHA Provider Number	6	9	17-22	Field must have 6 numeric characters.
7.	Fiscal Year Beginning Date	7	9	23-29	YYYYDDD - Julian date; first day covered by this cost report
8.	Fiscal Year Ending Date	7	9	30-36	YYYYDDD - Julian date; last day covered by this cost report
9.	MCR Version	1	9	37	Constant "8" (for Form 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 2000305 (10/31/2000). Prior approval(s) 97090, 1998273, 1999304 and 2000121.

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

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

		Size	Usage	Loc.	Remarks
1.	Record Type	1	9	1	Constant "1"
2.	Spaces	10	X	2-11	
3.	Record Number	2	9	12-13	#2-99 - Reserved for future use.
4.	Spaces	7	X	14-20	Spaces (optional)
5.	ID Information	40	X	21-60	Left justified to position 21.

RECORD NAME: Type 2 Records for Labels

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

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

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

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

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

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

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

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

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

Type 2 records for Worksheet B-1, columns 1-5, for lines 1-6 are listed below. The numbers running vertical to line 1 descriptions are the general service cost center line designations.

	LINE 1	2	3	4	5	6
1	CAP REL	BLDGS &	FIXTURES	SQUARE	FEET	1
2	CAP REL	MOVABLE	EQUIPMENT	DOLLAR	VALUE	2
3	PLANT	OPERATION	& MAINT	SQUARE	FEET	1
4	TRANS-	PORTATION		MILEAGE		4
5	ADMINIS-	TRATIVE &	GENERAL	ACCUM	COST	3
5.01	A&G	SHARED	COSTS	ACCUM	COST	3
5.02	A&G	REMBURS	COSTS	ACCUM	COST	3
5.03	A&G	NONREMBURS	COSTS	ACCUM	COST	3

Type 2 records for Worksheet K-4, Part II, columns 1-6, for lines 1-5 are listed below. The numbers running vertical to line 1 descriptions are the general service cost center line designations.

	LINE 1	2	3	4	5
1	CAP REL	BLDGS &	FIXTURES	SQUARE	FEET
2	CAP REL	MOVABLE	EQUIPMENT	DOLLAR	VALUE
3	PLANT	OPERATION	& MAINT	SQUARE	FEET
4	TRANS-	PORTATION		MILEAGE	
5	VOLUNTEER	SERVICES	COORDNTR	HOURS	
6	ADMINIS-	TRATIVE &	GENERAL	ACCUM	COST

Examples of type 2 records are below. Either zeros or spaces may be used in the line, subline, column, and subcolumn number fields (positions 11-20). However, spaces are preferred. (See the first two lines of the example for a comparison.)* Refer to Table 5 and 6 for additional cost center code requirements.

Examples:

Worksheet A line labels with embedded cost center codes:

```
*  2A000000      1          0100CAP REL COSTS-BLDG & FIXT
*  2A00000000001010000000101CAP REL COSTS-BLDG & FIXT--WEST WING
   2A000000      2          0200CAP REL COSTS-MVBLE EQUIP
   2A000000      8          0800OCCUPATIONAL THERAPY
   2A000000     14          1400DME
   2A000000     17          1700PRIVATE DUTY NURSING
   2A000000     24 1        2401CORF
```

? See footnote on page 32-506.

Examples of column headings for Worksheets B-1 and B and Worksheets J-1 (Part III), K-5 (Part II),CM-1 (Part III), RH-1 (Part III), and FQ-1 (Part III) (lines 1-3); statistical bases used in cost allocation on Worksheet B-1 and Worksheets J-1 (Part III), CM-1 (Part III), RH-1 (Part III), and FQ-1 (Part III) (lines 4 and 5); and statistical codes used for Worksheet B-1 (line 6) are displayed below.

2B10000*	1	1	CAP REL
2B10000*	2	1	BLDGS &
2B10000*	3	1	FIXTURES
2B10000*	4	1	SQUARE
2B10000*	5	1	FEET
2B10000*	6	1	1
2B10000*	1	1	1CAPITAL
2B10000*	2	1	1WEST
2B10000*	3	1	1WING
2B10000*	4	1	1SQUARE
2B10000*	5	1	1FEET
2B10000*	6	1	11
2K41002*	1	1	CAP REL
2K41002*	2	1	BLDGS &
2K41002*	3	1	FIXTURES
2K41002*	4	1	SQUARE
2K41002*	5	1	FEET
2K41002*	1	5	VOLUNTEER
2K41002*	2	5	SERVICES
2K41002*	3	5	COORDNTR
2K41002*	4	5	HOURS

