
Medicare

Provider Reimbursement Manual

Part 2, Provider Cost Reporting Forms and Instructions, Chapter 47, Form CMS-1728-20

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

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HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
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NEW/REVISED MATERIAL--EFFECTIVE DATE: Cost reporting periods ending on or after June 30, 2026.

This transmittal updates Chapter 47, Home Health Agency Cost Report, Form CMS-1728-20, by clarifying the existing instructions, forms, and electronic cost report (ECR) specifications. Revisions include:

Worksheet S-2, Part II

- Updated worksheet and instructions for lines 9 and 10 to include reference for the “Paid Claims Verified Current As Of” date.

Worksheet D, Part II

- Clarified instructions for line 24.

Worksheet D-1

- Clarified instructions for lines 6 and 7.
- Shaded column 1, lines 6.01 and 6.02 on worksheet. Corrected footnote.

Edits:

- New Edits: 1002S, 1265S, 1266S and 1015D
- Revised Edit: 1100S

REVISED ELECTRONIC SPECIFICATIONS EFFECTIVE DATE: Changes to the electronic reporting specifications are effective for cost reporting periods ending on or after June 30, 2026.

DISCLAIMER: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revise information only, and not the entire table of contents.

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CHAPTER 47

HOME HEALTH AGENCY COST REPORT
FORM CMS-1728-20

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4700. GENERAL

The Paperwork Reduction Act of 1995 requires that the private sector be informed why information is collected and how it will be used by the government. Under the authority of §§1815(a) and 1833(e) of the Social Security Act (the Act), a home health agency (HHA) as defined under §1861(o), participating in the Medicare program is required to submit annual information to determine costs for health care services rendered to Medicare beneficiaries. HHAs are required to follow reasonable cost principles under §1861(v)(1)(A) when completing the Medicare cost report. The regulations at 42 CFR 413.20 and 413.24 require adequate cost data and cost reports from HHAs on an annual basis. The information reported on Form CMS-1728-20, must conform to the requirements and principles set forth in the Provider Reimbursement Manual, (CMS Pub. 15-1), as well as those set forth in the Medicare Benefit Policy Manual, (CMS Pub. 100-02, chapter 7), and the Medicare Claim Processing Manual, (CMS Pub. 100-04, chapter 10). These instructions are effective for cost reporting periods beginning on or after January 1, 2020, and ending on or after December 31, 2020.

The HHA cost report must be submitted to the Medicare administrative contractor (hereafter referred to as contractor) in an electronic format in accordance with 42 CFR 413.24(f)(4). Cost reports are due on or before the last day of the fifth month following the close of the period covered by the report. For cost reports ending on a day other than the last day of the month, cost reports are due 150 days after the last day of the cost reporting period, in accordance with 42 CFR 413.24(f)(2).

Form CMS-1728-20 must be used by all freestanding HHAs. HHAs that are considered part of a hospital healthcare complex must use Form CMS-2552 and HHAs that are considered part of a skilled nursing facility (SNF) healthcare complex must use Form CMS-2540.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0022. The expiration date of this information collection instrument is [January 31, 2027]. The time required to complete this information collection is estimated to average 195 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Direct any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form to: Centers for Medicare and Medicaid Services, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documentation containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

4701. ROUNDING STANDARDS FOR FRACTIONAL COMPUTATIONS

Throughout the Medicare cost report, where computations result in the use of fractions, use the following rounding standards:

1. Round to 2 decimal places
 - a. Percentages
 - b. Averages
 - c. Full time equivalent employees
 - d. Per diems, hourly rates
2. Round to 5 decimal places
 - a. Sequestration (e.g., 2.092 percent is expressed as .02092)
3. Round to 6 decimal places
 - a. Ratios (e.g., unit cost multipliers, cost/charge ratios, days to days)

If a residual exists as a result of computing costs using a fraction, adjust the residual in the largest amount resulting from the computation. For example, in cost finding, a unit cost multiplier is applied to the statistics in determining costs. After rounding each computation, the sum of the allocation may be more or less than the total cost allocated. This residual is adjusted to the largest amount resulting from the allocation so that the sum of the allocated amounts equals the amount allocated.

4702. ACRONYMS AND ABBREVIATIONS

Throughout the Medicare cost report and instructions, a number of acronyms and abbreviations are used. Commonly used acronyms and abbreviations are listed below.

A&G	-	Administrative and General
CAP REL	-	Capital-Related
CBSA	-	Core Based Statistical Area
CCN	-	CMS Certification Number
CFR	-	Code of Federal Regulations
CMS	-	Centers for Medicare & Medicaid Services
COL	-	Column
DME	-	Durable Medical Equipment
ECR	-	Electronic Cost Report
FR	-	Federal Register
FTE	-	Full Time Equivalent
HCHC	-	Hospice Continuous Home Care
HCRIS	-	Healthcare Cost Report Information System
HFS	-	Health Financial Systems
HGIP	-	Hospice General Inpatient Care
HHA	-	Home Health Agency
HIRC	-	Hospice Inpatient Respite Care
HO/CO	-	Home Office/Chain Organization
HRHC	-	Hospice Routine Home Care
IRS	-	Internal Revenue Service
LCC	-	Lesser of Reasonable Cost or Customary Charges
LOC	-	Level of Care
LUPA	-	Low Utilization Payment Adjustment
MBI	-	Medicare Beneficiary Identifier

MFT	-	Marriage and Family Therapist
MHC	-	Mental Health Counselor
NPR	-	Notice of Program Reimbursement
NPWT	-	Negative Pressure Wound Therapy
OPPS	-	Outpatient Prospective Payment System
PEP	-	Partial Episode Payment
PHE	-	Public Health Emergency
PRF	-	Provider Relief Fund
PPS	-	Prospective Payment System
PS&R	-	Provider Statistical and Reimbursement Report (or System)
SNF	-	Skilled Nursing Facility
WKST	-	Worksheet

4703. RECOMMENDED SEQUENCE FOR COMPLETING FORM CMS-1728-20

All providers using Form CMS-1728-20 must adhere to the following sequence of completion. If worksheets are not completed because they are not applicable, do not include blank worksheets in the assembly of the cost report.

<u>Step</u>	<u>Worksheet</u>	<u>Instructions</u>
1	S-2	Read §§4705 through 4706. Complete entire worksheet.
2	S-3	Read §§4707 through 4707.5. Complete entire worksheet.
3	S-4	Read §§4708 through 4708.2. Complete entire worksheet.
4	A	Read §4709. Complete columns 1 through 6, lines 1 through 100.
5	A-6	Read §4710. Complete entire worksheet.
6	A	Read §4709. Complete columns 7 and 8, lines 1 through 100.
7	A-8-1	Read §4712. Complete entire worksheet.
8	A-8	Read §4711. Complete entire worksheet.
9	A	Read §4709. Complete columns 9 and 10, lines 1 through 100.

<u>Step</u>	<u>Worksheet</u>	<u>Instructions</u>
10	B and B-1	Read §4713. Complete all worksheets.
11	C	Read §§4714 through 4714.2. Complete entire worksheet.
12	D	Read §§4715 through 4715.2. Complete lines 1 through 35.
13	D-1	Read §4716. Complete lines 1 through 4.
14	D	Read §4715.2. Complete lines 36 through 39.
15	F	Read §4717. Complete entire worksheet.
16	F-1	Read §4718. Complete entire worksheet.
17	O-1, O-2, O-3, O-4	Read §4720. Complete all worksheets, if applicable.
18	O	Read §4719. Complete entire worksheet, if applicable.
19	O-5	Read §4721. Complete entire worksheet, if applicable.
20	O-6	Read §4722. Complete both worksheets in entirety, if applicable.
21	O-7	Read §4723. Complete entire worksheet, if applicable.
22	O-8	Read §4724. Complete entire worksheet, if applicable.
23	S	Read §§4704 through 4704.3. Complete Part III, then complete Parts I and II.

4704. WORKSHEET S - HOME HEALTH AGENCY COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

Worksheet S consists of the following three parts:

- Part I - Cost Report Status
- Part II - Certification
- Part III - Settlement Summary

4704.1 Part I - Cost Report Status.--This section is to be completed by the HHA and contractor as indicated on the worksheet.

Provider use only.--The provider completes lines 1 through 4.

Line 1.--Indicate if the cost report is electronically prepared by entering "Y" for yes or "N" for no in column 1. If yes, enter the electronic file creation date and time in columns 2 and 3, respectively. If no, line 2 must be completed.

Line 2.--HHA cost reports are required to be prepared in an electronic format. If line 1 is no, indicate this cost report is a manual submission by entering "Y" for yes. This line is only completed by HHAs filing low utilization cost reports in accordance with CMS Pub. 15-2, chapter 1, §110, or HHAs demonstrating financial hardship in accordance with CMS Pub. 15-2, chapter 1, §133. If line 1 is yes, enter "N" for no on this line.

Line 3.--If this is an amended cost report, enter the number of times the cost report has been amended.

Line 4.--Enter an "F" if this is full cost report, an "L" if this is a low Medicare utilization cost report ("L" requires prior contractor approval, see CMS Pub. 15-2, chapter 1, §110), an "N" if this is a no Medicare utilization cost report. If the HHA provided no Medicare HHA services but provided Medicare hospice services during this cost reporting period, enter an "F" in column 1, and enter an "H" in column 2.

Contractor use only.--The contractor completes lines 5 through 12.

Line 5.--Enter the Healthcare Cost Report Information System (HCRIS) cost report status code that corresponds to the filing status of the cost report: 1=As submitted; 2=Settled without audit; 3=Settled with audit; 4=Reopened; or 5=Amended.

Line 6.--Enter the date (mm/dd/yyyy) the accepted cost report was received from the HHA.

Line 7.--Enter the 5-position contractor number.

Lines 8 and 9.--If this is an initial cost report, enter "Y" for yes in the box on line 8. If this is a final cost report, enter "Y" for yes in the box on line 9; if neither, enter "N". An initial report is the very first cost report for a particular HHA CMS certification number (CCN). A final cost report is a terminating cost report for a particular HHA CCN.

Line 10.--Enter the Notice of Program Reimbursement (NPR) date (mm/dd/yyyy). The NPR date must be present if the cost report status code is 2, 3, or 4.

Line 11.--Enter the software vendor code of the cost report software used by the contractor to process this HCRIS cost report file; use "3" for HFS CompuMax or "4" for HFS MCRIF32.

Line 12.--Complete this line only if the cost report status code on line 5 is "4". If this is a reopened cost report (response to line 5 cost report status, is "4"), enter the number of times the cost report has been reopened.

4704.2 Part II - Certification.--This certification is read, prepared, and signed by a Chief Financial Officer or administrator of the HHA after the cost report has been completed in its entirety.

LINE DESCRIPTIONS

Line 1.--The signatory (administrator or Chief Financial Officer) must:

- sign in column 1 as provided in 42 CFR 413.24(f)(4)(iv)(C)(1); and enter Y in column 2 to check the electronic signature checkbox to transmit the HHA cost report electronically with an electronic signature; or
- sign in column 1 as provided in 42 CFR 413.24(f)(4)(iv)(C)(1); and enter Y in column 2 to check the electronic signature checkbox to submit the HHA cost report with an electronic signature; or
- sign in column 1 as provided in 42 CFR 413.24(f)(4)(iv)(C)(2); and make no entry in column 2 to submit the HHA cost report with an original signature.

Lines 2, 3, and 4.--Enter the signatory's name, the signatory title, and the date signed, respectively.

4704.3 Part III - Settlement Summary.--Enter the balance due to or due from the Medicare program. Transfer the amount from Worksheet D, line 38, to line 1, column 1.

4705. WORKSHEET S-2, PART I - IDENTIFICATION DATA

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

Lines 1 and 2.--Enter the street address, post office box (if applicable), the city, state, and ZIP code of the HHA.

Line 3.--Enter the HHA component name, CCN, and certification date in the appropriate columns.

Line 4.--Enter the component name, CCN, and certification date for the distinct part hospice, an HHA-based and separately certified component of the HHA, that 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 5.--Enter the inclusive dates covered by this cost report. Enter in column 1, the cost report beginning date and enter in column 2, the cost report ending date.

Line 6.--Indicate the type of control under which the HHA operates by entering a number from the list below.

1 = Voluntary Nonprofit, Church	8 = Governmental, Federal
2 = Voluntary Nonprofit, Other	9 = Governmental, State
3 = Proprietary, Individual	10 = Governmental, City
4 = Proprietary, Partnership	11 = Governmental, City-County
5 = Proprietary, Corporation	12 = Governmental, County
6 = Private Non-Profit	13 = Governmental, Health District
7 = Governmental and Private Combined	

- Combined Governmental and Private.--This is an HHA administered jointly by a private organization and a governmental agency, supported by tax funds, public funds, earnings, and contributions, which provides nursing and therapeutic services.
- Governmental Agency.--This is an HHA administered by a state, county, city, or other local unit of government and having as a major responsibility prevention of disease and community education. It must offer nursing care of the sick in their homes.
- Voluntary Non-Profit.--This is an HHA governed by a community-based board of directors and is usually financed by earnings and contributions. The primary function is the care of the sick in their homes. Some voluntary agencies are operated under church auspices.
- Private Not-for-Profit.--This is a privately developed HHA governed as a non-profit organization that provides care of the sick in the home. This agency must qualify as a tax exempt organization under title 26 USC 501 of the Internal Revenue Code.
- Proprietary Organization.--This is an HHA that is owned and operated by non-governmental interests and is not a non-profit organization.

Line 7.--Did the HHA qualify as a nominal charge provider (as explained in 42 CFR 409.3)? Enter "Y" for yes or "N" for no.

Line 8.--Did the HHA contract with outside suppliers for physical therapy services? Enter "Y" for yes or "N" for no.

Line 9.--Did the HHA contract with outside suppliers for occupational therapy services? Enter "Y" for yes or "N" for no.

Line 10.--Did the HHA contract with outside suppliers for speech-language pathology services? Enter "Y" for yes or "N" for no.

Line 11.--Are there any costs included on Worksheet A that resulted from transactions with a related organization as defined in CMS Pub. 15-1, chapter 10, or home office and/or chain organization (HO/CO) as defined in CMS Pub. 15-1, chapter 21? Enter "Y" for yes or "N" for no. If yes, complete Worksheet A-8-1.

Line 12.--Is the HHA legally required to carry malpractice insurance? Enter "Y" for yes and "N" for no.

Line 13.--If line 12 is yes, is the malpractice insurance a claims-made or occurrence policy? Enter "1" for claims made or "2" for occurrence policy. A claims-made insurance policy covers claims first made (reported or filed) during the year the policy is in force for any incidents that occur that year or during any previous period during which the insured was covered under a "claims-made" contract. The occurrence policy covers an incident occurring while the policy is in force regardless of when the claim arising out of that incident is filed.

Line 14.--Enter the amount of malpractice insurance premiums paid in column 1, the total amount of paid losses in column 2, and the total amount of self-insurance in column 3.

Malpractice insurance premiums are money paid by the provider to a commercial insurer to protect the HHA against potential negligence claims made by their patients/clients. Malpractice paid losses is money paid by the HHA to compensate a patient/client for professional negligence. Malpractice self-insurance is money paid by the HHA where the HHA acts as its own insurance company (either as a sole or part-owner) to financially protect itself against professional negligence. Often HHAs will manage their own funds or purchase a policy referred to as captive insurance, which provides insurance coverage they need but could not obtain economically through the mainstream insurance market.

Line 15.--Are malpractice premiums and/or paid losses reported in a cost center other than the A&G cost center? Enter "Y" for yes or "N" for no. If yes, submit a supporting schedule listing the cost centers and amounts contained therein.

Line 16.--If this HHA was part of a HO/CO as defined in CMS Pub. 15-1, chapter 21, §2150, and received allocations of cost from the HO/CO (or from multiple HO/COs, such as from a corporate home office and one or more regional or district offices), enter "Y" for yes in column 1; otherwise, enter "N" for no. If column 1 is "Y", in column 2 enter the number of HO/COs from which the HHA received allocations of cost.

Line 17.--If line 16, column 1, is "Y" and line 16, column 2, is "1", enter the name of the HO/CO that allocated HO/CO costs to the HHA (column 1); the HO/CO CCN (column 2); the HO/CO contractor number (column 3); and the HO/CO street address, city, state, and ZIP code (columns 4, 5, 6, and 7, respectively). If line 16, column 1, is "Y" and line 16, column 2, is greater than 1 (the HHA received allocations of cost from multiple HO/COs), enter the HO/CO name (column 1); HO/CO CCN (column 2); HO/CO contractor number (column 3); and the street address, city, state, and ZIP code (columns 4, 5, 6, and 7, respectively); for each HO/CO that allocated HO/CO costs to the HHA, beginning on line 17 and subscripting as necessary.

4706. WORKSHEET S-2, PART II - REIMBURSEMENT DATA

This worksheet collects organizational, financial and statistical information previously reported on Form CMS-339. Where instructions for this worksheet direct the HHA to submit documentation/information, mail or otherwise transmit the requested documentation to the contractor with submission of the electronic cost report (ECR), the contractor has the right under §§1815(a) and 1833(e) of the Act to request any missing documentation.

For questions that require a yes or no response, enter a “Y” or “N,” respectively. When the instructions require documentation, indicate on the documentation the Worksheet S-2, Part II, line number that the documentation supports. Lines 1 through 17 are required to be completed by all HHAs reported on Worksheet S-2, Part I, line 3.

Line 1.--Did the HHA change ownership prior to the beginning of this cost reporting period? Enter “Y” or “N” in column 1. If column 1 is “Y”, enter the date the change of ownership occurred in column 2. Also, submit the name and address of the new owner and a copy of the sales agreement with the cost report.

Line 2.--Did the HHA terminate participation in the Medicare program? Entering “Y” or “N” in column 1. If column 1 is “Y”, enter the date of termination in column 2, and “V” for voluntary or “I” for involuntary in column 3.

Line 3.--Was the HHA involved in business transactions, including management contracts, with individuals or entities (e.g., HO/COs, drug or medical supply companies) that are related to the HHA or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? Enter “Y” or “N” in column 1. If column 1 is “Y,” submit a list of the individuals, the organizations involved, and a description of the transactions with the cost report.

NOTE for line 3: A related party transaction occurs when services, facilities, or supplies are furnished to the provider by organizations related to the provider through common ownership or control. (See CMS Pub. 15-1, chapter 10, and 42 CFR 413.17.)

Line 4.--Were the HHA’s financial statements prepared by a certified public accountant? Enter “Y” or “N.” If column 1 is “Y,” enter in column 2 “A” for audited, “C” for compiled, or “R” for reviewed. Submit a complete copy of the financial statements (i.e., the independent public accountant’s opinion, the statements themselves, and the footnotes) with the cost report. If the financial statements are not available for submission with the cost report, enter the date they will be available in column 3.

If column 1 is “N,” submit a copy of the internally prepared financial statements, and written statements of significant accounting policy and procedure changes affecting Medicare reimbursement that occurred during the cost reporting period. You may submit the changed accounting or administrative procedures manual in lieu of written statements.

Line 5.--Do the total expenses and total revenues reported on the cost report differ from those on the filed financial statements? Enter “Y” or “N.” If “Y,” a reconciliation must be submitted with the cost report.

Line 6.--Are you are seeking reimbursement for bad debts resulting from Medicare deductible and/or coinsurance amounts that are uncollectible from Medicare beneficiaries? (See 42 CFR 413.89(e) and CMS Pub. 15-1, chapter 3, §§306-324, for the criteria for an allowable bad debt.) Enter “Y” or “N”. If “Y,” submit a completed Exhibit 1 to support the bad debt amount claimed.

Exhibit 1, Listing of Medicare Bad Debts and Appropriate Supporting Data, displayed at the end of this section requires the following documentation:

Columns 1, 2, 3, 4, and 5 - Patient Last Name, Patient First Name, Medicare Beneficiary Identifier (MBI) Number, and Dates of Service (From - To).--The documentation required for these columns is derived from the beneficiary's bill. Furnish the patient's name, MBI number, and dates of service that correlate to the claimed bad debt. (See CMS Pub. 15-1, chapter 3, §314, and 42 CFR 413.89.)

Columns 6 and 7 - Eligible Medicaid Beneficiary or Beneficiary Deemed Indigent.--If the beneficiary included in column 1 is eligible for Medicaid, enter the Medicaid beneficiary identification number in column 6. If the beneficiary is not eligible for Medicaid but has been deemed indigent, enter "yes" in column 7. See the criteria in CMS Pub. 15-1, chapter 3, §§312 and 322, and 42 CFR 413.89 for guidance on the billing requirements for indigent and Medicaid beneficiaries.

Column 8 - Medicare Remittance Advice Dates.--Enter the Medicare remittance advice date that correlates with the beneficiary name, MBI number, and dates of service shown in columns 1, 2, 3, 4, and 5, of this exhibit.

Column 9 - Medicaid Remittance Advice Dates (if applicable).--Enter the crossover Medicaid remittance advice date that correlates with the Medicare beneficiary name, MBI number, and dates of service shown in columns 1, 2, 3, 4, and 5, of this exhibit.

Column 10 - Beneficiary Responsibility.--Enter the amount the beneficiary is liable to pay. If the beneficiary is Medicaid eligible or deemed indigent by the provider, enter the dollar amount the beneficiary is deemed responsible to pay. For beneficiaries deemed indigent the application and documentation to support the indigent determination will be required to support the bad debts. For Medicaid eligible crossover claims, if there is a state cost sharing responsibility enter the amount. If the Medicaid eligible crossover claim is for a QMB, they are exempt from any Medicare cost sharing requirement; therefore, do not enter an amount but enter "QMB."

Column 11 - Date First Bill Sent to Beneficiary.--Enter the date that the first bill was sent to the beneficiary.

Column 12 - Accounts Receivable Write-Off Date.--Enter the date the beneficiary's liability was written off of the accounts receivable in the provider's financial accounting system. This should be evidenced by corresponding journal entries, as well as entries in the beneficiary's account history. However, this may not be the date the account was recorded as a Medicare bad debt. A bad debt cannot be claimed for Medicare purposes until it has been written off in the provider's financial accounting system and all collection efforts have ceased. If an account was sent to a collection agency, complete column 13.

Column 13 - Account Sent to Collection Agency.--Enter a response of "Y" for yes or "N" for no to indicate whether an account was sent to a collection agency.

Column 14 - Date Account Returned from Collection Agency.--Enter the date the account was returned to the provider from the collection agency. This is the date that the collection agency ceased collection effort on an account that had been referred to them. A bad debt must not be written off prior to the cessation of all collection efforts, internal and external.

Column 15 - Date Collection Effort Ceased.--Enter the date all collection effort ceased, both internal and external, including Medicaid.

Column 16 - Medicare Write-Off Date.--Enter the date the deductible and coinsurance amounts were written off as a Medicare bad debt. In order to be considered "written off" for Medicare purposes, the amount must be written off as a bad debt in the provider's own accounting system, all collection effort against the patient or other third parties (internal and external) must have ceased, and a valid Medicaid RA must have been received from the State for Medicaid beneficiaries.

Column 17 - Recoveries.--Enter the amount of recoveries for amounts previously written off as an allowable Medicare bad debt (see CMS Pub. 15-1, chapter 3, §316).

Columns 18 and 19 - Deductibles and Coinsurance.--Enter the beneficiary's deductible and coinsurance amounts, reflected on the Medicare remittance advice, that relate to covered services.

Column 20 - Current Year Payments.--Enter any payments received from the beneficiary, the beneficiary's estate, third party insurance, etc. that were applied towards the beneficiary's deductible and coinsurance liability.

Column 21 - Payment Type.--If column 20 contains an amount, identify the source of the payment in this column. Enter a general description of beneficiary, estate, third party, etc.

Column 22 - Allowable Medicare Bad Debts.--Enter the bad debt amount for each claim. This amount must be less than or equal to the amounts report in columns 18 and 19, less any payments received from the beneficiary. This total amount reported in this column must agree with the bad debts claimed on Worksheet D, line 27.

Column 23 - Comments.--This column is for informational purposes. Enter any comments or additional information as needed.

Line 7.--If line 6 is "Y", did the bad debt collection policy change during the cost reporting period? Enter "Y" or "N". If "Y", submit a copy of the revised bad debt policy.

Line 8.--If line 6 is "Y", were patient coinsurance amounts waived? Enter "Y" or "N" in column 1. If column 1 is "Y", ensure the coinsurance amounts are not included on the bad debt listing (Exhibit 1) submitted with the cost report.

Line 9.--Was this cost report prepared using the Provider Statistical & Reimbursement (PS&R) Report only. Enter "Y" or "N" in column 1. If column 1 is "Y", *in column 2, from the PS&R used to prepare this cost report, enter the "Paid Claims Verified Current As Of" date, if present; otherwise, enter the paid through date.* Also, submit a crosswalk between revenue codes and charges found on the PS&R to the cost center groupings on the cost report. This crosswalk will reflect a cost center to revenue code match only.

Line 10.--Was this cost report prepared using the PS&R for totals and HHA records for allocation? Enter "Y" or "N" in column 1. If column 1 is "Y", *in column 2, from the PS&R used to prepare this cost report, enter the "Paid Claims Verified Current As Of" date, if present; otherwise, enter the paid-through date.* Also, submit a detailed crosswalk between revenue codes, departments, and charges on the PS&R to the cost center groupings on the cost report. This crosswalk must show dollars by cost center and include the revenue codes allocated to each cost center. The total revenue on the cost report must match the total charges on the PS&R (as appropriately adjusted for unpaid claims, etc.) to use this method. Supporting work papers must accompany this crosswalk to provide sufficient documentation as to the accuracy of the provider records. If the contractor does not find the documentation sufficient, the PS&R will be used in its entirety.

Line 11.--If you entered "Y" on either line 9 or 10, indicate whether adjustments were made to the PS&R data for additional claims that have been billed but not included on the PS&R used to file this cost report. Enter "Y" or "N" in column 1. If column 1 is "Y", include a schedule supporting any claims not included on the PS&R. This schedule should include totals consistent with the breakdowns on the PS&R, and should reflect claims that are unprocessed or unpaid as of the cut-off date of the PS&R used to file the cost report.

Line 12.--If you entered "Y" on either line 9 or 10, column 1, indicate whether adjustments were made to the PS&R data for corrections of other PS&R information. Enter "Y" or "N" in column 1. If column 1 is "Y", submit a detailed explanation and documentation to provide an audit trail from the PS&R to the cost report.

Line 13.--If you entered "Y" on either line 9 or 10, column 1, indicate whether other adjustments were made to the PS&R data. Enter "Y" or "N" in column 1. If column 1 is "Y", include a description of the other adjustments and documentation to provide an audit trail from the PS&R to the cost report.

Line 14.--Indicate whether the cost report was prepared using HHA records only. Enter "Y" or "N" in column 1. If column 1 is "Y", submit detailed documentation of the system used to support the data reported on the cost report. If detail documentation was previously supplied, submit only necessary updated documentation with the cost report.

