
Medicare

Provider Reimbursement Manual

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

Department of Health &
Human Services (DHHS)
Centers for Medicare & Medicaid
Services (CMS)

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REVISED COST REPORTING FORMS AND INSTRUCTIONS--EFFECTIVE DATE: Changes effective for cost reporting periods beginning on or after October 1, 2000.

Transmittal 11 clarifies and makes corrections to the immediately preceding transmittal 10, Chapter 32, Home Health Agency Cost Reporting Form CMS-1728-94 instructions.

Worksheet D, Part I instructions are revised to reflect the transfer of osteoporosis drug costs exclusively from Worksheet C, Part III to Worksheet D, Part I for cost reporting periods beginning on or after October 1, 2000.

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

Worksheet C, Part II instructions clarify the compilation of beneficiary visits for services rendered on or after October 1, 2000, for cost reporting periods which overlap October 1, 2000.

Worksheet S-6 and the J series worksheet instructions are revised to reflect the elimination of the completion requirements for these worksheets for HHA based CORFs effective for cost reporting periods ending on or after June 30, 2001 where 100 percent of the services rendered are reimbursed on a fee schedule basis.

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

Form CMS

1728-94 Wkst.:

Summary of Changes:

C, Part II

Eliminated the subscripts for lines 1-6 and column 11.

C, Part III

Eliminated the subscripts for lines 15 and 16.

CMS-Pub. 15-2-32

K-1 and K-2 Unshaded line 19 which was shaded in transmittal 10.

K-4 Correction of column 7 label reference.

CM-3 Shaded column 1, lines 2-8, 12 and 14.

NEW/REVISED ELECTRONIC REPORTING SPECIFICATIONS--EFFECTIVE DATE: See Individual Edits.

The following is a summary of some of the more significant revisions to the electronic reporting specifications to the cost report. Table 3 revises the usage for numeric (9) to alphanumeric (X) for MSA codes on Worksheet S-3, Part III, line 29. 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.

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. **Effective for cost reporting periods beginning on or after October 1, 2000, do not complete lines 8 through 14 as all HHAs are reimbursed under PPS and no longer subject to per visit cost limitations; but continue to complete lines 1 through 7.**

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

Columns 5 and 8.--To determine the Medicare Part A cost of services, multiply the number of covered Part A visits made to beneficiaries prior to October 1, 2000 (column 5, lines 1 through 6, excluding subscripts) from your records by the average cost per visit amount in column 4 for each discipline. Enter the product in column 8.

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

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

NOTE: For cost reporting periods which overlap October 1, 2000, the sum of Worksheets C, Part II, columns 5 and 6, lines 1.01, 2.01, 3.01, 4.01, 5.01 and 6.01, respectively, **must equal** the corresponding amounts on Worksheet S-3, Part IV, column 7, lines 30, 32, 34, 36, 38 and 40, respectively. For cost reporting periods which begin on or after October 1, 2000, the sum of Worksheets C, Part II, columns 5 and 6, lines 1 through 6, respectively, **must equal** the corresponding amounts on Worksheet S-3, Part IV, column 7, lines 30, 32, 34, 36, 38 and 40.

Columns 7 and 10.--**DO NOT USE THESE COLUMNS.** See §3215.5.

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

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

Column Descriptions for Cost Limitation Computation

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

Columns 5 and 8.--To determine the Medicare limitation cost for Part A cost of services, multiply the number of covered Part A visits made to beneficiaries prior to October 1, 2000 (column 5) from your records by the Medicare cost limit amount in column 4 for each discipline. Enter the product in column 8.

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

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

Columns 7 and 10.--**DO NOT USE THESE COLUMNS.** See §3215.5.

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

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

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

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

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

Line 15.--Enter in columns 5, 6, and 7 the charges for medical supplies not paid on a fee schedule for services rendered prior to October 1, 2000. **For cost reporting periods beginning on or after October 1, 2000, continue to capture medical supply charges in columns 5, 6, and 7 for statistical**

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

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

Line 16.--Enter in column 6 the charges for pneumococcal vaccine and its administration, influenza vaccine and its administration, and hepatitis B vaccine and its administration for services rendered prior to October 1, 2000. Enter in column 7 the charge for covered osteoporosis drugs for services rendered prior to October 1, 2000. For cost reporting periods beginning on or after October 1, 2000, do not enter any amounts in column 6 as pneumococcal vaccine and its administration, influenza vaccine and its administration, and hepatitis B vaccine and its administration are covered under the PPS benefit, but continue to enter in column 7 the charge for covered osteoporosis drugs as they remain cost reimbursed. (See §1833(m)(5) of the Act.)

