
Medicare

Provider Reimbursement Manual

Part 2, Provider Cost Reporting Forms and Instructions, Chapter 35, Form CMS-2540-96

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

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NEW/REVISED MATERIAL--EFFECTIVE DATE: Cost Reporting Periods beginning on or After October 1, 2003.

This transmittal facilitates data collection for Skilled Nursing Facilities (SNF). The responses to this data collection effort will be used to determine the impact on direct patient care as a result of increased Resource Utilization Group (RUG) payments in accordance with a notice published in the **Federal Register** Vol. 68, No. 149 – August 4, 2003 which provided for an increase in the RUG payments to Skilled Nursing Facilities (SNF) services rendered on or after October 1, 2003.

REVISED ELECTRONIC SPECIFICATIONS EFFECTIVE DATE: Changes to the electronic reporting specifications are effective for cost reporting periods ending on or after December 31, 2002. There are no edit implications for the above referenced revision.

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

3508. WORKSHEET S-2 - SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX IDENTIFICATION DATA

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

Lines 1 and 2.--Enter the address of the skilled nursing facility.

Line 3.--Indicate the county and MSA Code of this SNF. Enter a "U" or "R" designating urban or rural.

Line 3.1.--Enter the Facility Specific Rate, supplied by your intermediary. Enter the transition period of 1 = 25/75, (25 percent Federal Case Mix - 75 percent Facility Specific Rate), 2 = 50/50, 3 = 75/25, (75 percent Federal Case Mix - 25 percent Facility Specific Rate), or 100 for 100 percent Federal Case Mix Rate.

Line 3.2.-- Enter in column 1 the wage adjustment factor in effect before October 1, and in column 2 the adjustment in effect on or after October 1.

This information is needed to properly determine which RUG rates are applicable.

Lines 4 through 12.--On the appropriate lines and columns indicated, enter the names, provider identification numbers, and certification dates of the skilled nursing facility (SNF) and its various components, if any. For each health care program, indicate the payment system applicable to the SNF and its various components by entering "p" (prospective payment system), "o" (indicating cost reimbursement), or "n" (for not applicable) respectively.

Line 4.--This is an institution which meets the requirements of §1819 of the Social Security Act. Skilled Nursing Facility cost reporting periods beginning on and after 07/01/98 and reimbursed under title XVIII will be using the Prospective Payment System.

Line 6.--This is a portion of a SNF which has been issued a separate identification number and which meets the requirements of §1919 of the Act.

Line 6.1.--This is a portion of a SNF which has been issued a separate identification number and which meets the requirements of §1905(d) of the Act.

Line 7.--This is a distinct part and separately certified component of a SNF which meets the requirements of §1886(d)(1)(B) of the Act.

Line 8.--This is a distinct part HHA that has been issued an identification number and which meets the requirements of §§1861(o) and 1891 of the Act. If you have more than one SNF based HHA, subscript this line and report the required information for each HHA.

Line 9.--Do not enter any data on line 9.

Line 10.--This is a SNF-based outpatient rehabilitation facility that has been issued a separate identification number. Indicate the type of facility through subscripted line numbers, as follows. Use line 10.00 for a CORF, line 10.10 for a CMHC, line 10.20 for an OPT, line 10.30 for an OOT, and line 10.40 for an OSP.

Line 11.--This is a distinct part and separately certified component of an SNF which meets the requirements of §1861 (aa) of the Act.

Line 12.--This is a distinct part and separately certified component of an SNF which meets the requirements of §1861 (dd) of the Act.

Line 13.--Enter the inclusive dates covered by this cost report. In accordance with 42 CFR 413.24(f), you are required to submit periodic reports of operations which generally cover a consecutive 12-month period of operations. (See §§102.1 - 102.3 for situations when you may file a short period cost report.)

Cost reports are due on or before the last day of the fifth month following the close of the period covered by the report. The ONLY provision for an extension of the cost report due date is identified in 42 CFR 413.24(f)(2)(ii).

When you voluntarily or involuntarily cease to participate in the health insurance program or experience a change of ownership, a cost report is due no later than 150 days following the effective date or termination of your agreement or change of ownership.

Line 14.--Enter a number from the list below which indicates the type of ownership or auspices under which the SNF is conducted.

- | | |
|----------------------------------|--------------------------------------|
| 1 = Voluntary Nonprofit, Church | 8 = Governmental, City-County |
| 2 = Voluntary Nonprofit, Other * | 9 = Governmental, County |
| 3 = Proprietary, Individual | 10 = Governmental, State |
| 4 = Proprietary, Corporation | 11 = Governmental, Hospital District |
| 5 = Proprietary, Partnership | 12 = Governmental, City |
| 6 = Proprietary, Other * | 13 = Governmental, Other * |
| 7 = Governmental, Federal | |

* Where an "other" item is selected, please specify on line 19.