The minimum requirements for detailed documentation of the system used to submit the data reported are:

- Internal records supporting program utilization statistics, charges, prevailing rates and payment information broken into each Medicare bill type in a manner consistent with the PS&R report.
- A reconciliation of remittance totals to the provider's internal records.
- The name of the system used and system maintainer (vendor or HHA). If the HHA maintained the system, include date of last software update.

NOTE for line 14: Additional information may be submitted, such as narrative documentation, internal flow charts, or outside vendor informational material, to further describe and validate the reliability of the system.

Line 15.--Enter the cost report preparer's first name, last name, and title/position, in columns 1, 2, and 3, respectively.

Line 16.--Enter the employer/company name of the cost report preparer.

Line 17.--Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.

**EXHIBIT 1
LISTING OF MEDICARE BAD DEBTS AND APPROPRIATE SUPPORTING DATA**

HHA Name: _____
 HHA CCN: _____
 FYE: _____

Prepared By: _____
 Date Prepared: _____

Patient Last Name	Patient First Name	MBI No.	Dates of Service		Eligible Medicaid Beneficiary Medicaid #	Beneficiary Deemed Indigent (Not Medicaid Eligible) Yes or No	Medicare Remittance Advice Dates	Medicaid Remittance Advice Dates (If Applicable)	Beneficiary Responsibility \$ (Enter QMB if Medicaid QMB Beneficiary)	Date First Bill Sent to Beneficiary	Internal Accounts Receivable (A/R Write-Off Date)	Account Sent to Collection Agency
			From	To								
1	2	3	4	5	6	7	8	9	10	11	12	13

Date Account Returned from Collection Agency (If Applicable)	Date Collection Efforts Ceased (Internal and External, Including Medicaid RA)	Medicare "Write-Off Date"	Recoveries Only	Medicare Deductible*	Medicare Coinsurance*	Current Year Payments (Prior to Account Write-Off)	Payment Type (Patient, Third Party Insurance, etc.)	Allowable Bad Debts (As Reported on Cost Report)	Comments
14	15	16	17	18	19	20	21	22	23

*These amounts must not be claimed unless the HHA or HHA-based entity bills for these services with the intention of payment. See instructions for columns 6 and 7 - Medicaid or Indigent Beneficiary, for possible exception.

4707. WORKSHEET S-3 - STATISTICAL DATA

Worksheet S-3 consists of the following five parts:

- Part I - Visits Data
- Part II - Employment Data (Full Time Equivalent)
- Part III - Core Based Statistical Area (CBSA) Data
- Part IV - PPS Activity Data
- Part V - Direct Care Expenditures

In accordance with 42 CFR 413.20 and 42 CFR 413.24, you are required to maintain statistical records for proper determination of costs payable under titles XVIII and XIX. The statistics required on Part I of this worksheet pertain to an HHA. The data to be maintained, depending on the services provided by the HHA, includes the number of program visits, total number of HHA visits, number of program home health aide hours, total HHA home health aide hours, program patient census count, total patient census count, program patient unduplicated census count, and total patient unduplicated census count. Part II of this worksheet collects required FTE data by employee staff, contracted staff, and total staff. Part III of this worksheet identifies the total number of CBSAs where Medicare services were provided.

HHA Visits.--A visit is an episode of personal contact with the patient by staff of the HHA, or others under arrangements with the HHA, for the purpose of providing a covered home health service as described in 42 CFR 409.45(b) through (g). Medicare type visits generally fall under the definition of Medicare visits as described in 42 CFR 409.48. In counting Medicare type visits, it is critical that non-Medicare visits are of the same type as those that would be covered by Medicare. This ensures that costs of services are comparable across insurers and that costs are apportioned appropriately between Medicare and non-Medicare. A visit is initiated with the delivery of covered home health services and ends at the conclusion of delivery of covered home health services. In those circumstances in which all reasonable and necessary home health services cannot be provided in the course of a single visit, HHA staff or others providing services under arrangements with the HHA may remain at the patient's home between visits (e.g., to provide non-covered services). However, if all covered services could be provided in the course of one visit, only one visit may be covered. (See 42 CFR 409.48(c)(4)).

Patient Census.--Each patient is counted once for each type of service. For example, if a patient receives multiple Medicare covered skilled nursing visits from a registered nurse and multiple Medicare covered medical social service visits, he or she is counted only once in column 2 for the corresponding service. Another example is if a patient receives both covered services and non-covered services, he or she is counted once as title XVIII (for covered services), once as other (for non-covered services), and only once as total.

Unduplicated Census Count.--Each patient is counted only once, no matter how many HHA services they receive during the cost reporting period. A patient who receives HHA services throughout the year should be counted and reported no more than one time. The unduplicated census count answers the question: How many patients did the HHA serve during this cost reporting period?

On lines 1 through 10, report the number of visits and corresponding patient census count. The patient census count in columns 2, 4, 6, and 8, includes each individual who received each type of service. Include each individual patient only once for each type of service. For example, a patient who received multiple Medicare covered skilled nursing visits from a registered nurse and multiple Medicare covered medical social service visits is counted only once in column 2 for the corresponding service. The total of lines 1 through 9 for columns 2 and 4, and the total of lines 1 through 10, for columns 6 and 8, may not equal line 13, unduplicated census count, since many patients receive more than one type of service. Beneficiaries who experience multiple spells of illnesses (multiple visits, multiple episodes, and/or multiple discharges and admissions) within a cost reporting period must be counted only once in the unduplicated census count.

4707.1 Part I - Visits Data.--

Columns 1 and 2.--Enter data pertaining to title XVIII-Medicare patients only. Enter in column 1 all Medicare visits rendered during the entire cost reporting period. See CMS Pub. 100-02, chapter 7, §70.2, for visit count determination. For each line, enter in column 2 the patient census count applicable to the Medicare visits reported in column 1.

Columns 3 and 4.--Enter data pertaining to title XIX-Medicaid patients only. Enter in column 3 all Medicaid visits rendered during the entire cost reporting period. For each line, enter in column 4 the patient census count applicable to the Medicaid visits reported in column 3.

Columns 5 and 6.--Enter data pertaining to Medicare Managed Care, Medicaid Managed Care, and all other patients. Do not include data reported in columns 1 through 4. Enter in column 5 all visits from patients not covered by Medicare (reported in column 1) or Medicaid (reported in column 3). For each line, enter in column 6 the patient census count applicable to all other patient visits reported in column 5.

Columns 7 and 8.--Enter total HHA visits and patient census count. Enter in column 7, all visits rendered for all patients during the cost reporting period for each discipline. For each line, enter in column 8, the patient census count for all patients during the cost reporting period. The sum of columns 1, 3, and 5, must equal column 7. The sum of columns 2, 4, and 6, may not equal column 8. For example if a patient receives both Medicare covered services (columns 1 and 2) and Medicare non-covered services (columns 5 and 6), count the patient once in column 2 (for covered services), once in column 6 (for non-covered services), and once in column 8, total.

Lines 1 through 9.--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 10.--This line may not be used for columns 1 through 4. Enter in columns 5 and 7 the total of all other visits provided by the HHA. Enter in columns 6 and 8 the patient census count applicable to the other visits furnished by the HHA.

Line 11.--Enter the sum of lines 1 through 9 for each of columns 1 and 3. Enter the sum of lines 1 through 10 for each of columns 5 and 7.

Line 12.--Enter the number of hours applicable to home health aide services.

Line 13.--Enter the unduplicated count of all patients receiving home visits or other care provided by employees of the HHA or under contractual arrangement in the appropriate column for the entire cost reporting period. 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 patient census counts. For purposes of calculating the unduplicated census count, if a beneficiary has received health care by more than one HHA, you must prorate the unduplicated census count based on the ratio of visits provided by this HHA to the total visits furnished to the beneficiary by all HHAs so as to not exceed a total of one (1). For example, if an HHA furnishes 100 visits to an individual beneficiary in Maryland during the cost reporting period and the same individual received a total of 400 visits (the other 300 visits were furnished in Florida 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. An HHA must 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.

4707.2 Part II - Employment Data (Full Time Equivalent).--

Line 14.--Enter the number of hours in a normal work week (i.e., 40 hours per week or 35 hours per week).

Lines 15 through 33.--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 15 through 32. Enter any additional categories needed on line 33 and its subscripts.

Report in column 1 the full time equivalent (FTE) employees on the HHA's payroll. These are staff for which an Internal Revenue Service (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: For each category listed on lines 15 through 33, add all hours that employees were paid 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. For each category listed on lines 15 through 33, add all hours that 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.

4707.3 Part III - Core Based Statistical Area (CBSA) Data.--

Line 34.--Enter the total number of CBSAs where Medicare covered services were provided during this cost reporting period. Each five-character CBSA code identifies the geographic area where Medicare covered services are furnished. Obtain these codes from your contractor.

Line 35.--List all CBSA codes where Medicare covered home health services were provided during the cost reporting period. Line 35 contains the first code. Enter one CBSA code on each line. If additional lines are needed, subscript line 35 beginning with lines 35.01, 35.02, etc., as necessary, entering one CBSA code on each subscripted line. Obtain these codes from your contractor.

4707.4 Part IV - PPS Activity Data.--

The statistics required on this worksheet pertain to home health services reimbursed under the HHA PPS in accordance with §1895 of the Act. Depending on the services provided by the HHA the data to be maintained for each episode/period of care payment category for each covered discipline include aggregate program visits, corresponding aggregate program charges, total visits, total charges, total episodes/period and total outlier episodes/periods, and total non-routine medical supply charges.

All data captured in Part IV of this worksheet is associated with episodes/periods of care that end during the current cost reporting period for payment purposes. Similarly, when an episode/period of care begins in one cost reporting period and ends in the subsequent cost reporting period, all data required in Part IV of this worksheet associated with that episode/period will appear in the cost reporting period on the PS&R in which the episode/period of care ended.

HHA Visits. See the second paragraph of §4707 for the definition of an HHA visit.

Episode/Period of Care. Home health services under a plan of care are paid based on a 60-day episode of care (beginning on or before December 31, 2019) or a 30-day period of care (beginning on or after January 1, 2020) as required by section 1895(b)(2)(B) of the Act, as amended by section 51001(a)(1) of the Bipartisan Budget Act (BBA) of 2018.

Episode of Care: Effective prior to January 1, 2020, under home health PPS, the 60-day episode is the basic unit of payment where the episode payment is specific to one individual beneficiary. The duration of a full-length episode will be 60 days. An episode begins with the start of care date on or prior to December 31, 2019, and must end by the 60th day from the start of care date. Beneficiaries are covered for an unlimited number of non-overlapping episodes provided that the start of care date is prior to January 1, 2020. **Note:** The latest a full 60-day episode that spans the crossover date effectuating the change to period of care on January 1, 2020, will end on February 28, 2020.

Period of Care: Effective beginning on or after January 1, 2020, under home health PPS, the 30-day period of care is the basic unit of payment where the period payment is specific to one individual beneficiary. A period begins with the start of care date on or after January 1, 2020 and must end by the 30th day from the start of care. Beneficiaries are covered for an unlimited number of non-overlapping periods.

Less than a full Episode/Period of Care.

For episodes of care beginning before January 1, 2020, if an HHA provides four or fewer visits in a 60-day episode, the result is a low utilization payment adjustment (LUPA). In this instance the HHA will be reimbursed based on a standardized per visit payment.

Additionally, 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.

For periods of care beginning on or after January 1, 2020, if an HHA provides fewer than the threshold of visits specified for the period's home health resources group, they will be paid a standardized per visit payment called a LUPA.

Additionally, a period may end before the 30th 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.

On lines 1 through 12, report the number of visits and the corresponding visit charges for each discipline for each episode/period payment category. Lines 13 and 15 identify the total number of visits and the total corresponding charges, respectively, for each episode/period payment category. Line 16 identifies the total number of episodes/periods completed for each episode/period payment category. Line 17 identifies the total number of outlier episodes/periods completed for each episode/period payment category. Outlier episodes/periods do not apply to: 1) Full Episodes/Periods without Outliers, and 2) LUPA Episodes/Periods. Line 18 identifies the total non-routine medical supply charges incurred for each episode/period payment category. The statistics and data required on this worksheet are obtained from the PS&R report.

Columns 1 through 4.--Enter in the appropriate columns 1 through 4, lines 1 through 12, the number of aggregate program visits furnished in each episode/period of care payment category for each covered discipline and the corresponding aggregate program visit charges imposed for each covered discipline for each episode/period of care payment category. The visit counts and corresponding charge data are mutually exclusive for all episode/period of care payment categories.

Line 13.--Enter in columns 1 through 4 for each episode/period of care payment category, respectively, the sum total of visit from lines 1, 3, 5, 7, 9, and 11.

Line 14.--Enter in columns 1 through 4 for each episode/period of care payment category, respectively, the sum total of other charges for all other unspecified services reimbursed under PPS.

Line 15.--Enter in columns 1 through 4 for each episode/period of care payment category, respectively, the sum total of charges for services from lines 2, 4, 6, 8, 10, 12, and 14.

NOTE for lines 16 and 17: The standard episodes/periods entered on line 16 and outlier episodes/periods entered on line 17 are mutually exclusive.

Line 16.--Enter in columns 1, 3, and 4, for each episode/period of care payment category identified, respectively, the total number of standard episodes/periods of care rendered and concluded in the HHA's fiscal year.

Line 17.--Enter in columns 2 and 4 for each episode/period of care payment category identified, respectively, the total number of outlier episodes/periods of care rendered and concluded in the HHA's fiscal year. Outlier episodes/periods do not apply to columns 1 and 3 (Full Episodes/Periods without Outliers and LUPA Episodes/Periods, respectively).

Line 18.--Enter in columns 1 through 4 for each episode/period of care payment category, respectively, the total non-routine medical supply charges for services rendered and concluded in the provider's fiscal year.

Column 5.--Enter on lines 1 through 18, respectively, the sum total of amounts from columns 1 through 4.

4707.5 Part V - Direct Care Expenditures.--This part provides for the collection of HHA direct care expenditures. Report only the costs associated with Medicare and Medicare like visits in reimbursable cost centers. Complete this form for employees who are full-time and part-time, directly hired, and acquired under contract.

Column 1.--Enter the total of paid wages and salaries for the specified category of HHA employees including overtime, vacation, holiday, sick, lunch, and other paid-time-off, severance, and bonuses on lines 1 through 3, and lines 5 through 12. Enter on line 13, any HHA direct care expenditures for clinicians not identified on lines 1 through 12.

Enter the amount paid (include only those costs attributable to services rendered in the HHA), rounded to the nearest dollar, for contracted direct patient care services on lines 14 through 16, and lines 18 through 25. Enter on line 26, any HHA contracted direct care expenditures for clinicians not identified on lines 14 through 25.

Column 2.--Enter on lines 1 through 3, and lines 5 through 13, the amount of fringe benefits.

Column 3.--Enter on each line the result of column 1 plus column 2.

Column 4.--Enter on each line the number of paid hours corresponding to the amount reported in column 3.

Column 5.--Enter on each line the average hourly wage resulting from dividing column 3 by column 4.

4708. WORKSHEET S-4 - HHA-BASED HOSPICE STATISTICAL 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(f) 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 an HHA-based hospice. Complete a separate Worksheet S-4 for each HHA-based hospice.

4708.1 Part I - Enrollment Days.--

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:

Hospice Continuous Home Care (HCHC) Day.--An HCHC day is a day when the hospice patient is not in an inpatient facility, and receives continuous care during a period of crisis in order to maintain the individual at home. A day consists of a minimum of 8 hours and a maximum of 24 hours of predominantly nursing care. For each day a beneficiary received 8 or more hours of predominantly nursing care, count the day as one HCHC day. Note: Do not count days by dividing the total hours by 24.

Hospice Routine Home Care (HRHC) Day.--An HRHC day is a day when the hospice patient is at home and not receiving HRHC.

Hospice Inpatient Respite Care (HIRC) Day.--An HIRC day is a day when the hospice patient receives care in an approved inpatient facility, to provide respite for the individual's family or other persons caring for the individual at home.

Hospice General Inpatient Care (HGIP) Day.--An HGIP day is a day when the hospice patient receives care in a Medicare certified hospice facility, hospital or SNF for pain control or acute or chronic symptom management that cannot be managed in other settings.

Lines 1 through 4.--Enter the enrollment days applicable to each level of care (LOC) in columns 1 through 3. Include dually eligible (Medicare/Medicaid) beneficiaries in column 1. Enrollment days are unduplicated days of care received by a hospice patient. Report a day for each day a hospice patient received one of four levels of care -- HCHC, HRHC, HIRC, or HGIP. When a patient was transferred from one LOC to another, count the day of transfer as one day of care at the LOC billed. Report an HIRC day on line 3 only when the hospice provided or arranged to provide the inpatient respite care.

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

4708.2 Part II - Contracted Statistical Data.--

This section collects unduplicated day's data for inpatient services at a contracted facility. The days reported in Part II are a subset of the days reported in Part I.

Lines 6 and 7.--Enter the contracted inpatient service enrollment days applicable to each LOC in columns 1 through 3. Include dually eligible (Medicare/Medicaid) beneficiaries in column 1. Enrollment days are unduplicated days of care received by a hospice patient. Report a day for each day a hospice patient received HIRC or HGIP care at a contracted facility. When a patient was transferred from one LOC to another, count the day of transfer as one day of care at the LOC billed. Enter the total unduplicated days by LOC (sum of columns 1 through 3) in column 4.

4709. WORKSHEET A - RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

Worksheet A provides for recording the trial balance of expense accounts from the HHA accounting books and records. The worksheet also provides for the necessary reclassifications and adjustments to certain accounts prior to the cost finding calculations. Also include on Worksheet A all expenses incurred for only those visits completed in the current cost reporting period when the episode of care overlaps the cost report year end. Enter directly on Worksheet A the total expenses for Salaries (column 1), Employee Benefits (column 2), Transportation (column 3), Contracted/Purchased Services (column 4), and Other Costs (column 5) in the appropriate cost center.

This worksheet lists cost centers in a manner that facilitates the transfer of the cost center expenses 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 CMS Pub. 15-1, chapter 23, §2313.

Standard (i.e., preprinted) CMS 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, e.g., if two lines are added between lines 2 and 3, identify them as lines 2.01 and 2.02. 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 16 through 24, may not be subscripted beyond those which are preprinted. (See CMS Pub. 15-1, chapter 23, §2313.2c.)

Submit the working trial balance of the HHA 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 CMS-1728-20 provides for 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 CMS approved cost reporting software. These cost center descriptions are hereafter referred to as the standard cost centers. An additional cost center with general meaning has been identified in the following sections: General Service Cost Centers, HHA Reimbursable Services, HHA Nonreimbursable Services and Special Purpose Cost Centers. These additional cost centers must contain a description if used, and will hereafter be referred to as nonstandard label cost centers to provide for situations where no match in meaning to the standard cost centers can be found. Refer to Worksheet A, lines 9, 30, 50, and 58.

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 §4790, Table 5, of the electronic reporting specifications.

If the cost elements of a cost center are separately maintained on the HHA books, 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 contractor.

Column 1.--Salaries are the gross salaries paid to employees before taxes and other items are withheld. Salaries include deferred compensation, overtime, incentive pay, and bonuses. Enter salaries from the HHA accounting books and records.

Column 2.--Enter the costs of employee benefits from the HHA accounting books and records.

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.--Enter the cost of contracted purchased services.

Column 5.--Enter on the applicable lines in column 5 all HHA costs that 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 that are needed to effect proper cost allocation.

Worksheet A-6 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 provider's circumstances. Show reductions to expenses in parentheses ().

The net total of the entries in column 7 must equal zero on line 100.

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 100.

Column 9.--Enter on the appropriate lines the amounts of any adjustments to expenses. Enter on the appropriate lines the amounts of any adjustments to expenses indicated on Worksheet A-8, column 2. The amount on Worksheet A, column 9, line 100, must equal the amount on Worksheet A-8, column 2, line 50.

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 58, to the corresponding lines on Worksheet B, column 0.

Line Descriptions

General Service Cost Centers

Lines 1 and 2 - Capital Related - Buildings & Fixtures and Capital Related - Movable Equipment.--Capital related buildings and fixtures and capital related moveable equipment costs 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 - Plant Operation & Maintenance.--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 HHA property.

Line 4 - 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 5 - Telecommunication Technology.--Enter allowable administrative costs related to the use of telecommunication technology (other than audio-only telephone calls) in the provision of home health care as described in 42 CFR 409.46(e). This can include: remote patient monitoring, defined as the collection of physiologic data (for example, ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient or caregiver or both to the home health agency; teletypewriter (TTY) technology; and 2-way audio-video telecommunications technology that allows for real-time interaction between the patient and clinician. If telecommunications technologies are used by the home health agency, the costs of any equipment, set-up, and service related to the technology are allowable only as administrative costs. Visits to a beneficiary's home for the sole purpose of supplying, connecting, or training the patient on the technology, without the provision of a skilled service are not separately billable.

Line 6 - Administrative and General.--Enter all A&G costs, including services that are allowable as administrative costs as described in 42 CFR 409.46(a) through (d). A&G costs are general service costs that benefit the entire HHA that are not included on lines 1 through 5. Examples include fiscal services, legal services, accounting, data processing, taxes, and malpractice costs. If the option to componentize A&G 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 §4713 for additional information on componentized A&G costs.

Line 7 - Nursing Administration.--Enter the cost of overall management and direction of the nursing services. Do not include the cost of direct nursing services including nursing supervisor services assigned on lines 16 through 30, 39 through 50, or 57 and 58.

Line 8 - Medical Records.--Enter the direct cost of medical records including the medical record library. Costs associated with a general library and/or medical library are reported in administrative and general and must not be included in this cost center.

Line 9.--Use this line to identify expenses for other general service costs not identified on lines 1 through 8. Provide a description for the amount reported on this line. See Table 5 in §4790 for proper cost center coding for this line.

Lines 10 through 15.--Reserved for future use.

HHA Reimbursable Services

Line 16 - Skilled Nursing Care - Registered Nurse.--This cost center includes skilled nursing care which is a service that must be provided by or under the supervision of a registered nurse for the purpose of assessing a beneficiary's health needs, determining if the HHA can meet those health needs, and formulating a plan of care for the beneficiary are allowable administrative costs.

Line 17 - Skilled Nursing Care - Licensed Practical Nurse.--This cost center includes the costs of nursing care furnished by licensed practical nurses. Do not include costs for certified nursing assistant (CNA) services on this line; report the costs for CNA services on line 24.

Line 18 - Physical Therapy.--This cost center includes the costs of physical therapy services provided by a qualified physical therapist as prescribed by a physician. These services meet the individual's medical needs, promote recovery, and ensure medical safety for the purpose of rehabilitation.

Line 19 - Physical Therapy Assistant.--This cost center includes the costs of physical therapy assistant services performed under the direct supervision of a qualified physical therapist as prescribed by a physician. These services are planned, delegated, and supervised by the physical therapist. The physical therapy assistant also provides support to the physical therapist as they assist in preparing clinical notes and progress reports, and participate in educating the patient and family.

Line 20 - Occupational Therapy.--This cost center includes the costs of occupational therapy services provided by a qualified occupational therapist as prescribed by a physician. These services meet the individual's medical needs, promote recovery, and ensure medical safety for the purpose of rehabilitation.

Line 21 - Certified Occupational Therapy Assistant.--This cost center includes the costs of certified occupational therapy assistant services performed under the direct supervision of a qualified occupational therapist as prescribed by a physician. These services are planned, delegated, and supervised by the occupational therapist. The certified occupational therapy assistant also provides support to the occupational therapist as they assist in preparing clinical notes and progress reports, and participate in educating the patient and family.

Line 22 - Speech-Language Pathology.--This cost center includes the costs of 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 23 - Medical Social Services.--Enter the cost of medical social services. 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 HHA; (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 HHA care.

Line 24 - Home Health Aide.--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 therapist, speech-language pathologist, 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, indicating 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. Include the cost of CNAs that meet the criteria for an aide in this cost center.

Line 25 - Medical Supplies Charged to Patients.--The cost of medical supplies reported in this cost center are those costs that 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 not reported on this line are those minor medical and surgical supplies not 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 A&G cost center.

Line 26 - Drugs.--Enter the cost incurred for pneumococcal, influenza, hepatitis B vaccines and osteoporosis drugs. Enter the cost for the COVID-19 vaccine and monoclonal antibody products to treat COVID-19, authorized and furnished for use during the COVID-19 public health emergency (PHE). The COVID-19 vaccine and monoclonal antibody product costs and its administration will be reimbursed in the same way influenza vaccine cost and its administration is reimbursed. When COVID-19 vaccine doses are provided by the government without charge, providers may only report the cost for the vaccine administration on line 27. In addition, Medicare will not provide payment for the monoclonal antibody products to treat COVID-19 that health care providers receive for free, as will be the case upon the product's initial availability in response to the COVID-19 PHE. Do not include the cost of administering vaccines, drugs or monoclonal antibodies on this line. 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(s)(10).

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 (excluding administration of osteoporosis drugs which are covered in the PPS rate) 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.

Line 27 - Cost of Administering Vaccines.--Enter the cost of administering pneumococcal, influenza, and hepatitis B vaccines. Enter the cost incurred to administer the COVID-19 vaccine, and monoclonal antibody products to treat COVID-19, authorized for use during the COVID-19 PHE. All vaccine administration costs reported on this line are reimbursed under OPPS.

Attach a schedule detailing the methodology employed to develop the administration of these vaccines. These vaccines are reimbursable under Part B only. 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 nonreimbursable.

Line 28 - Durable Medical Equipment/Oxygen.--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 29 - Disposable Devices.--Enter the cost of disposable devices, i.e., negative pressure wound therapy (NPWT) devices.

Line 30.--Use this line and subscripts of this line to identify expenses for other reimbursable services not identified on lines 16 through 29. Provide a description for each amount reported on this line and its subscripts. See Table 5 in §4790 for proper cost center coding for this line.

Lines 31 through 38.--Reserved for future use.

HHA Nonreimbursable Services

Line 39.--Enter the cost of home dialysis aide services furnished in connection with a home dialysis program.

Line 40.--For respiratory therapy services enter the cost incurred for the assessment, diagnostic evaluation, treatment, management, and monitoring of patients with deficiencies or abnormalities of cardiopulmonary function.

Lines 41 through 49.--Identify additional nonreimbursable services commonly provided by HHAs.

Line 41 - Private Duty Nursing.--Enter the costs of private duty nurses, who may be licensed as RNs, LPNs/LVNs (Licensed Practical Nurses), or CNAs that provide private duty care work one-on-one with individual beneficiaries.

Line 42 - Clinic.--Enter the nonreimbursable clinic costs. A clinic is a facility that is primarily focused on the care of outpatients.

Line 43 - Health Promotion Activities.--Enter the costs of health promotion and disease prevention programs focus on keeping people healthy.

