1710. WORKSHEET C - APPORTIONMENT OF PATIENT SERVICE COSTS

This worksheet provides for the apportionment of home health patient service costs to title XVIII only. In addition, this worksheet provides for the computation of the reasonable cost limitation, applied to each home health agency's total allowable cost attributable to Medicare patient care visits. This computation is required by 42 CFR 413.53 and 42 CFR 413.30.

The computation of the lower of cost or cost limits is applied using either Worksheet C or Worksheet C - Aggregate Limits as follows:

Worksheet C.--Computation of the lesser of the Medicare cost per visit or the Medicare limitation cost compared on a per discipline basis for cost reporting periods beginning on or after 7/1/85, and prior to 7/1/86

Worksheet C - Aggregate Limits - Computation of the lesser of the aggregate Medicare cost or the aggregate of the Medicare limitation cost for cost reporting periods beginning on or after 7/1/86

1710.1 Worksheet C - Computation of the lesser of the Medicare cost per visit or the Medicare limitation cost compared on a per discipline basis for cost reporting periods beginning on or after 7/1/85, and prior to 7/1/86.--

Cost Per Visit Computation.--

COLUMN DESCRIPTIONS

Column 2--Enter in column 2 the amount for each discipline from Supplemental Worksheet H-4, column 6, lines as indicated.

Column 3--Enter the total agency visits from statistical data (Worksheet S-1, column 5, lines 1-6) 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.

Column 5--Enter the Medicare limitation (title XVIII of the Social Security Act, §1814(b)(1)) for each discipline, lines 1 through 6. The fiscal intermediary furnishes these limits to the HHA.

Column 6--Compare the amounts per discipline in columns 4 and 5 and enter the lesser amount in column 6.

Columns 7 and 9--To determine the Medicare Part A cost of service, multiply the number of covered Part A visits made to beneficiaries (column 7) (from provider records) by the per visit amount in column 6 for each discipline. The product is entered in column 9.

Columns 8 and 10--To determine the Medicare Part B cost of service, multiply the number of visits to Part B beneficiaries (column 8) (from provider records) by the per visit amount in column 6 for each discipline. The product is entered in column 10.

Note: The sum of the title XVIII visits on each line for columns 7 and 8 should equal the visits shown on Worksheet S-1, column 1, lines 1-6.

Supplies and Durable Medical Equipment Cost Computation.--Certain services 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 services.

EPNT items which are considered prosthetic devices furnished by a home health agency 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 services are only reimbursable under Part B.) Charges for these items must be included in the total charges, but excluded from the title XVIII charge statistics in the apportionment of DME and medical supply costs on Worksheet C, lines 8, 9 and 10.

Note: Section 2321 of the Deficit Reduction Act of 1984 changed the way Medicare reimburses HHAs for durable medical equipment and medical appliances. Effective with services rendered on or after July 18, 1984, medical appliances are no longer covered as a home health benefit. However, durable medical equipment furnished by an HHA is covered under both Part A and Part B of Medicare, subject to a 20 percent coinsurance payment under both Part A and Part B. Also, reimbursement for durable medical equipment furnished by an HHA is based on the lesser of reasonable cost or customary charges, computed separately for durable medical equipment.

Columns 1 through 4--Enter the total costs of each line item in this part, column 2, lines 8, 9 and 10, from Worksheet B, column 6, lines 12, 13 and 14, respectively. Develop a ratio of total cost (column 2) to total charges (column 3) and enter this ratio in column 4.

Columns 5 and 6--For Part A and Part B, enter in the appropriate column the Medicare charges for durable medical equipment - rented, durable medical equipment - sold and medical supplies charged to patients.

LINE DESCRIPTIONS FOR COLUMNS 5 AND 6

Lines 8 and 9--Enter the charges for medical appliances and/or durable medical equipment rented (line 8) and or sold (line 9).

Line 10--Enter the charges (from provider's records) for medical supplies charged to patients.

Columns 5 and 7--To determine the Medicare Part A cost, multiply the Medicare charges (column 5) by the ratio (column 4) for each line item. The product is entered in column 7.

Columns 6 and 8--To determine the Medicare Part B cost, multiply the Medicare charges (column 6) by the ratio (column 4) for each line item. The product is entered in column 8.

1710.2 Worksheet C - Aggregate Limits - Computation of the lesser of the aggregate Medicare cost or the aggregate of the Medicare limitation cost for cost reporting periods beginning on or after 7/1/86.--

Cost Per Visit Computation.--

COLUMN DESCRIPTIONS

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-1, column 5, lines 1-6) 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.

Columns 5 and 7--To determine the Medicare Part A cost of service, multiply the number of covered Part A visits made to beneficiaries (column 5) (from provider records) by the average cost per visit amount in column 4 for each discipline. The product is entered in column 7.

Columns 6 and 8--To determine the Medicare Part B cost of service, multiply the number of visits made to Part B beneficiaries (column 6) (from provider records) by the average cost per visit amount in column 4 for each discipline. The product is entered in column 8.

Note: The sum of the title XVIII visits on each line for columns 5 and 6 should equal the visits shown on Worksheet S-1, column 1, lines 1-6.

Column 9--Enter the total Medicare cost for each discipline, sum of columns 7 and 8. Add the amounts on lines 1 through 6 and enter this total on line 7.

Limitation Cost Computation.--

COLUMN DESCRIPTIONS

Column 4--Enter the Medicare limitation (title XVIII of the Social Security Act, §1814(b)(1)) for each discipline, lines 8 through 13. The fiscal intermediary furnishes these limits to the HHA.

Columns 5 and 7--To determine the Medicare limitation cost for Part A cost of service, multiply the number of covered Part A visits made to beneficiaries (column 5) (from provider records) by the Medicare cost limit amount in column 4 for each discipline. The product is entered in column 7.

Columns 6 and 8--To determine the Medicare limitation cost for Part B cost of service, multiply the number of visits to Part B beneficiaries (column 6) (from provider records) by the Medicare cost limit amount in column 4 for each discipline. The product is entered in column 8.

Column 9--Enter the total Medicare limitation cost for each discipline, sum of columns 7 and 8. Add the amounts on lines 8 through 13 and enter this total on line 14.

COMPARISON OF TOTAL MEDICARE COST WITH TOTAL MEDICARE LIMITATION COST

In order to determine the net cost of covered services, an HHA computes the lesser of aggregate Medicare cost or the aggregate of the Medicare limitation cost. To accomplish this, the total amount in column 9, line 7, is compared with the total amount in column 9, line 14. Whichever "total" is less determines the reimbursable amounts to be used for Part A (column 7, lines 7 or 14) and Part B (column 8, lines 7 or 14).

Supplies and Durable Medical Equipment Cost Computation.--Certain services 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 services.

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 services are only reimbursable under Part B.) Charges for these items must be included in the total charges, but excluded from title XVIII charge statistics in the apportionment of DME and medical supply costs on Worksheet C, lines 15, 16 and 17.

Note: Section 2321 of the Deficit Reduction Act of 1984 changed the way Medicare reimburses home health agencies for durable medical equipment and medical appliances. Effective with services rendered on or after July 18, 1984 medical appliances are no longer covered as a home health benefit. However, durable medical equipment furnished by a home health agency is covered under both Part A and Part B of Medicare, subject to a 20 percent coinsurance payment under both Part A and Part B. Also, reimbursement for durable medical equipment furnished by a home health agency is based on the lesser of reasonable cost or customary charges, computed separately for durable medical equipment.

Columns 1 through 4--Enter the total costs of each line item in this part, column 2, lines 15, 16 and 17, from Worksheet B, column 6, lines 12, 13 and 14, respectively. Develop a ratio of total cost (column 2) to total charges (column 3) and enter this ratio in column 4.

Columns 5 and 6--Enter in the appropriate column the Medicare charges for medical appliances, durable medical equipment and medical supplies charged to patients.

LINE DESCRIPTIONS FOR COLUMNS 5 AND 6

Lines 15 and 16--Enter the charges for durable medical equipment rented (line 15) and or sold (line 16).

Line 17--Enter the charges for medical supplies charged to patients.

Columns 5 and 7--To determine the Medicare Part A cost, multiply the Medicare charges (column 5) by the ratio (column 4) for each line item. The product is entered in column 7.

Columns 6 and 8--To determine the Medicare Part B cost, multiply the Medicare charges (column 6) by the ratio (column 4) for each line item. The product is entered in column 8.

1711. 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)(2) or customary charges as defined in 42 CFR 413.13(b)(1).

Part II - Computation of Reimbursement Settlement. Part II provides for the comparison of the lesser of reasonable cost, customary charges and reasonable cost minus billed coinsurance in accordance with §942 of the Omnibus Reconciliation Act of 1980.

1711.1 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)(2) or customary charges as defined in the 42 CFR 413.13(b)(1).

LINE DESCRIPTIONS

Lines 1 through 5--These lines provide for the computation of reasonable cost of title XVIII - Part A and Part B services.

