



RF-3

Added column 3 for lines 8 through 14.

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

The following is a summary of some of the more significant revisions to the electronic reporting specifications to the cost report. Table 3 revises required data requirements for on Worksheet C, part III, line 16 and Worksheet RF-3. All changes indicated should be given equal importance, and failure to do so may result in the rejection of a cost report and/or suspension of a software vendor's authority to market the program until such changes are incorporated.

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

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

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

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

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

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

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

Column 8.--To determine the Medicare Part A cost, multiply the Medicare charges (column 5) by the ratio (column 4) for each line item. Enter the product in column 8.

Column 9-9.01.--To determine the Medicare Part B cost, multiply the Medicare charges (column 6) by the ratio (column 4) for each line item. Enter the product in column 9. **If applicable, multiply the Medicare charges (column 6.01) by the ratio (column 4) for each line item.**

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

3215.4 Part IV - Comparison of the Lesser of the Aggregate Medicare Cost, the Aggregate of the Medicare Per Visit Limitation and the Aggregate Per Beneficiary Cost Limitation.--This part provides for the comparison of the reasonable cost limitation applied to each home health agency's total allowable cost attributable to Medicare patient care visits. This comparison is required by 42 CFR 413.30 and 42 CFR 413.53. For cost reporting periods beginning on or after October 1, 1997, §1861(v)(1)(L) of the Social Security Act is amended by §4601 of BBA 1997, requiring home health agency net cost of covered services to be based on the lesser of the aggregate Medicare cost, the aggregate of the Medicare cost per visit limitation or the aggregate per beneficiary cost limitation. The per beneficiary cost limitation is derived by totaling the application of each MSA/non-MSA's unduplicated census count (two decimal places) (see §3205) to the per-beneficiary cost limitation for

the corresponding MSA/non-MSA. To accomplish this, the sum of all Worksheets C, Part II amounts in column 11, line 7, plus the applicable cost of medical supplies is compared with the sum of all Worksheets C, Part II amounts in column 11, line 14 plus the applicable cost of medical supplies and with the amount in column 6, line 24.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**3215.5 Part V - Outpatient Therapy Reduction Computation.**--This section computes the reduction in the reasonable costs of outpatient physical therapy services (which includes outpatient speech language pathology) and outpatient occupational therapy provided under arrangement for beneficiaries who are not homebound and are not covered by a physician's plan of care as required by §1834(k) of the Act and enacted by §4541 of BBA 1997. The amount of the reduction is 10 percent for services rendered on or after January 1, 1998. For outpatient therapy services rendered on or after January 1, 1999, §4541 of BBA 1997 mandates a fee schedule payment basis for outpatient physical therapy, outpatient occupational therapy, and outpatient speech pathology. Therefore, any outpatient therapy services furnished on or after January 1, 1999 **must not be included** in this section due to the application of a fee schedule for these services, but the corresponding visits must be recorded in column 5.01. These outpatient therapy services are reimbursed the lesser of the fee scheduled amount or the statutory limitation which is applied on a beneficiary specific basis through the Medicare claims system. This requires no provider input on the cost report. Columns 7 (visits) and 10 (costs) of Worksheet C, Part II represent data subject to deductible and coinsurance which should never have been subject to per visit cost limitations. This section (Worksheet C, Part V) was introduced in transmittal 6 (November 1998) to separately compile such visit and cost data not subject to deductible and coinsurance. As such, columns 7 and 10 of Worksheet C, Part II should not be used. Instead, such data should be captured in this section.

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

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

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

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

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

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

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

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

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

Worksheet D consists of the following two parts:

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

Part II - Computation of Reimbursement Settlement.