Line 44 - Day Care Program.--Adult day care programs provide frail seniors and persons with Alzheimer's with supervision and care in a structured setting during daytime hours allowing their primary caregivers to work or take a break from their caregiving responsibilities. Medicare does not cover adult day care programs.

Line 45 - Home Delivered Meals Program.--Home health coverage does not include home delivered meals or personal care as part of its coverage. Enter the costs of the HHA's home delivered meals program on this line.

Line 46 - Homemaker Service.--Services such as shopping, cleaning, laundry, etc. are considered homemaker services and they are not reimbursed by Medicare. Enter the costs of homemaker services on this line.

Line 47 - Telehealth.--Enter the direct costs associated with telehealth. Telecommunication technology is considered remote patient monitoring and not a telehealth service. Telehealth services are subject to limitations under §1834(m) of the Act, namely that the beneficiary must be located in a health professional shortage area (HPSA) or rural area, and that the beneficiary must be physically present at a specific site of service. Telehealth services performed by a physician/practitioner under §1834(m) of the Act are outside the scope of the Medicare home health benefit and home health PPS. Effective January 1, 2023, this line is no longer used. See instructions for line 5.

Line 48 - Advertising.--Enter the costs associated with nonallowable community education, business development, marketing and advertising. (See CMS Pub. 15-1, chapter 21, §2136.)

Line 49 - Fundraising.--Enter the costs associated with nonallowable fundraising. (See CMS Pub. 15-1, chapter 21, §2136.)

Line 50.--Use this line and subscripts of this line to identify expenses for other nonreimbursable services not identified on lines 39 through 49. Provide a description for each amount reported on this line and its subscripts. See Table 5 in §4790 for proper cost center coding for this line.

Lines 51 through 56.--Reserved for future use.

Special Purpose Cost Centers

Line 57 - Hospice.--Enter the direct costs associated with the HHA-based hospice. Do not include shared service costs on this line. Likewise, if there are general service costs unique to the hospice and not related to the HHA, report those direct costs on this line and separately identify them on Worksheet O.

Line 58.--Use this line and subscripts of this line to identify expenses for all other special purpose cost centers not identified on line 57. Provide a description for each amount reported on this line and its subscripts. See Table 5 in §4790 for the proper cost center coding for this line.

Lines 59 through 99.--Reserved for future use.

Line 100.--Enter the total of lines 1 through 58.

4710. WORKSHEET A-6 - RECLASSIFICATIONS

This worksheet provides for the reclassification of expense accounts to effect proper cost allocation under cost finding. Submit copies of any workpapers used to compute reclassification affected on this worksheet.

COMPLETE WORKSHEET A-6 ONLY TO THE EXTENT THAT EXPENSES HAVE BEEN INCLUDED IN COST CENTERS THAT DIFFER FROM THE RESULT THAT IS OBTAINED USING THE INSTRUCTIONS FOR THIS SECTION.

Examples of reclassifications that may be needed are:

A. Licenses and Taxes (Other Than Income Taxes).--This expense consists of the business license expense and tax expense incidental to the operation of the HHA. Such expenses are normally included in the A&G cost centers.

Licenses and taxes applicable to buildings and fixtures must be reclassified to the capital related - buildings and fixtures account (Worksheet A, line 1). Any licenses and taxes that cannot be identified to a specific cost center and are incidental to the general overall operation of the HHA must be included in the A&G account (Worksheet A, line 6).

B. Interest.--Interest expense related to loans for HHA working capital is includable in A&G (Worksheet A, line 6). Interest expense attributable to mortgages on buildings is includable in Capital Related - Buildings and Fixtures (Worksheet A, line 1). Interest related to loans for movable equipment is includable in Capital Related - Movable Equipment (Worksheet A, line 2).

C. Insurance.--Malpractice insurance may be reclassified to cost centers, other than A&G, only if the insurance policy specifically identifies the premium for each cost center involved.

D. Services Under Arrangements.--Where a provider purchases services (e.g., physical therapy) under arrangements for Medicare patients, but does not purchase such services under arrangements for non-Medicare patients, the providers' books reflect only the cost of the Medicare services. However, if the provider does not use the grossing up technique for purposes of allocating overhead, and if the provider incurs related direct costs applicable to all patients, Medicare and non-Medicare (e.g., paramedics or aides who assist a physical therapist in performing physical therapy services), reclassify such related costs from the HHA reimbursable service cost center and allocate them as part of administrative and general expense.

E. Leases.--This expense consists of all rental costs of buildings and equipment incidental to the operation of the HHA. Leases applicable to buildings or movable equipment must be reclassified to the capital related account. Any lease which cannot be identified to a special cost center and is incidental to the general overall operation of the HHA must be included in the A&G account (Worksheet A, line 6).

4711. WORKSHEET A-8 - ADJUSTMENTS TO EXPENSES

In accordance with 42 CFR 413.9(c)(3), if the HHA operating costs include amounts not related to patient care, these amounts are not reimbursable under the program. If operating costs include amounts flowing from the provision of luxury items or services (i.e., those items or services substantially in excess of or more expensive than those generally considered necessary for the provision of needed health services), such amounts are not allowable.

This worksheet provides for the adjustments to the expenses listed on Worksheet A, column 8. These adjustments, which are required under the Medicare principles of reimbursement, are to be made on the basis of cost or amount received (revenue) only if the costs (including direct costs and all applicable overhead) cannot be determined. If the total direct and indirect cost can be determined, enter the cost. Submit with the cost report a copy of any work papers used to compute a cost adjustment. Once an adjustment to an expense is made on the basis of cost, you may not determine the required adjustment to the expense on the basis of revenue in future cost reporting periods. Enter the following symbols in column 1 to indicate the basis for adjustment: "A" for cost, "B" for amount received. Line descriptions indicate the more common activities affecting allowable costs or result in costs incurred for reasons other than patient care and, thus, require adjustments.

Types of items entered on Worksheet A-8 are: (1) those needed to adjust expenses to reflect actual expenses incurred; (2) those items which constitute recovery of expenses through sales, charges, fees, etc.; (3) those items needed to adjust expenses in accordance with the Medicare principles of reimbursement; and (4) those items which are provided for separately in the cost apportionment process. If an adjustment to an expense affects more than one cost center, record the adjustment to each cost center on a separate line on this worksheet.

Line Descriptions

Columns 2, 3, and 4.--For each adjustment, enter the amount in column 2, enter the Worksheet A cost center line number reference in column 4, and enter the corresponding cost center description in column 3.

Line 1.--Enter funds received from miscellaneous sources not specifically listed on this schedule.

Line 4.--Enter the amount from Worksheet A-8-1, Part I, column 8, line 50. The amount from Worksheet A-8-1, Part I, lines 1 through 49, represent the detail of the various cost centers for related party and HO/CO costs that were allocated to the HHA and may or may not already be included on Worksheet A.

Line 5.--Enter the amount received from the sale of medical records and abstracts and offset the amount against the A&G cost centers.

Line 6.--Enter the cash received from imposition of interest, finance, or penalty charges on overdue receivables. This income must be used to offset the allowable A&G costs.

Line 9.--Enter interest expense imposed by the contractor on Medicare overpayments to the provider. Also, enter the interest expense on loans incurred to repay Medicare overpayments to the provider.

Line 10.--Enter the expense incurred for political and lobbying activities be identified and disallowed. (See CMS Pub. 15-1, chapter 21, §§2139-2139.3.)

Line 11.--Enter the expense incurred for advertising costs be identified and disallowed. (See CMS Pub. 15-1, chapter 21, §§2136-2136.2.)

Line 12 through 49.--Use these lines and any subscripts thereof to enter any additional adjustments required under the Medicare principals of reimbursement. Provide a description for each amount reported on these lines that indicates the nature of the required adjustment and the amount.

Line 50.--Enter the sum of lines 1 through 49. Transfer the amounts in column 2 to the appropriate lines on Worksheet A, column 9.

4712. WORKSHEET A-8-1 - COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND/OR HOME OFFICE/CHAIN ORGANIZATIONS

Worksheet A-8-1 consists of the following two parts:

- Part I - Adjustments Required as a Result of Transactions with Related Organizations or Home Office/Chain Organizations Costs
- Part II - Interrelationship Between Related Organizations and/or Home Office/Chain Organizations

In accordance with 42 CFR 413.17, costs applicable to services, facilities, and supplies furnished to the HHA by organizations related to the HHA by common ownership or control are includable in the HHA allowable cost at the cost to the related organization, see exceptions outlined in 42 CFR 413.17(d). This worksheet provides for the computation of any needed adjustments to costs applicable to services, facilities, and supplies furnished to the HHA by related organizations or costs associated with the HO/CO.

Complete this worksheet if you answered yes to question 11 on Worksheet S-2, Part I, and there are costs included on Worksheet A resulting from transactions with related organizations as defined in CMS Pub. 15-1, chapter 10, or HO/CO cost as described in CMS Pub. 15-1, chapter 21. If there are no costs incurred as a result of transactions with related organizations or HO/CO cost allocations, DO NOT complete Worksheet A-8-1.

4712.1 Part I - Adjustments Required as a Result of Transactions with Related Organizations and/or Home Office/Chain Organizations. This part of this worksheet provides for the computation of adjustments needed to properly report costs of services, facilities, and supplies furnished to the HHA by related organizations or costs associated with the HO/CO. However, such costs must not exceed the amount a prudent and cost conscious buyer would pay for the comparable services, facilities, or supplies that are purchased elsewhere.

Columns 1 and 2.--Enter in column 1 the Worksheet A cost center line number to be adjusted. Enter the corresponding cost center description in column 2.

Column 3.--Enter the description of the related organization or HO/CO expenses.

Column 4.--Enter the Worksheet A-8-1, Part II, line number on which the related organization is reported. For example, Brothers HHA leases office space from Brothers Property Management, a related party. Brothers HHA reports the lease expense on line 1 and identifies Brothers Property Management as a related organization in Part II, line 1. On Part I, line 1, column 4, Brothers HHA enters a 1 (the line number from Part II) to identify the interrelationship.

Column 5.--Enter the Worksheet S-2, Part I, line number (line 17 or subscript) of the HO/CO that allocated the cost reported in column 6. For example, Brothers HHA receives a cost allocation from Brothers Home Office. Brothers Home Office is identified on Worksheet S-2, Part I, line 17.01. Brothers HHA reports the A&G HO/CO costs on line 2 and enters 17.01 (the line number from Worksheet S-2, Part I) to identify the HO/CO.

Column 6.--Enter the allowable costs from the books and/or records of the related organization or HO/CO. Allowable costs are the actual costs incurred by the related organization or HO/CO for services, facilities, and/or supplies and exclude any markup, profit or amounts that otherwise exceed the acquisition cost of such items.

Column 7.--Enter the amount included on Worksheet A for services, facilities, and/or supplies acquired from related organizations and/or HO/CO.

Column 8.--Enter the result of column 6 minus column 7. Transfer this amount to Worksheet A-8, line 4, column 2.

4712.2 Part II - Interrelationship between Related Organizations and/or Home Office/Chain Organizations. This part of the worksheet identifies the interrelationship between the HHA and individuals, partnerships, corporations, or other organizations having either a related interest to, a common ownership with, or control over the HHA as defined in CMS Pub. 15-1, chapter 10. Complete columns 1 through 6, as applicable, for each interrelationship. For additional information on HO/CO, see CMS Pub. 15-1, chapter 21.

Complete only those columns that are pertinent to the type of relationship that exists.

Column 1.--Enter the symbol that represents the interrelationship between the HHA and the related organization or HO/CO. Select from the following choices:

<u>Symbol</u>	<u>Relationship</u>
A	Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider
B	Corporation, partnership or other organization has financial interest in provider
C	Provider has financial interest in corporation, partnership, or other organization
D	Director, officer, administrator or key person of provider or organization
E	Individual is director, officer, administrator or key person of provider and related organization
F	Director, officer, administrator or key person of related organization or relative of such person has financial interest in provider
G	Other (financial or non-financial) -- specify

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.

Column 3.--If the individual reported in column 2, or the organization reported in column 4, has a financial interest in the HHA, enter the percent of ownership.

Column 4.--Enter the name of each related corporation, partnership, or other organization.

Column 5.--If the HHA, or an individual reported in column 2, has a financial interest in the organization reported in column 4, enter the percent of ownership.

Column 6.--Enter the type of business applicable to the related organization (e.g., medical drugs and/or supplies, janitorial services).

4713. WORKSHEET B - COST ALLOCATION - ALLOCATION OF 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 58) 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 Worksheet A.

NOTE: General services, columns 1 through 9, must be consistent on Worksheets B and B-1.

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 CMS Pub. 15-1, chapter 23, §2306.1, which also clarifies the order of allocation for step-down 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 HHA 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 contractor, in writing, within 90 days prior to the end of that fiscal year. The contractor 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 CMS Pub. 15-1, chapter 23, §2313.)

If the amount of any cost center on Worksheet A, column 10, has a credit balance, show this amount as a credit balance on Worksheet B, 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 100. This enables column 10, line 100, to cross foot to columns 0 and 5A, line 100. After receiving costs from the applicable overhead cost centers, if a revenue producing cost center has a credit balance on Worksheet B, column 10, do not carry forward a credit balance to any worksheet.

On Worksheet B-1, 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 - 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 the HHA 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 B-1, line 100, the total expenses of the cost center to be allocated. Obtain this amount from Worksheet B 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 B, column 1, line 1.

Divide the amount entered on line 100 by the total statistical base entered in the same column on the first line. Enter the resulting unit cost multiplier on line 101. 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 B 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 100) of all of the cost centers receiving the allocation on Worksheet B 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 B and B-1 before proceeding to the next cost center.

After all the costs of the general service cost centers have been allocated on Worksheet B, enter in column 10 the sum of the expenses on lines 16 through 58. The total expenses entered in column 10, line 100, should equal the total expenses entered in column 0, line 100.

Transfer the amounts in column 10 to Worksheet C, column 2, as follows:

<u>From Worksheet B</u> <u>Column 10, Line:</u>	<u>To Worksheet C</u> <u>Column 2, Line:</u>
16	1
17	2
18	3
19	4
20	5
21	6
22	7
23	8
24	9

Column Descriptions

Worksheet B, 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.

If an HHA occupies more than one building (e.g., several branch offices), it may allocate the depreciation and related expenses by building, using a supportive worksheet showing the detailed allocation and transferring the accumulated costs by cost center to Worksheet B, column 1.

Worksheet B, column 2--Allocate all expenses (e.g., interest, personal property tax) for movable equipment to the appropriate cost centers on the basis of dollar value or if approved, the alternative basis of square feet.

Worksheet B, column 3--Allocate all expenses for plant operation and maintenance to the appropriate cost centers on the basis of square feet.

Worksheet B, column 4.--The cost of vehicles owned or rented by the HHA and all other transportation costs that were not directly assigned to another cost center on Worksheet A, 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. The HHA may use weighted trips rather than actual miles as a basis of allocation for transportation costs that are not directly assigned. However, the HHA must request the use of the alternative method in accordance with CMS Pub. 15-1, chapter 23, §2313. The HHA must maintain adequate records to substantiate the use of this allocation.

Worksheet B, column 4A.--For each line enter the sum of columns 0 through 4.

Worksheet B, column 5.--Allocate all expenses for telecommunication technology to the appropriate cost centers on the basis of accumulated costs. Transfer the amounts from Worksheet B, column 4A, lines 16 through 24, and 57, to Worksheet B-1, column 5, lines 16 through 24, and 57.

Worksheet B-1, column 5A.--Enter on line 5, the costs attributable to the difference between the total accumulated cost reported on Worksheet B, column 4A, lines 5, 16 through 24, and 57, and the accumulated costs reported on Worksheet B-1, column 5, line 5. For lines 16 through 24, and 57, enter a negative one (-1) in this column to identify the cost center that should be excluded from receiving an allocation. If only a portion of the costs from a cost center are to receive an allocation, use the reconciliation column to reduce the allocation statistic by that amount to ensure proper allocation.

Worksheet B, column 5A.--For each line enter the sum of columns 4A and 5.

Worksheet B, 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 B-1, column 6, from Worksheet B, columns 5A.

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.

When contract service costs include A&G the contracted services must be excluded from the total cost statistic on Worksheet B-1, column 6. For purposes of determining the basis of allocation, use Worksheet B-1, column 6A to adjust the allocation statistic on Worksheet B-1, column 6. This procedure may be followed when the HHA contracts for services to be performed for the HHA or HHA-based hospice and the contract identifies the A&G costs applicable to those purchased services.

Worksheet B-1, column 6A--Enter the costs attributable to the difference between the total accumulated cost reported on Worksheet B, column 5A, line 100, and the accumulated cost reported on Worksheet B-1, column 6, line 6. Enter any amounts reported on Worksheet B, column 5A, for (1) any service provided under arrangements to program patients that is not grossed up and (2) negative balances. Enter a negative one (-1) in the accumulated cost column to identify the cost center which should be excluded from receiving any A&G costs. If some of the costs from that cost center are to receive A&G costs then enter in the reconciliation column the amount not to receive A&G costs to assure that only those costs to receive overhead receive the proper allocation. 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 B, column 6, line 6, since these costs are not included on Worksheet B-1, column 6, as an accumulated cost statistic.

For fragmented or componentized A&G cost centers, the accumulated cost center line number must match the reconciliation column number. Include in the column number the alpha character "A", i.e., if the accumulated cost center for A&G is line 6 (A&G), the reconciliation column designation must be 6A.

Worksheet B-1, column 6--The administrative and general expenses are allocated on the basis of accumulated costs. Therefore, the amount entered on Worksheet B-1, column 6, line 6, is the difference between the amounts entered on Worksheet B, column 5A, and Worksheet B-1, 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.

An HHA 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 Hospice worksheets must equal the corresponding A&G shared costs on Worksheet B. The following three A&G cost center categories will be created: (1) A&G shared costs, (2) 100 percent HHA reimbursable costs, and (3) 100 percent HHA nonreimbursable costs, in this order only. Do not allocate A&G reimbursable costs to the A&G nonreimbursable cost center. Calculate the accumulated cost statistics as follows:

<u>A&G Cost Center</u>	<u>Sum of Worksheet B</u>	<u>Transfer to Worksheet B-1</u>
A&G Shared Costs	Col. 5A, lines 6.02 through 58	Col. 6.01, lines 6.02 through 58
A&G Reimb. Costs	Col. 5A plus 6.01, lines 16 through 30	Col. 6.02, lines 16 through 30
A&G Nonreimb. Costs	Col. 5A plus 6.01, lines 39 through 50	Col. 6.03, lines 39 through 50

Under the second methodology (also referred to as option 2), unique A&G cost centers may be created (see CMS Pub. 15-1, chapter 23, §2313.1) to further refine the allocation process. The statistical basis used to allocate fragmented A&G costs must represent, as accurately as possible, the consumption or usage of A&G services by the benefiting cost centers. An HHA wishing to use an alternative allocation methodology (i.e., a change in allocation basis or the sequence of cost center allocation) must do so in accordance with CMS Pub. 15-1, chapter 23, §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 CMS Pub. 15-1, chapter 23, §2307.

Worksheet B, column 7.--Allocate all expenses for nursing administration to the appropriate cost centers on the basis of direct nursing hours.

Worksheet B, column 7A.--For each line enter the sum of columns 5A through 7.

Worksheet B, column 8.--Allocate all expenses for medical records to the appropriate cost centers on the basis of accumulated costs. Transfer the amounts from Worksheet B, column 7A, lines 16 through 24, 39 through 42, 44, 47 and 57, to Worksheet B-1, column 8, lines 16 through 24, 39 through 42, 44, 47 and 57.

Worksheet B-1, column 8A.--Enter the costs attributable to the difference between the total accumulated cost reported on Worksheet B, column 7A, lines 8, 16 through 24, 39 through 42, 44, 47 and 57, and the accumulated costs reported on Worksheet B-1, column 8, line 8. For lines 16 through 24, 39 through 42, 44, 47 and 57, enter a negative one (-1) in this column to identify the cost center which should be excluded from receiving an allocation. If only a portion of the costs from a cost center are to receive an allocation, use the reconciliation column to reduce the allocation statistic by that amount to ensure proper allocation.

Worksheet B, column 9.--Allocate all expenses for other general service costs not identified in columns 1 through 8 using a statistical basis that will equitably allocate costs.

4714. WORKSHEET C - APPORTIONMENT OF PATIENT SERVICE COSTS

Worksheet C consists of the following two parts:

- Part I - Aggregate HHA Cost per Visit and Aggregate Medicare Cost Computation
- Part II - Supplies, Drugs, and Disposable Devices Cost Computation

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 and are reimbursed in accordance with §1833(a)(2)(B) of the Act under OPSS. If a beneficiary receives any of these services, the beneficiary is liable for coinsurance (i.e., 20 percent of reasonable charges) and/or deductibles. 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. The HHA 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.

4714.1 Part I - Aggregate HHA Cost per Visit and Aggregate Medicare Cost Computation.--This part provides for the computation of the average HHA cost per visit used to derive the total allowable cost attributable to Medicare patient care visits. This part also provides for the computation of the reasonable cost for Medicare services provided by the HHA. Complete this part once for the entire HHA. This computation is required by 42 CFR 413.30 and 42 CFR 413.53.

Column Descriptions for Cost per Visit and Aggregate Medicare Cost Computation

Column 2.--Enter in column 2 the amount for each discipline from Worksheet B, column 10, lines as indicated on the worksheet.

Column 3.--Transfer the total HHA visits from Worksheet S-3, Part I, column 7, lines 1 through 9, for each discipline listed on lines 1 through 9.

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

Column 5.--Enter in column 5 the Medicare HHA visits by practitioner from your records or the PS&R data on lines 1 through 9. The total visits on line 10, column 5 must equal the total visits on Worksheet S-3, part IV, line 13, column 5.

Column 6.--To determine the Medicare cost of services, multiply the average cost per visit amount in column 4 by the number of Medicare covered visits in column 5, lines 1 through 9, for each discipline. Enter the product in column 6.

Line 10.--For each column 2, 3, 5, and 6, respectively, enter the sum total of lines 1 through 9.

4714.2 Part II - Supplies, Drugs, and Disposable Devices 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 does 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.

Lines 11 through 14.--Enter in column 1 the total applicable costs for the entire cost reporting period for each line item from Worksheet B, column 10, lines 25, 26, 27, and 29. Enter in column 2 the corresponding total charges for the entire cost reporting period. Enter in column 3 the ratio of costs in column 1 to charges in column 2 for each line.

Line 11.--Enter in columns 5 (not subject to deductibles and coinsurance) and 6 (subject to deductibles and coinsurance) charges for medical supplies from the HHA records or the PS&R. These charges are captured for statistical purposes only (has no reimbursement impact) as all medical supplies are covered under the HHA PPS.

Line 12.--Enter in column 5 the charges for pneumococcal vaccine, influenza vaccine, hepatitis B vaccine, COVID-19 vaccine, and monoclonal antibody products for treatment of COVID-19. These vaccines are not subject to deductibles and coinsurance. Enter in column 6 the charge for covered osteoporosis drugs. Osteoporosis drugs are subject to deductibles and coinsurance. Do not include the charges for administering vaccines or drugs.

Line 13.--Enter in column 4 the charges for administering pneumococcal, influenza, hepatitis B, and COVID-19 vaccines; and administration of monoclonal antibody products from the HHA records or the PS&R.

Line 14.--Enter in column 4 the charges for covered disposable devices from the HHA records or the PS&R. Disposable devices are subject to deductibles and coinsurance.

Column 7.--To determine the Medicare cost of disposable devices reimbursed under OPPS, multiply the cost to charge ratio column 3 by the Medicare charges in column 4. Enter the product in column 7.

Column 8.--To determine the Medicare cost not subject to deductibles and coinsurance, multiply the cost to charge ratio in column 3 by the Medicare charges in column 5 for each line item as applicable. Enter the product in column 8.

Column 9.--To determine the Medicare cost subject to deductibles and coinsurance, multiply the cost to charge ratio in column 3 by the Medicare charges in column 6 for each line item, as applicable. Enter the product in column 9.

4715. WORKSHEET D - CALCULATION OF REIMBURSEMENT SETTLEMENT

Worksheet D consists of the following two parts:

- Part I - Computation of the Lesser of Reasonable Cost or Customary Charges for Vaccines
- Part II - Computation of Reimbursement Settlement

This worksheet applies to title XVIII only. This computation is required by 42 CFR 413.9, 42 CFR 413.13, and 42 CFR 413.30.

4715.1 Part I - Computation of the Lesser of Reasonable Cost or Customary Charges for Vaccines.--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 (42 CFR 413.13(a) and (f)) are not subject to the LCC. Therefore, a nominal charge HHA (Worksheet S-2, Part I, line 7, is "Y" for yes) only completes Part I, lines 1 and 9.

Line Descriptions

Line 1.--Transfer the cost from Worksheet C, Part II, column 8, line 12, to column 1, and the cost from Worksheet C, Part II, column 9, line 12, to column 2 of this worksheet.

Line 2.--Transfer the charges from Worksheet C, Part II, column 5, line 12, to column 1, and the charges from Worksheet C, Part II, column 6, line 12.

Lines 3 through 6.--These lines provide for the accumulation of charges which relate to the reasonable cost on line 1.

Lines 3, 4, 5, and 6.--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 6 the product of multiplying the ratio on line 5 by line 2 for each column. Providers that 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 3, 4, and 5, but enter on line 6 the amount from columns 1 and 2 the amount from line 2. (See 42 CFR 413.13(b).) In no instance may the customary charges on line 6 exceed the actual charges on line 2.

Line 7.--Enter in each applicable column on this line the excess of total customary charges (line 6) over the total reasonable cost (line 1). In situations when in any column the total charges on line 6 are less than the total cost on line 1 of the applicable column, enter zero (0) on line 7.

Line 8.--Enter in each applicable column on this line the excess of total reasonable cost (line 1) over total customary charges (line 6). In situations when in any column the total cost on line 1 is less than the customary charges on line 6 of the applicable column, enter zero (0) on line 8. A nominal charge provider (response of "Y" to Worksheet S-2, Part I, line 7) enters zero (0) on this line.

Line 9.--Enter the sum of the amounts on line 1, columns 1 and 2, minus the sum of the amounts on line 8, columns 1 and 2.

4715.2 Part II - Computation of Reimbursement Settlement.--

Lines 10 through 13.--Under PPS, enter only payment amounts associated with episodes/periods completed in the current cost reporting period (see §4707.4 for additional information on episodes and periods). Payments for episodes/periods of care that overlap fiscal years must be recorded in the fiscal year in which the episode was completed. Enter on lines 10 through 13, as applicable, the appropriate PPS payment for each episode of care payment category indicated on the worksheet.

Lines 14 and 15.--Enter as applicable, the appropriate PPS outlier payment for each episode/period of care payment category indicated on the worksheet.

Line 16.--Enter the total of other payments, excluding NPWT. Also, include on this line the value of Other Adjustments as found on the PS&R.