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.

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

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

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

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

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

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

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

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

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

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

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

3215.5 Part V - Outpatient Therapy Reduction Computation.--This section computes the reduction in the reasonable costs of outpatient physical therapy services (which includes outpatient speech language pathology) and outpatient occupational therapy provided under arrangement for beneficiaries who are not homebound and are not covered by a physician's plan of care as required by §1834(k) of the Act and enacted by §4541 of BBA 1997. The amount of the reduction is 10 percent for services rendered on or after January 1, 1998. For outpatient therapy services rendered on or after January 1, 1999, §4541 of BBA 1997 mandates a fee schedule payment basis for outpatient physical therapy, outpatient occupational therapy, and outpatient speech pathology. Therefore, any outpatient therapy services furnished on or after January 1, 1999 **must not be included** in this section due to the application of a fee schedule for these services, but the corresponding visits must be recorded in column 5.01. These outpatient therapy services are

reimbursed the lesser of the fee scheduled amount or the statutory limitation which is applied on a beneficiary specific basis through the Medicare claims system. This requires no provider input on the cost report. **Columns 7 (visits) and 10 (costs) of Worksheet C, Part II represent data subject to deductible and coinsurance which should never have been subject to per visit cost limitations. This section (Worksheet C, Part V) was introduced in transmittal 6 (November 1998) to separately compile such visit and cost data not subject to deductible and coinsurance. As such, columns 7 and 10 of Worksheet C, Part II should not be used. Instead, such data should be captured in this section.**

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

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

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

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

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

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

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

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

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

Worksheet D consists of the following two parts:

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

Part II - Computation of Reimbursement Settlement.

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

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

Line Descriptions

Line 1-- Reporting periods beginning prior to October 1, 2000, enter the cost of services from Worksheet C, Parts III, IV and V 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). For cost reporting periods beginning on or after October 1, 2000, transfer only the cost of osteoporosis drugs from Worksheet C, Part III, column 10 line 16 to column 3 of this worksheet:

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 1From Worksheet C

Col. 1, Part A

Part IV, col. 3, line 24

Col. 2, Part B

Part III, sum of col. 9, line 16 (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.

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. **Do not complete this worksheet if all services are paid under an established fee schedule for CORF providers for cost reporting periods ending on or after June 30, 2001.**

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. **If all CORF services are paid under established fee schedules, 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.

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 subscribed for lines 1 through 18 for cost reporting periods which overlap August 1, 2000. Column 1 must also be subscribed 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.

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

Line 1.--For cost reporting periods overlapping August 1, 2000, 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, and 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.

For cost reporting periods beginning on or after August 1, 2000, through December 31, 2001, enter in column 1 the cost of CMHC services rendered from Worksheet CM-2, Part III, column 5, line 17. Do not complete column 1.01. Perform this same procedure for calendar year cost reporting periods ending December 31, 2002 and 2003 (beginning on or after January 1 of the year, but ending prior to December 31 of the same year).

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 times line 1.02.

Line 1.04.--Line 1.01 divided by line 1.03. Express the results as a percentage to 2 decimal places, i.e., 94.82%.

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 \Rightarrow 90% but $<$ 100% enter 80% of line 1.03 minus line 1.01.
- b. If line 1.04 is \Rightarrow 80% but $<$ 90% enter the result of .71 times line 1.03 minus .70 times line 1.01.
- c. If line 1.04 is \Rightarrow 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 \Rightarrow 90% but $<$ 100% enter 70% of line 1.03 minus line 1.01.
- b. If line 1.04 is \Rightarrow 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 \Rightarrow 90% but $<$ 100% enter 60% of line 1.03 minus line 1.01.
- b. If line 1.04 is $<$ 90% enter 6% of line 1.03.