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

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

#### Line Descriptions

Line 1-- Reporting periods beginning prior to October 1, 2000, enter the cost of services from Worksheet C, Parts III, IV and V **based on the following table**. If the amount in column 6, line 19 is less than the amount in column 6, line 22, and the amount in column 6, line 24, transfer (aggregate Medicare cost). For cost reporting periods beginning on or after October 1, 2000, transfer the cost of osteoporosis drugs from Worksheet C, Part III, column 10, line 16 to column 3 of this worksheet. **For services rendered on or after January 1, 2003, do not transfer the cost of hepatitis vaccines from Worksheet C, Part III, column 9, line 16, as they remain OPSS reimbursed; however, transfer the cost of pneumococcal and influenza vaccines from Worksheet C, Part III, column 9.01, line 16 to column 2 of this worksheet, and the cost of osteoporosis drugs from Worksheet C, Part III, column 10, line 16 to column 3 of this worksheet.**

#### To Worksheet D, Line 1

#### From Worksheet C

Col. 1, Part A

Part IV, col. 3, line 19

Col. 2, Part B

Part III, sum of col. 9 line 16 (excluding subscripted lines), and Part IV, col. 4, line 19

Col. 3, Part B

Part III, sum of col. 10, lines 15 (excluding subscripted lines), 16 and 16.01, and Part V, col. 8, line 28

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

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

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

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

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

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

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

Line 4.01.--In column 2, enter from your records only the charges for applicable Medicare covered pneumococcal and influenza vaccines (see §3215.3) rendered on or after January 1, 2003 (from worksheet C, line 16, column 6.01). In column 3, enter from your records only the charges for applicable Medicare covered osteoporosis drugs (see §3215.3) rendered on or after October 1, 2000 (from worksheet C, line 16, column 7). For all other services rendered on or after October 1, 2000, do not enter any charges in columns 1 and 2.

Lines 5 through 8.--These lines provide for the accumulation of charges which relate to the reasonable cost on line 3.

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

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

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

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

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

Medicare program in a secondary payer include:

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

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

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



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

### 3216.2 Part II - Computation of Reimbursement Settlement.--

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Line 4.--Divide line 2 by line 3 and enter the result. Multiply each amount in Part I, column 6, lines 2 through 11, by the unit cost multiplier and enter the result on the corresponding line of column 7.

**3225.3 Part III - Allocation of General Service Costs to CMHC Cost Centers - Statistical Basis.**--Worksheet CM-1, Parts II and III, provide for the proration of the statistical data needed to equitably allocate the expenses of the general service cost centers on Worksheet CM-1, Part I. If there is a difference between the total accumulated costs reported on the Part III statistics and the total accumulated costs calculated on Part I, use the reconciliation column on Part III for reporting any adjustments. See §3214 for the appropriate usage of the reconciliation columns. For componentized A&G cost centers, the accumulated cost center line must match the reconciliation column number.

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

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

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

Lines 1 through 11.--On Worksheet CM-1, Part III, for all cost centers to which the general service cost center is being allocated, enter that portion of the total statistical base applicable to each.

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

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

Line 14.--Enter the unit cost multiplier which is obtained by dividing the cost entered on line 13 by the total statistic entered in the same column on line 12. Round the unit cost multiplier to six decimal places.

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

After the unit cost multiplier has been applied to all the cost centers receiving the services, the total cost (line 12, Part I) must equal the total cost on line 13, Part III.

Perform the preceding procedures for each general service cost center.

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

In column 7, Part I, for lines 2 through 11, multiply the amount in column 6 by the unit cost multiplier on line 4, Part II, and enter the result in this column. On line 12, enter the total of the amounts on lines 2 through 11. The total on line 12 equals the amount in column 6, line 1.

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

## 3226. WORKSHEET CM-2 - COMPUTATION OF CMHC COSTS

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

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

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

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

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

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

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

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

Column 4.--For each cost center, enter the corresponding charges from your records for Title XVIII CMHC services rendered on or after August 1, 2000, January 1, 2002, January 1, 2003, or January 1, 2004. For cost reporting periods beginning on or after January 1, 2004, enter zero (0).

Column 5.--For each cost center, enter the costs on or after **August 1, 2000, January 1, 2002, January 1, 2003, or January 1, 2004**, by multiplying the charges in column 4 by the ratio in column 3.