Line 1--

For Cost Reporting Periods Beginning On Or After 7/1/85, and Prior to 7/1/86.-

Enter on line 1, the cost of services from Worksheet C, Part I, as follows:

To Worksheet D, Line 1	From Worksheet C
Col. 1, Part A - Other than DME	Col. 9, line 7, plus col. 7, line 10
Col. 2, Part A - DME	Col. 7, sum of lines 8 and 9
Col. 3, Part B - Other than DME	Col. 10, line 7, plus col. 8, line 10
Col. 4, Part B - DME	Col. 8, sum of lines 8 and 9

For Cost Reporting Periods Beginning On Or After 7/1/86.--

Enter on line 1, the cost of services from Worksheet C, Aggregate Limits, as follows:

a. Determine the lesser amount from Worksheet C, Aggregate Limits, by comparing the amount in column 9, line 7, with the amount in column 9, line 14.

b. After determining the line with the lesser amount (column 9, line 7 or 14), transfer the total amount from Worksheet C, Aggregate Limits, line 7 or 14 as follows:

To Worksheet D, Line 1	From Worksheet C Aggregate Limits
Col. 1, Part A - Other than DME	Col. 7, lesser of line 7 or 14; plus Col. 7, line 17
Col. 2, Part A - DME	Col. 7, sum of lines 15 and 16
Col. 3, Part B - Other than DME	Col. 8, lesser of line 7 or 14; plus Col. 8, line 17
Col. 4, Part B - DME	Col. 8, sum of lines 15 and 16

Line 2--Enter the amounts paid or payable by workers' compensation and other primary payers where program liability is secondary to that of the primary payer. There are five situations under which Medicare payment is secondary to a primary payer:

1. Workers' compensation,
2. Automobile, medical or no fault coverage,
3. General liability coverage,
4. Working aged provisions, and
5. Working ESRD beneficiary provisions.

Generally, when payment by the primary payer satisfies the liability of the program beneficiary, for cost reporting purposes, 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 will note 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 2.

However, where the payment by the primary payer does not satisfy the beneficiary's obligation, the program pays - in situations 1, 2 and 3, above -the amount it would otherwise pay (absent primary payer payment) less the primary payer payment, less applicable deductible and coinsurance. In situations 1, 2 and 3, primary payer payment is not credited toward the beneficiary's deductible and coinsurance. In situations 4 and 5, 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. In situations 4 and 5, primary payer payment is credited toward the beneficiary's deductible and coinsurance and are not entered on line 2.

Where 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 2 to the extent that primary payer payment is not credited toward the beneficiary's deductible and coinsurance (situation 4 and 5). Primary payer payments that are credited toward the beneficiary's deductible and coinsurance are not entered on line 2.

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

Line 4--Enter the allowable return on equity capital from the indicated line on Supplemental Worksheet F-3, Part III, as follows:

	From Supplemental Worksheet F-3, Part III, Column 2
Col. 1 - Part A - Other than DME	Line 1
Col. 2 - Part A DME	Line 2
Col. 3 - Part B - Other than DME	Line 3
Col. 4 - Part B DME	Line 4

Line 5--In each column, enter the amount on line 1 plus the amount on line 4.

Lines 6 through 10--These lines provide for the accumulation of charges which relate to the reasonable cost on line 5.

Do not include on these lines (1) the portion of charges applicable to the excess costs of luxury items or services (see HCFA Pub. 15, Part I, chapter 21) and (2) provider charges to beneficiaries for excess costs as described in HCFA Pub. 15, Part I, §2570. Where provider operating costs include amounts that flow from the provision of luxury items or services, such amounts are not allowable in computing reimbursable costs.

Enter in the applicable column, line 6, the Medicare charges for Part A other than DME, Part A DME, Part B other than DME, and Part B DME. These amounts are taken from provider records.

Lines 7 through 10--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. 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 7, 8 and 9, but should enter on line 10 the amount from line 6. See 42 CFR 405.455(b). In no instance may the customary charges on line 10 exceed the actual charges on line 6.

Line 11--Enter in each applicable column on line 11, the excess of total customary charges (line 10) over the total reasonable cost (line 5). Transfer any amount on line 11 to Supplemental Worksheet D-2, Part I, as follows:

	To Supplemental Worksheet D-2, Part I
Part A, column 1	Column 1, line 1
Part B, column 3	Column 2, line 1
Part A, column 2	Column 1, line 2
Part B, column 4	Column 2, line 2

In situations where in any column the total charges on line 10 are less than the total cost on line 5 of the applicable column, enter zero (0) on line 11.

Line 12--Enter in each applicable column on line 12, the excess of total reasonable cost (line 5) over total customary charges (line 10). Transfer the amount on line 12 to Supplemental Worksheet D-2, Part I, line as follows:

	To Supplemental Worksheet D-2, Part I
Part A, column 1	Column 1, line 4
Part B, column 3	Column 2, line 4
Part A, column 2	Column 1, line 5
Part B, column 4	Column 2, line 5

In situations where in any column the total cost on line 5 are less than the customary charges on line 10 of the applicable column, enter zero (0) on line 12.

1711.2 Part II - Computation of Reimbursement Settlement.--

Line 13--Enter in column 1, the sum of the amounts on lines 3 and 4 of columns 1 and 2. Enter in column 2, the sum of the amounts on lines 3 and 4 of columns 3 and 4.

Line 14--Enter in column 2, the Part B deductibles billed to Medicare patients - exclude coinsurance amounts. Include any amounts of deductibles satisfied by primary payer payments.

Line 16--If there is an excess of reasonable cost over customary charges in any column on line 12, enter the amount of the excess in the appropriate column of line 16.

Line 18--Enter all coinsurance billable to Medicare beneficiaries including amounts satisfied by primary payer payments. Coinsurance is applicable to durable medical equipment under either Part A or Part B and to Part B services that are not part of a home health plan of care.

Line 23--Enter on this line the program's share of any net depreciation adjustment applicable to prior years resulting from the gain or loss on the disposition of depreciable assets. (See HCFA Pub. 15, Part I, chapter 1.) Enter the amount of any excess depreciation taken as a negative amount.

Line 24--Enter on this line the program's share of any recovery of excess depreciation applicable to prior years resulting from provider termination or a decrease in Medicare utilization. (See HCFA Pub. 15, Part I, chapter 1.)

Line 25--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 on this line any amounts which are not refunded, either because they are less than $5 collected from a beneficiary or because the provider is unable to locate the beneficiary. (See HCFA Pub. 15, Part I, §2577.)

Line 26--Line 26 will be separated into three lines as follows:

NOTE: Public Law 99-177, the Balanced Budget and Emergency Deficit Control Act of 1985 (Gramm-Rudman) provides for an automatic deficit reduction procedure to be established for Federal fiscal years (FYs) 1986 through 1991, when the deficit would reach zero. With regard to title XVIII, each payment amount would be reduced by a specified percentage which could not exceed 1 percent for FY 1986 and 2 percent for each subsequent year in which sequestration (reduction of otherwise payable program payment amount pursuant to a Presidential Order under P.L. 99-177) takes place. Section IM 199 of HCFA Pub. 15-II outlines the methodology by which the sequestration adjustment will be computed.

Line 26A--Enter on this line the total cost that is reimbursable to the provider. The total cost reimbursable to the provider would consist of the sum of the total costs for the current reporting period (line 21), the recovery of unreimbursed cost from line 22 plus or minus the amounts applicable to prior cost reporting periods resulting from the disposition of depreciable assets on line 23, minus the sum of lines 24 and 25.

Line 26B--Using the methodology explained in §IM 199 of HCFA Pub. 15-II, enter the sequestration adjustment on this line.

Line 26C--Enter on this line the amount on line 26A minus the amount on line 26B.

Line 29--Enter on this line the Medicare reimbursement effect of protested items. The reimbursement effect of the nonallowable items should be estimated by applying reasonable methodology which will closely approximate the actual effect of the item as if it had been determined through the normal cost finding process. (See HCFA Pub. 15-II, §115.2(B).) A schedule must be attached showing the supporting details and computations for this line.

Line 30--The amounts on this line will show the balance due the provider or program. Overpayments should be indicated by parentheses ( ).

1712. WORKSHEET D-1 - ANALYSIS OF PAYMENTS TO HOME HEALTH AGENCIES FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

This worksheet should be completed for Medicare interim payments only. (See 42 CFR 405.454.)

The column headings designate two categories of payments:

Category 1 - Part A
Category 2 - Part B

Providers should complete the identifying information on lines 1 through 4. The remainder of the supplemental worksheet will be completed by your fiscal intermediary.

LINE DESCRIPTIONS

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

Line 2--Enter on line 2 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 should not include payments reported on line 1.

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

Line 4--Enter on line 4 the total amount of the interim payments (sum of lines 1, 2 and 3k). Transfer these totals to the appropriate column on Worksheet D, Part II, line 27.

DO NOT COMPLETE THE REMAINDER OF WORKSHEET D-1. THE REMAINDER OF THE WORKSHEET WILL BE 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 will be reported 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, where 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, 5g and 6 a or b in columns 2 and 4 as appropriate. The amount in column 2 must equal the amount on Worksheet D, Part II, column 1, line 26. The amount in column 4 must equal the amount on Worksheet D, Part II, column 2, line 26.

1713. WORKSHEETS F, F-1 AND F-2 - FINANCIAL STATEMENTS

These worksheets are to be prepared from the provider's accounting books and records. Additional worksheets may be submitted if necessary.