Lines 15 through 18.--These lines provide for furnishing certain information concerning the provider. All applicable items must be completed.

Subscript line 15 in the following:

Lines 15.01 through 15.20--A notice published in the August 4, 2003, **Federal Register**, Vol. 68, No. 149 provided for an increase in RUG payments to Skilled Nursing Facilities (SNF) for payments on or after October 1, 2003, however, this data is required for cost reporting periods beginning on or after October 1, 2003. Congress expected this increase to be used for direct patient care and related expenses. Subscript line 15 into the following lines: 15.01 - Staffing, 15.02 - Recruitment, 15.03 - Retention of Employees, 15.04 - Training, and 15.05-15.20 - Other. Enter in column 1 the percentage, of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 1, column 3. For each line, indicate in column 2 whether the increased RUG payments received for cost reporting periods beginning on or after 10/01/2003 reflects increases associated with direct patient care and related expenses by responding "Y" for yes. Indicate "N" for no if there was no increase in spending in any of these areas. If the increased spending is in an area not previously identified in areas one through four, identify on the "Other (Specify)" line(s), the cost center(s) description and the corresponding information as indicated above.

Line 21.--Enter ONLY A, D, or E for the all-inclusive method, or leave it BLANK. Do not enter an "N". (See CMS Pub 15-I, §2208.2.)

Lines 23 through 30.--These lines provide for furnishing certain information concerning depreciation. All applicable items must be completed. (See CMS Pub. 15-I, chapter 1, regarding depreciation.)

Lines 23, 24, and 25.--Indicate, on the appropriate lines, the amount of depreciation claimed under each method of depreciation used by the SNF during the cost reporting period.

Line 26.--The total depreciation shown on this line may not equal the amount shown on lines 1 and/or 2 on the Trial Balance of Expenses Worksheet, but represents the amount of depreciation included in costs on Worksheet A, column 7.

Lines 29 through 32.--Indicate a "Yes" or "No" answer to each question on these lines.

Lines 33 through 44.--Indicate a "Yes" or "No" answer, where applicable, to each component and type of service that qualifies for the exception.

If you are a provider (public or non public) that qualifies for an exemption from the application of the lower of cost or charges (as explained in 42 CFR 413.13(f)), indicate the component and the appropriate services that qualify for this exemption. Subscript lines 35 through 40 as required for additional component(s).

Line 43.--Indicate whether the provider is licensed in a state that certifies the provider as an SNF as described on line 4 above, regardless of the level of care given for Titles V and XIX patients.

Line 44.--This line is not used for cost reporting periods beginning on and after July 1, 1998. Indicate whether the provider participated in the NHCMQ demonstration during the cost reporting period. All NHCMQ demonstration participants must file Form CMS 2540-96, including facilities reporting less than 1,500 program days which would otherwise be allowed to utilize the Form CMS 2540S-97. Only facilities in Kansas, Maine, Mississippi, New York, South Dakota, and Texas are eligible to participate in the NHCMQ demonstration. This demonstration will not be applicable for cost reporting periods beginning on and after July 1, 1998. At that time all SNFs will be reimbursed under PPS.

Section 222 (a)(1) of P.L. 92-603 (42 U.S.C. Section 1395b-1, note) authorizes the Secretary of the Department of Health and Human Services to engage in experiments and demonstrations regarding alternative methods of making payment on a prospective basis to SNFs and other providers. Section 222 (a)(3) authorizes the Secretary to grant waivers of certain Title XVIII requirements insofar as such requirements relate to methods of payment for services provided. Additional forms have been added to the SNF cost report to accommodate the NHCMQ demonstration project. Worksheet D-1 must be completed by a provider participating in the demonstration.

A provider participating in the NHCMQ demonstration, which otherwise is reimbursed by other than the Prospective Payment System and which indicates either an "O" or "N" on line 4, must complete Worksheet E, Part V in place of Worksheet E, Part I or Worksheet E, Part II.

Line 45.--List the total amount of malpractice premiums paid, (column 1) the total amount of paid losses, (column 2), and the total amount of self insurance, (column 3) allocated in this fiscal year.

Line 46.--Indicate if malpractice premiums and paid losses are reported in other than the Administrative and General cost center. If yes, provide a supporting schedule and list the amounts applicable to each cost center.

Line 47.--Are you claiming ambulance costs? Enter in column 1, "Y" for yes or "N" for no. If this is your first year of providing and reporting ambulance services, you are not subject to the payment limit. Enter in column 2, Y if this is your first year of providing ambulance service, or N if it is not.

