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

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

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

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

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

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

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

Close the general service cost centers in accordance with 42 CFR 413.24(d)(1) which states, in part, that the cost of nonrevenue-producing cost centers serving the greatest number of other centers, while receiving benefits from the least number of centers, is apportioned first. This is further clarified in HCFA Pub. 15-I, §2306.1 which also clarifies the order of allocation for stepdown purposes. Consequently, first close those cost centers that render the most services to and receive the least services from other cost centers. The cost centers are listed in this sequence from left to right on the worksheet. However, the circumstances of an agency may be such that a more accurate result is obtained by allocating to certain cost centers in a sequence different from that followed on these worksheets.

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

EXCEPTION: A small HHA, as defined in 42 CFR 413.24(d), does not have to request written permission to use the procedures outlined for small HHAs below.

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 29. This enables column 6, line 29, to crossfoot to columns 0 and 4A, line 29. After receiving costs from the applicable overhead cost centers, if a revenue producing cost center has a credit balance on Worksheet B, column 6, 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 your records.

For all cost centers (below the cost center being allocated) to which the service rendered is being allocated, enter that portion of the total statistical base applicable to each. The total sum of the statistical base applied to each cost center receiving the services rendered must equal the total statistics entered on the first line.

Enter on Worksheet B-1, line 30, 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 30 by the total statistical base entered in the same column on the first line. Enter the resulting unit cost multiplier on line 31. 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 30) 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 6 the sum of the expenses on lines 6 through 28. The total expenses entered in column 6, line 29, should equal the total expenses entered in column 0, line 29.

Transfer the amounts in column 6 to Worksheet C, column 2, as follows:

From Worksheet B Column 6	To Worksheet C Column 2
Line 6	Line 1
7	2
8	3
9	4
10	5
11	6
12	15
13	16

Column Descriptions

Column 1--Depreciation on buildings and fixtures and expenses pertaining to buildings and fixtures such as insurance, interest, rent, and real estate taxes are combined in this cost center to facilitate cost allocation. Allocate all expenses to the cost centers on the basis of square feet of area occupied. The square footage may be weighted if the person who occupies a certain area of space spends their time in more than one function. For example, if a person spends 10 percent of time in one function, 20 percent in another function, and 70 percent in still another function, the square footage may be weighted according to the percentages of 10 percent, 20 percent, and 70 percent to the applicable functions.

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 detail allocation and transferring the accumulated costs by cost center to Worksheet B, column 1.

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

Column 4--The cost of vehicles owned or rented by the agency and all other transportation costs which were not directly assigned to another cost center on Worksheet 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.

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

Column 5--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 5, from Worksheet B, columns 0 through 4.

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

A&G costs applicable to contracted services may be excluded from the total cost (Worksheet B, column 0) for purposes of determining the basis of allocation (Worksheet B-1, column 5) of the A&G costs. This procedure may be followed when the HHA contracts for services to be performed for the HHA and the contract identifies the A&G costs applicable to the purchased services.

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

Worksheet B-1, Column 5A--Enter the costs attributable to the difference between the total accumulated cost reported on Worksheet B, column 4A, line 29 and the accumulated cost reported on Worksheet B-1, column 5, line 5. Enter any amounts reported on Worksheet B, column 4A for (1) any service provided under arrangements to program patients that is not grossed up and (2) negative balances. Including these costs in the statistics for allocating administrative and general expenses causes an improper distribution of overhead. In addition, report on line 5 the administrative and general costs reported on Worksheet B, column 5, line 5 since these costs are not included on Worksheet B-1, column 5 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 5 (A&G), the reconciliation column designation must be 5A.

Worksheet B-1, Column 5--The administrative and general expenses are allocated on the basis of accumulated costs. Therefore, the amount entered on Worksheet B-l, column 5, line 5, is the difference between the amounts entered on Worksheet B, column 4A and Worksheet B-1, column 5A. 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.

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

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

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

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

Column Descriptions for Small HHAs

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

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

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

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

Columns 3, 4, and 5.--Not needed.

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

3215. WORKSHEET C - APPORTIONMENT OF PATIENT SERVICE COSTS

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

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

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

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

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

Column Descriptions for Cost Per Visit Computation

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

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

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

3215.2 Part II - Computation of the Aggregate Medicare Cost and the Aggregate of the Medicare Limitation.--This part provides for the computation of the cost of Medicare patient care visits and the corresponding reasonable cost limitation for Medicare services provided in the MSA/CBSA/CBSA identified. Complete this part one time for each MSA/CBSA where Medicare beneficiary visits were provided during the cost reporting period. Lines 1 through 6 and column 11 are subscripted to isolate pre October 1, 2000 costs to facilitate the application of the lesser of aggregate costs or aggregate visit limits. Effective for cost reporting periods beginning on or after October 1, 2000, do not complete lines 8 through 14 as all HHAs are reimbursed under PPS and no longer subject to per visit cost limitations; but continue to complete lines 1 through 7.