Column 6.-- For each cost center, enter the costs associated with services rendered prior to August 1, 2000, **January 1, 2002, January 1, 2003, or January 1, 2004**, by subtracting the amount in column 5 from the amount in column 3.02.

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

3226.2 Part II - Apportionment of Cost of CMHC Services Furnished by HHA Departments.-- Use this part only when the provider complex maintains a separate department for any of the cost centers listed on this worksheet, and the department provides services to patients of the HHA's CMHC.

Column 1.--Enter on each line the total cost for the HHA cost center as previously computed on Worksheet B, column 6, for the corresponding cost centers only when CHMC services are furnished by shared HHA departments.

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

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

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

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

Column 4.--For each cost center, enter the charges from your records for Title XVIII CMHC services rendered on or after August 1, 2000, **January 1, 2002, January 1, 2003, or January 1, 2004**. **For cost reporting periods beginning on or after January 1, 2004, enter zero (0).**

Column 5.--For each cost center, enter the costs **on or after August 1, 2000, January 1, 2002, January 1, 2003, or January 1, 2004** obtained by multiplying the charges in column 4 by the ratio in column 3.

Column 6.-- For each cost center, enter the costs associated with services rendered prior to August 1, 2000, **January 1, 2002, January 1, 2003, or January 1, 2004**, by subtracting the amount in column 5 from the amount in column 3.02.

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

3226.3 Part III - Total CMHC Costs.--

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

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

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

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

**NOTE:** Column 1 is subscripted for lines 1 through 18 for cost reporting periods which overlap August 1, 2000, January 1, 2002, January 1, 2003, or January 1, 2004, to accommodate the transitional corridor payment calculation associated with the portion of the cost reporting period which overlaps any of the aforementioned dates. For cost reporting periods which overlap a transition date enter in column 1 any data applicable to CMHC services rendered prior to the transition and enter in column 1.01 data applicable to CMHC services rendered on or after the transition date. For cost reporting periods that do not overlap transition dates and for cost reporting periods beginning on or after January 1, 2004, only complete column 1.

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

Line 1.--For cost reporting periods ending prior to August 1, 2000, enter in column 1 the applicable cost from Worksheet CM-2, column 5, line 17. CMHCs with cost reporting periods overlapping August 1, 2000, January 1, 2002, January 1, 2003, or January 1, 2004, enter in the applicable column the cost of services provided prior to the applicable transition date from Worksheet CM-2, column 6, line 17, and enter in the applicable column the cost of services provided on or after the applicable transition date from Worksheet CM-2, column 5, line 17. CMHCs with cost reporting periods beginning on or after January 1, 2004, enter zero (0) as CMHC services are reimbursed under 100% PPS.

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

Line 1.01.--Enter the gross PPS payments (includes deductible and coinsurance) received including payments for drugs and outliers.

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

Line 1.03.--Line 1 times line 1.02.

Line 1.04.--Line 1.01 divided by line 1.03. Express the results as a percentage to 3 decimal places, i.e., 94.824%. If this line is equal to or greater than 100%, enter zero on line 1.05.

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

For services rendered August 1, 2000 through December 31, 2001:

- a. If line 1.04 is => 90% but < 100% enter 80% of line 1.03 minus line 1.01.
- b. If line 1.04 is => 80% but < 90% enter the result of .71 times line 1.03 minus .70 times line 1.01.
- c. If line 1.04 is => 70% but < 80% enter the result of .63 times line 1.03 minus .60 times line 1.01.
- d. If line 1.04 is < 70% enter 21% of line 1.03.

For services rendered January 1, 2002 through December 31, 2002:

- a. If line 1.04 is => 90% but < 100% enter 70% of line 1.03 minus line 1.01.
- b. If line 1.04 is => 80% but < 90% enter the result of .61 times line 1.03 minus .60 times line 1.01.
- c. If line 1.04 is < 80% enter 13% of result line 1.03.