Line 48.--If line 47 column 1 is Y, and column 2 is N, enter on line 48 column 1 the payment limit provided from your fiscal intermediary. If your fiscal year is OTHER than a year beginning on October 1st, enter in column 1 the payment limit for the period prior to October 1, and enter in column 2 the payment limit for the period beginning October 1st. The per trip rate is updated October 1st of each year. Subscript this line as needed.

Report your ambulance trip limits chronologically, in accordance with your fiscal year. Applicable chronological dates are 01/01/2001, 07/01/2001, 01/01/2002, 04/01/2002 (effective date of the blend), 01/01/2003, 01/01/2004, 01/01/2005, and 01/01/2006.

Line 48.01—For services rendered on or after 04/01/2002, enter if applicable, the fee schedule amount for the period. Ambulance services will be based on a blend until 100% fee schedule is transitioned on 01/01/2006. The blend is effective for services on 04/01/2002 through 12/31/2005

Line 49.--Did you operate an ICF/MR facility for the purposes of title XIX? Enter “Y” for yes and “N” for no.

Line 50.-- Did this facility report less than 1500 Medicare days in its previous year’s cost report? Enter “Y” for yes or “N” for no.

Line 51.--If line 50 is yes, did you file your previous year’s cost report using the “simplified” step-down method of cost finding? (See §3500.) Enter “Y” for yes or “N” for no.

Line 52.--Is this cost report being filed under 42 CFR 413.321, (the “simplified” cost report)? Enter “Y” for yes, or “N” for no.

3509. WORKSHEET S-3 - SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX STATISTICAL DATA

In accordance with 42 CFR 413.60(a), 42 CFR 413.24(a), and 42 CFR 413.40(c), you are required to maintain statistical records for proper determination of costs payable under the Medicare program. The statistics reported on this worksheet pertain to SNF, nursing facility, ICF/MR, other long term care services, HHA, CORF, CMHC, and hospice. The data to be maintained, depending on the services provided by the component, include the number of beds available, the number of admissions, the number of discharges, the average length of stay, the number of inpatient days, the bed days available, and full time equivalents (FTEs).

Column Descriptions

Column 1.--Enter on the appropriate line the beds available for use by patients at the end of the cost reporting period (SNF on line 1, nursing facility on line 3, ICF/MR on line 3.1, SNF-based other long term care facility on line 4 or hospice on line 8). Do not enter any data on line 2.

Column 2.--Enter the total bed days available. Bed days are computed by multiplying the number of beds available throughout the period by the number of days in the reporting period. If there is an increase or decrease in the number of beds available during the period, multiply the number of beds available for each part of the cost reporting period by the number of days for which that number of beds was available.

Columns 3 through 6.--Enter the number of inpatient days for each component by program.

Column 4.--For fiscal years beginning on October 1st., enter on line 10 the number of ambulance trips, as defined by §4531(a)(1) of the BBA, provided for Medicare patients. If your fiscal year begins on a date other than October 1st, subscript line 10, to line 10.01. For cost reporting periods that overlap the October 1 date, enter on line 10 the trips prior to October 1 and enter on line 10.01 the number of trips after October 1. Subscript line 10 to line 10.02 if you entered amounts on Worksheet S-2, line 48.02. If you further subscripted line 48.02 to account for more than one limit on Worksheet S-2, you must subscript line 10 further to account for the trips applicable to each set of rates.

Column 7.--Enter the total number of inpatient days to include all classes of patients for each component.

Columns 8 through 11.--Enter the number of discharges, including deaths (excluding newborn and DOAs), for each component by program. A patient discharge, including death, is a formal release of a patient. (See 42 CFR 412.4.)

Column 12.--Enter the total number of discharges (including deaths) for all classes of patients for each component.

Columns 13 through 16.--The average length of stay is calculated as follows:

- | | | |
|----|-------------------------------|-------------------------------|
| a. | Column 13, lines 1 & 3 | Column 3 divided by column 8 |
| b. | Column 14, line 1 | Column 4 divided by column 9 |
| c. | Column 15, lines 1 & 3 | Column 5 divided by column 10 |
| d. | Column 16, lines 1, 3, 4, & 9 | Column 7 divided by column 12 |

EXCEPTION: Where the skilled nursing facility is located in a State that certifies the provider as an SNF regardless of the level of care given for Titles V and XIX patients, combine the statistics on lines 1 and 3.

Columns 17 through 21.--Enter the number of admissions (from your records) for each component by program.

Columns 22 and 23.--The average number of employees (full-time equivalent) for the period may be determined either on a quarterly or semiannual basis. When quarterly data are used, add the total number of hours worked by all employees on the first payroll at the beginning of each quarter and divide the sum by four times the number of hours in the standard work period. When semiannual data are used, add the total number of hours worked by all employees on the first payroll of the first and seventh months of the period, and divide this sum by two times the number of hours in the standard work period. Enter the average number of paid employees in column 22 and the average number of non-paid worker's in column 23 for each component, an applicable.