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

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

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

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

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

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

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

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

Column Descriptions for Cost Limitation Computation

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

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

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

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

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

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

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

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

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

Lines 15 and 16.--Enter in column 2 the total applicable costs for the entire cost reporting period for each line item from Worksheet B, column 6, lines 12 and 13, respectively (the costs entered on lines 15 and 15.01 must be equal; the costs entered on lines 16 and 16.01 must be equal). Enter in column 3 the total charges for the entire cost reporting period for each line (the charges entered on lines 15 and 15.01 must be equal; the charges entered on lines 16 and 16.01 must be equal). The language in the two preceding parentheticals is only applicable for cost reporting periods which overlap October 1, 2000. *For cost reporting periods ending on or after July 1, 2006, enter in column 2 the total charges for services rendered on lines 15, 16, and 16.20, respectively.* Enter in column 4 the ratio of costs (column 2) to charges (column 3) for each line.

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

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

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

Line 16.--Enter in column 6 the charges for pneumococcal vaccine and its administration, influenza vaccine and its administration, and hepatitis B vaccine and its administration for services rendered prior to 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 through June 30, 2006, 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 through June 30, 2006, 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.

Effective for cost reporting periods ending on or after July 1, 2006 (see section 3206, line 13), line 16 represents pneumococcal, influenza, and hepatitis B vaccines, *and osteoporosis drugs,* but not the administration of these vaccines. See the chart below for proper placement of charges.

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 December 31, 2002, enter the charges in column 6. 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 and will use line 16 to record applicable data.

Line 16.20.--Effective for cost reporting periods ending on or after July 1, 2006 (see section 3206, line 13), line 16.20 represents the administration of pneumococcal, influenza, and hepatitis B vaccines. See the chart below for proper placement of charges.

Effective for cost reporting periods ending on or after July 1, 2006, enter vaccine charges according to the chart below:

Vaccines Charges

	Column 6	Column 7
Line 16	Enter charges for 7/1/2006 & subsequent hepatitis B vaccines. Enter charges for the full fiscal year for pneumococcal and influenza vaccines.	Enter charges for the full fiscal year for osteoporosis drugs.

Vaccines Charges (Continued)

	Column 6	Column 7
Line 16	Do not enter charges for pre 7/1/2006 hepatitis B vaccines.	
Line 16.20	Enter charges for pre 7/1/2006 pneumococcal and influenza vaccine administration. Do not enter charges for the full fiscal Year for hepatitis B vaccine administration. Do not enter charges for 7/1/2006 & subsequent pneumococcal and influenza vaccine administration. For fiscal years beginning on or after 7/1/2006 enter 0 (zero).	This location is shaded as the administration of the osteoporosis drugs is included in the skilled nursing visit.

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. Do not subscript column 9 for cost reporting periods ending after June 30, 2006.

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 are OPPS 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.

For cost reporting periods ending after July 1, 2006 (see §3206, line 13), transfer the cost of pneumococcal, influenza, and hepatitis vaccines from Worksheet C, Part III, column 9, 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. Also transfer the administration of pneumococcal and influenza vaccines from Worksheet C, Part III, column 9, line 16.20, to column 2.

To Worksheet D, Line 1	From Worksheet C
Col. 1, Part A .	Part IV, col. 3, line 19
Col. 2, Part B..	Part III, sum of col. 9 line 16 (excluding subscripted lines), and Part IV, col. 4, line 19
Col. 3, Part B..	Part III, sum of col. 10, lines 15 (excluding subscripted lines), 16 and 16.01, and Part V, col. 8, line 28

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

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

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

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

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

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

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

Line 4.01.--In column 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.

Effective for cost reporting periods ending after June 30, 2006, in column 2, enter the charges for Medicare covered pneumococcal, influenza, and hepatitis B vaccines (from worksheet C, Part III, lines 16 and 16.20, column 6). In column 3, enter the charges for Medicare covered osteoporosis drugs (from worksheet C, Part III, lines 16, column 7).

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 subscripted 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 25.5.--Enter any other adjustments. For example, enter an adjustment resulting from changing the recording of vacation pay from cash basis to accrual basis. (See CMS Pub. 15-I, §2146.4.) For purposes of reimbursing costs associated with the Outcome and Assessment Information Set (OASIS) as required by Program Memorandum A-00-03 (cost reporting periods beginning in Federal fiscal year 2000 only), report on this line, in column 1, the result of multiplying the Medicare unduplicated census count on Worksheet S-3, column 2, line 10 (excluding subscripts), times $10, minus the interim OASIS payment made to the provider on April 1, 2000. Do not include this interim OASIS payment on Worksheet D-1, but rather attach documentation supporting the payment(s). (For intermediary use only during final settlement.)

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

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

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

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

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

Line 31.--Do not use this line.

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

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

The column headings designate two categories of payments:

Category 1 - Part A
Category 2 - Part B

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

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

Line Descriptions

Line 1.--Enter the total Medicare interim payments paid to the HHA for all covered services rendered prior to October 1, 2000. Additionally, for services rendered on or after October 1, 2000, enter the total Medicare interim payments paid to the HHA for applicable covered osteoporosis drugs and any other vaccines 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.

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

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

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

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

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

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

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

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

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

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

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

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