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

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

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

Worksheets That Apply to the HHA Complex

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

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

Worksheets That Apply to the HHA Complex (Continued)

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

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

Worksheets That Apply to the HHA Complex (Continued)

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

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

FOOTNOTES:

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

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

(c) Multiple Worksheets for Reclassifications and Adjustments Before Stepdown
The fifth and sixth digits of the worksheet indicator (positions 6 and 7 of the record) are numeric from 01-99 to accommodate reports with more lines on Worksheets A-4 and A-5. For reports that do not need additional worksheets, the default is 01. For reports that do need additional worksheets, the first page is numbered 01. The number for each additional page of the worksheet is incremented by 1.

(d) Multiple Worksheets C, Part II for Cost Limitations Based on the MSA
The fifth and sixth digits of the worksheet indicator (positions 6 and 7 of the record) are numeric from 00-24 and correspond to the two digit subscript of line 29 on Worksheet S-3 (i.e., insert the identifier 02 for line 29.02) which identifies the 4 digit MSA code. If services are provided in only one MSA, the default is 00. Where an HHA provides services in multiple MSAs, one Worksheet C, Part II must be completed for each MSA.

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

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

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

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

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

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

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

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

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

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

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

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
WORKSHEET S-2 (Continued)				
If this facility contains a non-public provider that qualifies for an exemption from the lower of costs or charges, enter "Y" for each component and type of service that qualifies, otherwise enter "N":				
Home Health Agency	23	1, 2	1	X
CORF	24	2	1	X
CMHC	25	2	1	X
If the HHA componentized or fragmented its administrative and general service costs, enter "1" or "2" to indicate the method used.	26	1	1	9
List amounts of malpractice premiums and paid losses:				
Premiums:	27.01	1	9	9
Paid losses:	27.02	1	9	9
Self insurance	27.03	1	9	9
Are malpractice premiums and paid losses reported in other than the administrative and general cost center? (Y/N)	28	1	1	X
WORKSHEET S-3				
Part I:				
County	1	0	36	X
Number of HHA visits by discipline:				
Title XVIII	1-6, 8	1	9	9
Other Than Title XVIII	1-8	3	9	9
Visits by discipline	1-7	5	9	9
Total visits	8	5	9	9
Patient count by discipline:				
Title XVIII	1-6	2	9	9
Other Than Title XVIII	1-7	4	9	9
In Total	1-7	6	9	9
Home health aide hours:				
Title XVIII	9	1	9	9
Other Than Title XVIII	9	3	9	9
Total	9	5	9	9

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

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
WORKSHEET S-3 (Continued)				
Unduplicated census count:				
Title XVIII	10-10.02	2	9	9(6).99
Other Than Title XVIII	10-10.02	4	9	9(6).99
In Total	10-10.02	6	9	9(6).99
Part II:				
Number of hours in normal work week	11	0	6	9(3).99
Text as needed for blank lines	26, 27	0	36	X
Number of full-time equivalent employees				
Staff	11-27	1	6	9(3).99
Contract	11-27	2	6	9(3).99
Part III:				
Total number of MSAs where services were provided	28	1	2	9
Four digit MSA code for each MSA where services were provided	29	1	4	9
Part IV:				
Covered Home Health Visits by Discipline for each Payment Category	30, 32, 34, 36, 38, 40	1-6	9	9
Home Health Charges by Discipline for each Payment Category	31, 33, 35, 37, 39, 41	1-6	9	9
Total Visits	42	1-6	9	9
Other Charges	43	1-6	9	9
Total Charges	44	1-6	9	9
Total Number of Episodes	45	1, 3-6	9	9
Total Number of Outlier Episodes	46	2, 4-6	9	9
Total Non-Routine Medical Supply Charges for each Payment Category	47	1-6	9	9
Total Home Health Visits by Discipline for each Payment Category	30, 32, 34, 36, 38, 40	7	9	9
Total Medical Supply Charges for each Payment Category	31, 33, 35, 37, 39, 41	7	9	9