For services rendered January 1, 2003 through December 31, 2003:

- a. If line 1.04 is  $\geq$  90% but  $<$  100% enter 60% of line 1.03 minus line 1.01.
- b. If line 1.04 is  $<$  90% enter 6% of line 1.03.

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

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

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

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

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

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

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

### 3227.2 Part II - Computation of Reimbursement Settlement.--

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

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

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

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

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

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

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

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

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

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

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

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

**Line 21.**--Enter any other adjustment. For example, if you change the recording of vacation pay from the cash basis to the accrual basis, enter the adjustment. (See CMS Pub. 15-I, §2146.4.) Specify the adjustment in the space provided.

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

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

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

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

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

3228. WORKSHEET CM-4 - ANALYSIS OF PAYMENTS TO PROVIDER FOR CMHC SERVICES RENDERED TO PROGRAM BENEFICIARIES

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



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

#### Line Descriptions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

#### Line Descriptions

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

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

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

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

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

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

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

Lines 8 and 9.--Per visit payment limits are revised each January 1, (except calendar year 2003 updates that occurred January 1 and March 1 (see PM A-03-21)). Complete columns 1, 2 and 3, if

applicable (add column 3 for lines 8-14 if the cost reporting period overlaps 3 limit update periods) for lines 8 and 9 to identify costs and visits affected by different payment limits during a cost reporting period. Enter the rates and the corresponding data chronologically in the appropriate column as they occur during the cost reporting period.

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

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

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

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

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

#### Line Descriptions

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

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

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

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

Line 14.--Enter the limit adjustment. This is computed by multiplying the amount on line 13 by the outpatient mental health service limit of 62 1/2 percent. This limit applies only to therapeutic services, not initial diagnostic services.

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

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

Line 16.--Enter the total Medicare cost. This is equal to the sum of the amounts on line 11, columns 1, 2, and 3 plus line 14, columns 1, 2 and 3 plus line 15 minus line 15.5.

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

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

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

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

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

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

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

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

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

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

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

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

The cost and administration of pneumococcal and influenza vaccines to Medicare beneficiaries is 100 percent reimbursable by Medicare. This worksheet provides for the computation of these vaccines for services rendered from April 1, 2001 through December 31, 2002. Except for these dates, all vaccines are reimbursed through the parent provider and cannot be claimed by the RHC and FQHC.

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

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

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

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

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

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

Line 7.--Enter the amount from Worksheet RF-2, line 17.

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

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

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

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

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

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

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

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

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

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

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

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

The following are requirements for all records:

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

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

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

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

FILE NAMING CONVENTION

Name each cost report file in the following manner:

HHNNNNNN.YYL, where

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

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

RECORD NAME: Type 1 Records - Record Number 1

	<u>Size</u>	<u>Usage</u>	<u>Loc.</u>	<u>Remarks</u>
1. Record Type	1	X	1	Constant "1"
2. NPI	10	9	2-11	Numeric only
3. Spaces	1	X	12	
4. Record Number	1	X	13	Constant "1"
5. Spaces	3	X	14-16	
6. HHA Provider Number	6	9	17-22	Field must have 6 numeric characters.
7. Fiscal Year Beginning Date	7	9	23-29	YYYYDDD - Julian date; first day covered by this cost report
8. Fiscal Year Ending Date	7	9	30-36	YYYYDDD - Julian date; last day covered by this cost report
9. MCR Version	1	9	37	Constant "8" (for FORM CMS-1728-94)
10. Vendor Code	3	X	38-40	To be supplied upon approval. Refer to page 32-503.
11. Vendor Equipment	1	X	41	P = PC; M = Main Frame
12. Version Number	3	X	42-44	Version of extract software, e.g., 001=1st, 002=2nd, etc. or 101=1st, 102=2nd. The version number must be incremented by 1 with each recompile and release to client(s).
13. Creation Date	7	9	45-51	YYYYDDD – Julian date; date on which the file was created (extracted from the cost report)
14. ECR Spec. Date	7	9	52-58	YYYYDDD – Julian date; date of electronic cost report specifications used in producing each file. Valid for cost reporting periods ending on or after <b>2004031 (1/31/2004)</b> . Prior approval(s) 97090, 1998273, 1999304, 2000121, 2000305, and <b>2001273</b> .