Worksheets F and F-2 are to be completed by all providers maintaining fund-type accounting records. Providers not maintaining fund-type accounting records should complete the "General Fund" columns only.

1714. SUPPLEMENTAL WORKSHEET A-6 - STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS

This supplemental worksheet provides for the computation of any needed adjustments to costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control. In addition, certain information concerning the related organizations with which the provider has transacted business should be shown. (See HCFA Pub. 15, Part I, chapter 10.) Providers must file a home office cost statement if they are part of a chain organization. (See HCFA Pub. 15-I, §2150ff.)

Part A--must be completed by all providers. If the answer to Part A is "Yes," Parts B and C must also be completed.

Part B--Costs applicable to services, facilities and supplies furnished to the provider by organizations related to the provider by common ownership or control are includable in the allowable cost of the provider at the cost to the related organization. For example, where the provider shares office space with or has the same administrator as a related entity, then as adjustment will be reflected on this worksheet. However, such cost must not exceed the amount a prudent and cost-conscious buyer would pay for comparable services, facilities or supplies that could be purchased elsewhere.

Part C--This part is used to show the interrelationship of the HHA to organizations furnishing services, facilities or supplies to the HHA. The requested data relative to all individuals, partnerships, corporations, or other organizations having either a related interest to the HHA, a common ownership of the HHA, or control over the HHA as defined in HCFA Pub. 15, Part I, chapter 10, must be shown in columns 1 through 6, as appropriate.

Only those columns which are pertinent to the type of relationship which exists should be completed.

Column 1--Enter the appropriate symbol which describes the interrelationship of the HHA to related organization.

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

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

Column 4--Enter in this column the name of the related corporation, partnership or other organization.

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

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

1715. SUPPLEMENTAL WORKSHEET A-7 - LIMITATION ON FEDERAL PARTICIPATION FOR CAPITAL EXPENDITURES QUESTIONNAIRE

NOTE: This worksheet is not required unless the provider's answer to the question on line 2 of the worksheet is "yes." Accordingly, the provider should determine the answer for line 2 before complete line 2.

In accordance with §1122 of the Social Security Act and 42 CFR 405.435 with respect to any capital expenditure as defined in 42 CFR Part 100, the obligation which is incurred after December 31, 1972, or after the effective date of an agreement executed between a State and the Department of Health and Human Services, whichever date is later, the depreciation, interest on borrowed funds, return on equity capital (in the case of proprietary providers), and any other costs attributable to such capital expenditure where a determination has been made by the Secretary that such proposed capital expenditure has not been submitted to the Designated Planning Agency as required, or that it has been determined by such agency to be inconsistent with the standards, plans, or criteria developed to meet the need for adequate health care facilities, are not allowable. Other costs related to such capital expenditures include title fees, permit and license fees, broker commissions, architect, legal, accounting and appraisal fees, interest, finance or charring charges on bonds or notes, and other costs incurred for borrowing funds.

Line 1--The analysis of changes in capital asset balances during the cost reporting period must be completed by all home health agencies. The amount to be entered should not be reduced by any accumulated depreciation reserves.

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

Columns 2 through 4--Enter the cost of capital assets acquired by purchase (including assets transferred from another provider) in column 2, and the fair market value at date acquired of donated assets in column 3. Enter the sum of columns 2 and 3 in column 4.

Column 5--Enter the cost or other approved basis of all capital assets sold, traded, transferred to another provider, or retired or disposed of in any other manner during the provider's cost reporting period.

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

Line 2--A "Capital Expenditure" which is subject to the provisions of §1122 of the Social Security Act is an expenditure for plant and equipment that is not properly chargeable as an expense of operation and maintenance and (1) exceeds $600,000 (or such lesser amount as the State may establish), (2) changes the bed capacity of the facility, or (3) substantially changes the services of the facility. See HCFA Pub. 15-I, §§2422-2422.4 for further explanation.

LINES 3 AND 4 WILL NOT BE COMPLETED IF THE ANSWER TO LINE 2 IS "NO."

Line 3--The data requested must be provided for each capital expenditure (as defined in HCFA Pub. 15-I, chapter 24) made by or on behalf of the provider during the period to which this cost report applies and (1) subsequent to December 31,1982, or (2) the effective date of the agreement between the State and the Secretary, whichever is later.

Column 1--Use the following symbols to indicate how the asset was acquired: "A" by purchase on the open market; "B" by donation or transfer; and "C" by lease or comparable arrangement.

Column 2--Enter the date on which the obligation for the capital expenditure was incurred by or on behalf of the provider, or in the case of donated assets, the date the capital expenditure was acquired by the provider.

Column 3--The cost of the capital expenditure includes the cost of studies, surveys, designs, plans, working drawings, specifications and other activities essential to the acquisition, improvement, modernization, expansion or replacement of the land, plant, buildings and equipment. Also, included are expenditures directly or indirectly related to capital expenditures, including expenses with respect to grading, paving, broker commissions, taxes assessed during the construction period, and costs involved in demolishing or razing structures on land.

Columns 4 through 9--All expenses on Worksheet A, column 8, related to capital expenditures made in this cost reporting period must be included in columns 4, 5, 6 and 8, as appropriate.

The type of expense included in column 8 should be described in column 7.

The sum of the expenses entered in columns 4, 5, 6 and 8 must equal the amount entered in column 9.

Line 4--

Column 1--Enter the date on which the written notice of intention for each capital expenditure by or on behalf of the provider was submitted to the Designated Planning Agency.

IF THE WRITTEN NOTICE SUBMITTED TO THE DESIGNATED PLANNING AGENCY IS STILL PENDING, DO NOT COMPLETE COLUMNS 2 THROUGH 5.

Column 2--Enter the date of notification of approval by the Designated Planning Agency for each capital expenditure made by or on behalf of the provider.

IF A CAPITAL EXPENDITURE WAS APPROVED, COLUMNS 3 THROUGH 5 SHOULD NOT BE COMPLETED.

Column 3--Enter in column 3 the date the notice of disapproval of the capital expenditure was received from the Designated Planning Agency.

NOTE: Where the Designated Planning Agency determines a capital expenditure is inconsistent with the State or local planning requirements, the provider must make an adjustment on Worksheet A-5, line 12, to exclude any expenses included on Worksheet A, column 8, related to the disapproved capital expenditures.

Columns 4 and 5--Complete columns 4 and 5 only if the Designated Planning Agency's decision has been appealed. If the decision has been appealed, show the date and status of appeal in columns 4 and 5, respectively.

1716. SUPPLEMENTAL WORKSHEET A-8-3- REASONABLE COST DETERMINATION FOR PHYSICAL THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

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

If a provider contracts with an outside supplier for physical therapy services, the potential for limitation and the amount of payment a provider can receive depends on several factors:

1. an initial test to determine whether these services are categorized as intermittent part-time or full-time services;

2. the location where the services are rendered, i.e, provider site or HHA home visit;

3. for HHA services, whether detailed time and mileage records are maintained by the contractor and HHA;

4. add-ons for supervisory functions, aides, overtime, equipment and supplies;

5. intermediary determinations of reasonableness of rates charged by the supplier compared with the going rates in the area.

1716.1 Part I - General Information--This part provides for furnishing certain information concerning physical therapy services furnished by outside suppliers.

Line 1--Enter on this line the number of weeks that services were performed at the provider site, count only those weeks during which a supervisor, therapist or an assistant was on site. For services performed at the patient's residence, count only those weeks during which services were rendered by supervisors, therapists, or assistants to patients of the home health agency. Weeks where services were performed both at the provider's site and at the patients home are only counted once. (See HCFA Pub. 15-I, chapter 14.)

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

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

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

Line 5--Enter on this line the Standard Travel Expense Rate applicable as published in HCFA Pub. 15-I, chapter 14.

Line 6--Enter on this line the Optional Travel Expense Rate applicable as published in HCFA Pub. 15-I, chapter 14. This rate may only be used for home health patient services for which time records are available.

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

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

Enter in column 1 the supervisors' AHSEA, adjusted for administrative and supervisory responsibilities, which are determined in accordance with the provisions of HCFA Pub. 15-I, §1412.5. Enter in columns 2, 3, and 4 (for therapists, assistants and aides respectively) the AHSEA from the appropriate exhibit found in HCFA Pub. 15-I, at the end of chapter 14 or the latest publication of rates. Where assistants' going hourly rate in the area is unobtainable, no more than 75% of the therapist AHSEA may be used. The cost of services of a therapy aide or trainee will be evaluated at the hourly rate not to exceed the hourly rate paid to the provider's employees of comparable classification and/or qualification, e.g., nurses' aides. (See HCFA Pub. 15-I, §1412.2.)

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

Lines 10 and 11--Enter on these lines, for HHA services only, the number of travel hours and number of miles driven, respectively, where time records of visits are kept. (See HCFA Pub. 15-1, §§1402.5 and 1403.1.)

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

1716.2 Part II - Salary Equivalency Computation--This part provides for the computation of the full-time or intermittent part-time salary equivalency.