Do not use lines 2 through 8, 12 and 14, columns as applicable for a) any part of the cost reporting period on or after August 1, 2000 when the reporting period overlaps August 1, 2000; and b) for all cost reporting periods beginning on or after August 1, 2000 as these lines are not applicable for the previously mentioned periods and are shaded on worksheet CM-3.

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. **This line is not applicable for services rendered on or after August 1, 2000.**

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

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

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

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

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

3227.2 Part II - Computation of Reimbursement Settlement.--

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

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

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

Line 12.--Enter excess reasonable cost from line 8. **This line is not applicable for services rendered on or after August 1, 2000.**

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

Line 14.--Enter 80 percent of line 13 in column 1. **This line is not applicable for services rendered on or after August 1, 2000.**

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

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

Line 18.--For services rendered prior to August 1, 2000, enter in the appropriate column the result of line 17 plus the lesser of lines 14 or 16. For services rendered on or after August 1, 2000, enter in the appropriate column the result of line 16 plus line 17.

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.

EXHIBIT 1 - FORM CMS-1728-94

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

<u>Worksheets</u>	<u>Page(s)</u>
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

<u>Worksheets</u>	<u>Page(s)</u>
Wkst. RH-2	32-339
Wkst. FQ-1, Parts I & II	32-340
Wkst. FQ-1, Part III	32-341
Wkst. FQ-2	32-342
Wkst. RF-1	32-343
Wkst. RF-2	32-344
Wkst. RF-3	32-345
Wkst. RF-4 (Do not complete. See instructions.)	32-346
Wkst. RF-5	32-347

To download pages 32-305.1 through 32-324, click [here](#).

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

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

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

The following are requirements for all records:

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

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

1	2	3	4	5	6
12345678901	2345678901	2345678901	2345678901	2345678901	234567890
1	1	147100199933420003058A99P00120000312000305			

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

FILE NAMING CONVENTION

Name each cost report file in the following manner:

HHNNNNNN.YYL, where

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

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

RECORD NAME: Type 1 Records - Record Number 1

	<u>Size</u>	<u>Usage</u>	<u>Loc.</u>	<u>Remarks</u>
1. Record Type	1	X	1	Constant "1"
2. NPI	10	9	2-11	Numeric only
3. Spaces	1	X	12	
4. Record Number	1	X	13	Constant "1"
5. Spaces	3	X	14-16	
6. HHA Provider Number	6	9	17-22	Field must have 6 numeric characters.
7. Fiscal Year Beginning Date	7	9	23-29	YYYYDDD - Julian date; first day covered by this cost report
8. Fiscal Year Ending Date	7	9	30-36	YYYYDDD - Julian date; last day covered by this cost report
9. MCR Version	1	9	37	Constant "8" (for FORM CMS-1728-94)
10. Vendor Code	3	X	38-40	To be supplied upon approval. Refer to page 32-503.
11. Vendor Equipment	1	X	41	P = PC; M = Main Frame
12. Version Number	3	X	42-44	Version of extract software, e.g., 001=1st, 002=2nd, etc. or 101=1st, 102=2nd. The version number must be incremented by 1 with each recompile and release to client(s).
13. Creation Date	7	9	45-51	YYYYDDD - Julian date; date on which the file was created (extracted from the cost report)
14. ECR Spec. Date	7	9	52-58	YYYYDDD - Julian date; date of electronic cost report specifications used in producing each file. Valid for cost reporting periods ending on or after 2001273 (9/30/2001). Prior approval(s) 97090, 1998273, 1999304, 2000121 and 2000305.

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

<u>DESCRIPTION</u>	<u>LINE(S)</u>	<u>COLUMN(S)</u>	<u>FIELD SIZE</u>	<u>USAGE</u>
WORKSHEET S-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				
<u>Part I:</u>				
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
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ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-1728-94
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

<u>DESCRIPTION</u>	<u>LINE(S)</u>	<u>COLUMN(S)</u>	<u>FIELD SIZE</u>	<u>USAGE</u>
WORKSHEET S-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
<u>Part II:</u>				
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
<u>Part III:</u>				
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	X
<u>Part IV:</u>				
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 CMS 1728-94
 TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN
 DESIGNATIONS