Line 17.--Enter OPPS payment amounts for services rendered. This includes OPPS payments for the administration of pneumococcal, influenza, hepatitis B, and COVID-19 vaccines, administration of monoclonal antibody products for treatment of COVID-19, and disposable devices such as NPWT devices.

Lines 18 through 20.--Enter the gross payments for DME, oxygen, and prosthetics and orthotics payments, respectively, associated with home health PPS services (bill type 32x only). Obtain these amounts from the HHA records or PS&R report.

Line 21.--Enter the amounts paid or payable by the primary payer and reported on the PS&R. The primary payer rules are more fully explained in 42 CFR 411.

Line 22.--Enter the applicable Part B deductibles billed to Medicare patients. Exclude coinsurance amounts. Include any amounts of deductibles satisfied by primary payer payments. Do not enter deductibles for DME, oxygen, and prosthetics and orthotics.

Line 23.--Enter the sum of lines 9 through 15, plus lines 17 through 20, minus lines 16, 21, and 22.

Line 24.--Enter 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. Do not enter coinsurance for DME, oxygen, and prosthetics and orthotics.

NOTE for line 24: 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 deductibles on line 22 and primary payment amount on line 21, from the costs subject to coinsurance in column 2, line 1. Multiply the resulting amount by 20 percent and enter it on line 24.
If the amount on line 1, column 2 is zero, enter zero on line 24.

Line 25.--Enter Medicare allowable bad debts, reduced by bad debt recoveries. If recoveries exceed the current year's bad debts, lines 25 and 26 will be negative.

Line 26.--Multiply the amount (including negative amounts) from line 25 by 65 percent.

Line 27.--Enter the gross reimbursable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. These amounts also are included on line 25.

Line 28.--Enter the result of line 23 minus line 24, plus line 26.

Line 29.--Use this line to enter any other adjustments not identified on lines 10 through 27. Provide a description for the amount reported on this line in the space provided. Enter reductions to expenses as an absolute value.

Line 30.--Enter all demonstration payment adjustment amounts before sequestration.

Line 31.--Enter the result of line 28 minus lines 29 and 30.

Line 32.--Enter the sequestration adjustment amount from the PS&R report (claims based amounts). In accordance with §3709 of the Coronavirus Aid, Relief, and Economic Security (CARES) Act, as amended by §102 of the Consolidated Appropriations Act of 2021, §1 of Public Law 117-7, and §2 of the Protecting Medicare and American Farmers from Sequester Cuts Act of 2021 (PAMA), the sequestration adjustment for the period of May 1, 2020, through March 31, 2022, is not applicable. In accordance with §2 of the PAMA 2021, the sequestration adjustment is 1 percent for the portion of the cost reporting period from April 1, 2022, through June 30, 2022; and 2 percent for the portion of the cost reporting period on or after July 1, 2022.

Line 32.75.--For cost reporting periods that overlap or begin on or after May 1, 2020, calculate the sequestration adjustment for non-claims based amounts as [(2 percent times (total days in the cost reporting period that occur during the sequestration period, divided by total days in the entire cost reporting period, rounded to six decimal places), rounded to four decimal places)) times the sum of (line 9, columns 1 and 2, plus line 26, plus or minus line 29 and its subscripts)]. If the sum of line 9, columns 1 and 2, plus line 26, plus or minus line 29 and its subscripts is less than zero, do not calculate the sequestration adjustment. In accordance with §3709 of the CARES Act, as amended by §102 of the Consolidated Appropriations Act of 2021, §1 of Public Law 117-7, and §2 of the PAMA, do not apply the sequestration adjustment to the period of May 1, 2020, through March 31, 2022. In accordance with §2 of the PAMA 2021, for cost reporting periods that overlap or begin on or after April 1, 2022, calculate the sequestration adjustment amount for the period of April 1, 2022, through June 30, 2022, as follows: [(1 percent times (total days in the cost reporting period that occur from April 1, 2022, through June 30, 2022, divided by total days in the entire cost reporting period, rounded to six decimal places), rounded to four decimal places), times the sum of (line 9, columns 1 and 2, plus line 26, plus or minus line 29 and its subscripts)]; and for cost reporting periods that overlap or begin on or after July 1, 2022, calculate the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur on or after July 1, 2022, through the end of the cost reporting period, divided by total days in the entire cost reporting period, rounded to six decimal places), rounded to four decimal places) times the sum of (line 9, columns 1 and 2, plus line 26, plus or minus line 29 and its subscripts)].

Line 33.--Enter the result of line 31 minus lines 32 and 32.75 due after sequestration adjustment.

Line 34.--Enter all demonstration payment adjustment amounts after sequestration.

Line 35.--Enter the result of line 33 minus line 34.

Line 36.--Enter the amount of interim payments from Worksheet D-1, column 2, line 4.

Line 37.--FOR CONTRACTOR USE ONLY.--Enter the tentative settlement amount from Worksheet D-1, column 2, line 5.99.

Line 38.--Enter the total amount from line 35 minus the amounts on lines 36 and 37. This represents the amount due to or from the provider. Indicate overpayments by parentheses (). Transfer this amount to Worksheet S, Part III, column 1, line 1.

Line 39.--Enter the Medicare reimbursement effect of protested items. The reimbursement effect of the nonallowable items is estimated by applying a reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See CMS Pub 15-2, chapter 1, §115.2.) A schedule showing the supporting details and computations for this line must be attached.

4716. WORKSHEET D-1 - ANALYSIS OF PAYMENTS TO HHA FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Complete lines 1 through 4 for Medicare interim payments only. (See 42 CFR 413.64.) Do not report interim payments for title XIX.

The remainder of the worksheet is completed by the Medicare contractor. All amounts reported on this worksheet must be for services rendered during the cost reporting period for which the costs are included in this cost report.

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 for all covered services. Additionally, enter the total Medicare interim payments paid to the HHA for covered osteoporosis drugs and any other vaccines (pneumococcal, influenza, hepatitis B, COVID-19 and monoclonal antibody products for treatment of COVID-19) paid on a cost reimbursement basis. The amount entered reflects the sum of all interim payments paid on individual bills (net of adjustment bills) for services rendered in this cost reporting period and includes amounts withheld from the HHA's interim payments due to an offset against overpayments to the HHA applicable to prior cost reporting periods. It does not include any retroactive lump sum adjustment amounts based on a subsequent revision of the interim rate, or tentative or net settlement amounts; nor does it include interim amounts; nor does it include interim payments payable. If the HHA is reimbursed under the periodic interim payment method of reimbursement, enter the periodic interim payments received for this cost reporting period. Do not include payments received for services reimbursed on a fee schedule basis.

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 Worksheet D, line 36.

DO NOT COMPLETE THE REMAINDER OF WORKSHEET D-1. LINES 5 THROUGH 7 ARE FOR CONTRACTOR USE ONLY. (EXCEPTION: IF WORKSHEET S, PART I, LINE 3, IS GREATER THAN ZERO (AMENDED COST REPORT), THE HHA MAY COMPLETE LINES 5 THROUGH 7.)

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.

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

Line 6.--*If the amount on Worksheet D, line 38, is due the provider (underpayment or positive), transfer this amount to line 6.01, column 2; if the amount on Worksheet D, line 38, is due the program (overpayment or negative), transfer the absolute value of this amount to line 6.02, column 2.*

Line 7.--*In column 2, calculate the sum of line 4 plus line 5.99, plus line 6.01, minus line 6.02. The amount must equal the amount on Worksheet D, line 35.*

Line 8.--Enter the contractor's name, contractor number, and NPR date, in columns 0, 1, and 2, respectively.

4717. WORKSHEET F - BALANCE SHEET

Prepare this worksheet from the HHA's accounting books and records. Where applicable, the worksheets must be consistent with the HHA financial statements.

Line 1 - Cash on hand and in banks.--Enter the amount of cash on deposit in banks and immediately available for use in financing activities, amounts on hand for minor disbursements and amounts invested in savings accounts and certificates of deposit. Typical accounts would be cash, general checking accounts, payroll checking accounts, other checking accounts, impress cash funds, saving accounts, certificates of deposit, treasury bills and treasury notes and other cash accounts.

Line 2 - Temporary investments.--Enter current securities evidenced by certificates of ownership or indebtedness. Typical accounts would be marketable securities and other current investments.

Line 3 - Notes receivable.--Enter current unpaid amounts evidenced by certificates of indebtedness.

Line 4 - Accounts receivable.--Enter unpaid inpatient and outpatient billings. Include direct billings to patients for deductibles, co-insurance and other patient chargeable items not included elsewhere.

Line 5 - Other receivable.--Enter other unpaid amounts due to the HHA.

Line 6 - Less: Allowances for uncollectible notes and accounts receivable.--Enter the estimated amount of the HHA accounts receivable not expected to be paid.

Line 7 - Inventory.--Enter the costs of unused HHA supplies. Perpetual inventory records may be maintained and adjusted periodically to physical count. The extent of inventory control and detailed record-keeping will depend upon the size and organizational complexity of the hospice. The inventories may be valued by any generally accepted method, but the method must be consistently applied from year to year.

Line 8 - Prepaid expenses.--Enter the costs incurred that are properly chargeable to a future accounting period.

Line 9 - Other current assets.--Enter the balances of all other current assets not identified and reported on lines 1 through 8.

Line 10 - Total current assets.--Enter the sum of lines 1 through 9.

Line 11 - Land.--Enter the cost of land as defined in CMS Pub. 15-1, chapter 1, §104.6.

Lines 12 and 13 - Land improvements.--Enter on line 12 the costs of land improvements as defined in CMS Pub. 15-1, chapter 1, §104.7. Enter accumulated depreciation on line 13.

Lines 14 and 15 - Buildings.--Enter on line 14 the costs of the HHA buildings as defined in CMS Pub. 15-1, chapter 1, §104.2. Enter accumulated depreciation on line 15.

Lines 16 and 17 - Leasehold improvements.--Enter on line 16 the costs of leasehold improvements as defined in CMS Pub. 15-1, chapter 1, §104.8. Enter accumulated depreciation on line 17.

Lines 18 and 19 - Fixed equipment.--Enter on line 18 the costs of building equipment as defined in CMS Pub. 15-1, chapter 1, §104.3. Enter accumulated depreciation on line 19.

Lines 20 and 21 - Automobiles and trucks.--Enter on line 20 the costs of automobiles and trucks used in HHA operations. Enter accumulated depreciation on line 21.

Lines 22 and 23 - Major movable equipment.--Enter on line 22 the costs of equipment as defined in CMS Pub. 15-1, chapter 1, §104.4. Enter accumulated depreciation on line 23.

Lines 24 and 25 - Minor equipment depreciable.--Enter on line 24 the costs of minor equipment as defined in CMS Pub. 15-1, chapter 1, §106(c). Enter accumulated depreciation on line 25.

Line 26 - Minor equipment (non-depreciable).--Enter the costs of minor equipment non-depreciable as defined in CMS Pub. 15-1, chapter 1, §106(c).

Line 26.50 - Other fixed assets.--Enter the costs of other fixed assets not identified on lines 11 through 26.

Line 27 - Total fixed assets.--Enter the sum of lines 11 through 26 and 26.50.

Line 28 - Investments.--Enter the cost of investments purchased with HHA funds and the fair market value (at date of donation) of securities donated to the HHA.

Line 29 - Deposits on leases.--Enter the amount of deposits on leases including security deposits.

Line 30 - Due from owners/officers.--Enter the amount loaned to the owner's and/or officers by the HHA.

Line 30.50 - Other assets.--Enter the balances of all other assets not identified and reported on lines 28 through 30. This could include intangible assets such as goodwill, unamortized loan costs and other organization costs.

Line 31 - Total other assets.--Sum of lines 28 through 30 and 30.50.

Line 32 - Total assets.--Sum of lines 10, 27, and 31.

Line 33 - Accounts payable.--Enter amounts due trade creditors and others for supplies and services purchased.

Line 34 - Salaries, wages and fees payable.--Enter the actual or estimated liabilities of salaries and wages/fees payable.

Line 35 - Payroll taxes payable.-- Enter the actual or estimated liabilities of amounts payable for payroll taxes withheld from salaries and wages, payroll taxes to be paid and other payroll deductions, such as hospitalization insurance premiums.

Line 36 - Notes and loans payable (short term).--Enter amounts payable on notes and loans as evidenced by certificates of indebtedness due in the next 12 months.

Line 37 - Deferred income.--Enter the amount of deferred income received or accrued applicable to services to be rendered within the next accounting period. Deferred income applicable to accounting periods extending beyond the next accounting period is included as other current liabilities.

Line 38 - Accelerated payments.--Enter the amounts payable for accelerated payments in accordance with CMS Pub 15-1, chapter 24, §2412.

Line 39 - Other current liabilities.--Enter the balances of all other current liabilities not identified and reported on lines 33 through 38.

Line 40 - Total current liabilities.--Enter the sum of lines 33 through 39.

Line 41 - Mortgage payable.--Enter the long-term financing obligation as evidenced by certificates of indebtedness used to purchase real estate/property.

Line 42 - Notes payable.--Enter amounts payable on notes and loans as evidenced by certificates of indebtedness due after the next 12 months.

Line 43 - Unsecured loans.--Enter amounts payable for unsecured liabilities due after the next 12 months.

Line 44 - Other long-term liabilities.--Enter the balances of all other long-term liabilities not identified and reported on lines 41 through 43.

Line 45 - Total long-term liabilities.--Enter the sum of lines 41 through 44.

Line 46 - Total liabilities.--Enter the sum of lines 40 and 45.

Line 47 - Fund balance.--Enter the end of period fund balance.

Line 48 - Total liabilities and fund balance.--Enter the sum of lines 46 and 47.

4718. WORKSHEET F-1 - STATEMENT OF REVENUES AND EXPENSES

This worksheet is prepared from the HHA's accounting books and records. It requires the reporting of total patient revenues (specifically including Medicare, Medicaid and other revenues) for the entire HHA and operating expenses for the entire HHA. Additional worksheets may be submitted if necessary.

Line 1.--Enter total patient revenue from the HHA accounting books and/or records in columns 1 through 3, by program as indicated. Note: revenue from a managed care program must be entered in column 3, "Other". Enter the sum of columns 1 through 3 in column 4.

Line 2.--Enter allowances and discounts in columns 1 through 3, by program as indicated. These allowances and discounts are total patient revenues not received including:

Provision for Bad Debts,
Contractual Adjustments,
Charity Discounts,
Teaching Allowances,
Policy Discounts,
Administrative Adjustments, and
Other Deductions from Revenue

Line 3.--Enter in each column the sum of line 1 minus line 2.

Line 4.--Enter in column 2, total operating expenses from Worksheet A, column 6, line 100.

Lines 5 through 10.--Use these lines to enter any additions to operating expenses in column 1. Provide a description for each amount reported on these lines and any subscripts thereof.

Lines 11 through 16.--Use these lines to enter any subtractions to operating expenses in column 1. Provide a description for each amount reported on these lines and any subscripts thereof.

Line 17.--Enter in column 2, the sum of line 4, column 2, and lines 5 through 16, column 1.

Line 18.--Enter in column 2, the sum of line 3, column 4, minus line 17, column 2.

Lines 19 through 27.--Enter all other income as specified in column 1.

Line 20.--Enter net investment income or loss. Enter net loss as a negative amount.

Lines 28 through 31.--Use these lines to enter any other revenues in column 1. Provide a description for each amount reported on these lines and any subscripts thereof.

Line 31.50.--Enter the aggregate revenue received for COVID-19 Public Health Emergency (PHE) funding including both PRF and Small Business Association (SBA) Loan Forgiveness amounts.

Line 32.--Enter in column 2, the sum of the amounts on lines 19 through 31, column 1.

Line 33.--Enter in column 2, the sum of line 18 plus line 32, column 2.

4719. WORKSHEET O - ANALYSIS OF HHA-BASED HOSPICE COSTS

The O series of worksheets must be completed by all HHA-based hospices. This worksheet is to record the trial balance of expense accounts from the provider's 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 that facilitates the combination of the various groups of cost centers for purposes of cost finding. Cost centers listed may not apply to every provider using these forms. Complete only those lines that are applicable.

Column Descriptions

For columns 1, 2, 4, and 6, direct patient care service costs (lines 25 through 46) are reported by LOC on Worksheet O-1, O-2, O-3, and O-4. For each cost center on Worksheet O, enter the sum of the amounts from Worksheets O-1, O-2, O-3, and O-4, for salaries, other costs, reclassifications, and adjustments, in columns 1, 2, 4, and 6, respectively.

Column 1--Enter salaries from the provider's accounting books and records. Salaries for the direct patient care service cost centers (lines 25 through 46) must equal the sum of amounts reported in column 1 of Worksheets O-1, O-2, O-3, and O-4. The total salaries for column 1, line 100, must equal the salaries reported on Worksheet A, column 1, line 57.

Column 2--Enter all costs other than salaries from the provider's accounting books and records. Other costs for the direct patient care service cost centers (lines 25 through 46) must equal the sum of amounts reported in column 2 of Worksheets O-1, O-2, O-3, and O-4. The total other costs for column 2, line 100, must equal the other costs reported on Worksheet A, the sums of columns 2 through 5, line 57.

Column 3--For each cost center, enter the total of columns 1 plus 2.

Column 4--Enter any reclassifications among cost center expenses in column 3 that are needed to effect proper cost allocation. This column need not be completed by all providers, but is completed to the extent reclassifications are needed or reported on Worksheet A, line 57. Show reductions to expenses as negative amounts.

If reclassifications are needed for direct patient care service cost centers (lines 25 through 46), enter the reclassification amounts on the appropriate Worksheet O-1, O-2, O-3, and O-4, column 4, for each level of care.

Reclassifications for the direct patient care service cost centers (lines 25 through 46) must equal the sum of amounts reported on the corresponding lines in column 4 of Worksheets O-1, O-2, O-3, and O-4. The total reclassifications for column 4, line 100, must equal the reclassifications reported on Worksheet A, column 7, line 57.

Column 5--For each cost center, enter the total of the amount in column 3 plus or minus the amount in column 4.

Column 6.--In accordance with 42 CFR 413.9(c)(3), enter on the appropriate lines, the amounts of any adjustments to expenses required under Medicare principles of reimbursements. (See §4711). This column need not be completed by all providers but is completed only to the extent adjustments are needed or reported on Worksheet A, column 9, line 57. Show reductions to expenses as negative amounts.

If adjustments are needed for direct patient care service cost centers (lines 25 through 46), enter the adjustment amounts on the appropriate Worksheet O-1, O-2, O-3, and O-4, column 6, for each level of care.

Adjustments for the direct patient care service cost centers (lines 25 through 46) must equal the sum of amounts reported on the corresponding lines in column 6 of Worksheet O-1, O-2, O-3, and O-4. The total adjustments for column 6, line 100, must equal the adjustments reported on Worksheet A, column 9, line 57.

Column 7.--For each cost center, enter the total of the amount in column 5 plus or minus the amount in column 6. Transfer the amounts in column 7 for cost centers marked with an asterisk (*) to Worksheet O-5, as follows:

From Worksheet O, Column 7, Line Number and Cost Center Description	To Worksheet O-5, Column 1:
1 Cap Rel Costs-Bldg & Fixt	Line 1
2 Cap Rel Costs-Mvble Equip	Line 2
3 Employee Benefits Department	Line 3
4 Administrative & General	Line 4
5 Plant Operation & Maintenance	Line 5
6 Laundry & Linen	Line 6
7 Housekeeping	Line 7
8 Dietary	Line 8
9 Nursing Administration	Line 9
10 Routine Medical Supplies	Line 10
11 Medical Records	Line 11
12 Staff Transportation	Line 12
13 Volunteer Service Coordination	Line 13
14 Pharmacy	Line 14
15 Physician Administrative Services	Line 15
16 Other General Service	Line 16
60 Bereavement Program	Line 60
61 Volunteer Program	Line 61
62 Fundraising	Line 62
63 Hospice/Palliative Medicine Fellows	Line 63
64 Palliative Care Program	Line 64
65 Other Physician Services	Line 65
66 Residential Care	Line 66
67 Advertising	Line 67
68 Telehealth/Telemonitoring	Line 68
69 Thrift Store	Line 69
70 Nursing Facility Room & Board	Line 70
71 Other Nonreimbursable	Line 71

Line Descriptions

The Worksheet O cost centers are segregated into general service, direct patient care service, and nonreimbursable categories to facilitate the transfer of costs to the various worksheets. For example, the general service cost centers appear on Worksheet O-5, and Worksheets O-6, Parts I and II, using the same line numbers as Worksheet O. The direct patient care service cost centers appear on Worksheets O-1, O-2, O-3, and O-4, using the same line numbers as Worksheet O.

General service cost centers (lines 1 through 17) include expenses incurred in operating the hospice as a whole that are not directly associated with furnishing patient care such as mortgage, rent, plant operations, administrative salaries, utilities, telephone, and computer hardware and software costs. General service cost centers furnish services to other general service cost centers and to reimbursable and nonreimbursable cost centers.

Lines 1 and 2 - Cap Rel Costs-Bldg & Fixt and Cap Rel Costs-Mvble Equip.--Enter in column 2, the capital-related costs for buildings and fixtures and the capital-related costs for moveable equipment on lines 1 and 2, respectively.

Line 3 - Employee Benefits Department.--This cost center includes the costs of the employee benefits department. In addition, this cost center includes the fringe benefits paid to, or on behalf of, an employee when a provider's accounting system is not designed to accumulate the benefits on a departmentalized or cost center basis. (See CMS Pub. 15-1, chapter 21, §2144, and CMS Pub. 15-1, chapter 23, §2307.) Enter the employee benefits.

Line 4 - Administrative & General.--Enter in columns 1 and 2, the salary and other costs of A&G.

If the option to subscript A&G costs into more than one cost center is elected (in accordance with CMS Pub. 15-1, chapter 23, §2313), eliminate line 4. Begin numbering the subscripted A&G cost centers with line 4.01 and continue in sequential order.

Line 5 - Plant Operation & Maintenance.--This cost center includes expenses incurred in the operation and maintenance of the plant and equipment (see §4709). Enter in columns 1 and 2, the costs of plant operation and maintenance.

Line 6 - Laundry & Linen Service.--This cost center includes the cost of routine laundry and linen services whether performed in-house or by outside contractors.

Line 7 - Housekeeping.--This cost center includes the cost of routine housekeeping activities such as mopping, vacuuming, cleaning restrooms, lobbies, waiting areas and otherwise maintaining patient and non-patient care areas.

Line 8 - Dietary.--This cost center includes the cost of preparing meals for patients. Do not include the cost of dietary counseling in this cost center; report dietary counseling on line 35.

Line 9 - Nursing Administration.--This cost center includes the cost of overall management and direction of the nursing services. Do not include the cost of direct nursing services reported on lines 27 through 29. The salary cost of direct nursing services, including the salary cost of nurses who render direct service in more than one patient care area, is directly assigned to the various patient care cost centers in which the services were rendered. However, if the hospice accounting system fails to specifically identify all direct nursing services to the applicable direct patient care cost centers, then the salary cost of all direct nursing service is included in this cost center.

Line 10 - Routine Medical Supplies.--This cost center includes the cost of supplies used in the normal course of caring for patients, such as gloves, masks, swabs, or glycerin sticks, that generally are not traceable to individual patients. Do not include the costs of non-routine medical supplies that can be traced to individual patients; report non-routine medical supplies on line 42.

Line 11 - Medical Records.--This cost center includes cost of the medical records department where patient medical records are maintained. The general library and the medical library are not included in this cost center but are included in the A&G cost center.

Line 12 - Staff Transportation.--This cost center includes the cost of owning or renting vehicles, public transportation expenses, parking, tolls, or payments to employees for driving their private vehicles to see patients or for other hospice business. Staff transportation costs do not include patient transportation costs; report patient transportation costs on line 39.

Line 13 - Volunteer Service Coordination.--This cost center includes the cost of the overall coordination of service volunteers including their recruitment and training costs of volunteers.

Line 14 - Pharmacy.--This cost center includes the costs of drugs (both prescription and over-the-counter), pharmacy supplies, pharmacy personnel, and pharmacy services. Do not report the cost of palliative chemotherapy drugs on this line; report the cost of palliative chemotherapy on line 46. For additional information, please refer to the instructions for line 43 - Drugs Charged to Patients prior to completing this line.

Line 15 - Physician Administrative Services.--This cost center includes the costs for physicians' administrative and general supervisory activities that are included in the hospice payment rates. These activities include participating in the establishment, review and updating of plans of care, supervising care and services, conducting required face-to-face encounters for recertification, and establishing governing policies. These activities are generally performed by the physician serving as the medical director and the physician member of the interdisciplinary group. Nurse practitioners may not serve as or replace the medical director or physician member of the interdisciplinary group.

Line 16.--Use this line to identify expenses for other general service costs not identified on lines 1 through 15. Provide a description for the amount reported on this line. See Table 5 in §4790 for proper cost center coding for this line.

Line 17 - Patient/Residential Care Services.--Do not use this line on this worksheet. This cost center is used on Worksheet O-5 to accumulate in-facility costs not separately identified as HIRC, HGIP, or residential care services that are not part of a separate and distinct residential care unit (e.g., depreciation related to in-facility areas that provide HIRC, HGIP, or residential care). The amounts allocated to this cost center on Worksheet O-5 are allocated to HIRC, HGIP, and residential care services that are not part of a separate and distinct residential care unit, based on in-facility days. This cost center does not include any costs related to contracted inpatient services.

When a residential care unit is separate and distinct and only used for resident care services (such as hospice home care provided in a residential unit), costs are reported directly on line 66.

Lines 18 through 24.--Reserved for future use.

Direct patient care service costs are reported by LOC on Worksheets O-1, O-2, O-3, and O-4. For each cost center on Worksheet O, enter the sum of the amounts from Worksheets O-1, O-2, O-3, and O-4, for salaries, other costs, reclassifications, and adjustments in columns 1, 2, 4, and 6, respectively.

Line 25 - Inpatient Care - Contracted.--This cost center includes the contractual costs paid to another facility for use by the hospice for hospice inpatient care (HIRC or HGIP) in accordance with 42 CFR 418.108(c). This cost center does not include the cost of any direct patient care services or nonreimbursable services provided by hospice staff in the contracted setting. Costs of any services provided by hospice staff in the contracted setting are included in the appropriate direct patient care service or nonreimbursable cost center. Costs in this cost center are excluded from the allocation of A&G costs.

Line 26 - Physician Services.--This cost center includes the costs incurred by the hospice for physicians, or nurse practitioners providing physician services, for direct patient care services and general supervisory services, participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care, and establishment of governing policies by the physician member of the interdisciplinary group. (See 42 CFR 418.304.) Reclassify the cost for the portion of time physicians spent on general supervisory services or other hospice administrative activities to Physician Administrative Services (line 15). This cost center must not include costs associated with palliative care or other nonreimbursable physician services. Those nonreimbursable physician services must be reported in the appropriate nonreimbursable cost center.