Where the provider furnishes physical therapy services by outside suppliers for health care program patients, but simply arranges for such services for nonhealth care program patients and does not pay the nonhealth care program portion of such services, its books will reflect only the cost of the health care program portion. Where the provider can "gross up" its costs and charges in accordance with provisions of HCFA Pub. 15-I, §2314, it will complete Part II, lines 12 through 17 and 20 in all cases, and lines 18 and 19 where appropriate.

Line 12 - 17--These lines are to be completed for computing the total salary equivalency allowance amounts by multiplying the total hours worked (line 7) times the adjusted hourly salary equivalency amount for supervisors, therapists, assistants and aides.

Lines 18 and 19--These lines are to be completed if the sum of hours in columns 1-3, line 7, is less than or equal to the product found on line 2. (See exception above where the provider cannot "gross up" its costs and charges and services are provided to program patients only.)

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

1716.3 Part III - Travel Allowance and Travel Expense Computation - HHA Services Outside Provider Site.--This part provides for the computation of both the standard travel allowance and standard travel expense and the optional travel allowance and the optional travel expense. (See HCFA Pub. 15-I, §§1402, 1403.1 and 1412.6.)

Lines 21 - 24--These lines provide for the computation of the standard travel allowance and standard travel expense for physical therapy services performed in conjunction with home health agency visits. These lines will only be used if the provider does not use the optional method of computing travel. A standard travel allowance is recognized for each visit to a patient's residence. If services are furnished to more than one patient at the same location, only one standard travel allowance is permitted, regardless of the number of patients treated.

Lines 25 - 28--These lines provide for the optional travel allowance and optional travel expense computations for physical therapy services in conjunction with home health services only. The optional travel allowance is computed on lines 25 through 27. The optional travel expense is computed on line 28.

Lines 29 - 31--Only one of the options on lines 29-31 may be chosen and completed. However, lines 30 or 31 may only be used where the provider maintains time records of visits. (See HCFA Pub. 15-I, §1402.5.)

1716.4 Part IV - Overtime Computation--This part provides for the computation of an overtime allowance when an individual employee of the outside supplier performs services for the provider in excess of the provider's standard work week. No overtime allowance may be given to a therapist who receives an additional allowance for supervisory or administrative duties. (See HCFA Pub. 15-I, §1412.4.)

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

Line 33--Enter in the appropriate column the overtime rate which is the AHSEA from line 8, column as appropriate, times 1.5.

Line 35--Enter the percentage of overtime hours, by class of employee, which is determined by dividing each column on line 32 by the total overtime hours in column 4, line 32.

Line 36--This line is for the allocation of a provider's standard work year for one full-time employee. Enter the numbers of hours in the standard work year for one full-time employee in column 4 of this line. Multiply the standard work year in column 4 by the percentage on line 35 and enter the results in the corresponding columns of this line.

Line 37--Enter in columns 1 through 3 the AHSEA from Part I, line 8, columns 2 through 4, as appropriate.

1716.5 Part V - Computation of Physical Therapy Limitation and Excess Cost Adjustment--This part provides for the calculation of the adjustment to physical therapy service costs in determining the reasonableness of physical therapy cost.

Lines 45 and 46--Where the outside supplier provides the equipment and supplies used in furnishing direct services to the provider's patients, the actual cost of the equipment and supplies incurred by the outside supplier, as specified in HCFA Pub. 15-I, § 1412.1, may be considered as an additional allowance in computing the limitation.

Line 48--Enter the amounts paid and/or payable to the outside suppliers for physical therapy services rendered during the period as reported in the cost report. This includes any payments for supplies, equipment use, overtime or any other expenses related to supplying physical therapy services for the provider.

Line 49--Enter on this line the excess cost over the limitation, i.e., line 48 minus line 47. If negative, enter zero. Transfer the amount on this line to Worksheet A-5, line 10.

1717. SUPPLEMENTAL WORKSHEET D-2 - RECOVERY OF UNREIMBURSED COST FOR HOME HEALTH AGENCIES (HHAs)

This supplemental worksheet provides for the recovery of unreimbursed cost and is to be used by HHAs in the "New Provider" category and the "Other Than New Provider" category. Supplemental Worksheet D-2 consists of two parts as follows:

Part I - Computation of Recovery of Unreimbursed Cost Under Lesser of Cost or Charges

Part II - Computation of Carryover of Unreimbursed Cost Under Lesser of Cost or Charges

This supplemental worksheet should not be completed by a public HHA which renders services free of charge or at a nominal charge. (See HCFA-Pub. 15-I, §§2604.2 - 2604.4.)

This supplemental worksheet should be used by the HHA to accumulate unreimbursed cost and to compute the recovery of previously unreimbursed cost under 42 CFR 405.455 (Lesser of Cost or Charges).

Check the agency status - either "New Provider" or "Other Than New Provider." A "New Provider" is a HHA that has operated as the type of agency (or the equivalent thereof) for which it is certified in the program under present and previous ownership for less than 3 full years.

"Other Than New Provider" refers to a HHA which has operated as the type of agency (or the equivalent thereof) for which it is certified in the program under present and previous ownership for 3 full years or more and which is not currently operating within the new agency recovery period.

1717.1 Part I - Computation of Recovery of Unreimbursed Cost Under Lesser of Cost or Charges.--This part is provided for the computation of the recovery of unreimbursed cost under 42 CFR 405.455 (Lesser of Cost or Charges), and must be completed by both "New Providers" and "Other Than New Providers." This part should not be completed in any cost reporting period in which costs are unreimbursable under 42 CFR 405.460 (Limitations on Coverage of Costs).

Line 1--Enter the excess of customary charges over reasonable cost for services other than DME as follows:

Enter In	From Worksheet D, line 11
col. 1	col. 1
col. 2	col. 3

Line 2--Enter the excess of customary charges over reasonable cost for DME as follows:

Enter In	From Worksheet D, line 11
col. 1	col. 2
col. 2	col. 4

Line 3--Enter in each column the sum of the amounts entered on lines 1 and 2, respectively.

Line 4--Enter the excess of reasonable cost over customary charges for services other than DME as follows:

Enter In	From Worksheet D, line 12
col. 1	col. 1
col. 2	col. 3

Line 5--Enter the excess of reasonable cost over customary charges for DME as follows:

Enter In	From Worksheet D, line 12
col. 1	col. 2
col. 2	col. 4

Line 6--Enter in each column the sum of the amounts entered on lines 4 and 5, respectively.

Line 7--Subtract the amount on line 6 from the amount on line 3. Enter zero in any column for which the amount on line 6 is greater than the amount on line 3.

Line 8--Enter the carryover of unreimbursed cost from the prior year's cost report, Supplemental Worksheet D-3, or equivalent worksheet for the "Recovery of Unreimbursed Cost," from Part II, column 1 and column 2, respectively, line 14.

NOTE: Columns 2 and 3 from the prior year's cost report should be combined and reported in column 2 of the current year's cost report.

1717.2 Part II - Computation of Carryover of Unreimbursed Cost Under Lesser of Cost or Charges.--This part should be completed according to the agency status using the following instructions.

A. Computation of Carryover of Unreimbursed Cost Under Lesser of Cost or Charges - New Providers.--Part II should be used by a new HHA to accumulate unreimbursed cost under 42 CFR 405.455 (Lesser of Cost or Charges) during both the new provider base period and the new provider recovery period. That is, a new HHA should continue to complete Part II in this manner until all costs which were unreimbursed during the new HHA base period are recovered or the new HHA recovery period ends, whichever event occurs first.

For purposes of computing the carryover of unreimbursed cost under the lesser of cost or charges for "New Providers," complete lines 10 through 14, 15 through 19, 20 through 24, and 25 through 32.

The new agency base period is any cost reporting period under which costs are unreimbursed under 42 CFR 405.455 and which end on or before the last day of the new agency's third year of operation.

The new agency recovery period is the five cost reporting periods immediately succeeding the new agency base period. If the five succeeding cost reporting periods combined include fewer than 60 full calendar months, the new agency may carry forward such unreimbursed cost for one additional reporting period.

The amounts entered in columns 1 and 2, lines 10 through 32 should be obtained as follows:

Lines 10 through 14--

1. The amounts for columns 1 and 2, lines 10, 11, 12 and 13, should be obtained from the prior year's cost report Supplemental Worksheet D-3 for the "Recovery of Unreimbursed Cost," Part II, columns 1, 2 and 3, lines 1a, 1b, 1c and 1d, respectively.

2. If the amounts entered on the prior year's cost report Supplemental Worksheet D-3 for the "Recovery of Unreimbursed Cost," Part II, columns 1, 2 and 3, lines 1c and 1d, represent cost reporting periods which, when combined, contain at least 24 full calendar months, then such amounts should be entered in columns 1 and 2, lines 12 and 13. However, if such combined cost reporting periods contain fewer than 24 full calendar months, the amounts entered on the worksheet for the "Recovery of Unreimbursed Cost," Part II, columns 1, 2 and 3, lines 1b, 1c and 1d, of the prior year's cost report should be entered in columns 1 and 2, lines 11, 12 and 13, respectively.

3. Add the amounts on lines 10 through 13 and enter the total on line 14. Complete this for each column.

Lines 15 through 19--The total amount of unreimbursed cost recovered in the current cost reporting period and to be entered in columns 1 and 2, line 19, should be obtained from Part I, line 9, columns 1 and 2.