<u>DESCRIPTION</u>	<u>LINE(S)</u>	<u>COLUMN(S)</u>	<u>FIELD SIZE</u>	<u>USAGE</u>
WORKSHEET 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				
<u>Part I:</u>				
Net expenses for cost allocation	1-12	0	9	9
Total allocation	12	1-4, 5	9	9
<u>Part III:</u>				
Reconciliation	1-11	5A	9	-9
Cost allocation statistics	1-11	1-4, 5	9	9
WORKSHEET CM-2				
<u>Part I:</u>				
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
<u>Part II:</u>				
HHA charges for CMHC services				
In total	13-15	2	9	9
Total Title XVIII charges	13-15	3.01	9	9
Post 7/31/2000 Title XVIII charges	13-15	4	9	9

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

<u>DESCRIPTION</u>	<u>LINE(S)</u>	<u>COLUMN(S)</u>	<u>FIELD SIZE</u>	<u>USAGE</u>
WORKSHEET CM-3				
<u>Part I:</u>				
CMHC PPS payments including outlier payments	1.01	1 & 1.01	9	9
CMHC specific payment to cost ratio	1.02	1 & 1.01	5	9.9(3)
CMHC transitional corridor payment	1.05	1 & 1.01	9	9
Total charges for CMHC services	2	1	9	9
Amount collected from patients	3	1	9	9
Amount collectible from patients	4	1	9	9
Primary payment amounts	9	1 & 1.01	9	9
<u>Part II:</u>				
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 CMS 1728-94
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

<u>DESCRIPTION</u>	<u>LINE(S)</u>	<u>COLUMN(S)</u>	<u>FIELD SIZE</u>	<u>USAGE</u>
WORKSHEET RF-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	9
All other	3-33	8	11	9
WORKSHEET K-2				
Employee benefits	3-33	1-7	11	9
All other	3-33	8	11	9

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

<u>DESCRIPTION</u>	<u>LINE(S)</u>	<u>COLUMN(S)</u>	<u>FIELD SIZE</u>	<u>USAGE</u>
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				
<u>Part I:</u>				
Cost allocation	7-33	7	11	-9
Total	34	1-5	11	9
<u>Part II:</u>				
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				
<u>Part I:</u>				
Total cost after cost finding	2-28	8	11	9
Total cost	29	0-4 & 5	11	9
<u>Part II:</u>				
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.				
<u>Part III:</u>				
Total HHA charges	1-6	3	11	9
Total hospice charges	1-6	5	11	9
Total hospice shared ancillary costs	1-6	6	11	9

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

<u>Reject Code</u>	<u>Condition</u>
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 which are pre 10/1/2000 visits (excluding subscripts)), plus Worksheet C, Part V, columns 5.01 (pre 10/1/2000 visits), lines 25-27 must equal the sum of the visits reported on Worksheet S-3, column 1, sum of lines 1-6. [FYs which overlap 10/1/2000]
1002C	For the home health agency, total Medicare program (Title XVIII) visits reported as the sum of all Worksheets C, Part II (sum of columns 5 and 6, lines 1-6, must equal the sum of the visits reported on Worksheet S-3, Part IV, column 7, sum of lines 30, 32, 34, 36, 38 and 40. [FYs beginning on or after 10/1/ 2000]