Line 27 - Nurse Practitioner.--This cost center includes the costs of nursing care provided by nurse practitioners. Do not include costs for nurse practitioners providing physician services on this line; report the costs for nurse practitioners providing physician services on line 26.

Line 28 - Registered Nurse.--This cost center includes the costs of nursing care provided by registered nurses other than nurse practitioners.

Line 29 - LPN/LVN.--This cost center includes the costs of nursing care provided by licensed practical nurses (LPN) or licensed vocational nurses (LVN). Do not include costs for certified nursing assistant (CNA) services on this line; report the costs for CNA services on line 37.

Line 30 - Physical Therapy.--This cost center includes the costs of physical or corrective treatment of bodily or mental conditions by the use of physical, chemical, and other properties of heat, light, water, electricity, sound massage, and therapeutic exercise by or under the direction of a registered physical therapist as prescribed by a physician. Physical therapy 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 31 - Occupational Therapy.--This cost center includes the costs of purposeful goal-oriented activities in the evaluation, diagnosis, and/or treatment of persons whose function is impaired by physical illness or injury, emotional disorder, congenital or developmental disability, or the aging process, in order to achieve optimum functioning, to prevent disability, and to maintain health. Occupational therapy 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 32 - Speech-Language Pathology.--This cost center includes the costs of 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 33 - Medical Social Services.--This cost center includes the cost of the medical social services defined in CMS Pub. 100-02, chapter 9, §40.1.2. Costs for nonreimbursable activities included in this cost center must be reclassified to the appropriate nonreimbursable cost center.

Line 34 - Spiritual Counseling.--This cost centers includes the cost of spiritual counseling services. Costs for nonreimbursable activities included in this cost center must be reclassified to the appropriate nonreimbursable cost center.

Line 35 - Dietary Counseling.--This cost center includes the costs of dietary counseling services.

Line 36 - Counseling - Other.--This cost center includes the cost of counseling services not already identified as spiritual, dietary or bereavement counseling. Effective for services rendered on or after January 1, 2024, in accordance with the CAA 2023, §4121, also include the costs incurred for Marriage and Family Therapists (MFT) and Mental Health Counselors (MHC) services. MFT and MHC provide services for the diagnosis and treatment of mental illness. Costs for nonreimbursable activities included in this cost center must be reclassified to the appropriate nonreimbursable cost center.

Line 37 - Hospice Aide and Homemaker Services.--This cost center includes the costs of:

- Hospice aide services such as personal care services and household services to maintain a safe and sanitary environment in areas of the home used by the patient; and,
- Homemaker services such as assistance in the maintenance of a safe and healthy environment and services to enable the individual to carry out the plan of care.

Include the cost of CNAs that meet the criteria for an aide in this cost center.

Line 38 - Durable Medical Equipment/Oxygen.--This cost center includes the costs of DME and oxygen, as defined in 42 CFR 410.38 and 42 CFR 418.202(f), furnished to individual HRHC or HCHC patients. Report DME costs by the LOC the patient was receiving at the time the DME/oxygen was delivered. If the LOC of a patient changed after delivery of the DME/Oxygen, the hospice may report the costs proportionally between HRHC and HCHC based on patient days.

Line 39 - Patient Transportation.--This cost center includes the costs of ambulance transports of hospice patients, related to the terminal prognosis and occurring after the effective date of the hospice election, that are the responsibility of the hospice. (See CMS Pub. 100-02, chapter 9, §40.1.9.) When a patient is transferred to a new LOC, report the transportation cost to that LOC. For example, a patient in a HGIP LOC is transferred to HRHC LOC and transported to their home, the transportation cost associated with the transfer must be included in the HRHC LOC.

Line 40 - Imaging Services.--This cost center includes the costs of imaging services.

Line 41 - Labs and Diagnostics.--This cost center includes the costs of laboratory and diagnostic tests.

Line 42 - Medical Supplies - Non routine.--This cost center includes the costs of medical supplies furnished to individual patients for which a separate charge would be applicable. These supplies are specified in the patient's plan of treatment and furnished under the specific direction of the patient's physician. Do not include the cost of routine medical supplies used in the normal course of caring for patients, (such as gloves, masks, swabs, or glycerin sticks) on this line; report routine medical supplies on line 10. When a provider does not track the use of non-routine medical supplies by LOC, the provider may report the costs proportionally between LOCs based on patient days.

Line 43 - Drugs Charged to Patients.--This cost center includes the costs of drugs furnished to individual patients for which a separate charge would be applicable. These drugs are specified in the patient's plan of treatment and furnished under the specific direction of the patient's physician. When a provider does not track the use of drugs by LOC, the provider must report the costs on line 14.

Line 44 - Outpatient Services.--This cost center includes the costs of outpatient services costs not captured elsewhere. This cost can include the cost of an emergency room department visit when related to the terminal condition.

Lines 45 and 46 - Palliative Radiation Therapy and Palliative Chemotherapy.--These cost centers include costs of radiation, chemotherapy and other modalities used for palliative purposes based on the patient's condition and the hospice's caregiving philosophy.

Line 47.--Use this line and subscripts of this line to identify expenses for other direct patient care service costs not identified on lines 25 through 46. Provide a description for each amount reported on this line and its subscripts. See Table 5 in §4790 for proper cost center coding for this line.

Lines 48 and 49.--Reserved for future use.

Lines 50 through 53.--Reserved for use on Worksheet O-6, Parts I and II.

Lines 54 through 59.--Reserved for future use.

Nonreimbursable cost centers include costs of nonreimbursable services and programs. Report the costs applicable to nonreimbursable cost centers to which general service costs apply. If additional lines are needed for nonreimbursable cost centers other than those shown, subscript one or more of these lines with a numeric code. The subscripted lines must be appropriately labeled to indicate the purpose for which they are being used. However, when the expense (direct and all applicable overhead) attributable to any non-allowable cost area is so insignificant as to not warrant establishment of a nonreimbursable cost center, remove the expense on Worksheet A-8. (See CMS Pub. 15-1, chapter 23, §2328.)

Line 60 - Bereavement Program.--This cost center includes the cost of bereavement services, defined as emotional, psychosocial, and spiritual support and services provided before and after the death of the patient to assist with grief, loss, and adjustment (42 CFR 418.3). Bereavement counseling is a required hospice service, but it is not reimbursable (see §1814(i)(1)(A) of the Act).

Line 61 - Volunteer Program.--This cost center includes costs of volunteer programs. (See 42 CFR 418.78 and CMS Pub. 15-1, chapter 7.)

Line 62 - Fundraising.--This cost center includes costs of fundraising. (See CMS Pub. 15-1, chapter 21, §2136.2.)

Line 63 - Hospice/Palliative Medicine Fellows.--This cost center includes costs of hospice and palliative medicine fellows.

Line 64 - Palliative Care Program.--Enter in columns 1 and 2, the salary and other costs of palliative care provided to non-hospice patients. This includes physician services.

Line 65 - Other Physician Services.--Enter in columns 1 and 2, the salary and other costs of other physician services that are provided outside of a palliative care program to non-hospice patients.

Line 66 - Residential Care.--Enter in columns 1 and 2, the salary and other costs of residential care for patients living in the hospice, but who are not receiving inpatient hospice services. Patients living in the hospice are considered residents, where the hospice is their home. These patients are liable for their room and board charges; however, the outpatient hospice care services provided must be recorded in the direct patient care cost centers on the appropriate HRHC and/or HCHC LOC worksheet.

Line 67 - Advertising.--Enter in columns 1 and 2, the salary and other costs of nonallowable community education, business development, marketing and advertising (see CMS Pub. 15-1, chapter 21, §2136).

Line 68 - Telehealth/Telemonitoring.--Enter in columns 1 and 2, the salary and other costs of telehealth/telemonitoring services. These costs are nonreimbursable since a hospice is not an approved originating site (see 42 CFR 410.78(b)(3)).

Line 69 - Thrift Store.--Enter in columns 1 and 2, the salary and other costs of thrift stores.

Line 70 - Nursing Facility Room & Board.--Enter the costs incurred by a hospice for dually eligible beneficiaries residing in a nursing facility (NF) when room and board is paid by the State to the hospice. The full amount paid to the NF by the hospice must be included on this line and offset by the State payment via an adjustment on Worksheet A-8. The residual cost is the net cost incurred.

For example, a dually eligible beneficiary is residing in a NF and has elected the Medicare hospice benefit. The NF charges \$100 per day for room and board. The State pays the hospice \$95 for the NF room and board. The hospice has a written agreement with the NF that requires full room and board payment of \$100 per day. The hospice receives \$95 per day, but pays the NF \$100 per day, thereby incurring a net cost of \$5 per day.

Line 71.--Use this line and subscripts of this line to identify expenses for other nonreimbursable costs not identified on lines 60 through 70. Provide a description for each amount reported on this line and its subscripts. See Table 5 in §4790 for proper cost center coding for this line.

Lines 72 through 99.--Reserved for future use.

4720. WORKSHEETS O-1, O-2, O-3, AND O-4 - ANALYSIS OF HHA-BASED HOSPICE COSTS

Worksheet O-1 - Analysis of HHA-Based Hospice Costs - Continuous Home Care

Worksheet O-2 - Analysis of HHA-Based Hospice Costs - Routine Home Care

Worksheet O-3 - Analysis of HHA-Based Hospice Costs - Inpatient Respite Care

Worksheet O-4 - Analysis of HHA-Based Hospice Costs - General Inpatient Care

Worksheets O-1, O-2, O-3, and O-4 provide for recording the direct patient care costs by LOC, including reclassifications and adjustments. The general format of these worksheets is identical to Worksheet O in order to facilitate the transfer of direct patient care costs to Worksheet O. For each cost center, the sums of the amounts reported in columns 1, 2, 4, and 6 of these worksheets are transferred to the corresponding columns on Worksheet O.

Column 1.--For each LOC worksheet, enter salaries from the provider's accounting books and records.

Column 2.--For each LOC worksheet, enter all costs other than salaries from the provider's accounting books and records.

Column 3.--For each cost center, add the amounts in columns 1 and 2 and enter the total in column 3.

Column 4.--For each LOC worksheet enter any reclassification of direct patient care service costs needed to effect proper cost allocation. For each line, the sum of the reclassification entries on Worksheet O-1, O-2, O-3, and O-4, column 4, must equal the amount on the corresponding line on Worksheet O, column 4.

Column 5.--For each cost center, enter the total of the amount in column 3 plus or minus the amount in column 4.

Column 6.--For each LOC worksheet, enter any adjustments for direct patient care service costs (lines 25 through 46) required under Medicare principles of reimbursements. (See §4711.) Show reductions to expenses as negative amounts. For each line, the sum of the adjustment entries on Worksheets O-1, O-2, O-3, and O-4, column 6, must equal the amount on the corresponding line of Worksheet O, column 6.

Column 7.--For each cost center, enter the total of the amount in column 5 plus or minus the amount in column 6. For each LOC worksheet, transfer the amount on line 100 to the corresponding LOC line on Worksheet O-5, column 1, as follows:

<u>From line 100 of:</u>	<u>To Worksheet O-5, column 1, line:</u>
Worksheet O-1	50
Worksheet O-2	51
Worksheet O-3	52
Worksheet O-4	53

4721. **WORKSHEET O-5 - DETERMINATION OF HHA-BASED HOSPICE TOTAL EXPENSES FOR ALLOCATION**

Worksheet O-5 determines total expenses of each general service cost center for proper allocation of general service costs to each LOC and to nonreimbursable cost centers. This worksheet combines the direct general services costs reported on Worksheet O, lines 1 through 17, with the overhead allocation of the HHA general services costs reported on Worksheet B, line 57, columns 1 through 7.

Column Descriptions

Column 1.--For each general service and nonreimbursable cost center, transfer the amount from the corresponding cost center on Worksheet O, column 7. For each LOC line, transfer amounts as follows:

<u>Line:</u>	<u>From column 7, line 100 of:</u>
50	Worksheet O-1
51	Worksheet O-2
52	Worksheet O-3
53	Worksheet O-4

The total on line 100, column 1, must equal the amount on Worksheet A, column 10, line 57.

Column 2.--For each general service cost center, transfer the amount from the corresponding column on Worksheet B, line 57 as follows:

<u>Line:</u>	<u>From Worksheet B, line 57, column(s):</u>	<u>Line:</u>	<u>From Worksheet B, line 57, column(s):</u>
1	1	9	7
2	2	10	N/A
3	N/A	11	8
4	5 and 6	12	4
5	3	13	N/A
6	N/A	14	N/A
7	N/A	15	N/A
8	N/A	16	9

Column 3.--For each line, enter the sum of columns 1 and 2. The total on line 100, column 3, must equal the amount on Worksheet B, column 10, line 57. Transfer the amount from each cost center to the corresponding line on Worksheet O-6, Part I, column 0.

4722. WORKSHEET O-6 - COST ALLOCATION - HHA-BASED HOSPICE

Worksheet O-6 consists of the following two parts:

- Part I - Allocation of HHA-Based Hospice General Service Costs
- Part II - Statistical Bases

In accordance with 42 CFR 413.24, cost data must be based on an approved method of cost finding and on the accrual basis of accounting except where governmental institutions operate on a cash basis of accounting.

Worksheet O-6, Parts I and II, facilitate the step-down method of cost finding. This method recognizes that general services of the hospice are utilized by other general service, LOC, and nonreimbursable cost centers. Worksheet O-6, Part I, provides for the equitable allocation of general service costs based on statistical data reported on Worksheet O-6, Part II. To facilitate the allocation process, the general format of Worksheet O-6, Part I, is identical to that of Worksheet O-6, Part II. The column and line numbers for each general service cost center are identical on the two worksheets. The direct patient care service cost centers (lines 25 through 46 of Worksheet O) are reported by LOC on lines 50 through 53 of Worksheets O-6, Parts I and II. The line numbers for nonreimbursable cost centers are identical on Worksheet O and Worksheet O-6, Parts I and II.

When certain general services costs are related to in-facility days and are not separately identifiable by LOC or service, Worksheet O-6, Parts I and II, provide for the accumulation of these costs on line 17, Patient/Residential Care Services. The amounts accumulated in this cost center are allocated based on the in-facility days for HIRC, HGIP, and residential care services that are not part of a separate and distinct residential care unit. This cost center does not include any costs related to contracted inpatient services.

The statistical basis shown at the top of each column on Worksheet O-6, Part II, is the recommended basis of allocation. The total statistic for cost centers using the same basis (e.g., square feet) may differ with the closing of preceding cost centers. A hospice can elect to change the order of allocation and/or allocation statistics, as appropriate, for the current cost reporting period if a request is submitted in accordance with CMS Pub. 15-1, chapter 23, §2313.

Close the general service cost centers in accordance with 42 CFR 413.24(d)(1) so that the cost centers rendering the most services to and receiving the least services from other cost centers are closed first (see CMS Pub. 15-1, chapter 23, §2306.1). If a more accurate result is obtained by allocating costs in a sequence that differs from the recommended sequence, the hospice must request approval in accordance with CMS Pub. 15-1, chapter 23, §2313.

If the amount of any cost center on Worksheet O-5, column 3, has a negative balance, show this amount as a negative balance on Worksheet O-6, Part I, column 0. Allocate the costs from the overhead cost centers in the normal manner, including to those cost centers with a negative balance. Close a general service cost center with a negative balance by entering the negative balance in parentheses on the first line and on lines 99 and 100 of the column, and do not allocate. This enables Worksheet O-6, Part I, line 100, column 18, to cross foot to Worksheet O-6, Part I, line 100, column 0. After receiving costs from overhead cost centers, LOC cost centers with negative balances on Worksheet O-6, Part I, column 18, are not transferred to Worksheet O-7.

On Worksheet O-6, Part II, enter on the first available line of each column the total statistics applicable to the cost center being allocated (e.g., in column 1, Capital-Related Cost - Buildings & Fixtures, enter on line 1 the total square feet of the building on which depreciation was taken). Use accumulated cost for allocating A&G expenses.

Such statistical base, including accumulated cost for allocating A&G expenses, 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 the hospice's accounting books and records; or
- The contractor determines that the hospice is able to and does gross up the costs and charges for services to non-Medicare patients so that both cost and charges are recorded as if the hospice had furnished such services directly to all patients. (See CMS Pub. 15-1, chapter 23, §2314.)

For each cost center being allocated, enter that portion of the total statistical base applicable to each cost center receiving services. For each column, the sum of the statistics entered for cost centers receiving services must equal the total statistical base entered on the first line.

For each column on Worksheet O-6, Part II, enter on line 101, the total expenses of the cost center to be allocated. Obtain the total expenses from the first line of the corresponding column on Worksheet O-6, Part I, which includes the direct expenses from Worksheet O-6, Part I, column 0, plus the allocated costs from previously closed cost centers. Divide the amount entered on Worksheet O-6, Part II, line 101, by the total statistical base entered in the same column on the first line. Enter the resulting unit cost multiplier (rounded to six decimal places) on line 102.

For each column on Worksheet O-6, Part II, multiply the unit cost multiplier on line 102 by the portion of the total statistical base applicable to each cost center receiving services and enter the result in the corresponding column and line on Worksheet O-6, Part I. For each column on Worksheet O-6, Part I, the sum of the costs allocated (line 100) must equal the total cost on the first line.

After the costs of the general service cost centers have been allocated on Worksheet O-6, Part I, enter on each line 50 through 71, column 18, the sum of the costs in columns 3A through column 17. The total costs entered on Worksheet O-6, Part I, column 18, line 100, must equal the total costs entered in column 0, line 100.

Column Descriptions

Column 0.--For each line, enter the total direct costs from the corresponding line on Worksheet O-5, column 3.

Column 3A.--For each line, enter the sum of columns 0 through 3. The sum for each line is the accumulated cost and, unless an adjustment is required, is the Worksheet O-6, Part II, column 4, statistic for allocating A&G costs.

If an adjustment to the accumulated cost statistic on Worksheet O-6, Part II, column 4, is required to properly allocate A&G costs, enter the adjustment amount on Worksheet O-6, Part II, column 4A, for the applicable line. For example, when the hospice contracts for HIRC or HGIP services and the contractual costs include A&G costs, the contractual costs reported on Worksheet O-3, column 7, line 25, or Worksheet O-4, column 7, line 25, may be used to reduce the accumulated cost statistic on Worksheet O-6, Part II, column 4A, line 52 or line 53, respectively.

For each line, the accumulated cost statistic on Worksheet O-6, Part II, column 4, is the difference between the amount on Worksheet O-6, Part I, column 3A, and the adjustment amount on Worksheet O-6, Part II, column 4A. Accumulated cost for A&G is not included in the total statistic for the A&G cost center; therefore, transfer the amount on Worksheet O-6, Part I, column 3A, line 4, to Worksheet O-6, Part II, column 4A, line 4.

The total accumulated cost statistic for Worksheet O-6, Part II, column 4, line 4, is the difference between the total on Worksheet O-6, Part I, column 3A, line 101, and the amounts in column 4A of Worksheet O-6, Part II.

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.

Column 18.--Transfer the amounts on lines 50 through 53 as follows:

From Worksheet O-6, Part I, column 18:	To Worksheet O-8, column 3:
Line 50	Line 1
Line 51	Line 6
Line 52	Line 11
Line 53	Line 16

4723. WORKSHEET O-7 - APPORTIONMENT OF HHA-BASED HOSPICE SHARED SERVICE COSTS BY LEVEL OF CARE

This worksheet calculates the cost of ancillary services provided by HHA departments to HHA-based hospice patients.

Column Descriptions

Column 1.--For each cost center, enter in column 1, the cost for each discipline from Worksheet B, column 10, lines as indicated.

Column 2.--For each cost center, enter on the appropriate lines the total HHA charges from the provider's records, applicable to the HHA-based hospice.

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

Columns 4 through 7.--For each cost center, enter the charges, from the provider's records, for ancillary services provided by HHA ancillary departments to HHA-based hospice patients. Enter the charges by LOC in the appropriate LOC column.

Columns 8 through 11.--For each column, calculate cost of ancillary services provided by HHA ancillary departments to HHA-based hospice patients as follows:

<u>Column:</u>	<u>Calculation:</u>
8	col. 3 x col. 4
9	col. 3 x col. 5
10	col. 3 x col. 6
11	col. 3 x col. 7

For each column 8 through 11, enter the sum of lines 1 through 9, on line 10.

4724. WORKSHEET O-8 - CALCULATION OF HHA-BASED HOSPICE PER DIEM COST

Worksheet O-8 calculates the average cost per diem by level of care and in total.

Line 1.--Enter in column 3, the total HCHC cost from Worksheet O-6, Part I, column 18, line 50, plus Worksheet O-7, column 8, line 10.

Line 2.--Enter in column 3, the total HCHC days from Worksheet S-4, column 4, line 1.

Line 3.--Enter in column 3, the average HCHC cost per diem by dividing column 3, line 1, by column 3, line 2.

Line 4.--Enter in column 1, the title XVIII - Medicare HCHC days from Worksheet S-4, Part I, column 1, line 1. Enter in column 2, the title XIX - Medicaid HCHC days from Worksheet S-4, Part I, column 2, line 1.

Line 5.--Enter in column 1, the title XVIII - Medicare program cost calculated by multiplying column 3, line 3, by column 1, line 4. Enter in column 2, the title XIX - Medicaid program cost calculated by multiplying column 3, line 3, by column 2, line 4.

Line 6.--Enter in column 3, the total HRHC cost from Worksheet O-6, Part I, column 18, line 51, plus Worksheet O-7, column 9, line 10.

Line 7.--Enter in column 3, the total HRHC days from Worksheet S-4, column 4, line 2.

Line 8.--Enter in column 3, the average HRHC cost per diem by dividing column 3, line 6, by column 3, line 9.

Line 9.--Enter in column 1, the title XVIII - Medicare HRHC days from Worksheet S-4, column 1, line 2. Enter in column 2, the title XIX - Medicaid HRHC days from Worksheet S-4, column 2, line 2.

Line 10.--Enter in column 1, the title XVIII - Medicare program cost calculated by multiplying column 3, line 8, by column 1, line 9. Enter in column 2, the title XIX - Medicaid program cost calculated by multiplying column 3, line 8, by column 2, line 9.

Line 11.--Enter in column 3, the total HIRC cost from Worksheet O-6, Part I, column 18, line 52, plus Worksheet O-7, column 10, line 10.

Line 12.--Enter in column 3, the total HIRC days from Worksheet S-4, column 4, line 3.

Line 13.--Enter in column 3, the average HIRC cost per diem by dividing column 3, line 11, by column 3, line 12.

Line 14.--Enter in column 1, the title XVIII - Medicare HIRC days from Worksheet S-4, column 1, line 3. Enter in column 2, the title XIX - Medicaid HIRC days from Worksheet S-4, column 2, line 3.

Line 15.--Enter in column 1, the title XVIII - Medicare program cost calculated by multiplying column 3, line 13, by column 1, line 14. Enter in column 2, the title XIX - Medicaid program cost calculated by multiplying column 3, line 13, by column 2, line 14.

Line 16.--Enter in column 3, the total HGIP cost from Worksheet O-6, Part I, column 18, line 53, plus Worksheet O-7, column 11, line 10.

Line 17.--Enter in column 3, the total HGIP days from Worksheet S-4, column 4, line 4.

Line 18.--Enter in column 3, the average HGIP cost per diem by dividing column 3, line 16, by column 3, line 17.

Line 19.--Enter in column 1, the title XVIII - Medicare HGIP days from Worksheet S-4, column 1, line 4. Enter in column 2, the title XIX - Medicaid HGIP days from Worksheet S-4, column 2, line 4.

Line 20.--Enter in column 1, the title XVIII - Medicare program cost calculated by multiplying column 3, line 18, by column 1, line 19. Enter in column 2, the title XIX - Medicaid program cost calculated by multiplying column 3, line 18, by column 2, line 19.

Line 21.--Enter in column 3, the sum of lines 1, 6, 11, and 16.

Line 22.--Enter in column 3, total days from Worksheet S-4, column 4, line 5.

Line 23.--Enter the average cost per diem by dividing column 3, line 21, by column 3, line 22.

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**ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-1728-20
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This page is reserved for future use.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-1728-20
TABLE 1 - RECORD SPECIFICATIONS

Table 1 specifies the standard record format to be used for electronic cost reporting (ECR) file. Each electronic cost report submission (file) has four types of records. The first group (type 1 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 2 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 ECR files to contractors is CD, flash drive, or the CMS-approved Medicare Cost Report E-filing (MCREF) portal, [URL: <https://mcref.cms.gov>]. ECR files must comply with the CMS specifications. Providers should seek approval from their contractors regarding the method 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	1471002020001	20203668A99P001	20210902020366		
1	2	1728-20				
1	4	14:30				

Record #1: This is a cost report file submitted by Provider 147100 for the period from January 1, 2020 (2020001) through December 31, 2020 (2020366). It is filed on Form CMS-1728-20. 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 March 31, 2021 (2021090). The electronic cost report specification dated December 31, 2020 (2020366) is used to prepare this file.

FILE NAMING CONVENTION

Name each cost report ECR file in the following manner:

HHNNNNNN.YYLC, where

1. HH (Home Health Agency Cost Report) is constant;
2. NNNNNN is the 6 digit CMS Certification Number;
3. YY is the year in which the provider's cost reporting period ends;
4. L is a character variable (A-Z) to enable separate identification of files from HHAs with two or more cost reporting periods ending in the same calendar year; and
5. C is the number of times this original cost report is being filed.

Name each cost report PI file in the following manner:

PINNNNNN.YYLC, where

1. PI (Print Image) is constant;
2. NNNNNN is the 6 digit CMS Certification Number;
3. YY is the year in which the provider's cost reporting period ends;
4. L is a character variable (A-Z) to enable separate identification of files from HHAs with two or more cost reporting periods ending in the same calendar year; and
5. C is the number of times this original cost report is being filed.

**ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-1728-20
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.	Space	1	X	12	
4.	Record Number	1	X	13	Constant "1"
5.	Spaces	3	X	14-16	
6.	HHA CCN	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-1728-20)
10.	Vendor Code	3	X	38-40	To be supplied upon approval. Refer to page 47-503.
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 <i>2026181</i> . Prior approvals: <i>2024001</i> , 2023365, 2023001, 2022243, and 2020366.

**ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-1728-20
TABLE 1 - RECORD SPECIFICATIONS**

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

		<u>Size</u>	<u>Usage</u>	<u>Loc.</u>	<u>Remarks</u>
1.	Record Type	1	9	1	Constant "1"
2.	Spaces	10	X	2-11	
3.	Record Number	2	9	12-13	#2 - Cost report iteration identifier is 1728-20 in positions 21 through 27. #3 - Vendor information; optional record for use by vendors. Left justified in positions 21 through 60. #4 - The time that the ECR file is created. This is represented in military time as alpha numeric. Use positions 21 through 25. Example 2:30PM is expressed as 14:30. #5 through 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

		<u>Size</u>	<u>Usage</u>	<u>Loc.</u>	<u>Remarks</u>
1.	Record Type	1	9	1	Constant "2"
2.	Worksheet 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.	Sub column 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

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-1728-20
TABLE 1 - RECORD SPECIFICATIONS

RECORD NAME: Type 2 Records for Labels (Cont.)