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

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
WORKSHEET S-3 (Continued)				
Total Visits	42	7	9	9
Other Charges	43	7	9	9
Total Charges	44	7	9	9
Total Number of Episodes	45	7	9	9
Total Number of Outlier Episodes	46	7	9	9
Total Medical Supply Charges	47	7	9	9
WORKSHEET A				
Direct salaries by department	3-28	1	9	-9
Total direct salaries	29	1	9	9
Employee benefits by department	3-28	2	9	-9
Total employee benefits	29	2	9	9
Transportation costs by department	1-28	3	9	-9
Total transportation costs	29	3	9	9
Contracted/purchased services by department	3-28	4	9	-9
Total contracted/purchased services	29	4	9	9
Other direct costs by department	1-28	5	9	-9
Total other direct costs	29	5	9	9

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

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
WORKSHEET A-6 (Continued)				
Part C - For each related organization:				
Type of interrelationship (A through G)	1-5	1	1	X
If type is G, specify description of relationship	1-5	0	36	X
Name of related individual or organization	1-5	2	36	X
Address of related individual or organization	1-5	3	36	X
Percent owned by provider	1-5	4	6	9(3).99
Percent ownership of provider	1-5	5	6	9(3).99
Type of business	1-5	6	15	X
WORKSHEET A-7				
Analysis of changes in capital assets balances for land, land improvements, buildings and fixtures, building improvements, fixed and movable equipment, and in total:				
Beginning balances	1-7	1	9	9
Purchases	1-7	2	9	9
Donations	1-7	3	9	9
Disposals and retirements	1-7	5	9	9
WORKSHEETS B and B-1 AND WORKSHEETS J-1, CM-1, RH-1, and FQ-1, PART III; and K-5, Part II HEADINGS				
Column heading (cost center name)	1-3 +	1-5	10	X
Statistical basis	4, 5 +	1-5	10	X

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

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

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

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

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

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

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

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
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 1/1/99 to 9/30/00	25-27	5.01	9	9
Medicare visits for services rendered on or after 10/1/00	25-27	5.02	9	9
WORKSHEET D				
Part I:				
Charges for Title XVIII - Part A and B services (Pre 10/1/2000 services)	4	1-3	9	9
Charges for Title XVIII - Part A and B services (Post 9/30/2000 services)	4.01	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
Part II:				
Total PPS Payments – Part A	12.01-12.14	1,2	9	9
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

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

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
WORKSHEET J-4 (Continued)				
Amount of each lump sum adjustment				
Program to provider	3.01-3.49	2	9	9
Provider to program	3.50-3.98	2	9	9
WORKSHEET CM-1				
Part I:				
Net expenses for cost allocation	1-12	0	9	9
Total allocation	12	1-4, 5	9	9
Part III:				
Reconciliation	1-11	5A	9	-9
Cost allocation statistics	1-11	1-4, 5	9	9
WORKSHEET CM-2				
Part I:				
CMHC charges				
In total	2-11	2	9	9
Total Title XVIII charges	2-11	3.01	9	9
Post 7/31/2000 Title XVIII charges	2-11	4	9	9
Part II:				
HHA charges for CMHC services				
In total	13-15	2	9	9
Total Title XVIII charges	13-15	3.01	9	9
Post 7/31/2000 Title XVIII charges	13-15	4	9	9

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

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
WORKSHEET CM-3				
Part I:				
CMHC PPS payments including outlier payments	1.01	1 & 1.01	9	9
CMHC specific payment to cost ratio	1.02	1 & 1.01	4	9.99
CMHC transitional corridor payment	1.05	1 & 1.01	9	9
Total charges for CMHC services	2	1	9	9
Amount collected from patients	3	1	9	9
Amount collectible from patients	4	1	9	9
Primary payment amounts	9	1 & 1.01	9	9
Part II:				
Part B deductibles billed	11	1 & 1.01	9	9
Coinsurance billed	15	1 & 1.01	9	9
Reimbursable bad debts	17	1 & 1.01	9	9
Amount applicable to prior periods resulting from depreciable asset disposal	19	1	9	9
Recovery of excess depreciation	20	1	9	9
Text as needed for blank line	21	0	36	X
Other adjustments	21	1	9	-9
Sequestration adjustment	23	1	9	9
Protested amounts	27	1	9	-9
WORKSHEET CM-4				
Total interim payments paid to provider	1	2	9	9
Interim payments payable	2	2	9	9
Date of each retroactive lump sum adjustment (MM/DD/YYYY)	3.01-3.98	1	10	X

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

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

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

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
WORKSHEET K-3				
Contracted services/purchased services	3-33	1-7	11	9
All others	3-33	8	11	9
WORKSHEET K-4, PARTS I & II COLUMN HEADINGS				
Column heading (cost center name)	1-3 +	1-5, 6	10	X
Statistical basis	4, 5 +	1-5, 6	10	X