The recovery of unreimbursed cost applicable to each cost reporting period (lines 15 through 18) in which a carryover of previously unreimbursed cost exists will be made on a first-in-first-out basis. That is, the recovery should first be applied to columns 1 and 2, line 15, then to columns 1 and 2, line 16, etc. The amounts entered on lines 15 through 19 may not exceed the amounts on lines 10 through 14, respectively.

Exception to the first-in-first-out basis for recovering previously disallowed cost: If under the lesser of reasonable costs or customary charges, an agency has cost disallowed in its first or second cost reporting period of the new agency recovery period, it should

compute the recovery of these disallowed costs in columns 1 and 2, lines 16, 17 and 18 before computing any recovery applicable to the base period in columns 1 and 2, line 15. Of course, the first-in-first-out basis should be used with respect to columns 1 and 2, lines 16, 17 and 18. The reason for this exception is because the recovery period for costs disallowed in the first and second cost reporting period of the recovery period expires prior to the recovery period for costs disallowed in the new provider base period.

Lines 20 through 24--Lines 20 and 21 will be completed only when there is unreimbursed cost attributable to the current cost reporting period and the current cost reporting period is also included within the new provider base period.

Lines 22 and 23 will be used whenever there is unreimbursed cost in the current cost reporting period which is within the new provider recovery period. Lines 22 and 23 will not be used when the current cost reporting period is within the new provider base period.

If any amount is entered in columns 1 and 2, line 15, enter zero in the applicable column on lines 20 and 21.

B. Computation of Carryover of Unreimbursed Cost Under Lesser of Cost or Charges-Other Than New Providers.--For purposes of computing the carryover of unreimbursed cost under the lesser of cost or charges for "Other Than New Provider," complete lines 11 through 14, 16 through 19, 22 through 24, and 27 through 32.

Lines 10 through 14--If the amounts entered on the prior year's cost report worksheet for the "Recovery of Unreimbursed Cost," Part II, columns 1, 2 and 3, lines 1c and 1d represent cost reporting periods which, when combined, contain at least 24 calendar months, then such amounts should be entered in columns 1 and 2, lines 12 and 13, respectively. However, if such combined cost reporting periods contain fewer than 24 full calendar months, the amounts entered on the worksheet for the "Recovery of Unreimbursed Cost," Part II, columns 1, 2 and 3, lines 1b, 1c and 1d, of the prior year's cost report should be entered in columns 1 and 2, lines 11, 12 and 13, respectively.

The amount entered in columns 1 and 2, line 14, represents the sum of the amounts entered on lines 11 through 13.

Lines 15 through 19--The total amount of unreimbursed cost recovered in the current cost reporting period to be entered in columns 1 and 2, line 19, should be obtained from Part I, line 9. The recovery of unreimbursed cost applicable to each cost reporting period (lines 16, 17 and 18) in which a carryover of previously unreimbursed cost exists will be made on a first-in-first-out basis. That is, the recovery should first be applied to line 16, then to line 17, etc. The amounts entered on lines 16 through 19 may not exceed the amounts on lines 11 through 14, respectively. Transfer the amounts on line 19 to Worksheet D, Part II, columns as appropriate, line 22.

Lines 20 through 24--Enter in columns 1 and 2, line 22, the amounts obtained from Worksheet D, Part I, line 12, columns 1 and 3, respectively. Enter in columns 1 and 2, line 23, the amount of DME furnished by an HHA from Worksheet D, Part I, line 12, columns 2 and 4 respectively. If any amount is entered on lines 16 through 19, enter zero on lines 22 and 23, respectively.

1718. SUPPLEMENTAL WORKSHEET F-3 - RETURN ON EQUITY CAPITAL OF PROPRIETARY PROVIDERS

This supplemental worksheet provides for the calculation of a reasonable return on equity capital invested and used in the provision of patient care services by proprietary providers in accordance with section 1861(v)(1)(B) of the Social Security Act and 42 CFR 405.429. This supplemental worksheet is completed by an HHA only when item No. 5 - Proprietary is checked on Form HCFA-1728-85, page 1, Part I, line 2.

Supplemental Worksheet F-3 consists of the following three parts:

Part I - Balance Sheet for Computation of Equity Capital

Part II - Computation of Return on Equity Capital of Proprietary Providers

Part III - Apportionment of Allowable Return on Equity Capital of Proprietary Providers

1718.1 Part I - Balance Sheet for Computation of Equity Capital.--Proprietary providers are allowed a reasonable return on average equity capital used to provide patient care. (See HCFA Pub. 15, Part I, chapter 12.)

Equity capital, as used in the health care programs, is the owners' interest, subject to the prior claims of creditors, in the provider organization or that part of such organization rendering patient care. Equity capital is represented by the excess of the assets related to patient care over the liabilities related to patient care. The return allowed on such capital is based on the health care programs' principles of reimbursement.

The first step in determining average equity capital during the reporting period is to compute the amount of such capital at the end of the accounting period. Supplemental Worksheet F-3, Part I, is designed for this purpose. However, when a provider is reporting for the first time under the health care programs, it must complete Part I twice: once for the beginning of the cost reporting period, and once for the end of the cost reporting period. Part I should be completed through line 56 for the beginning of the provider's first reporting period under the health care programs. This is necessary so that the beginning equity capital under the health care programs (see Part II, column 2) can be determined.

At the end of the first reporting period under the health care programs and in all subsequent reporting periods, Part I should be completed through line 60. The ending equity capital (line 56) will be transferred to Part II, column 8, on the line representing the last month or period in the cost reporting period. For example, if the cost report is for a 12-month calendar year, this would be line 13 (December).

The ending equity capital (line 56) with adjustments (lines 57 through 59) will be the beginning equity capital for the following period (line 60).

Columns 2 and 6--Enter the balances recorded in the HHA's books of account at the end of the reporting period. Attachments may be used if the lines on this worksheet are not sufficient.

Columns 3 and 7--These columns are used to make any adjustments to the amounts recorded in columns 2 and 6 that are required to arrive at equity capital for Medicare cost reporting. Some examples of adjustments which may be required follow:

Line 1 - Cash on Hand and in Banks--Enter in column 3 the amount of cash included in column 2 which is excessive and, therefore, not needed for patient care services.

Funds deposited in a savings account for more than 6 consecutive months are considered to have been diverted to income producing activities which are not related to patient care.

Line 2 - Temporary Investments--Enter in column 3 the cost applicable to temporary investments not related to patient care. This item should be reduced by the amount, if any, that the investments as recorded in the books (column 2) exceed cost.

Lines 3 and 4 - Notes Receivable and Accounts Receivable--Enter in column 3 the notes and accounts receivable that are not for patient care services, but are included in the amounts recorded in column 2. This would include such items as balances due from owners, officers, employees, directors, stockholders and other miscellaneous sources.

Line 5 - Other Receivables--Enter in column 3 the amounts included in this receivable which did not result from patient care services. Normally, the total amount of this receivable would be entered in column 3.

Line 6 - Less: Allowance for Uncollectible Notes and Accounts Receivable--Enter in column 3 the amount of the allowance included in column 2 which is directly applicable to the amounts entered in column 3, lines 3, 4 and 5. The receivables on lines 3, 4 and 5 applicable to patient care services and includable in equity capital must reflect the amount that can reasonably be expected to be collected, regardless of the provider's method of computing bad debts.

Line 7 - Inventory--Enter in column 3 the cost of any inventory items which are not related to patient care.

Line 8 - Prepaid Expenses--Enter any amounts in column 3 which are included in column 2, but are not related to patient care. This would include any items resulting from costs that are unallowable under the health care programs, such as prepaid premiums on life insurance carried by a provider on officers and key employees, where the provider is designated as beneficiary.

Line 9 - Other Current Assets--Include in column 3 the full amount of any items in column 2 not related to patient care.

Lines 11, 12, 14, 16, 18, 20, 22, 24, 25 - Fixed Assets--Enter in column 3 the difference, if any, between the amounts entered in column 2 and the historical costs of the assets, or in the case of donated assets, the fair market value at the time of donation. Also, enter (1) the cost of any assets not related to patient care, and (2) the cost of any assets where acquisition was determined not to be consistent with the standards, plans or criteria developed to meet the need for adequate health care facilities. (See HCFA Pub. 15, Part I, chapter 24.)

Lines 13, 15, 17, 19, 21, 23 - Accumulated Depreciation and Amortization--The amounts should be adjusted to reflect accumulated depreciation under the health care programs. Also, adjust the accumulated depreciation and amortization in column 2 by any amounts applicable to the related assets adjusted in column 3.

Line 27 - Investments--Investments includable in equity capital are limited to those related to patient care. Primarily, these are temporary investments of operating funds (line 2). Operating funds invested for long periods of time would be considered in excess of patient care needs and should be deleted in column 3. (See HCFA Pub. 15, Part I, chapter 12.)