The type 2 records contain text that appears on the printed cost report. Of these, there are three groups: (1) Worksheet A cost center names (labels); (2) column headings for step down 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 sub-column numbers are always set to zero.

Column headings for the General Service cost centers on Worksheets B, B-1, and O-6, Parts I and II, are supplied once, consisting of one to three records (lines 1 through 3). The statistical basis shown on Worksheets B-1 and O-6, Part II, are also reported. The statistical basis consists of one or two records (lines 4 and 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, code 3 = mileage (for transportation costs), and code 4 = all others. 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.

**ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-1728-20
TABLE 1 - RECORD SPECIFICATIONS**

RECORD NAME: Type 2 Records for Labels (Cont.)

Use the following type 2 cost center descriptions for Worksheet A standard cost center lines.

<u>Line</u>	<u>Description</u>
1	CAPITAL RELATED-BUILDINGS & FIXTURES
2	CAPITAL RELATED-MOVABLE EQUIPMENT
3	PLANT OPERATION & MAINTENANCE
4	TRANSPORTATION
5	TELECOMMUNICATIONS TECHNOLOGY
6	ADMINISTRATIVE & GENERAL
6.01	A&G SHARED COSTS ▲
6.02	A&G REIMBURSABLE COSTS ▲
6.03	A&G NONREIMBURSABLE COSTS ▲
7	NURSING ADMINISTRATION
8	MEDICAL RECORDS
16	SKILLED NURSING CARE-RN
17	SKILLED NURSING CARE-LPN
18	PHYSICAL THERAPY
19	PHYSICAL THERAPY ASSISTANT
20	OCCUPATIONAL THERAPY
21	CERTIFIED OCCUPATIONAL THERAPY ASST
22	SPEECH-LANGUAGE PATHOLOGY
23	MEDICAL SOCIAL SERVICES
24	HOME HEALTH AIDE
25	MEDICAL SUPPLIES CHARGED TO PATIENTS
26	DRUGS
27	COST OF ADMINISTERING VACCINES
28	DURABLE MEDICAL EQUIPMENT/OXYGEN
29	DISPOSABLE DEVICES
39	HOME DIALYSIS AIDE SERVICES
40	RESPIRATORY THERAPY
41	PRIVATE DUTY NURSING
42	CLINIC
43	HEALTH PROMOTION ACTIVITIES
44	DAY CARE PROGRAM
45	HOME DELIVERED MEALS PROGRAM
46	HOMEMAKER SERVICES
47	TELEHEALTH
48	ADVERTISING
49	FUNDRAISING
57	HOSPICE

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

**ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-1728-20
TABLE 1 - RECORD SPECIFICATIONS**

Type 2 records for Worksheet B-1, columns 1 through 8, for lines 1 through 5, and line 6, for columns 1, 2, and 4 only (capital cost centers and transportation columns), are listed below. The numbers running vertical to line 1 description 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	
4	TRANS-	PORTATION		MILEAGE		3
5	TELE-	COMMUN.	TECHNOLOGY	ACCUM.	COST	
6	ADMINIS-	TRATIVE &	GENERAL	ACCUM.	COST	
6.01	A&G	SHARED	COSTS	ACCUM.	COST	
6.02	A&G	REIMBURS	COSTS	ACCUM.	COST	
6.03	A&G	NONREIMBUR	COSTS	ACCUM.	COST	
7	NURSING	ADMINIS-	TRATION	DIRECT	NURS. HRS.	
8	MEDICAL	RECORDS		ACCUM.	COST	