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

WORKSHEET K-4, PARTS I & II				
Part I:				
Cost allocation	7-33	7	11	-9
Total	34	1-5 & 6	11	9
Part II:				
All cost allocation statistics	1-33	1-5*	11	9
reconciliation	6-33	6A	11	-9

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

WORKSHEET K-5 PARTS I, II and III				
Part I:				
Total cost after cost finding	2-28	8	11	9
Total cost	29	0-4 & 5	11	9
Part II:				
All cost allocation statistics	1-28	1-4, 5*	11	9
Centers - Statistical Basis Reconciliation	1-28	5A	11	-9

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

Part III:				
Total HHA charges	1-6	3	11	9
Total hospice charges	1-6	5	11	9
Total hospice shared ancillary costs	1-6	6	11	9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM HCFA-1728-94

TABLE 3A - WORKSHEETS REQUIRING NO INPUT

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

TABLE 3B - TABLES TO WORKSHEET S-2

Type of Control

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

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

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

* Additionally, lines surrounded by parentheses may not be subscripted beyond those preprinted for reporting periods which overlap October 1, 2000. This footnote is not applicable for reporting periods which begin on or after October 1, 2000.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM HCFA-1728-94

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

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

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM HCFA-1728-94

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

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

* See footnote on page 32-531.

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

Home Health Disciplines

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

STANDARD COST CENTER DESCRIPTIONS AND CODES

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

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

STANDARD COST CENTER DESCRIPTIONS AND CODES (CONTINUED)

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

NONSTANDARD COST CENTER DESCRIPTIONS AND CODES

GENERAL SERVICE COST CENTERS		
Administrative and General - Shared	0523	(01)
Administrative and General 100% Reimbursable	0521	(01)
Administrative and General 100% Nonreimbursable	0522	(01)
HHA NONREIMBURSABLE SERVICES		
Other Nonreimbursable	2300	(10)
Other Nonreimbursable - Tele-Medicine	2320	(01)

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. Dates followed by a "b" are for cost reporting periods beginning on or after the specified date. Dates followed by an "s" are for services rendered on or after the specified date unless otherwise noted. [10/31/2000]

I. Level I Edits (Minimum File Requirements)

Reject Code	Condition
1000	The first digit of every record must be either 1, 2, 3 (HCRIS #2005), or 4 (encryption code only). [3/31/1997]
1005	No record may exceed 60 characters (HCRIS #2325). [3/31/1997]
1010	All alpha characters must be in upper case (HCRIS #2020). This is exclusive of the encryption code, type 4 record, record numbers 1, 1.01, and 1.02. [3/31/1997]
1015	For micro systems, the end of record indicator must be a carriage return and line feed, in that sequence (HCRIS #2180). [3/31/1997]
1020	The home health agency provider number (record #1, positions 17-22) must be valid and numeric (HCRIS #2025). [3/31/1997]
1025	All dates (record #1, positions 23-29, 30-36, 45-51, and 52-58) must be in Julian format and legitimate (HCRIS #2040). [9/30/1998]
1030	The fiscal year beginning date (record #1, positions 23-29) must be less than or equal to the fiscal year ending date (record #1, positions 30-36) (HCRIS #2045). [9/30/1998]
1035	The vendor code (record #1, positions 38-40) must be a valid code (HCRIS #2050). [3/31/1997]

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Reject Code	Condition
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]
1080S	Total visits on Worksheet S-3, Part I, column 5, line 8 must be greater than or equal to the unduplicated census count on Worksheet S-3, Part I, sum of columns 2 and 4, line 10. [FYs ending through 9/30/2000]
1081S	Total visits on Worksheet S-3, Part I, column 5, line 8 must be greater than or equal to the unduplicated census count on Worksheet S-3, Part I, column 6, line 10. [10/1/2000s]
1000A	All amounts reported on Worksheet A, columns 1-5, line 29, must be greater than or equal to zero. [3/31/1997]