Line 28 - Deposits on Leases--Generally, deposits required under the terms of a lease are included in equity capital. However, enter in column 3 the cost of deposits for assets leased from related organizations and for assets not related to patient care. See the instructions for column 8, line 54, for the treatment of assets leased from related organizations. Also, enter in column 3 any amount deposited under the terms of a lease or comparable arrangement for any facility or part thereof or equipment for a facility, the expenditures for which would have been considered a capital expenditure and subject to exclusion from reimbursement under title XVIII, had the provider acquired it by purchase. (See HCFA Pub. 15, Part I, chapter 24.)

Line 29 - Due from Owners/Officers--For adjustments to this account, see instructions for lines 3, 4 and 5 above.

The amounts deposited in a funded depreciation account and the earnings therefrom which remain in the fund are not includable in equity capital and should be entered in column 3.

Line 31--This space is provided for other assets for which no separate space is provided. An example of such assets is deferred charges, which includes such items as Organization Expense, and Unamortized Bond Discount and Expense. These items are properly included in equity capital if related to patient care services.

Another example is goodwill. Goodwill purchased in an acquisition prior to August 1970 of an existing organization is includable in the provider's equity capital. However, goodwill which has not been purchased, but has been internally generated, e.g., from a reorganization of the provider, is not includable in the provider's equity capital at any time.

For facilities or tangible assets acquired after July 1970, the excess of the purchase price paid for a facility or asset over (1) the historical cost of the tangible assets, or (2) the cost basis of the tangible assets, whichever is applicable, is not includable in the computation of equity capital. (See HCFA Pub. 15, Part I, chapter 12.)

Lines 34 through 50 - Liabilities--Enter in column 7 the amount of any liabilities which are directly attributable to and identifiable with the cost of any assets that were entered in column 3.

Lines 45 and 46 - Loans from Owners--Do not make adjustments in column 7 for funds borrowed prior to July 1, 1966, provided the terms and conditions of the loan agreement have not been modified subsequent to June 30, 1966. Such loans are considered as a liability in computing equity capital since interest expense related to such loans is included in allowable costs.

Where the terms and conditions of the loan agreement of loans made prior to July 1, 1966, have been modified subsequent to June 30, 1966, such loans are not included as a liability in column 8 and, therefore, should be adjusted in column 7. Loans from owners made on or after July 1, 1966, are not to be included as a liability in computing equity capital and should be adjusted in column 7.

Line 51 - Capital--The capital accounts in column 5, line 51, are those applicable to the type of business organizations under which the provider operates as follows:

SOLE PROPRIETOR	-	Proprietor's Capital Account
PARTNERSHIP	-	Partner's Capital Accounts
CORPORATION	-	Capital Stock and Other Accounts

Line 52 - Total Capital--Subtract the amount in column 7, line 50, from the amount in column 3, line 33, and enter the result on this line in column 7.

Columns 4 and 8--Adjust the amounts entered in columns 2 and 6 by the amounts (increase or decrease) entered in columns 3 and 7, and extend the net amounts to columns 4 and 8, respectively.

Line 52 - Total Capital--Subtract the amount in column 8, line 50, from the amount in column 4, line 33, and enter the result on this line in column 8.

Line 54 - Equity in Assets Leased from Related Organizations--If lease payments for real or personal property are not included in allowable cost because the lessor is a related organization as defined in the HCFA Pub. 15, Part I, chapter 10, the owner's equity in the net cost of the leased assets is properly includable in equity capital. See the instructions for completing line 31. However, if the lease payments are included in allowable cost because of any of the exceptions cited in chapter 10, then the net value of the assets cannot be included in the equity capital. The amount to be entered on line 54 is computed on the same basis as for assets owned directly by the provider organization. If the owner (related organization) has a negative equity in the assets leased to the provider, the negative amount rather than zero must be included on this line.

Line 55 - Difference Between Total Interim Payments and Net Cost of Covered Services--Enter the difference between total interim payments received and receivable for the cost reporting period and the net cost of covered services. The net cost of covered services used in this computation will not include the reimbursable return on equity capital.

To obtain this difference, perform the following calculations:

1. Home Health Agency (HHA)--Enter the net cost of HHA services (Worksheet D, sum of columns 1 - 4, line 3), add Reimbursable Bad Debts (Worksheet D, sum of columns 1 and 2, line 20), minus the sum of (1) Deductibles (Worksheet D, column 2, line 14), (2) Coinsurance Amounts (Worksheet D, sum of columns 1 and 2, line 18), and (3) Interim Payments (Worksheet D, sum of columns 1 and 2, line 27). The result of this calculation will be the difference between Total Interim Payments and Net Cost of Covered Services for the HHA.

2. CORF--Enter the net cost of CORF services (Supplemental Worksheet J-3, line 3), add Reimbursable Bad Debts (Supplemental Worksheet J-3, line 11), minus Deductibles (Supplemental Worksheet J-3, line 6), minus Coinsurance Amounts (the higher of (1) Supplemental Worksheet J-3, line 9, or (2) 20 percent of the difference between Supplemental Worksheet J-3, line 3, and (3) Supplemental Worksheet J-3, line 6). The result of this calculation will be the difference between Total Interim Payments and Net Cost of Covered Services for the CORF.

Add the result of the HHA calculation to the resultant CORF calculation and the sum will be the total to be added to Supplemental Worksheet F-3, Part I, line 55.

If the interim payments exceed the cost of covered services, the amount constitutes a reduction of equity capital. If the interim payments are less than the cost, add the difference to equity capital. However, to the extent that the difference has already been considered in this balance sheet, no entry should be made on line 55.

Line 56 - Total Equity Capital--Enter the sum of line 52 plus/minus lines 54 and 55. Enter negative amounts in parenthesis ( ).

1. If line 56 is computed as of the end of the cost reporting period and the amount computed on line 56 is a positive or negative amount, transfer this amount to Part II, column 8, for the last month or period in the cost reporting period.

2. If line 56 is computed as of the beginning of a cost reporting period (first period under the health care programs only) and the amount computed on line 56 is a positive or negative amount, transfer this amount to Part II, column 2, all lines, and column 8, line 1.

The balance of this worksheet provides for adjusting equity capital for the beginning of the following cost reporting period. Do not complete lines 57 - 60 until the cost report has been completed for the current period.

Line 57 - Return on Equity Capital--Enter on this line the amount of reimbursable return on equity capital.

The amount to be entered is the sum of the following:

1. The return on equity capital for titles V and XIX where the HHA receives reimbursement from these sources, plus;

2. The return on equity capital computed in Part III, column 2, lines 1 -5 for the agency whose reasonable cost on Worksheet D, Part II, line 15, is less than customary charges on worksheet D, Part I, line 10; or

3. The amount from titles V and XIX (No. 1 above) plus the return on equity capital computed in Part III, column 2, lines 1 - 5 for the agency whose customary charges on Worksheet D, Part I, line 10 are less than reasonable cost on Worksheet D, Part II, line 15.

Line 58 - Adjustments to Health Care Program Costs--The total equity capital entered on line 56 should be adjusted to reflect any increases or decreases which may be needed to properly reflect the beginning equity for the subsequent cost reporting period. Some adjustments to be considered in this computation are:

1. a decrease by the amount of the excess reasonable cost over customary charges (sum of amounts entered on Worksheet D, Part I, columns 1 through 4, line 12);

2. an increase by the amount of the recovery of unreimbursed costs from prior reporting periods (sum of amounts entered on Worksheet D, Part II, columns 1 and 2, line 23); and

3. a decrease by the amount of the sequestration adjustments reflected on Worksheet D, line 26B and Supplemental Worksheet J-3, line 15B.

Line 59 - Federal, State and Local Income Taxes--For purposes of determining the amount of equity capital at the end of the reporting period, corporate providers and noncorporate providers taxed as corporations will accrue their income tax liability prior to the determination of the reimbursable return on equity capital, the cost limitations adjustments and reimbursable bad debts. The amount of this liability should be entered in column 8, line 40.

After reimbursable return on equity capital, bad debts and the computation of any adjustments entered on line 58 have been determined, any income taxes attributable to these amounts should be entered on line 59.

Line 60 - Total Equity Capital Beginning of Following Cost Reporting Period--Enter on this line the sum of lines 56 and 57, plus or minus lines 58 and 59. This total is the beginning equity capital for the following cost reporting period and will be shown in Part II, column 2, all lines, and in column 8, line 1. However, if a negative amount is entered on line 60, enter the negative amount in Part II, column 2, all lines and enter zero in column 8, line 1.

1718.2 Part II - Computation of Return on Equity Capital of Proprietary Providers.--This part provides for the computation of the average equity capital and the amount of return includable in allowable costs.

Column 1--List each of the months or periods included in the cost reporting period.

Column 2--Enter the equity capital as of the beginning of the cost reporting period, as computed on the previous year's Supplemental Worksheet F-3, Part I, column 8, line 60 (line 56 if first reporting period under the health care programs). This amount will be the same for all months or periods during the cost reporting period. Also, enter this amount in column 8, line 1.

Column 3--List by month or period the capital investments made during the cost reporting period. Capital investments include cash and other property contributed by owners, and proceeds from the issuance of corporate stocks. Do not include loans from owners here. The amount entered on the appropriate line in column 3 is carried forward to subsequent months in the period, and is increased by additional contributions in the month(s) or period(s) in which such contributions are made.