Examples of type 2 records are below. Either zeros or spaces may be used in the line, subline, column, and sub column number fields (positions 11 through 20). Spaces are preferred. (See first two lines of the example.)* 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-BLDGS & FIXT
* 2A0000000000200000000200CAP REL COSTS-MVBLE EQUIP
2A000000 6 0600ADMINISTRATIVE & GENERAL
2A000000 18 1800PHYSICAL THERAPY
2A000000 41 4100PRIVATE DUTY NURSING
2A000000 47 4700TELEHEALTH
```

Examples of column headings for Worksheets B-1 and B, O-6 (Part II) and O-6 (Part I); statistical bases used in cost allocation on Worksheets B-1, O-6 (Part II), and statistical codes used for Worksheet B-1 (line 6) are displayed below. Also below is an example of Worksheets O-6, Part II (4th character indicates the 1st Hospice).

2B10000*	1	1	CAP REL	2O61002*	1	1	CAP REL
2B10000*	2	1	BLDGS &	2O61002*	2	1	BLDG
2B10000*	3	1	FIXTURES	2O61002*	3	1	FIX
2B10000*	4	1	SQUARE	2O61002*	4	1	SQUARE
2B10000*	5	1	FEET	2O61002*	5	1	FEET
2B10000*	6	1	1	2O61002*	1	6	LAUNDRY
2B10000*	1	2	CAP REL	2O61002*	2	6	& LINEN
2B10000*	2	2	MOVABLE	2O61002*	4	6	IN-FACIL-
2B10000*	3	2	EQUIPMENT	2O61002*	5	6	ITY DAYS
2B10000*	4	2	DOLLAR				
2B10000*	5	2	VALUE				
2B10000*	6	2	2				

**ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-1728-20
TABLE 1 - RECORD SPECIFICATIONS**

Type 2 records for Worksheet O-6, Part II, columns 1 through 17, lines 1 through 5 are listed below. The numbers running vertical to line 1 description, are the general service cost center line designations.

LINE					
	1	2	3	4	5
1	CAP REL	BLDG	& FIX	SQUARE	FEET
2	CAP REL	MVBLE	EQUIP	DOLLAR	VALUE
3	EMPLOYEE	BENEFITS	DEPARTMENT	GROSS	SALARIES
4	ADMINIS-	TRATIVE &	GENERAL	ACCUM.	COST
5	PLANT	OP &	MAINT	SQUARE	FEET
6	LAUNDRY	& LINEN		IN-FACIL-	ITY DAYS
7	HOUSE-	KEEPING		SQUARE	FEET
8	DIETARY			IN-FACIL-	ITY DAYS
9	NURSING	ADMINIS-	TRATION	DIRECT	NURS. HRS.
10	ROUTINE	MEDICAL	SUPPLIES	PATIENT	DAYS
11	MEDICAL	RECORDS		PATIENT	DAYS
12	STAFF	TRANS-	PORTATION		MILEAGE
13	VOLUNTEER	SVC COOR-	DINATION	HOURS OF	SERVICE
14	PHARMACY				CHARGES
15	PHYSICIAN	ADMIN	SERVICES	PATIENT	DAYS
16	OTHER	GENERAL	SERVICE	SPECIFY	BASIS
17	PATIENT/	RESIDENT	CARE SVCS	IN-FACIL-	ITY DAYS

Worksheet O-6, Part II, records share the same size constraints as the Worksheet B-1 records.

**ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-1728-20
TABLE 1 - RECORD SPECIFICATIONS**

RECORD NAME: Type 3 Records for Non Label Data

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

A sample of type 3 records and a number line for reference are below.

	1		2		3		4		5		6
123456789012345678901234567890123456789012345678901234567890											
3A000000	5	1			20502						
3A000000	8	1			6347						
3A000000	17	2			98469						

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-1728-20
TABLE 1 - RECORD SPECIFICATIONS

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

Worksheet A-6, columns 3 and 7
 Worksheet A-8, column 4
 Worksheet A-8-1, Part I, column 1

Examples of records (*) with a Worksheet A line number as data and a number line for reference are listed below. Example of grand total record for Worksheet A-6 (**) is also listed below.

	1			2			3			4			5			6		
	1234567890	1234567890	1234567890	1234567890	1234567890	1234567890	1234567890	1234567890	1234567890	1234567890	1234567890	1234567890	1234567890	1234567890	1234567890	1234567890	1234567890	
**	3A600000	100	4					225321										
**	3A600000	100	8					225321										
	3A6000G0	13	0	RENTAL	EXPENSE													
	3A6000G0	13	1	G														
*	3A6000G0	13	3					1.00										
	3A6000G0	13	5					221409										
*	3A6000G0	13	7					42.00										
	3A6000G0	13	9					225321										
	3A6000G0	14	0	RENTAL	EXPENSE													
	3A6000G0	14	1	G														
*	3A6000G0	14	3					4.00										
	3A6000G0	14	5					3912										
	3A800000	12	0	IRS	PENALTY													
	3A800000	12	1	B														
	3A800000	12	2					-935										
*	3A800000	12	4					4.00										
	3A800000	13	0	ADVERTISING														
	3A800000	13	1	A														
	3A800000	13	2					-14525										
*	3A800000	13	4					4.00										
*	3A810001	3	1					6.00										
	3A810001	3	3	CAT	SCANS													
	3A810001	3	4					1.00										
	3A810001	3	5					17.00										
	3A810001	3	6					3352										
	3A810001	3	7					1122										

RECORD NAME: TYPE 4 RECORDS

File Encryption and Date and Tape Stamp

This type 4 record consists of 3 records: 1, 1.01, and 1.02. These records are created at the point in which the ECR file has been completed and saved to disk, CD, or flash drive to ensure the integrity of the file.

**ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-1728-20
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 through 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 hospices (e.g., S-4 and O series). Alternatively, it may be used as part of the worksheet, e.g., worksheet A-8-1. The fourth digit of the worksheet indicator (position 5 of the record identifier) is not used. For Worksheet A-6, the fifth and sixth digits of the worksheet indicator (positions 6 and 7 of the record identifier) identify the reclassification code. The seventh digit of the worksheet indicator (position 8 of the record identifier) represents the worksheet or worksheet part.

Worksheets That Apply to the Home Health Agency Cost Report

<u>Worksheet</u>	<u>Worksheet Indicator</u>	
S, Part I	S000001	
S, Part II	S000002	
S, Part III	S000003	
S-2, Part I	S200001	
S-2, Part II	S200002	
S-3, Parts I, II, & III	S300000	(a)
S-3, Part IV	S300004	
S-3, Part V	S300005	
S-4, Parts I and II	S410000	(a) (b)
A	A000000	
A-6	A600??0	(c)
A-8	A800000	
A-8-1, Part I	A810001	
A-8-1, Part II	A810002	
B-1 (For use in column headings)	B10000*	(d)
B	B000000	
B-1	B100000	
C, Parts I and II	C000000	(a)
D, Parts I and II	D000000	(a)
D-1	D100000	
F	F000000	
F-1	F100000	

**ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-1728-20
TABLE 2 - WORKSHEET INDICATORS**

Worksheets That Apply to the Home Health Agency Cost Report (Continued)

<u>Worksheet</u>	<u>Worksheet Indicator</u>	
O	O010000	(b)
O-1	O110000	(b)
O-2	O210000	(b)
O-3	O310000	(b)
O-4	O410000	(b)
O-5	O510000	(b)
O-6, Part I	O610001	(b)
O-6, Part II (For use in column headings)	O61002*	(b) (d)
O-6, Part II	O610002	(b)
O-7	O710000	(b)
O-8	O810000	(b)

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-1728-20
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, S-4, C, and D.
- (b) Multiple HHA-Based Hospices
The third digit of the worksheet indicator (position 4th of the record) is numeric from 1 to 0 to accommodate multiple HHA-based hospices. If there is only one HHA-based hospice, the default is 1. This affects Worksheets S-4; O; O-1; O-2; O-3; O-4; O-5; O-6, Parts I and II; O-7; and O-8.
- (c) Worksheet A-6
For Worksheet A-6, include in the worksheet identifier the reclassification code as the 5th and 6th digits (positions 6th and 7th of the record). For example, 3A6000A0 or 3A6000B0, 3A6000C0, 3A6000AA0, 3A6000AB0, or 3A6000ZZ0. Additionally, for Worksheet A-6 include in the worksheet identifier "00" in the 5th and 6th digits (6th and 7th of the record) (3A600000) to identify grand total reclassification increases and grand total reclassification decreases.
- (d) Type 2 Records for Use in Column Headings
The asterisk (*) as the 7th digit of the worksheet indicator (position 8th of the record) indicates the data is a type 2 record identifying the column heading and statistical basis. This affects Worksheets B-1 and O-6, Part II.

**ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-1728-20
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN
DESIGNATIONS**

This table identifies the collection of all data elements from all worksheets in a home health agency cost report. This includes data elements necessary to calculate a home health agency cost report, informational data, and calculated data. Calculated fields (e.g., Worksheet A, column 10) are used 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 Medicare contractor. 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 and 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 and any other nonstandard cost center lines, all subscripted lines should be in sequence and consecutively numbered beginning with subscripted line number 01. Subscripts of lines and columns are based on the format (line or column (as applicable), field size, and usage) of the primary/parent line or column where the specifications in Table 3 do not specifically identify line or column designations. Automated systems should reorder these numbers where providers skip or delete a line in the series.

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

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

**ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-1728-20
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE,
AND COLUMN DESIGNATIONS**

<u>Description</u>	<u>Line</u>	<u>Column</u>	<u>Field Size</u>	<u>Usage</u>
WORKSHEET S				
<u>Part I - Cost Report Status</u>				
<u>Provider Use Only</u>				
Electronically filed cost report	1	1	1	X
Manually submitted cost report	2	1	1	X
If this is an amended report enter the number of times the provider resubmitted this cost report	3	1	1	X
Medicare Utilization - Enter "F" for full, "L" for low, "N" for no utilization in column 1; if applicable, enter "H" for hospice only in column 2.	4	1, 2	1	X
<u>Contractor Use Only</u>				
Cost Report Status				
Enter the cost report status code: 1 for as submitted, 2 for settled without audit, 3 settled with audit, 4 reopened, or 5 amended.	5	1	1	X
Date received (mm/dd/yyyy)	6	2	10	X
Contractor Number	7	2	5	X
Initial report for this Provider CCN	8	2	1	X
Final report for this Provider CCN	9	2	1	X
Notice of Program Reimbursement (NPR) date (mm/dd/yyyy)	10	3	10	X
Enter contractor's vendor code (ADR)	11	3	1	X
If line 5, column 1 is 4: enter the number of times reopened = 0-9	12	3	1	X
<u>Part II - Certification</u>				
Signature of Chief Financial Officer or Administrator	1	1	36	X
Checkbox (enter "Y" if electronic signature; otherwise, leave blank)	1	2	1	X
Printed Name	2	1	36	X
Title	3	1	36	X
Signature date (mm/dd/yyyy)	4	1	10	X
<u>Part III - Settlement Summary</u>				
Balances due provider or program: Title XVIII	1	1	11	-9

**ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-1728-20
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE,
AND COLUMN DESIGNATIONS**

<u>Description</u>	<u>Line</u>	<u>Column</u>	<u>Field Size</u>	<u>Usage</u>
WORKSHEET S-2, PART I				
<u>Home Health Agency Complex Address</u>				
Street	1	1	36	X
P. O. Box	1	2	9	X
City	2	1	36	X
State	2	2	2	X
ZIP Code	2	3	10	X
<u>Home Health Agency Component Identification</u>				
Component Name	3, 4	1	36	X
Provider CCN	3, 4	2	6	X
Date Certified (mm/dd/yyyy)	3, 4	3	10	X
Cost reporting period beginning date (MM/DD/YYYY)	5	1	10	X
Cost reporting period ending date (MM/DD/YYYY)	5	2	10	X
Type of Control (See Table 3B)	6	1	2	X
Does the HHA qualify as a nominal charge provider?	7	1	1	X
Does the HHA contract with outside suppliers for physical therapy services? (Y/N)	8	1	1	X
Does the HHA contract with outside suppliers for occupational therapy services? (Y/N)	9	1	1	X
Does the HHA contract with outside suppliers for speech therapy services? (Y/N)	10	1	1	X
Are there any costs included in Worksheet A that resulted from transactions with related organizations or HO/CO costs as defined in CMS Pub. 15-1, chapter 10? (Y/N) If yes, complete Worksheet A-8-1.	11	1	1	X

**ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-1728-20
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE,
AND COLUMN DESIGNATIONS**

<u>Description</u>	<u>Line</u>	<u>Column</u>	<u>Field Size</u>	<u>Usage</u>
WORKSHEET S-2, PART I (Cont.)				
<u>Malpractice Insurance Information</u>				
Is this HHA legally required to carry malpractice insurance? (Y/N)	12	1	1	X
If line 12 is yes, is the malpractice insurance a claims-made or occurrence policy? Enter "1" for claims-made or "2" for occurrence policy.	13	1	1	X
List amounts of malpractice premiums in column 1, paid losses in column 2, or self-insurance in column 3.	14	1, 2, 3	11	9
Are malpractice premiums and paid losses reported in a cost center other than A&G? (Y/N) If yes, submit supporting schedule listing cost centers and amounts contained therein.	15	1	1	X
<u>Home Office/Chain Organization Information</u>				
Receive allocation (Y/N)	16	1	1	X
Number of allocations	16	2	2	X
Name	17-17.99	1	36	X
CCN	17-17.99	2	6	X
Contractor Number	17-17.99	3	6	X
Street	17-17.99	4	36	X
City	17-17.99	5	36	X
State	17-17.99	6	2	X
ZIP Code	17-17.99	7	10	X

**ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-1728-20
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE,
AND COLUMN DESIGNATIONS**

<u>Description</u>	<u>Line</u>	<u>Column</u>	<u>Field Size</u>	<u>Usage</u>
WORKSHEET S-2, PART II				
<u>Provider Organization and Operation</u>				
Has the HHA changed ownership prior to the beginning of this cost reporting period? (Y/N)	1	1	1	X
If yes, enter the date of the change in column 2. (mm/dd/yyyy)	1	2	10	X
Has the HHA terminated participation in the Medicare program? (Y/N)	2	1	1	X
If column 1 is yes, enter in column 2 the date of termination. (mm/dd/yyyy)	2	2	10	X
If column 1 is yes, enter in column 3, "V" for voluntary or "I" for involuntary.	2	3	1	X
Is the HHA involved in business transactions, including management contracts, with individuals or entities that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (Y/N)	3	1	1	X
<u>Financial Data and Reports</u>				
Were the financial statements prepared by a certified public accountant? (Y/N)	4	1	1	X
If column 1 is yes, enter in column 2 "A" for audited, "C" for compiled or "R" for reviewed.	4	2	1	X
Submit a complete copy of financial statements or enter date available in column 3. (mm/dd/yyyy)	4	3	10	X
Are the cost report total expenses and total revenues different from those on the filed financial statements? (Y/N)	5	1	1	X
<u>Bad Debts</u>				
Is the HHA or HHA-based entities seeking reimbursement for bad debts? (Y/N)	6	1	1	X
If line 6 is yes, did the HHA's bad debt collection policy change during this cost reporting period? (Y/N)	7	1	1	X
If line 6 is yes, were patient coinsurance amounts waived? (Y/N)	8	1	1	X

**ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-1728-20
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE,
AND COLUMN DESIGNATIONS**

<u>Description</u>	<u>Line</u>	<u>Column</u>	<u>Field Size</u>	<u>Usage</u>
WORKSHEET S-2, PART II				
<u>PS&R Report Data</u>				
Was the cost report prepared using the PS&R Report only? (Y/N)	9	1	1	X
If yes, enter in column 2 the paid-through date of the PS&R Report used to prepare the cost report. (mm/dd/yyyy)	9	2	10	X
Was the cost report prepared using the PS&R Report for totals and the HHA's records for allocation? (Y/N)	10	1	1	X
If yes, enter in column 2 the paid-through date of the PS&R Report. (mm/dd/yyyy)	10	2	10	X
If line 9 or 10 is yes, were adjustments made to the PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file the cost report? (Y/N)	11	1	1	X
If line 9 or 10 is yes, were adjustments made to the PS&R Report data for corrections of other PS&R Report information? (Y/N)	12	1	1	X
If line 9 or 10 is yes, describe the other adjustments.	13	0	36	X
If line 9 or 10 is yes, were adjustments made to the PS&R Report data for Other? (Y/N)	13	1	1	X
Was the cost report prepared only using the HHA's records? (Y/N)	14	1	1	X
<u>Cost Report Preparer Contact Information</u>				
Enter the preparer's information:				
First Name	15	1	36	X
Last Name	15	2	36	X
Title	15	3	36	X
Employer	16	1	36	X
Phone Number	17	1	36	X
Email Address	17	2	36	X

**ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-1728-20
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE,
AND COLUMN DESIGNATIONS**

<u>Description</u>	<u>Line</u>	<u>Column</u>	<u>Field Size</u>	<u>Usage</u>
WORKSHEET S-3, PART I, II, & III				
<u>Part I - Visits Data</u>				
Number of HHA Visits by Discipline:				
Title XVIII - Medicare	1-9	1	11	9
Title XIX - Medicaid	1-9	3	11	9
Other	1-10	5	11	9
Total All Visits	1-10	7	11	9
Patient Census by Discipline:				
Title XVIII - Medicare	1-9	2	11	9
Title XIX - Medicaid	1-9	4	11	9
Other	1-10	6	11	9
Total All Patients	1-10	8	11	9
Total Visits:				
Title XVIII - Medicare	11	1	11	9
Title XIX - Medicaid	11	3	11	9
Other	11	5	11	9
Total All Visits	11	7	11	9
Home Health Aide Hours:				
Title XVIII - Medicare	12	1	11	9
Title XIX - Medicaid	12	3	11	9
Other	12	5	11	9
Total Home Health Aide Hours	12	7	11	9
Unduplicated Census Count:				
Title XVIII - Medicare	13	2	9	9(6).99
Title XIX - Medicaid	13	4	9	9(6).99
Other	13	6	9	9(6).99
Total	13	8	9	9(6).99
<u>Part II - Employment Data (Full-Time Equivalent)</u>				
Number of hours in a normal work week	14	0	6	9(3).99
Other (specify)	33	0	36	X
Number of full-time equivalent employees:				
Staff, Contract staff, Total	15-33	1-3	6	9(3).99
<u>Part III - Core Based Statistical Area Data</u>				
Total number of CBSAs where Medicare covered services were provided during the cost reporting period	34	1	2	9
List all CBSA codes for areas where Medicare covered home health services were provided	35	1	5	X

**ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-1728-20
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE,
AND COLUMN DESIGNATIONS**

<u>Description</u>	<u>Line</u>	<u>Column</u>	<u>Field Size</u>	<u>Usage</u>
Worksheet S-3, Part IV				
<u>Part IV - PPS Activity Data</u>				
<u>For each payment category:</u>				
Covered home health visits by cost center	1, 3, 5, 7, 9, 11	1, 2, 3, 4	11	9
Home health charges by cost center	2, 4, 6, 8, 10, 12	1, 2, 3, 4	11	9
Total Visits	13	1, 2, 3, 4	11	9
Other Charges	14	1, 2, 3, 4	11	9
Total Charges	15	1, 2, 3, 4	11	9
Total Number of Episodes/Periods	16	1, 3, 4	11	9
Total Number of Outlier Episodes/Periods	17	2, 4	11	9
Total Non-Routine Medical Supply Charges	18	1, 2, 3, 4	11	9
<u>Totals:</u>				
Total home health visits by cost center	1, 3, 5, 7, 9, 11	5	11	9
Total home health charges by cost center	2, 4, 6, 8, 10, 12	5	11	9
Total Visits	13	5	11	9
Other Charges	14	5	11	9
Total Charges	15	5	11	9
Total Number of Episodes/Periods	16	5	11	9
Total Number of Outlier Episodes/Periods	17	5	11	9
Total Non-Routine Medical Supply Charges	18	5	11	9

**ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-1728-20
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE,
AND COLUMN DESIGNATIONS**

<u>Description</u>	<u>Line</u>	<u>Column</u>	<u>Field Size</u>	<u>Usage</u>
WORKSHEET S-3, PART V				
<u>Part V - Occupational Category</u>				
<u>Direct Salaries - Nursing Occupations and</u>				
<u>Total Nursing:</u>				
Reported salaries	1-13	1	11	9
Fringe benefits	1-13	2	11	9
Adjusted salaries	1-13	3	11	9
Paid hours related to salary in column 3	1-13	4	11	9(8).99
Average hourly wage	1-13	5	6	9(3).99
<u>Contract Labor - Nursing Occupations and</u>				
<u>Total Nursing:</u>				
Reported salaries	14-26	1	11	9
Adjusted salaries	14-26	3	11	9
Paid hours related to salary in column 3	14-26	4	11	9(8).99
Average hourly wage	14-26	5	6	9(3).99
WORKSHEET S-4, PARTS I & II				
<u>Part I - Enrollment Days</u>				
Hospice Continuous Home Care	1	1, 2, 3, 4	11	9
Hospice Routine Home Care	2	1, 2, 3, 4	11	9
Hospice Inpatient Respite Care	3	1, 2, 3, 4	11	9
Hospice General Inpatient Care	4	1, 2, 3, 4	11	9
Total Hospice Days	5	1, 2, 3, 4	11	9
<u>Part II - Contracted Statistical Data</u>				
Hospice Inpatient Respite Care	6	1, 2, 3, 4	11	9
Hospice General Inpatient Care	7	1, 2, 3, 4	11	9

**ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-1728-20
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE,
AND COLUMN DESIGNATIONS**

<u>Description</u>	<u>Line</u>	<u>Column</u>	<u>Field Size</u>	<u>Usage</u>
WORKSHEET A				
Salaries	3-9, 16-30, 39-50, 57-58	1	11	-9
Employee Benefits	3-9, 16-30, 39-50, 57-58	2	11	-9
Transportation Costs	1-9, 16-30, 39-50, 57-58	3	11	-9
Contracted Purchased Services	3-9, 16-30, 39-50, 57-58	4	11	-9
Other Costs	1-9, 16-30, 39-50, 57-58	5	11	-9
Total	1-9, 16-30, 39-50, 57-58	6	11	-9
Reclassifications	1-9, 16-30, 39-50, 57-58	7	11	-9
Reclassified Trial Balance	1-9, 16-30, 39-50, 57-58	8	11	-9
Adjustments	1-9, 16-30, 39-50, 57-58	9	11	-9
Expenses for Cost Allocation	1-9, 16-30, 39-50, 57-58	10	11	-9
Total Costs	100	1-10	11	9

**ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-1728-20
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE,
AND COLUMN DESIGNATIONS**

<u>Description</u>	<u>Line</u>	<u>Column</u>	<u>Field Size</u>	<u>Usage</u>
WORKSHEET A-6				
For each expense reclassification:				
Explanation	1-99	0	36	X
Reclassification identification code	1-99	1	2	X
Increases:				
Worksheet A cost center	1-99	2	36	X
Worksheet A line number	1-99	3	5	99.99
Reclassification salary amount	1-99	4	11	9
Reclassification other amount	1-99	5	11	9
Decreases:				
Worksheet A cost center	1-99	6	36	X
Worksheet A line number	1-99	7	5	99.99
Reclassification salary amount	1-99	8	11	9
Reclassification other amount	1-99	9	11	9
Total	100 [#]	4, 5, 8, 9	11	9
Total Reclassification Increases	100 [#]	4, 5	11	9
Total Reclassification Decreases	100 [#]	8, 9	11	9

[#] See footnote "c" in "Table 2 - Worksheet Indicators" for appropriate worksheet indicators.

**ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-1728-20
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE,
AND COLUMN DESIGNATIONS**

<u>Description</u>	<u>Line</u>	<u>Column</u>	<u>Field Size</u>	<u>Usage</u>
WORKSHEET A-8				
Description of adjustment	12-49	0	36	X
Basis (A or B) *	1, 2, 3, 5-49	1	1	X
Amount *	1-49	2	11	-9
Cost Center	1, 2, 3, 5-49	3	36	X
Worksheet A line number +	1, 2, 3, 5-49	4	5	99.99
Total	50	2	11	-9

* These include subscripts of lines 12 through 49, requiring records for columns 1 and 2.

+ Include only subscripts of those lines, if activated by an entry in either of columns 1 or 2.

WORKSHEET A-8-1

Part I

Worksheet A line number	1-49	1	5	99.99
Cost center	1-49	2	36	X
Expense item(s)	1-49	3	36	X
Worksheet A-8-2, Part II, line number	1-49	4	5	99.99
Worksheet S-2, Part I, line number	1-49	5	5	99.99
Amount of allowable cost	1-49	6	11	-9
Amount included in Worksheet A	1-49	7	11	-9
Net Adjustments	1-49	8	11	-9
Total	50	6-8	11	-9

Part II

Type of interrelationship (A through G)	1-50	1	1	X
If type is G, description of relationship must be included	1-50	0	36	X
Name of individual or partnership with interest in provider and related organization	1-50	2	36	X
Percentage of ownership in provider	1-50	3	6	9(3).99
Name of related individual or organization	1-50	4	36	X
Percentage of ownership of provider	1-50	5	6	9(3).99
Type of business	1-50	6	36	X

**ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-1728-20
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE,
AND COLUMN DESIGNATIONS**

<u>Description</u>	<u>Line</u>	<u>Column</u>	<u>Field Size</u>	<u>Usage</u>
WORKSHEETS B AND B-1 - COLUMN HEADINGS *				
Cost center name	1, 2, 3 *	1-9	10	X
Statistical basis	4, 5 *	1-9	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 B

Net expenses for cost allocation	1-9, 16-30, 39-50, 57-58	0	11	9
Total expenses for cost allocation	100	0	11	9
Costs after cost finding by department	1-9, 16-30, 39-50, 57-58	1-4, 5, 6-7, 8-9	11	-9
Subtotal	5-9, 16-30 39-50, 57-58	4A	11	-9
Subtotal	6-9, 16-30 39-50, 57-58	5A	11	-9
Subtotal	8-9, 16-30 39-50, 57-58	7A	11	-9
Costs after cost finding and post step-down adjustments by department	16-30, 39-50, 57-58	10	11	-9
Total costs after cost finding and post step-down adjustments	100	1-10	11	9

**ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-1728-20
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE,
AND COLUMN DESIGNATIONS**

<u>Description</u>	<u>Line</u>	<u>Column</u>	<u>Field Size</u>	<u>Usage</u>
	WORKSHEET B-1			
For each cost allocation using accumulated costs as the statistic, include a record containing an X.	0	1-9	1	X
All cost allocation statistics	1-9, 16-30, 39-50, 57-58	1-9 *	11	9
Reconciliation	5-9, 16-30, 39-50, 57-58▲	5A-9A	11	-9
Cost to be allocated	100	1-9 +	11	9
Unit cost multiplier	101	1-9	10	9(3).9(6)

* In any column using accumulated costs as the statistical basis for allocating costs, identify any cost center that is not to receive an allocation either by entering a negative 1 (-1) on the appropriate line in the accumulated cost column, or by entering the total accumulated cost as a negative amount on the appropriate line in the reconciliation column. Cost centers that are not to receive an allocation cannot have entries in both the reconciliation and accumulated costs columns when the accumulated cost statistic is offset to zero.

▲ For those cost centers that are to receive partial allocation of costs, enter only the cost to be excluded from the statistics as a negative amount on the appropriate line in the reconciliation column. This will result in entries in both the reconciliation column and accumulated column simultaneously on the same line where a partial accumulated cost statistic is offset.

If line 6 is fragmented, line 6 must be deleted and subscripts of line 6 must be used.

+ Include any column which uses accumulated cost as its basis for allocation.

**ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-1728-20
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE,
AND COLUMN DESIGNATIONS**

<u>Description</u>	<u>Line</u>	<u>Column</u>	<u>Field Size</u>	<u>Usage</u>
WORKSHEET C, PARTS I & II				
<u>Part I - Aggregate HHA Cost Per Visit and Aggregate Medicare Cost Computation</u>				
Total cost by discipline	1-9	2	11	9
Total visits by discipline	1-9	3	11	9
Average cost per visit by discipline	1-9	4	6	9(3).99
HHA Medicare program visits by discipline	1-9	5	11	9
HHA Medicare program costs by discipline	1-9	6	11	9
Total (sum of lines 1 through 9)	10	2, 3, 5, 6	11	9
<u>Part II - Supplies, Drugs, and Disposable Devices Cost Computation</u>				
Total cost	11, 12, 13, 14	1	11	9
Total charges	11, 12, 13, 14	2	11	9
Ratio of costs to charges	11, 12, 13, 14	3	8	9.9(6)
Medicare covered charges for medical supplies from HHA records or the PS&R	11	5, 6	11	9
Medicare covered charges for drugs from HHA records or the PS&R	12	5, 6	11	9
Medicare cost not subject to deductibles and coinsurance	11, 12	8	11	9
Medicare cost subject to deductibles and coinsurance	11, 12	9	11	9
Medicare covered charges for administering vaccines and disposable devices from HHA records or the PS&R	13, 14	4	11	9
Medicare cost of administering vaccines and disposable devices reimbursed under OPSS	13, 14	7	11	9

**ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-1728-20
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE,
AND COLUMN DESIGNATIONS**

<u>Description</u>	<u>Line</u>	<u>Column</u>	<u>Field Size</u>	<u>Usage</u>
WORKSHEET D				
<u>Part I - Computation of the Lesser of Reasonable Cost or Customary Charges for Vaccines</u>				
Reasonable cost of vaccines	1	1, 2	11	9
Total vaccines charges	2	1, 2	11	9
Aggregate amount actually collected from patients liable for payment for services on a charge basis	3	1, 2	11	9
Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	4	1, 2	11	9
Ratio of line 3 to line 4	5	1, 2	8	9.9(6)
Total customary charges	6	1, 2	11	9
Excess of total customary charges over total reasonable cost	7	1, 2	11	9
Excess of reasonable cost over customary charges	8	1, 2	11	9
Subtotal of reasonable cost	9	1, 2	11	9
<u>Part II - Computation of Reimbursement Settlement</u>				
Total PPS payments by episode type	10, 11, 12, 13	1	11	9
Total PPS outlier payments	14, 15	1	11	9
Total other payments (see instructions)	16	1	11	-9
Payment for services reimbursed under OPPTS	17	1	11	9
Payments for DME, oxygen, and prosthetics & orthotics	18, 19, 20	1	11	9
Primary payer payments	21	1	11	9
Part B deductibles billed to Medicare patients	22	1	11	9
Subtotal	23	1	11	9

**ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-1728-20
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE,
AND COLUMN DESIGNATIONS**

<u>Description</u>	<u>Line</u>	<u>Column</u>	<u>Field Size</u>	<u>Usage</u>
WORKSHEET D (CONT.)				
<u>Part II - Computation of Reimbursement Settlement (cont.)</u>				
Coinsurance billed to Medicare patents	24	1	11	9
Allowable bad debts	25	1	11	9
Adjusted reimbursable bad debts	26	1	11	9
Allowable bad debts for dual eligible beneficiaries	27	1	11	9
Subtotal	28	1	11	9
Other adjustments (specify)	29	0	36	X
Other adjustments	29	1	11	-9
Other demonstration payment adjustment amount before sequestration	30	1	11	-9
Amount due HHA prior sequestration adjustment	31	1	11	9
Sequestration adjustment	32	1	11	9
Sequestration adjustment for non-claims based	32.75	1	11	9
Amount due HHA after sequestration adjustment	33	1	11	9
Other demonstration payment adjustment amount after sequestration	34	1	11	-9
Amount due HHA	35	1	11	-9
Total interim payments	36	1	11	-9
Tentative settlement	37	1	11	-9
Balance due HHA/Medicare program	38	1	11	-9
Protested amounts	39	1	11	-9

**ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-1728-20
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE,
AND COLUMN DESIGNATIONS**

<u>Description</u>	<u>Line</u>	<u>Column</u>	<u>Field Size</u>	<u>Usage</u>
WORKSHEET D-1				
Total interim payments paid to HHA	1	2	11	9
Interim payments payable	2	2	11	9
Date of each retroactive lump sum adjustment (mm/dd/yyyy)	3.01-3.98	1	10	X
Amount of each retroactive lump sum adjustment:				
Program to Provider	3.01-3.49	2	11	9
Provider to Program	3.50-3.98	2	11	9
Subtotal	3.99	2	11	-9
Total interim payments	4	2	11	9
Date of each tentative settlement payment (mm/dd/yyyy)	5.01-5.98	1	10	X
Amount of each tentative settlement payment:				
Program to Provider	5.01-5.49	2	11	9
Provider to Program	5.50-5.98	2	11	9
Subtotal	5.99	2	11	-9
<i>Net</i> settlement amount Program to Provider	6.01	2	11	9
Net settlement amount Provider to Program	6.02	2	11	9
Total Medicare program liability	7	2	11	9
Name of Contractor	8	1	36	X
Contractor Number	8	2	5	X
NPR date (mm/dd/yyyy)	8	3	10	X

**ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-1728-20
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN
DESIGNATIONS**

<u>Description</u>	<u>Line</u>	<u>Column</u>	<u>Field Size</u>	<u>Usage</u>
WORKSHEET F				
Current Assets	1-9	1	11	-9
Total Current Assets	10	1	11	-9
Fixed Assets	11-26, 26.50	1	11	-9
Total Fixed Assets	27	1	11	-9
Other Assets	28, 29, 30, 30.50	1	11	-9
Total Other Assets	31	1	11	-9
Total Assets	32	1	11	-9
Current Liabilities	33-39	1	11	-9
Total Current Liabilities	40	1	11	-9
Long Term Liabilities	41-44	1	11	-9
Total Long Term Liabilities	45	1	11	-9
Total Liabilities	46	1	11	-9
Fund Balances	47	1	11	-9
Total Liabilities and Fund Balances	48	1	11	-9

NOTE: All amounts for lines 6, 13, 15, 17, 19, 21, 23, and 25 should be entered as positive amounts (the usage is 9).

WORKSHEET F-1

Gross patient revenues	1	1-4	11	9
Allowances and discounts on patients' accounts	2	1-4	11	-9
Net patient revenues	3	1-4	11	9
Operating expenses	4	2	11	9
Additions to operating expenses (specify)	5-10	0	36	X
Additions to operating expenses	5-10	1	11	9
Subtractions from operating expenses (specify)	11-16	0	36	X
Subtractions from operating expenses	11-16	1	11	9
Total operating expenses	17	2	11	9
Net income from service to patients	18	2	11	-9
Other revenues	19, 21-31	1	11	9
Income (or loss) from investments	20	1	11	-9
Other revenues (specify)	28-31	0	36	X
COVID-19 PHE funding	31.50	1	11	9
Total other income	32	2	11	9
Net income or loss for the period	33	2	11	-9

**ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-1728-20
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE,
AND COLUMN DESIGNATIONS**

<u>Description</u>	<u>Line</u>	<u>Column</u>	<u>Field Size</u>	<u>Usage</u>
WORKSHEET O				
Salaries	3-16, 26-47, 60-71	1	11	-9
Other Costs	1-16, 25-47, 60-71	2	11	-9
Subtotal	1-16, 25-47, 60-71	3	11	-9
Reclassifications	1-16, 25-47, 60-71	4	11	-9
Subtotal	1-16, 25-47, 60-71	5	11	-9
Adjustments	1-16, 25-47, 60-71	6	11	-9
Net Expenses for Allocation	1-16, 25-47, 60-71	7	11	-9
Total	100	1-7	11	9
WORKSHEETS O-1 & O-2				
Direct Patient Care Service Cost Centers	26-47	1-7	11	-9
Total	100	1-7	11	9
WORKSHEETS O-3 & O-4				
Direct Patient Care Service Cost Centers	26-47	1	11	-9
Direct Patient Care Service Cost Centers	25-47	2-7	11	-9
Total	100	1-7	11	9

**ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-1728-20
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE,
AND COLUMN DESIGNATIONS**

<u>Description</u>	<u>Line</u>	<u>Column</u>	<u>Field Size</u>	<u>Usage</u>
WORKSHEET O-5				
Hospice Direct Expenses	1-16, 50-53, 60-71	1	11	-9
General Service Expenses	1, 2, 4, 5, 9, 11, 12, 16	2	11	-9
Total Expenses	1-16, 50-53, 60-71	3	11	-9
Total	100	1, 2, 3	11	9

WORKSHEET O-6, PART II – COLUMN HEADINGS *

Cost center name	1, 2, 3 *	1-17	10	X
Statistical basis	4, 5 *	1-17	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 O-6, PART I

Net expenses for cost allocation	1-16, 50-53, 60-71	0	11	9
Total expenses for cost allocation	100	0	11	9
Costs after cost finding by department	1-17, 50-53, 60-71, & 99	1-3, 4-17	11	-9
Subtotal	4-17, 50-53, 60-71	3A	11	-9
Costs after cost finding and post step-down adjustments by department	50-53, 60-71, & 99	18	11	-9
Total costs after cost finding and post step-down adjustments	100	1-18	11	9

**ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-1728-20
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE,
AND COLUMN DESIGNATIONS**

<u>Description</u>	<u>Line</u>	<u>Column</u>	<u>Field Size</u>	<u>Usage</u>
WORKSHEET O-6, PART II				
For each cost allocation using accumulated costs as the statistic, include a record containing an X.	0	1-17	1	X
All cost allocation statistics	1-17, 50-53, 60-71	1-17 *	11	9
Reconciliation	4-17, 50-53, 60-71	4A	11	-9
Cost to be allocated	101	1-17 +	11	9
Unit cost multiplier	102	1-17	10	9(3).9(6)

* In any column using accumulated costs as the statistical basis for allocating costs, identify any cost center that is not to receive an allocation either by entering a negative 1 (-1) on the appropriate line in the accumulated cost column, or by entering the total accumulated cost as a negative amount on the appropriate line in the reconciliation column. Cost centers that are not to receive an allocation cannot have entries in both the reconciliation and accumulated cost columns when the accumulated cost statistic is offset to zero.

For those cost centers that are to receive partial allocation of costs, enter only the cost to be excluded from the statistics as a negative amount on the appropriate line in the reconciliation column. This will result in entries in both the reconciliation column and accumulated column simultaneously on the same line where a partial accumulated cost statistic is offset.

+ Include any column which uses accumulated cost as its basis for allocation.

WORKSHEET O-7

Total HHA Costs	1-9	1	11	9
Total HHA Charges	1-9	2	11	9
Cost to Charge Ratio	1-9	3	8	9.9(6)
Charges by Level Of Care:				
HCHC	1-9	4	11	9
HRHC	1-9	5	11	9
HIRC	1-8	6	11	9
HGIP	1-8	7	11	9
Shared Service Costs by Level Of Care:				
HCHC	1-9	8	11	9
HRHC	1-9	9	11	9
HIRC	1-8	10	11	9
HGIP	1-8	11	11	9
Total	10	8-11	11	9

**ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-1728-20
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE,
AND COLUMN DESIGNATIONS**

<u>Description</u>	<u>Line</u>	<u>Column</u>	<u>Field Size</u>	<u>Usage</u>
WORKSHEET O-8				
Level Of Care:				
Total cost	1, 6, 11, 16	3	11	9
Total unduplicated days	2, 7, 12, 17	3	11	9
Total average cost per diem	3, 8, 13, 18	3	9	9(6).99
Unduplicated program days	4, 9, 14, 19	1, 2	11	9
Program cost	5, 10, 15, 20	1, 2	11	9
Total Hospice Care:				
Total cost	21	3	11	9
Total unduplicated days	22	3	11	9
Total average cost per diem	23	3	9	9(6).99

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-1728-20**TABLE 3A - WORKSHEETS REQUIRING NO INPUT**

All Worksheets require input

TABLE 3B - TABLE TO WORKSHEET S-2, PART I

Type of Control:

- 1 = Voluntary Nonprofit, Church
- 2 = Voluntary Nonprofit, Other
- 3 = Proprietary, Individual
- 4 = Proprietary, Partnership
- 5 = Proprietary, Corporation
- 6 = Private Non-Profit
- 7 = Governmental and Private Combined
- 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 SUBSCRIBED
(BEYOND THOSE PREPRINTED)**

Worksheet S, Parts I, II, & III: ALL
 Worksheet S-2, Part I: lines 1, 2, 3, and 5 through 16
 Worksheet S-2, Part II: ALL
 Worksheet S-3, Parts I, II, & III: lines 1 through 32, and 34
 Worksheet S-3, Part IV: ALL
 Worksheet S-3, Part V: ALL
 Worksheet S-4, Parts I & II: ALL
 Worksheet A: lines 1 through 5, 7, 8, 16 through 29, 39 through 49, and 100
 Worksheet A-6: ALL
 Worksheet A-8: lines 1 through 11, and 50
 Worksheet A-8-1, Part I: line 50
 Worksheet A-8-1, Part II: line 50
 Worksheet B: SAME AS WORKSHEET A
 Worksheet B-1: SAME AS WORKSHEET A
 Worksheet C, Parts I & II: ALL
 Worksheet D: ALL, except line 29
 Worksheet D-1: lines 1, 2, 4, and 6, 7, 8

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-1728-20**TABLE 3C - LINES WHICH CANNOT BE SUBSCRIBED