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Reject Code	Condition
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] **NOTE:** For small HHAs that elect the optional A&G allocation method (see §3214) as defined in 42 CFR 413.24(d), do not apply edits 1000B, 1005B or 1010B.
1000C	For the home health agency, total Medicare program (Title XVIII) visits reported as the sum of all Worksheets C, Part II (sum of columns 5 and 6, lines 1-6, plus Worksheet C, Part V, columns 3, 5.01 and 5, lines 25-27) must equal the sum of the visits reported on Worksheet S-3 (column 1, sum of lines 1-6). [FYs ending through 9/30/2000]
1001C	For the home health agency, total Medicare program (Title XVIII) visits reported as the sum of all Worksheets C, Part II (sum of columns 5 and 6, lines 1-6 (excluding subscripts (pre 10/1/2000 visits)), plus Worksheet C, Part V, columns 5.01 (pre 10/1/2000 visits), lines 25-27 must equal the sum of the visits reported on Worksheet S-3, column 1, sum of lines 1-6. [10/1/2000s]
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). [FYs ending through 9/30/2000]

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Reject Code	Condition
1006C	For the home health agency, the total Medicare (Title XVIII) unduplicated census count (Worksheet S-3, Part I, column 2, line 10.01) must be equal to or greater than the sum of the unduplicated census count for all MSAs (Worksheet C, Part IV, column 1, line 24). [10/1/2000s]
1010C	If Medicare visits on Worksheet S-3, column 1, lines 1-6, respectively, are greater than zero, then the corresponding cost on Worksheet B, column 6, lines 6-11 must also be greater than zero. [FYs ending through 9/30/2000]
1011C	If the sum of Medicare visits on Worksheet S-3, column 1, lines 1-6 and Worksheet S-3, Part IV, column 7, lines 30, 32, 34 ,36, 38, and 40 are greater than zero, respectively, then the corresponding cost on Worksheet B, column 6, lines 6-11 must also be greater than zero. [10/1/2000s]
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]
1000K	Worksheet K-5, Part I, sum of columns 0-5, line 29, must equal the corresponding Worksheet B, column 6, line 25 (or its appropriate subscript). [10/31/2000]
1000H	If Worksheet S-4, line 13 equals “Y”, Worksheet RF-2, column 3, lines 1, 2, and 3 must each be greater than zero and at least one line must contain a value other than the standard amount. Conversely, if Worksheet S-4, line 13 equals “N”, Worksheet RF-2, column 3, lines 1, 2, and 3 must contain the values 4,200, 2,100 and 2,100, respectively. Apply this edit to both RHC and FQHC components. [4/30/2000]
1005H	If worksheet S-4, line 16 equals “Y”, Worksheet RF-1, column 10, line 20 must be greater than zero. [4/30/2000]
1010H	The sum of Worksheet RF-1, column 10, lines 1-9,11-13, 15-19, 23-27, and 29-30 must equal the amount on Worksheet A, column 10, RHC/FQHC lines as appropriate. [4/30/2000]

NOTE: The RF Worksheet series is identified by the alpha character “H”.

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.

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

Cost Center	Line	Code
Cap Rel-Bldg & Fixt	1	0100-0119
Cap Rel-Mvble Equip	2	0200-0219
Plant Operation and Maintenance	3	0300-0319
Transportation	4	0400-0409
Skilled Nursing Care	6	0600
Physical Therapy	7	0700
Occupational Therapy	8	0800
Speech Pathology	9	0900
Medical Social Services	10	1000
Home Health Aide	11	1100
Supplies	12	1200-1209
Drugs	13	1300-1309
DME	14	1400-1409
Home Dialysis Aide Services	15	1500-1509
Respiratory Therapy	16	1600-1609
Private Duty Nursing	17	1700-1709
Clinic	18	1800-1809

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Edit	Condition		
	Cost Center	Line	Code
	Health Promotion Activities	19	1900-1909
	Day Care Program	20	2000-2009
	Home Delivered Meals Program	21	2100-2109
	Homemaker Service	22	2200-2209
	CORF	24	2400-2408
	Hospice	25	2500-2508
	CMHC	26	2600-2608
	RHC	27	2700-2708
	FQHC	28	2800-2808

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

2040 All calendar format dates must be edited for 10 character format, e.g., 01/01/1996 (MM/DD/YYYY) (HCRIS #2100). [9/30/1998]

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

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

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

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

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

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

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

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

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

2105S If Medicare home health agency unduplicated census count of patients (Worksheet S-3, Part I, column 2, line 10) is greater than zero, then the following fields on Worksheet S-3, Part I, should also be greater than zero:

a. Total home health agency visits (line 8, sum of columns 1 and 3) [3/31/1997]; and

b. Medicare home health agency visits (column 1, sum of lines 1-7). [3/31/1997]

2000A Worksheet A-4, column 1 (reclassification code) must be alpha characters. [3/31/1997]