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

<u>Reject Code</u>	<u>Condition</u>
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]
1006C	For the home health agency, the total Medicare (Title XVIII) unduplicated census count (Worksheet S-3, Part I, column 2, line 10.01) must be equal to or greater than the sum of the unduplicated census count for all MSAs (Worksheet C, Part IV, column 1, line 24). [FYs which overlap 10/1/2000]
1010C	If Medicare visits on Worksheet S-3, column 1, lines 1-6, respectively, are greater than zero, then the corresponding cost on Worksheet B, column 6, lines 6-11 must also be greater than zero. [FYs ending through 9/30/2000]
1011C	If the sum of Medicare visits on Worksheet S-3, column 1, lines 1-6 and Worksheet S-3, Part IV, column 7, lines 30, 32, 34, 36, 38, and 40 are greater than zero, respectively, then the corresponding cost on Worksheet B, column 6, lines 6-11 must also be greater than zero. [10/1/2000]
1005D	If Medicare home health agency visits (Worksheet S-3, Part I, column 1, line 8) are greater than zero, then Medicare home health agency costs (Worksheet D, Part II, sum of columns 1 and 2, line 21) must be greater than zero. [9/30/1998]
1000J	Worksheet J-1, Part I, sum of columns 0-5, line 15, must equal the corresponding Worksheet B, column 6, line 24 (or its appropriate subscript). [FYs ending through 6/29/2001]
1001J	If the sum of Worksheet S-6, column 1, lines 1-7 plus column 3, lines 1-8 equals zero, then Worksheet B, column 6, line 24 (or its appropriate subscript) and Worksheet J-1, Part I, sum of columns 0-5, line 15, must also equal zero and vice versa. [6/30/2001]
1000M	Worksheet CM-1, Part I, sum of columns 0-5, line 12, must equal the corresponding Worksheet B, column 6, line 26 (or its appropriate subscript). [3/31/1997]
1000R	Worksheet RH-1, Part I, sum of columns 0-5, line 11, must equal the corresponding Worksheet B, column 6, line 27 (or its appropriate subscript). [Applicable for cost reporting periods beginning prior to 1/1/1998]
1000Q	Worksheet FQ-1, Part I, sum of columns 0-5, line 12, must equal the corresponding Worksheet B, column 6, line 28 (or its appropriate subscript). [Applicable for cost reporting periods beginning prior to 1/1/1998]
1000K	Worksheet K-5, Part I, sum of columns 0-5, line 29, must equal the corresponding Worksheet B, column 6, line 25 (or its appropriate subscript). [10/31/2000]
1000H	If Worksheet S-4, line 13 equals "Y", Worksheet RF-2, column 3, lines 1, 2, and 3 must each be greater than zero and at least one line must contain a value other than the standard amount. Conversely, if Worksheet S-4, line 13 equals "N", Worksheet RF-2, column 3, lines 1, 2, and 3 must contain the values 4,200, 2,100 and 2,100, respectively. Apply this edit to both RHC and FQHC components. [4/30/2000]
1005H	If worksheet S-4, line 16 equals "Y", Worksheet RF-1, column 10, line 20 must be greater than zero. [4/30/2000]
1010H	The sum of Worksheet RF-1, column 10, lines 1-9,11-13, 15-19, 23-27, and 29-30 must equal the amount on Worksheet A, column 10, RHC/FQHC lines as appropriate. [4/30/2000]

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

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

II. Level II Edits (Potential Rejection Errors)

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

<u>Edit</u>	<u>Condition</u>
2000	All type 3 records with numeric fields and a positive usage must have values equal to or greater than zero (supporting documentation may be required for negative amounts). [3/31/1997]
2005	Only elements set forth in Table 3, with subscripts as appropriate, are required in the file (HCRIS #2010). [3/31/1997]
2010	The cost center codes (positions 21-24) (type 2 records) must be a code from Table 5, and each cost center code must be unique. [3/31/1997]
2015	Standard cost center lines, descriptions, and codes should not be changed. (See Table 5.) This edit applies to the standard line only and not subscripts of that code. [3/31/1997]
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]

<u>Cost Center</u>	<u>Line</u>	<u>Code</u>
Cap Rel-Bldg & Fixt	1	0100-0119
Cap Rel-Mvble Equip	2	0200-0219
Plant Operation and Maintenance	3	0300-0319
Transportation	4	0400-0409
Skilled Nursing Care	6	0600
Physical Therapy	7	0700
Occupational Therapy	8	0800
Speech Pathology	9	0900
Medical Social Services	10	1000
Home Health Aide	11	1100
Supplies	12	1200-1209
Drugs	13	1300-1309
DME	14	1400-1409