(BEYOND THOSE PREPRINTED) - (Cont.)**

Worksheet F: ALL

Worksheet F-1: ALL, except lines 5 through 10, 11 through 16, and 28 through 31

Worksheet O, Part I: ALL

Worksheet O-1: ALL

Worksheet O-2: ALL

Worksheet O-3: ALL

Worksheet O-4: ALL

Worksheet O-5: ALL

Worksheet O-6, Part I: ALL

Worksheet O-6, Part II: ALL

Worksheet O-7: ALL

Worksheet O-8: ALL

This page is reserved for future use.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-1728-20 COST CENTER CODING

INSTRUCTIONS FOR PROGRAMMERS

Cost center coding is required because there are thousands of unique cost center names in use by providers. Many of these names are unique to the reporting provider and give no hint as to the actual function of the cost center. Cost center coding provides standardized meanings and facilitates data analysis.

Worksheet A presents the cost center codes and descriptions for standard cost centers (see Table 5). When the preparer subscribes a Worksheet A cost center, they must select from the list of allowed non-standard cost center codes and associated descriptions (if applicable) for that subscribed line (see Table 5). If the non-standard cost center code does not have an associated cost center label, the cost report preparer must enter a unique cost center label in the description column.

Additional guidelines are:

- Any pre-existing codes for the line must not be allowed to carry over.
- All "Other . . ." lines must not be pre-coded.
- The order of choice is standard first, followed by specific nonstandard, and lastly, the nonstandard "Other . . ." cost centers.
- When the nonstandard "Other . . ." is chosen, the preparer must be prompted with "Is this the most appropriate choice?" and offered a chance to answer yes or to select another description.
- The cost center coding process must be able to be edited for purposes of making corrections.
- A separate list showing the preparer's added cost center name on the left with the chosen standard or nonstandard descriptions and code on the right must be printed for review.
- The number of times a description can be selected on a given report must be displayed on the screen next to the description and this number must decrease with each usage to show the remaining number available. The number of times a description can be selected is shown on the standard and nonstandard cost center tables.
- Standard cost center lines, descriptions, and codes are not to be changed. The acceptable format for these are displayed in the STANDARD COST CENTER DESCRIPTIONS AND CODES listed on page 47-343. The proper line number is the first two digits of the cost center code. All "Other" nonstandard lines must include an appropriate cost center name.

INSTRUCTIONS FOR PREPARERS

Coding of Cost Center Labels

Cost center coding is a methodology for standardizing the meaning of cost center labels as used by the HHA on the Medicare cost report. The use of this coding methodology allows the HHA to use their labels for cost centers that have meaning within the institution.

The four digit codes are required and must be associated with each cost center label/description. The codes provide standardized meaning for data analysis. The preparer must code all added cost center labels/descriptions. Standard cost center labels/descriptions are automatically coded by CMS approved cost report software.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-1728-20 COST CENTER CODING

Coding of Cost Center Labels (cont.)

Additional cost center descriptions have been identified through analysis of provider labels. The meanings of these additional descriptions were sufficiently different when compared to the standard labels to warrant their use. These additional descriptions are hereafter referred to as the nonstandard labels. Included with the nonstandard descriptions are “Other . . .” designations to provide for situations where no match in meaning can be found. Refer to Worksheet A, lines 9, 30, 50, and 58. Both the standard and nonstandard cost center descriptions, along with their cost center codes, are shown on Table 5. The “USE” column on that table indicates the number of times that a given code can be used on one cost report. Compare your added cost center labels/descriptions to the standard and nonstandard table and select the appropriate cost center code. CMS approved software provides an automated process for selecting an appropriate code to properly match with your added cost center label/description.

Additional Guidelines

Categories

You must make your selection from the proper category such as general service description for general service cost center lines, nonreimbursable descriptions for nonreimbursable cost center lines, etc.

Cost Center Coding and Line Restrictions

Cost center codes may only be used in designated lines in accordance with the classification of the cost center(s), i.e., lines 1 through 9 may only contain cost center codes within the general service cost centers category of both standard and nonstandard coding. For example, in the general service cost centers category for “Other General Service (specify)” cost, line 9 and subscripts must contain cost center codes of 0900 through 0919 which are identified as nonstandard cost center codes. This logic must hold true for all other cost center categories, i.e., other health care costs, other than HHA services, and nonreimbursable cost centers.

Administrative and General Cost Centers

A&G can either be shown as one cost center with a code of 0600 or fragmented by one of two distinct methods. If A&G is fragmented, do not use line 6 or cost center code 0600. Elect one of the following options to allocate fragmented A&G service costs, but do not use both.

Option 1: Fragment the A&G service cost center into HHA shared costs, HHA 100% reimbursable costs, and HHA 100% nonreimbursable costs, in this order only:

<u>Cost Center Description</u>	<u>Line Numbers</u>	<u>Cost Center Codes</u>
A&G Shared costs	6.01	0623
A&G Reimbursable costs	6.02	0621
A&G Nonreimbursable costs	6.03	0622

Option 2: Standard A&G service cost center fragmentation:

<u>Line Numbers</u>	<u>Cost Center Codes</u>
6.01 through 6.19	0601 through 0619

**ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-1728-20
TABLE 5 - STANDARD COST CENTER DESCRIPTIONS AND CODES**

	<u>CODE</u>	<u>USE</u>
GENERAL SERVICE COST CENTERS		
Capital Related - Bldg & Fixt	0100	(01)
Capital Related - Mvble Equip	0200	(01)
Plant Operation & Maintenance	0300	(01)
Transportation	0400	(01)
Telecommunications Technology	0500	(01)
Administrative & General	0600	(20)
Nursing Administration	0700	(01)
Medical Records	0800	(01)
HHA REIMBURSABLE SERVICES		
Skilled Nursing Care-RN	1600	(01)
Skilled Nursing Care-LPN	1700	(01)
Physical Therapy	1800	(01)
Physical Therapy Assistant	1900	(01)
Occupational Therapy	2000	(01)
Certified Occupational Therapy Asst	2100	(01)
Speech-Language Pathology	2200	(01)
Medical Social Services	2300	(01)
Home Health Aide	2400	(01)
Medical Supplies Charged to Patients	2500	(01)
Drugs	2600	(01)
Cost of Administering Vaccines	2700	(01)
Durable Medical Equipment/Oxygen	2800	(01)
Disposable Devices	2900	(01)
HHA NONREIMBURSABLE SERVICES		
Home Dialysis Aide Services	3900	(01)
Respiratory Therapy	4000	(01)
Private Duty Nursing	4100	(01)
Clinic	4200	(01)
Health Promotion Activities	4300	(01)
Day Care Program	4400	(01)
Home Delivered Meals Program	4500	(01)
Homemaker Services	4600	(01)
Telehealth	4700	(01)
Advertising	4800	(01)
Fundraising	4900	(01)
SPECIAL PURPOSE COST CENTERS		
Hospice	5700	(10)

**ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-1728-20
TABLE 5 - NONSTANDARD COST CENTER DESCRIPTIONS AND CODES**

	<u>CODE</u>	<u>USE</u>
GENERAL SERVICE COST CENTERS		
A&G Shared Costs	0623	(01)
A&G Reimbursable Costs	0621	(01)
A&G Nonreimbursable Costs	0622	(01)
Other General Service Costs (specify)	0900	(20)
HHA REIMBURSABLE SERVICES		
Other HHA Reimbursable Service Costs (specify)	3000	(20)
HHA NONREIMBURSABLE SERVICES		
Other HHA Nonreimbursable Service Costs (specify)	5000	(20)
SPECIAL PURPOSE COST CENTERS		
Other Special Purpose Cost Centers (specify)	5800	(20)

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-1728-20 EDITS

Medicare cost reports submitted electronically must meet a variety of edits. These include mathematical accuracy edits, certain minimum file requirements, and other data edits. Any vendor software which produces an electronic cost report file for Medicare HHAs 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 HHA 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 submitted by a provider containing a level 1 edit will be rejected by the contractors. Notification must be made to CMS for any exceptions.

The edits are applied at two levels. Level 1 edits (1000 series reject codes) test the format of the data to identify error conditions that must be corrected or they will result in a cost report rejection. These edits also test for critical data elements specified in Table 3. Vendor programs must prevent HHAs from generating an electronic cost report (ECR) file when the cost report violates any level 1 edits. Level 2 edits (2000 series edit codes) identify potential inconsistencies and missing data items. These items should be resolved at the HHA site and supporting documentation (such as worksheets or data) should be submitted with the cost report.

The vendor requirements (above) and the edits (below) reduce both contractor processing time and unnecessary rejections. Vendors must develop their programs to prevent their client HHAs from generating an ECR file where Level 1 edit conditions exist. In addition, ample warnings should be given to the HHA where level 2 edit conditions are violated.

Level 1 edit conditions are to be applied against title XVIII services only. However, any inconsistencies or omissions that would cause a Level 1 condition for non-title XVIII services must be resolved prior to acceptance of the cost report. [01/01/2020b and ending on or after 12/31/2020]

NOTE: The date in brackets [] at the end of each edit indicates the effective date of the edit. A date without an alpha suffix, such as [12/31/2020], indicates the edit is effective for cost reporting periods ending on or after the date in brackets. A date followed by a "b", such as [01/01/2020b], indicates the edit is effective for cost reporting periods beginning on or after the date in brackets. A date followed by an "s", such as [01/01/2020s], indicates the edit is effective for services rendered on or after the date in brackets.

I. Level 1 Edits (Minimum File Requirements)

Edit Condition

- | | |
|------|---|
| 1000 | The first digit of every record must be either 1, 2, 3, or 4 (encryption code only).
[12/31/2020] |
| 1005 | No record may exceed 60 characters. [12/31/2020] |
| 1010 | All alpha characters must be in upper case. This is exclusive of the encryption code, type 4 record, record numbers 1, 1.01, and 1.02. [12/31/2020] |
| 1015 | For micro systems, the end of record indicator must be a carriage return and line feed, in that sequence. [12/31/2020] |

**ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-1728-20
TABLE 6 - EDITS****Edit Condition**

- 1020 The HHA provider number (record #1, positions 17 through 22) must be valid and numeric (issued by the applicable certifying agency and falls within the specified range). [12/31/2020]
- 1025 All calendar format dates must be edited for 10-character format, e.g., 01/01/2020 (MM/DD/YYYY). [12/31/2020]
- 1030 All dates (record #1, positions 23 through 29, 30 through 36, 45 through 51, and 52 through 58) must be in Julian format and legitimate. [12/31/2020]
- 1035 The fiscal year beginning date (record #1, positions 23 through 29) must be less than the fiscal year ending date (record #1, positions 30 through 36). [12/31/2020]
- 1036 The fiscal year ending date (record #1, positions 30 through 36) must be 30 days greater than the fiscal year beginning date (record #1, positions 23 through 29) and the fiscal year ending date (record #1, positions 30 through 36) must be less than 458 days greater than the fiscal year beginning date (record #1, positions 23 through 29). [12/31/2020]
- 1040 The vendor code (record #1, positions 38 through 40) must be a valid code. [12/31/2020]
- 1045 The type 1 record #1 must be correct and the first record in the file. [12/31/2020]
- 1050 All record identifiers (positions 1 through 20) must be unique. [12/31/2020]
- 1055 Only a Y or N is valid for fields which require a Yes/No response. [12/31/2020]
- 1060 Variable columns (Worksheet B and Worksheet B-1) must have a corresponding type 2 record (Worksheet A label) with a matching line number. [12/31/2020]
- 1065 All line, sub line, column, and sub column numbers (positions 11 through 13, 14 through 15, 16 through 18, and 19 through 20, respectively) must be numeric, except that each cost center using accumulated cost as the statistical basis must have a Worksheet B-1 reconciliation column numbered the same as the Worksheet A line number followed by an "A" as part of the line number followed by the sub line number. [12/31/2020]
- 1067 The cost center code (positions 21 through 24) (type 2 records) must be a code from Table 5, Cost Center Coding, and each cost center code must be unique. [12/31/2020]

**ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-1728-20
TABLE 6 - EDITS**

Edit Condition

1070 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. [12/31/2020]

<u>Cost Center</u>	<u>Line</u>	<u>Code</u>
Capital Related-Bldg & Fixt	1	0100
Capital Related-Mvble Equip	2	0200
Plant Operation & Maintenance	3	0300
Transportation	4	0400
Telecommunications Technology	5	0500
Administrative and General	6	0600
Nursing Administration	7	0700
Medical Records	8	0800
Physical Therapy Assistant	19	1900
Occupational Therapy	20	2000
Certified Occupational Therapy Asst	21	2100
Speech-Language Pathology	22	2200
Medical Social Services	23	2300
Home Health Aide	24	2400
Medical Supplies Charged to Patients	25	2500
Drugs	26	2600
Cost of Administering Vaccines	27	2700
Durable Medical Equipment/Oxygen	28	2800
Disposable Devices	29	2900
Home Dialysis Aide Services	39	3900
Respiratory Therapy	40	4000
Private Duty Nursing	41	4100
Clinic	42	4200
Health Promotion Activities	43	4300
Day Care Program	44	4400
Home Delivered Meals Program	45	4500
Homemaker Services	46	4600
Telehealth	47	4700
Advertising	48	4800
Fundraising	49	4900
Hospice	57	5700

1075 Cost center integrity must be maintained throughout the cost report. For subscripted lines, the relative position must be consistent throughout the cost report. [12/31/2020]

1080 Every line used on Worksheet A, B, B-1, and C, there must be a corresponding type 2 record. [12/31/2020]

**ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-1728-20
TABLE 6 - EDITS****Edit Condition**

- 1085 Fields requiring numeric data (charges, visits, days, costs, FTEs, etc.) may not contain any alpha character. [12/31/2020]
- 1090 A numeric field (except unit cost multipliers) cannot exceed more than 11 positions. Unit cost multipliers cannot exceed 13 positions. [12/31/2020]
- 1095 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. [12/31/2020]
- 1100 All dates must be possible, e.g., no “00”, no “30”, or “31” of February. [12/31/2020]
- 1000S The HHA provider name, address, provider CCN, and certification date (Worksheet S-2, Part I, line 3, column 1 (provider name); line 1, column 1 (street address); line 2, column 1 (city), column 2 (state), column 3 (ZIP code); line 3, column 2 (CCN); and line 3, column 3 (certification date), respectively) must be present and valid. [12/31/2020]
- 1001S If Worksheet S, Part I, line 5, is “5” (amended cost report), then line 3 must be greater than zero, and vice versa. [12/31/2020]
- 1002S If Worksheet S, Part I, column 1, line 4, is “L” or “N”, then Worksheet D, column 1, line 25, must be zero. [12/31/2020]*
- 1005S The cost report beginning date (Worksheet S-2, Part I, column 1, line 5) must be on or after January 1, 2020, and the cost report ending date (Worksheet S-2, Part I, column 2, line 5) must be on or after December 31, 2020. [12/31/2020]
- 1010S The type of control (Worksheet S-2, Part I, column 1, line 6) must have a value of 1 through 13. (See Table 3B.) [12/31/2020]
- 1015S All provider CCN and component numbers displayed on Worksheet S-2, Part I, column 2, lines 3 and 4, must contain six (6) alphanumeric characters. [12/31/2020]
- 1020S The cost report period beginning date (Worksheet S-2, Part I, column 1, line 5) must precede the cost report ending date (Worksheet S-2, Part I, column 2, line 5). [12/31/2020]
- 1025S For each provider/component name reported (Worksheet S-2, Part I, column 1, lines 3 and 4), there must be corresponding entries made on Worksheet S-2, Part I, lines 3 and 4, for the CCN (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. [12/31/2020]

**ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-1728-20
TABLE 6 - EDITS**

Edit Condition

1030S Worksheet S-2, Part I, column 2, lines as indicated below must only contain those CCNs as indicated for that line. The type of provider is also indicated. The first two characters “XX” corresponds to the two-digit state code. [12/31/2020]

<u>Line</u>	<u>Provider CCN</u>	<u>Type of Provider</u>
3	XX-3100 through 3199	Home Health Agency
	XX-7000 through 8499	Home Health Agency
	XX-9000 through 9799	Home Health Agency
4	XX-1500 through 1799	HHA-Based Hospice

1035S On Worksheet S-2, Part I, there must be a “Y” or “N” response for:
Column 1: lines 7 through 11, 12, 15, and 16. [12/31/2020]

1040S If Worksheet S-2, Part I, line 8, 9, or 10, is “Y”, respectively, then the corresponding line 18, 20, or 22, column 10, on Worksheet A must be greater than zero. If Worksheet S-2, Part I, line 8, 9, or 10, is “N”, then Worksheet A, column 4, the corresponding line 18, 20, or 22, must be zero. [12/31/2020]

1045S The CBSA count on Worksheet S-3, Part III, column 1, line 34, must be greater than zero. Do not apply this edit if Worksheet S, Part I, line 4, column 2, is “H”. [09/30/2021]

1050S If Worksheet S-2, Part I, line 12, is “Y”, then line 13 must contain a “1” or “2”, and line 14, sum of columns 1 through 3, must be greater than zero. [12/31/2020]

1060S If Worksheet S-2, Part I, line 16, column 1, is “Y”, then Worksheet S-2, Part I, line 16, column 2, must be greater than zero; and if Worksheet S-2, Part I, line 16, column 1, is “N”, then Worksheet S-2, Part I, line 16, column 2, must be blank. [12/31/2020]

1065S If Worksheet S-2, Part I, line 16, column 2, is greater than 1 (one), then Worksheet S-2, Part I, line 17, must be subscripted so that the total number of lines available (line 17 and subscripts) equals the number entered on Worksheet S-2, Part I, line 16, column 2. [12/31/2020]

1070S If Worksheet S-2, Part I, line 16, column 1, is “Y”, then Worksheet S-2, Part I, line 17 and each subscripted line thereof, must have a HO/CO name; HO/CO CCN; HO/CO contractor number; and the HO/CO street address, city, state, and ZIP code; entered in columns 1 through 7, respectively; and if Worksheet S-2, Part I, line 17, any of columns 1 through 7, has an entry, then Worksheet S-2 Part I, line 16, column 1, must be “Y” and Worksheet S-2, Part I, line 16, column 2, must be greater than zero. Conversely, if Worksheet S-2, Part I, line 16, column 1, “N”, then Worksheet S-2, Part I, line 17, columns 1 through 7, must be blank. [12/31/2020]

1100S On Worksheet S-2, Part II, there must be a “Y” or “N” response for:

Column 1: lines 1 through 6, 9, 10, and 14.

If column 1, line 6, is “Y”, then column 1, lines 7 and 8, must be “Y” or “N”.

If column 1, line 6, is “N”, then Worksheet D, column 1, line 25, must be zero.

If column 1, lines 9 or 10, is “Y”, then column 1, lines 11, 12, and 13, must be “Y” or “N”. [12/31/2020]

**ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-1728-20
TABLE 6 - EDITS****Edit Condition**

- 1105S If Worksheet S-2, Part II, column 1, line 1, is “Y”, then column 2 must contain a valid date (MM/DD/YYYY), and vice versa. [12/31/2020]
- 1110S If Worksheet S-2, Part II, column 1, line 2, is “Y”, then column 2 must contain a valid date (MM/DD/YYYY) and column 3 must contain a “V” or an “I”, and vice versa. [12/31/2020]
- 1120S If Worksheet S-2, Part II, column 1, line 3, is “N”, then Worksheet A-8-1 must not be present. [12/31/2020]
- 1130S If Worksheet S-2, Part II, column 1, line 3, is “Y”, then Worksheet A-8-1, Part I, columns 6 or 7, sum of lines 1 through 49, must not equal zero; and Worksheet A-8-1, Part II, column 1, any one of lines 1 through 50 must contain one of the alpha characters A, B, C, D, E, F, or G. [12/31/2020]
- 1140S If Worksheet S-2, Part II, column 1, line 4, is “Y”, then column 2 must be “A”, “C” or “R” and column 3, if entered, must be a valid date (MM/DD/YYYY). If Worksheet S-2, Part II, column 1, line 4, is “N”, then columns 2 and 3 must be blank. [12/31/2020]
- 1170S If Worksheet S-2, Part II, column 1, line 9, is “Y”, then column 2 must contain a valid date (MM/DD/YYYY), and vice versa. [12/31/2020]
- 1180S If Worksheet S-2, Part II, column 1, line 10, is “Y”, then column 2 must contain a valid date (MM/DD/YYYY), and vice versa. [12/31/2020]
- 1190S The cost report preparer information (Worksheet S-2, Part II, lines 15 through 17, all columns) must be valid and present. [12/31/2020]
- 1200S All amounts reported on Worksheet S-3, Part I, must not be less than zero. [12/31/2020]
- 1210S If the visits reported on Worksheet S-3, Part I, columns 1, 3, and 5, lines 1 through 9, respectively, are greater than zero, then the patient counts reported in columns 2, 4, and 6 must also be greater than zero, and vice versa. Apply this edit on a line by line basis. [12/31/2020]
- 1215S If Worksheet S, Part I, line 4, column 1 is “N” or Worksheet S, Part I, line 4, column 2 is “H”, then Worksheet S-3, Part I, column 1, line 11, must be zero, and vice versa. [12/31/2020]
- 1220S The patient count on Worksheet S-3, Part I, column 2, must be less than or equal to the visit count in column 1, on a line by line basis for lines 1 through 9. [12/31/2020]
- 1225S Total visits for the HHA in Worksheet S-3, Part I, column 7, line 11 and unduplicated census count for the HHA in Worksheet S-3, Part I, column 8, line 13, should be greater than zero. [12/31/2020] This edit was previously 2100S.
- 1230S Total visits on Worksheet S-3, Part I, column 7, line 11, must be greater than or equal to the unduplicated census count on Worksheet S-3, Part I, column 8, line 13. [12/31/2020]

**ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-1728-20
TABLE 6 - EDITS**

Edit Condition

- 1235S Total FTEs on Worksheet S-3, Part II, column 3, sum of line 15 through 33, must be greater than zero. [12/31/2020]
- 1240S If Worksheet S-3, Part III, line 34, has one or more CBSA codes, then line 35 and applicable subscripts, must be completed with a valid five-position alphanumeric CBSA code or more. [12/31/2020]
- 1260S For each column 1 through 4 on Worksheet S-3, Part IV, if either line 13 or 15 is greater than zero, then both lines 13 and 15 must be greater than zero. Additionally, if lines 13 and 15 are greater than zero, then the sum of lines 16 and 17 must also be greater than zero. [12/31/2020]
- 1265S For Worksheet S-3, Part IV, line 15, if column 1, 2, 3, or 4, is greater than zero, then the corresponding line on Worksheet D, lines 10 through 13, must be greater than zero. [12/31/2020]*
- 1266S For Worksheet S-3, Part IV, line 17, if column 2 or 4, is greater than zero, then the corresponding line on Worksheet D, line 14 or 15, must be greater than zero. [12/31/2020]*
- 1270S Medical supply charges on Worksheet S-3, Part IV, column 5, line 18, must equal Worksheet C, Part II, column 5, line 11. [12/31/2020]
- 1275S For each line on Worksheet S-3, Part IV, column 5, if the visits are greater than zero, then the amount on Worksheet A, column 10, for the applicable lines 16 through 24, must be greater than zero. Apply this edit as follows: [12/31/2020]
- | <u>Worksheet S-3, Part IV</u> | <u>Worksheet A, Column 10,</u> |
|-------------------------------|--|
| | <u>Column 5 is greater than zero must be greater than zero</u> |
| Line 1 | Sum of lines 16 and 17 |
| Line 3 | Sum of lines 18 and 19 |
| Line 5 | Sum of lines 20 and 21 |
| Line 7 | Line 22 |
| Line 9 | Line 23 |
| Line 11 | Line 24 |
- 1280S Worksheet S-3, Part V, column 3, sum of lines 4 through 13, and 17 through 26, must be greater than zero. [08/31/2022]
- 1300S If Worksheet S-4, Part I, column 4, line 1, is greater than zero, then Worksheet O-1, column 7, line 100, must be greater than zero, and vice versa. [12/31/2020]
- 1310S If Worksheet S-4, Part I, column 4, line 2, is greater than zero, then Worksheet O-2, column 7, line 100, must be greater than zero, and vice versa. [12/31/2020]

**ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-1728-20
TABLE 6 - EDITS****Edit Condition**

- 1320S If Worksheet S-4, Part I, column 4, line 3, is greater than zero, then Worksheet O-3, column 7, line 100, must be greater than zero, and vice versa. [12/31/2020]
- 1330S If Worksheet S-4, Part I, column 4, line 4, is greater than zero, then Worksheet O-4, column 7, line 100, must be greater than zero, and vice versa. [12/31/2020]
- 1340S Worksheet S-4, Part II, columns 1, 2, or 3, line 6, cannot be greater than Worksheet S-4, Part I, columns 1, 2, or 3, line 3, respectively. [12/31/2020]
- 1350S Worksheet S-4, Part II, columns 1, 2, or 3, line 7, cannot be greater than Worksheet S-4, Part I, columns 1, 2, or 3, line 4, respectively. [12/31/2020]
- 1360S If Worksheet S-4, Part II, column 4, line 6, is greater than zero, then Worksheet O-3, column 7, line 25, must be greater than zero, and if Worksheet S-4, Part II, column 4, line 7, is greater than zero, then Worksheet O-4, column 7, line 25, must be greater than zero. [12/31/2020]
- 1000A All amounts reported on Worksheet A, columns 1 through 5, and 10, line 100, must be greater than or equal to zero. [12/31/2020]
- 1010A For each amount on Worksheet A, column 10, lines 16 through 24, that are greater than zero, the corresponding total visits on Worksheet S-3, Part I, column 7, lines 1 through 9, must also be greater than zero, and vice versa. [12/31/2020]
- 1015A Worksheet A, column 10, line 47 (Telehealth), must equal zero effective for cost reporting periods beginning on or after January 1, 2023. [01/01/2023b]
- 1020A For reclassifications reported on Worksheet A-6, the sum of all increases (column 4 plus column 5) must equal the sum of all decreases (column 8 plus column 9). [12/31/2020]
- 1025A For each line on Worksheet A-6, when an entry is present in column 4 or 5, there must be an entry in columns 1 and 3, and if an entry is present in column 8 or 9, there must be an entry in columns 1 and 7. All entries in column 1 must be upper case alpha characters. [12/31/2020]
- 1032A Worksheet A-6, column 0, must have an explanation present on the first line for each reclassification code. [12/31/2020]
- 1040A For Worksheet A-8 adjustments on lines 1 through 3 and 5 through 11, if column 2 has an amount, then column 1 must be either "A" or "B", and column 4 for that line must have an entry, and if lines 12 through 49, column 2 have entries, then columns 0, 1, and 4, for the corresponding line must have entries. [12/31/2020]
- 1045A Worksheet A-8-1, Part I, columns 1 and 3, must have an entry when there is an amount in column 6 or 7 for each of lines 1 through 49. [12/31/2020]

**ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-1728-20
TABLE 6 - EDITS**

Edit Condition

1000B On Worksheet B-1, all statistical amounts must be greater than or equal to zero, except for reconciliation columns. [12/31/2020]

1005B Worksheet B, column 10, line 100, must be greater than zero. [12/31/2020]

1010B For each general service cost center with a net expense for cost allocation greater than zero (Worksheet B-1, columns 1 through 9, line 100), 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. [12/31/2020]

1015B For any column that uses accumulated cost as its basis of allocation (on Worksheet B-1), if there is a “-1” in the accumulated cost column, then there may not be an amount in the reconciliation column for the same cost center line. [12/31/2020]

1010C Total Medicare program (Title XVIII) visits reported on Worksheet C, Part I, column 5, must equal the visits reported on Worksheet S-3, Part IV, column 5, as follows:

<u>Worksheet C, Part I, column 5:</u>		<u>Worksheet S-3, Part IV, column 5:</u>
Sum of lines 1 and 2		Line 1
Sum of lines 3 and 4		Line 3
Sum of lines 5 and 6	Must equal	Line 5
Line 7		Line 7
Line 8		Line 9
Line 9		Line 11
[12/31/2020]		

1015C For Worksheet C, Part II, lines 11 and 12, on a line by line basis, column 2, (total charges), must be greater than or equal to Worksheet C, Part II, sum of columns 5 and 6 (Medicare charges); and Worksheet C, Part II, lines 13 and 14, on a line by line basis, column 2, (total charges), must be greater than or equal to Worksheet C, Part II, column 4 (Medicare charges). [12/31/2020]

1020C For Worksheet C, Part II, lines 11 and 12, on a line by line basis, column 1, (total costs), must be greater than or equal to Worksheet C, Part II, sum of columns 8 and 9 (Medicare costs); and Worksheet C, Part II, lines 13 and 14, on a line by line basis, column 1 (total costs), must be greater than or equal to Worksheet C, Part II, column 7 (Medicare costs). [12/31/2020]

1010D If Medicare HHA visits (Worksheet S-3, Part I, column 1, line 11) are greater than zero, then Medicare HHA costs (Worksheet D, Part II, column 1, line 28) must also be greater than zero, and vice versa. [12/31/2020]

1015D If Worksheet D, column 1, lines 10 through 15, or 17, are greater than zero, then Worksheet D, column 1, line 32, must be greater than zero, for cost reporting periods ending on or after April 1, 2022. [04/01/2022]

**ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-1728-20
TABLE 6 - EDITS****Edit Condition**

- 1020D If Worksheet D, Part II, column 1, line 35, is greater than zero, then Worksheet D-1, column 2, line 4, must also be greater than zero, and vice versa. [12/31/2020]
- 1030D If Worksheet S, Part I, line 4, column 1, is “F” then Worksheet D-1, column 2, line 4, and the sum of Worksheet D, Part II, column 1, lines 10 through 15 and lines 17 through 21, minus line 16, must both be greater than zero. If Worksheet S, Part I, line 4, column 2, is “H” do not apply this edit. [12/31/2020]
- 1000O For each HHA-based hospice, Worksheet O, column 7, line 100, must equal Worksheet A, column 10, line 57 (or the applicable subscript), when Worksheet S-2, columns 2 and 3, line 4 (or applicable subscripts), must have entries. [12/31/2020]
- 1050O Worksheet O-5, column 3, line 100, must equal Worksheet B, column 10, line 57. [12/31/2020]
- 1110O For each general service cost center with a net expense for cost allocation greater than zero (Worksheet O-6, Part II, columns 1 through 17, line 101), the corresponding total allocation statistic (Worksheet O-6, Part II, column 1, line 1; column 2, line 2, etc.) must also be greater than zero. Exclude from this edit any reconciliation column. [12/31/2020]
- 1120O Worksheet O-6, Part II, columns 6, 8, and 17, line 52, the statistic in each column must equal Worksheet S-4, column 4, line 3, minus Worksheet S-4, column 4, line 6. For Worksheet O-6, Part II, for each column 6, 8, and 17, if there is no cost on line 101, do not apply this edit. [12/31/2020]
- 1130O Worksheet O-6, Part II, columns 6, 8, and 17, line 53, the statistic in each column must equal Worksheet S-4, column 4, line 4, minus Worksheet S-4, column 4, line 7. For Worksheet O-6, Part II, for each column 6, 8, and 17, if there is no cost on line 101, do not apply this edit. [12/31/2020]
- 1140O Worksheet O-6, Part II, columns 10, 11, and 15, line 50, the statistic in each column must equal Worksheet S-4, column 4, line 1. For Worksheet O-6, Part II, for each column 10, 11, and 15, if there is no cost on line 101, do not apply this edit. [12/31/2020]
- 1150O Worksheet O-6, Part II, columns 10, 11, and 15, line 51, the statistic in each column must equal Worksheet S-4, column 4, line 2. For Worksheet O-6, Part II, for each column 10, 11, and 15, if there is no cost on line 101, do not apply this edit. [12/31/2020]
- 1160O Worksheet O-6, Part II, columns 10, 11, and 15, line 52, the statistic in each column must equal Worksheet S-4, column 4, line 3. For Worksheet O-6, Part II, for each column 10, 11, and 15, if there is no cost on line 101, do not apply this edit. [12/31/2020]
- 1170O Worksheet O-6, Part II, columns 10, 11, and 15, line 53, the statistic in each column must equal Worksheet S-4, column 4, line 4. For Worksheet O-6, Part II, for each column 10, 11, and 15, if there is no cost on line 101, do not apply this edit. [12/31/2020]

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-1728-20
TABLE 6 - EDITS**II. Level 2 Edits (Potential Rejection Errors)**

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

Edit Condition

- 2000 All type 3 records with numeric fields and a positive usage must have values greater than zero (supporting documentation may be required for negative amounts). [12/31/2020]
- 2005 All elements set forth in Table 3, with subscripts as appropriate, are required in the file. [12/31/2020]
- 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. [12/31/2020]
- 2020 All standard cost center codes must be entered on the designated standard cost center line and subscripts thereof as indicated in Table 5. [12/31/2020]
- 2025 Only nonstandard cost center codes within a cost center category may be placed on lines 9, 30, 50, and 58, and subscripts. [12/31/2020]
- 2035 Administrative and general cost center codes 00600, 00621, 00622, and 00623 (standard and nonstandard) may only appear on line 6 and subscripts of line 6. Other nonstandard descriptions and codes may also appear on subscripts of line 6, but must be within the general services cost center category. [12/31/2020]
- 2010S The HHA certification date (Worksheet S-2, Part I, column 3, line 3) should be on or before the cost report beginning date (Worksheet S-2, Part I, column 1, line 5). [12/31/2020]
- 2100S This edit has been redesignated as 1225S.
- 2105S If Medicare HHA unduplicated census count (Worksheet S-3, Part I, column 2, line 13) is greater than zero, then Worksheet S-3, Part I, sum of columns 1 and 5, line 11, and column 8, line 13, should be greater than zero. [12/31/2020]

**ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-1728-20
TABLE 6 - EDITS****Edit Condition**

2110S Worksheet S-3, Part I, column 1, line 11 (total Medicare visits), must not equal Worksheet S-3, Part IV, column 5, line 13 (PPS Medicare visits). [12/31/2020]

2010A Worksheet A, column 1, line 6 (A&G salaries), must be greater than zero. [12/31/2020]

Column headings (Worksheets B and B-1) are required as indicated for codes 2000B and 2005B:

2000B At least one cost center description (lines 1 through 3), at least one statistical basis label (lines 4 through 5), and one statistical basis code (line 6) (capital cost center lines only) must be present for each general service cost center with cost greater than zero (Worksheet B-1, columns 1 through 9, line 100). Exclude any reconciliation columns from this edit. [12/31/2020]

2005B 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. [12/31/2020]

2010B If the sum of Medicare visits on Worksheet S-3, Part I, column 1, lines 1 through 9, are greater than zero, then the corresponding cost on Worksheet B, column 10, lines 16 through 24, respectively (for each discipline), must also be greater than zero. [12/31/2020]

**ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-1728-20
TABLE 6 - EDITS****Edit Condition**

- 2000F Total assets on Worksheet F, line 32, must equal total liabilities and fund balances, line 48. [12/31/2020]
- 2005F Gross patient revenues (Worksheet F-1, column 4, line 1) should be equal to or greater than Medicare covered vaccines and drugs (Worksheet D, sum of columns 1 and 2, line 2). [12/31/2020]
- 2010F Net income or loss (Worksheet F-1, column 2, line 33) should not equal zero. [12/31/2020]
- 2015F Gross patient revenues (Worksheet F-1, column 4, line 1) must be greater than or equal to net patient revenues (Worksheet F-1, column 4, line 3). [12/31/2020]
- 2020F Worksheet F, line 48, must be greater than zero. [12/31/2020]

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.

This page is reserved for future use.

FORM CMS-1728-20 Worksheets

The following is a listing of the FORM CMS-1728-20 worksheets and the page number location.

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