Column 4--Enter the net gain or loss from the disposition of depreciable assets computed in accordance with HCFA Pub. 15, Part I, chapter 1. Gains and losses on investments related to patient care and included in equity capital will also be shown in this column.

Beginning with the month or period in which the transaction occurs, the amount of gain or loss is carried forward to subsequent months or periods in the cost reporting period and is increased or decreased as further asset disposals occur.

Column 5--Enter in this column, the amounts withdrawn by owners or disbursed for the personal benefit of owners; any amounts paid as dividends to corporate stockholders are also entered. This column includes the cumulative amount for the period, e.g., if withdrawals occur at the rate of $600 per month or period, the first month or period of the cost reporting period will show $600, the second - $1,200, etc. However, if withdrawals are made and are reflected in the profit or loss for the period (e.g., as salaries), they should not be entered here.

Column 6--Enter other changes in equity capital such as loans from owners made after July 1, 1966 (increases) and repayments of the same (decreases). Unrestricted donations and contributions are also entered in this column. Beginning with the first month or period in which a transaction occurs, the applicable amount is carried forward to subsequent months or periods and is increased by additional loans or decreased by repayments of loans. Direct equity allocation from a home office or other related organization should be reflected in the appropriate month in this column.

Column 7--Equity capital increases or decreases as income is earned or as losses are incurred in operations of the provider during the cost reporting period.

The net amount of the change in equity capital that results from operations is determined by analyzing the difference between equity capital at the beginning of the period and equity capital at the end of the period. From this increase or decrease in equity capital are added or subtracted the amounts included under the other categories of changes on this worksheet, columns 3 through 6. The balance then will represent the increase or decrease due to operations.

To compute the increase or decrease due to operations for the last month or period within the cost reporting period (if the cost report is for a 12-month calendar year, this would be line 13 - December) subtracted from the ending equity capital (from Part I, line 56), which should be entered on line 13, column 8, the total of columns 2 through 6 (same line). If

the amount in Part I, line 56, is negative, use the negative amount for this computation. Enter the resulting amount in column 7 (same line). This increase or decrease due to operations is considered to have been experienced uniformly during each of the months or periods of the cost reporting period and to have affected equity cumulatively. Therefore, if the net increase due to profits for 12 months is $24,000 (as entered in column 7, line 13), there would be $2,000 entered on line 2, $4,000 entered on line 3, etc.

Column 8--For each month or period within the cost reporting period, enter the net total of columns 2 through 7. If this amount is a negative amount, do not enter a zero, enter the negative amount.

Column 9--Where the provider includes a distribution of pooled equity capital from a home office (or other related organization), enter the monthly amounts of equity capital allocated from the home office (or other related organization) where positive or negative. See HCFA Pub. 15, Part I, chapter 12 and §§2150 - 2153.

NOTE: Column 9 will reflect actual home office and/or related organization pooled equity, even if negative in amount. The months in the provider's cost reporting period must be matched with corresponding months in the cost statement(s).

Line 1 will show the pooled equity at the beginning of the provider's reporting period. This will be equal to the amount allocated from the related organization(s) in the last month of the preceding period.

Lines 2 through 13 (in a 12-month cost reporting period) will reflect the monthly pooled equity capital balances as shown in the cost statement(s).

These procedures are especially important where the provider has a year end which is nonconcurrent with that of the related organization.

The pooled equity capital allocations must not be reflected on the provider's balance sheet (Supplemental Worksheet F, Part I). Specifically, it is not proper to use line 54 entitled "equity in assets leased from related organizations" for pooled equity allocations.

Column 10--Add the total of column 8 and column 9, and enter the total in column 10. If a negative amount is obtained, enter zero (0). Add the individual months' equity capital and enter the total of column 10 on line 15.

Line 19 - Computation of Return on Equity Capital--Divide the total amount shown in column 10, line 15, by the number of months or periods in the cost reporting period plus one to determine average equity capital during the period. If this is a short period report, make this computation as stated in the previous line and an adjustment will be made on line 20. Apply the appropriate rate of return (line 18) to the average equity capital (line 17) to determine the amount of return includable in allowable costs. The intermediary will furnish the rate of return.

Line 20--The amount computed on line 19 will yield the allowable return for a full year. If a shorter reporting period is covered by this worksheet, the full year return must be divided by the number of months (12) or periods that would otherwise be contained in a

full reporting period. This resulting amount will then be multiplied by the number of months or periods included in the worksheet to arrive at the amount of return to be included in allowable costs. Enter this amount on line 20.

Lines 21 and 22--Complete these lines in accordance with line descriptions. The ratio of allowable return on equity capital to total allowable cost is used in Part III -Apportionment of Allowable Return on Equity Capital of Proprietary Agencies.

1718.3 Part III - Apportionment of Allowable Return on Equity Capital of Proprietary Providers.--This part provides for the apportionment of the allowable return on equity capital to title XVIII only.

The return on equity capital is computed by multiplying the applicable "cost" (column 1) by the ratio developed in Part II, column 10, line 22. The following chart provides the needed reference for the "cost" amounts to be entered in column 1 as well as the required references for transferring the return on equity capital to be included in reimbursement.

Lines	Description	Costs To Be Included In Column 1 Transferred From	Return on Equity Capital To Be Transferred to
1	Part A - Other Than DME	Worksheet D, Column 1, Line 3	Worksheet D, Column 1, Line 4
2	Part A - DME	Worksheet D, Column 2, Line 3	Worksheet D, Column 2, Line 4
3	Part B - Other Than DME	Worksheet D, Column 3, Line 3	Worksheet D, Column 3, Line 4
4	Part B - DME	Worksheet D, Column 4, Line 3	Worksheet D, Column 4, Line 4
5	CORF	Worksheet J-3, Line 3	Worksheet J-3, Line 4

1719. SUPPLEMENTAL WORKSHEET S-2--HOME HEALTH AGENCY (HHA)-BASED CORF STATISTICAL DATA

In accordance with 42 CFR 405.406(a), 42 CFR 405.453(a) and 42 CFR 405.453(c), providers are required to maintain statistical records for proper determination of costs payable under the Medicare program. The statistics required to be reported on this Supplemental Worksheet pertain to an HHA CORF. The data needed to be maintained, depending on the services provided by the CORF, include number of program treatments, total number of treatments, number of program patients, total number of patients. In addition, FTE data is required by employee staff, contracted staff, and total.

CORF Treatments--Lines 1 through 8 are used to identify the number of service treatments and corresponding number of patients. The patient count in columns 2 and 4 should include each individual who received each type of service. The sum of the patient count in columns 2 and 4 will equal the total in column 6 for each line.

Columns 1 and 3--Enter the number of treatments for title XVIII and other, respectively, for each discipline. Enter the total for each column on line 9.

Columns 2 and 4--Enter the number of patients corresponding to the number of treatments in columns 1 and 3 for title XVIII and other, respectively, for each discipline.

Columns 5 and 6--Enter in column 5 the total of columns 1 and 3. Enter in column 6 the total of columns 2 and 4.

LINE DESCRIPTIONS

Lines 1 through 7--These lines identify the type of CORF services which are reimbursable by the program. These lines should reflect the number of times a person was a patient receiving a particular service and related number of treatments.

Line 8--This line identifies other services not listed on lines 1 through 7 which are not reimbursable by the program.

Line 9--Enter in column 1 the total of the amounts on lines 1 through 7. Enter in columns 3 and 5 the total of the amounts on lines 1 through 8.

Lines 10 through 28--These lines provide statistical data related to the human resources of the CORF. The human resources statistics are required for each of the job categories specified on lines 10 through 26. Enter any additional categories needed on lines 27 and 28.

Enter the number of hours in your normal work week in the space provided.

Report in column 1 the full-time equivalent (FTE) employees in the CORF's payroll. These are staff for which an IRS form W-2 is used.

Report in column 2 the FTE contracted and consultant staff of the CORF.

Staff FTE's are computed for column 1 as follows: sum of all hours for which employees were paid divided by 2080 hours, round to two decimal places, e.g., .04447 should be rounded to .04. Contract FTE's are computed for column 2 as follows: sum of all hours for which contracted and consultant staff worked divided by 2080 hours, round to two decimal places.

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

1720. SUPPLEMENTAL WORKSHEET J-1

This supplemental worksheet is to be used only if a provider operates a certified home health agency-based CORF as part of its complex.

1720.1 Part I -- Allocation of General Service Costs to CORF Cost Centers.--Supplemental Worksheet J-1, Part I, provides for the allocation of the expenses of each general service cost center to those cost centers which receive the services. The total direct expenses (column 0, line 15) are obtained from Worksheet A, column 10, line 22. The cost center allocation (column 0, lines 1 through 14) is obtained from the provider's records.

1720.2 Part II -- Computation of Unit Cost Multiplier for Allocation of CORF Administrative and General Costs.

1720.3 Part III -- Allocation of General Services Costs to CORF Cost Centers -Statistical Basis.--Supplemental Worksheet J-1, Parts II and III provide for the proration of the statistical data needed to equitably allocate the expenses of the general service cost centers on Supplemental Worksheet J-1, Part I.

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

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

NOTE: A provider wishing to change its allocation basis for a particular cost center must make a written request to its 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 will be the beginning of the cost reporting period for which the request has been made. (See HCFA Pub. 15-I, §2313.)