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

<u>DESCRIPTION</u>	<u>LINE(S)</u>	<u>COLUMN(S)</u>	<u>FIELD SIZE</u>	<u>USAGE</u>
WORKSHEET A-6 (Continued)				
<u>Part C</u> - For each related organization:				
Type of interrelationship (A through G)	1-5	1	1	X
If type is G, specify description of relationship	1-5	0	36	X
Name of related individual or organization	1-5	2	36	X
Address of related individual or organization	1-5	3	36	X
Percent owned by provider	1-5	4	6	9(3).99
Percent ownership of provider	1-5	5	6	9(3).99
Type of business	1-5	6	15	X

WORKSHEET A-7

Analysis of changes in capital assets balances for land, land improvements, buildings and fixtures, building improvements, fixed and movable equipment, and in total:

Beginning balances	1-7	1	9	9
Purchases	1-7	2	9	9
Donations	1-7	3	9	9
Disposals and retirements	1-7	5	9	9

WORKSHEETS B and B-1 AND WORKSHEETS J-1, CM-1, RH-1, and FQ-1, PART III; and K-5, Part II HEADINGS

Column heading (cost center name)	1-3 +	1-5	10	X
Statistical basis	4, 5 +	1-5	10	X

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



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

<u>DESCRIPTION</u>	<u>LINE(S)</u>	<u>COLUMN(S)</u>	<u>FIELD SIZE</u>	<u>USAGE</u>
WORKSHEET B				
Adjustment for A&G costs applicable to contracted services	6-28 ▲	0	9	-9
Costs after cost finding by department	6-28	6	9	-9
Total costs after cost finding	29	6	9	9
WORKSHEET B-1				
All cost allocation statistics	1-28	1-5 *	9	9
Reconciliation	5-28	5A	9	-9
For each cost allocation using accumulated costs as the statistic, include a record containing an X.	0	1-5	1	X
<p>* In each column using accumulated costs as the statistical basis for allocating costs, identify each cost center that is to receive no allocation with a negative 1 (-1) placed in the accumulated cost column. Providers may elect to indicate total accumulated cost as a negative amount in the reconciliation column. However, there should never be entries in both the reconciliation column and accumulated column simultaneously. For those cost centers that are to receive partial allocation of costs, provide only the cost to be excluded from the statistic as a negative amount on the appropriate line in the reconciliation column. If line 5 is fragmented, line 5 must be deleted and subscripts of line 5 must be used.</p> <p>▲ For each cost center with associated A&amp;G service costs applicable to contracted services (see §3214), the amount entered in column 0 reduces the net expenses for allocation dollar for dollar. <b>After</b> all general service costs have been allocated on Worksheet B and column 6 totaled, but before any amounts are transferred to from Worksheet B to Worksheet C, add back the contracted A&amp;G service cost adjustment amount to the corresponding cost center.</p>				
WORKSHEET C				
<u>Parts I and II:</u>				
Medicare visits – Parts A and B	1-6 (and subscripts)	5-6	9	9
Medicare cost limits by discipline	8-13	4	6	9(3).99
<u>Parts III, IV, and V:</u>				
Total charges for medical supplies and drugs	15, 15.01, 16, 16.01	3	9	9
Charges for medical supplies – Medicare Parts A and B	15, 15.01	5-7	9	9
Charges for drugs – Medicare Part B	16, 16.01	6, 6.01, 7	9	9
Medicare unduplicated census count for each MSA	23-23.24	1	9	9(6).99
Medicare total unduplicated census count	24	1	9	9(6).99

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

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

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

WORKSHEET RF-1

Provider based cost	1-9, 11-13, 15-20, 23-27, & 29-30	1-5, 7, 9, & 10	9	-9
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ELECTRONIC REPORTING SPECIFICATIONS FOR FORM HCFA-1728-94  
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

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