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

<u>Edit</u>	<u>Condition</u>																																										
	<table border="1"> <thead> <tr> <th style="text-align: left;"><u>Cost Center</u></th> <th style="text-align: center;"><u>Line</u></th> <th style="text-align: center;"><u>Code</u></th> </tr> </thead> <tbody> <tr> <td>Home Dialysis Aide Services</td> <td style="text-align: center;">15</td> <td style="text-align: center;">1500-1509</td> </tr> <tr> <td>Respiratory Therapy</td> <td style="text-align: center;">16</td> <td style="text-align: center;">1600-1609</td> </tr> <tr> <td>Private Duty Nursing</td> <td style="text-align: center;">17</td> <td style="text-align: center;">1700-1709</td> </tr> <tr> <td>Clinic</td> <td style="text-align: center;">18</td> <td style="text-align: center;">1800-1809</td> </tr> <tr> <td>Health Promotion Activities</td> <td style="text-align: center;">19</td> <td style="text-align: center;">1900-1909</td> </tr> <tr> <td>Day Care Program</td> <td style="text-align: center;">20</td> <td style="text-align: center;">2000-2009</td> </tr> <tr> <td>Home Delivered Meals Program</td> <td style="text-align: center;">21</td> <td style="text-align: center;">2100-2109</td> </tr> <tr> <td>Homemaker Service</td> <td style="text-align: center;">22</td> <td style="text-align: center;">2200-2209</td> </tr> <tr> <td>CORF</td> <td style="text-align: center;">24</td> <td style="text-align: center;">2400-2408</td> </tr> <tr> <td>Hospice</td> <td style="text-align: center;">25</td> <td style="text-align: center;">2500-2508</td> </tr> <tr> <td>CMHC</td> <td style="text-align: center;">26</td> <td style="text-align: center;">2600-2608</td> </tr> <tr> <td>RHC</td> <td style="text-align: center;">27</td> <td style="text-align: center;">2700-2708</td> </tr> <tr> <td>FQHC</td> <td style="text-align: center;">28</td> <td style="text-align: center;">2800-2808</td> </tr> </tbody> </table>	<u>Cost Center</u>	<u>Line</u>	<u>Code</u>	Home Dialysis Aide Services	15	1500-1509	Respiratory Therapy	16	1600-1609	Private Duty Nursing	17	1700-1709	Clinic	18	1800-1809	Health Promotion Activities	19	1900-1909	Day Care Program	20	2000-2009	Home Delivered Meals Program	21	2100-2109	Homemaker Service	22	2200-2209	CORF	24	2400-2408	Hospice	25	2500-2508	CMHC	26	2600-2608	RHC	27	2700-2708	FQHC	28	2800-2808
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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 27.01 or 27.03. [9/30/1998]																																										
2100S	The following statistics from Worksheet S-3, Part I should be greater than zero: <ul style="list-style-type: none"> 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] 																																										
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ELECTRONIC REPORTING SPECIFICATIONS FOR FORM HCFA 1728-94
TABLE 6 - EDITS

<u>Edit</u>	<u>Condition</u>
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: <ul style="list-style-type: none"> a. Total home health agency visits (line 8, sum of columns 1 and 3) [3/31/1997]; and b. Medicare home health agency visits (column 1, sum of lines 1-7). [3/31/1997]
2000A	Worksheet A-4, column 1 (reclassification code) must be alpha characters. [3/31/1997]
2020A	Worksheet A-6, Part A, must contain a "Y" or "N" response. [3/31/1997]
2035A	For Worksheet A-7, the sum of columns 1-3, line 7, minus column 5, line 7, must be greater than zero. [3/31/1997] Column headings (Worksheets B-1 and B and Worksheets J-1, Part III, CM-1, Part III, RH-1, Part III, and FQ-1, Part III) are required as indicated in codes 2000B and 2005B:
2000B	a. At least one cost center description (lines 1-3), at least one statistical basis label (lines 4-5), and one statistical basis code (line 6) must be present for each general service cost center. This edit applies to all general service cost centers required and/or listed. Exclude any reconciliation columns from this edit. [3/31/1997]
2005B	b. The column numbering among these worksheets must be consistent. For example, data in capital related costs - buildings and fixtures is identified as coming from column 1 on all applicable worksheets. [3/31/1997]
2000F	Total assets on Worksheet F (line 33, sum of columns 1-4) must equal total liabilities and fund balances (line 59, sum of columns 1-4) (HCRIS #2545). [3/31/1997]
2005F	Net income or loss (Worksheet F-1, column 2, line 33) should not equal zero (HCRIS #2560). [3/31/1997]
2050F	Total patient revenue (Worksheet F-1, column 1, line 1) should be equal to or greater than Medicare Part B home health agency charges (Worksheet D, line 4, sum of columns 2 and 3). [3/31/1997]

NOTE: CMS reserves the right to require additional edits to correct deficiencies that become evident after processing the data commences and, as needed, to meet user requirements.