Lines 1 through 14--On Supplemental Worksheet J-1, Part III, for all cost centers to which the general service cost center is being allocated, enter that portion of the total statistical base applicable to each.

Line 15--Enter the total of lines 1 through 14 for each column. The total in each column must be the same as shown for the corresponding column on Worksheet B-1, line 22.

Line 16--Enter the total expenses of the cost center to be allocated. This amount is obtained from Worksheet B, line 22, from the same column used to enter the statistical base on Supplemental Worksheet J-1, Part III (e.g., in the case of Capital Related Cost -Buildings and Fixtures, this amount is on Worksheet B, column 1, line 22).

Line 17--Enter the "Unit Cost Multiplier" which is obtained by dividing the cost entered on line 16 by the total statistic entered in the same column on line 15. The "Unit Cost Multiplier" must be rounded 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 Supplemental Worksheet J-1, Part I, in the corresponding column and line.

After the "Unit Cost Multiplier" has been applied to all the cost centers receiving the services, the total cost (line 15, Part I) must equal the total cost on line 16, Part III.

The preceding procedures must be performed for each general service cost center.

In column 6, Part I, enter the total of columns 0 through 5.

In Part II, compute the "Unit Cost Multiplier" for allocation of CORF Administrative and General costs as follows:

Line 1--Enter the amount from Part I, column 6, line 15.

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

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

Line 4--Divide the amount on line 2 by the amount on line 3 and enter the result rounded to six decimal places.

In column 7, Part I, for lines 2 through 14, multiply the amount in column 6 by the "Unit Cost Multiplier" on line 4, Part II, and enter the result in this column. On line 15, enter the total of the amounts on lines 2 through 14. The total on line 15 should equal the amount in column 7, line 1.

In column 8, Part I, enter on lines 2 through 14 the sum of the amounts in columns 6 and 7. The total on line 15 should equal the total in column 6, line 15.

1721. SUPPLEMENTAL WORKSHEET J-2 - COMPUTATION OF CORF COSTS

This supplemental worksheet is to be used only if the provider operates an HHA-based CORF.

1721.1 Part I -- Apportionment of CORF Cost Centers.--

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

Column 2--Enter the charges for each cost center. The charges will be obtained from the provider's records.

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

Column 4--For each cost center, enter the charges from the provider's records for title XVIII CORF patients.

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

Line 15--Enter the totals for columns 1, 2, 4 and 5.

1721.2 Part II -- Apportionment of Cost of CORF Services Furnished by Shared Home Health Agency (HHA) Departments.--This part is to be used only when the HHA maintains a shared department for any of the cost centers listed on this worksheet, and the department provides services both to patients of the HHA and the HHA's CORF.

Column 1--For each cost center listed, enter the amounts from Worksheet B, column 6, lines as appropriate.

Column 2--For each cost center listed, enter the total provider charges for services rendered in the shared HHA department.

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

Column 4--For each cost center, enter the charges from the provider's records for title XVIII CORF patients.

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

Line 25--Enter the total for columns 3, 4 and 5.

1721.3 Part III -- Total CORF Costs.--

Line 26--Enter the total costs from Part I, column 5, line 15 plus Part II, column 5, line 25. Transfer the amount to the Supplemental Worksheet J-3, line 1.

1722. SUPPLEMENTAL WORKSHEET J-3 - CALCULATION OF REIMBURSEMENT SETTLEMENT -- CORF SERVICES

Supplemental Worksheet J-3 is to be submitted only if the provider operates a home health agency-based CORF.

Line 1--Enter the cost of CORF services from Supplemental Worksheet J-2, Part III, line 26, column 5.

Line 2--Enter the amounts paid and payable by Worker's Compensation and other primary payers (from provider's records).

Line 3--Enter the amount obtained by subtracting line 2 from line 1. For proprietary providers, the amount on this line is transferred to Supplemental Worksheet F-3, Part III, line 5, column 1.

Line 4--Enter the allowable return on equity capital from Supplemental Worksheet F-3, Part III, line 5, column 2.

Line 6--Enter the Part B deductibles billed to program patients (from provider's records), excluding any coinsurance amounts.

Line 8--Enter 80 percent of line 7 for title XVIII. No entry should be made for title V or title XIX.

Line 9--Enter the actual coinsurance billed to program patients (from provider's records).

Line 11--Enter reimbursable bad debts, net of recoveries, applicable to any deductibles and coinsurance (from provider's records).

Line 12--Enter the lesser of the amounts on line 8 or line 10, plus the amount on line 11.

Line 13--Enter on this line the program's share of any net depreciation adjustment applicable to prior years resulting from the gain or loss on the disposition of depreciable assets. (See HCFA-Pub. 15-I, §§ 132ff.) Enter the amount of any excess depreciation taken in parentheses ( ).

Line 14--Enter on this line the program's share of any recovery of excess depreciation applicable to prior years resulting from provider termination or a decrease in Medicare utilization. (See HCFA-Pub. 15-I, §§ 136ff.)

Line 15--

NOTE: Public Law 99-177, the Balanced Budget and Emergency Deficit Control Act of 1985 (Gramm-Rudman) provides for an automatic deficit reduction procedure to be established for Federal fiscal years (FYs) 1986 through 1991, when the deficit would reach zero. With regard to title XVIII, each payment amount would be reduced by a specified percentage which could not exceed one percent for FY 1986 and two percent for each subsequent year in which sequestration (reduction

of otherwise payable program payment amounts pursuant to Presidential Order under P.L. 99-177) takes place. Section IM 199 of HCFA Pub. 15-II outlines the methodology by which the sequestration adjustment will be computed.

Line 15A--Enter on this line the amount on line 12 plus/minus the amount on line 13, minus the amount on line 14.

Line 15B--Using the methodology explained in § IM 199 of HCFA Pub. 15-II, enter the sequestration adjustment on this line.

Line 15C--Enter on this line the amount on line 15A minus the amount on line 15B.

Line 16--Enter on this line the total interim payments applicable to this cost reporting period. For title XVIII this amount is transferred from Supplemental Worksheet J-4, column 2, line 4.

Line 18--Enter on this line the program reimbursement effect of nonallowable cost report items which the provider is disputing. The reimbursement effect must be computed in accordance with HCFA-Pub. 15-II, § 115.2(B). A schedule must be attached showing the supporting details and computation for this line.

Line 19--Enter the balance due provider/program.

1723. SUPPLEMENTAL WORKSHEET J-4--ANALYSIS OF PAYMENTS TO PROVIDER-BASED CORF FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

This supplemental worksheet should be completed for Medicare interim payments only.

Providers should complete the identifying information on lines 1 through 4. The remainder of the supplemental worksheet will be completed by your fiscal intermediary.

LINE DESCRIPTIONS

Line 1--Enter on line 1 the total program interim payments paid to the CORF. The amount entered should reflect 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 on this line should include amounts withheld from the CORF's interim payments due to an offset against overpayments to the CORF applicable to prior cost reporting periods. It should not include any retroactive lump sum adjustment amounts based on a subsequent revision of the interim rate, or tentative or net settlement amounts; nor should it include interim payments payable.

Line 2--Enter on line 2 the total program 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 should not include payments reported on line 1.

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

Line 4--Transfer the total interim payments to the title XVIII Supplemental Worksheet J-3, line 16.

DO NOT COMPLETE THE REMAINDER OF SUPPLEMENTAL WORKSHEET J-4. LINES 5 -7 ARE FOR INTERMEDIARY USE ONLY.

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 will be reported 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, where 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, 5g and 6 in column 2. The amount in column 2 must equal the amount on Supplemental Worksheet J-3, line 15.

1724. GENERAL INSTRUCTIONS FOR HOME HEALTH AGENCY (HHA)-BASED HOSPICE

The Paperwork Reduction Act of 1980 establishes the requirement that the private sector be informed as to why information is collected and what the information will be used for by the government. In accordance with 42 CFR 418.310 providers of service participating in the Medicare program are required to submit annual information for health care services rendered to Medicare beneficiaries. Also, 42 CFR 418.310 requires that cost reports will be required from providers on an annual basis. The data submitted on the cost report supports management of the Federal programs. In completing form HCFA-1728-K, the information reported must conform to the requirements and principles set forth in the Provider Reimbursement Manual, Part I (HCFA Pub. 15-I) and the Hospice Manual (HCFA Pub. 21). These instructions are effective for cost reporting periods ending after November 1, 1983.

In completing the worksheets, reductions in expenses must always be shown in parentheses ( ).

An HHA-based hospice, as the term is used in this report, refers to a hospice that is part of an HHA participating in Medicare and meeting the requirements of §1861(dd) of the Social Security Act. Refer to the Hospice Manual (HCFA Pub. 21) and the Provider Reimbursement Manual, Part I (HCFA Pub. 15-I) for further definitions of terms. Your intermediary will furnish any additions and revisions to the documents cited.

Form HCFA-1728-K must be used by Medicare certified HHA-based hospices and must be submitted to the HHAs Medicare fiscal intermediary as part of the HHAs Medicare cost report. HHAs that operate hospice programs which are not certified hospices should not complete the "K" series worksheets.