3509.1 Part II - SNF Wage Index Information.--This part provides for the collection of skilled nursing facility and nursing facility data to develop an SNF wage index that is applied to the labor related portion of the SNF cost limits. The Social Security Act Amendments of 1994 (P.L. 103-432) requested the Secretary to begin collecting data on employee compensation and hours of employment specific to skilled nursing facilities for the purposes of constructing an SNF wage index. In order to collect the data necessary to develop an SNF wage index, CMS has developed an SNF wage index form, as part of the cost report, to be completed by all SNFs.

NOTE: Any line reference for Worksheets A and A-6 includes all subscripts of that line.

Line 1.--Enter the wages and salaries paid to employees from Worksheet A, column 1, line 75.

Line 2.--Enter physician salaries paid to employees which are included on Worksheet A, column 1, line 75.

Line 3.--Enter the total physician and physician assistant salaries and wage related costs that are related to patient care and are included on line 1. Under Medicare, these services are billed separately under Part B.

Line 4.--Enter from Worksheet A the sum of salaries reported in column 1 of line 14 for interns and residents. Base the hours reported in column 4 on 2080 hours per each full time intern and resident employee.

Line 5.--If you are a member of a chain or other related organization, as defined in CMS Pub 15-I, 2150, enter the allowable wages and salaries and wage related costs for home office personnel from your records that are included in line 1.

Line 6.--Enter the sum of lines 2 through 5.

Line 7.--Subtract line 6 from line 1 and enter the result.

Line 8.--Enter the total of Worksheet A, column 1, line 19. This amount represents other long term care.

Line 9.- For cost reports ending on and after 11/30/1999, do not use this line.

Line 10.--Enter the amount from Worksheet A, column 1, line 49. Line 11.--Enter the total of Worksheet A, column 1, lines 37 through 47. If these lines are subscribed to accommodate more than one HHA, also enter the total of the subscribed lines.

Line 12.--Enter the amount from Worksheet A, column 1, line 50.

Line 13.--Enter the amount from Worksheet A, column 1, line 55.

Line 14.--Enter the amount from Worksheet A, column 1, lines 58 through 63.

Line 15.--Enter the sum of lines 8 through 14.

Line 16.--Subtract line 15 from line 7 and enter the result.

Line 17.--Enter the amount paid (include only those costs attributable to services rendered in the SNF and/or NF), rounded to the nearest dollar, for contracted direct patient care services, i.e., nursing, therapeutic, rehabilitative, or diagnostic services furnished under contract rather than by employees and management contract services as defined below. Report only those personnel costs associated with these contracts. Eliminate all supplies and other miscellaneous items. Do not apply the guidelines for contracted therapy services under §1861(v)(5) of the Act and 42 CFR 413.106. For example, you have a contract with a nursing service to supply nurses for the general routine service area on weekends. Contracted labor for purposes of this worksheet does **NOT** include the following services: consultant contracts, billing services, legal and accounting services, Part A CRNA services, clinical psychologists and clinical social worker services, housekeeping services, planning contracts, independent financial audits, or any other service not directly related to patient care.

Include the amount paid (rounded to the nearest dollar) for contract management services, as defined below, furnished under contract rather than by employees. Report only those personnel costs associated with the contract. Eliminate all supplies, travel expenses, and other miscellaneous items. Contract management is limited to the personnel costs for those individuals who are working at the facility in the capacity of chief executive, chief operating officer, chief financial officer, or nursing administrator. The titles given to these individuals may vary from the titles indicated above. However, the individual should be performing those duties customarily given these positions.

For purposes of this worksheet, contract labor does **NOT** include the following services: other management or administrative services, consultative services, unmet physician guarantees, physician services, clinical personnel, security personnel, housekeeping services, planning contracts, independent financial audits, or any other services not related to the overall management and operation of the facility.

Per instructions on Form CMS-339, details, including the type of service, wages, and hours associated with each direct patient care related contract must be submitted to your intermediary as well as the aggregate total wages and hours for management contracts.

In addition, if you have no contracted labor as defined above or management contract services, enter a zero in column 1. If you are unable to accurately determine the number of hours associated with contracted labor, enter a zero in column 1.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 2540-96
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

<u>DESCRIPTION</u>	<u>LINE(S)</u>	<u>COLUMN(S)</u>	<u>FIELD SIZE</u>	<u>USAGE</u>
WORKSHEET S-2 (Continued)				
For the skilled nursing facility and SNF-based components (continued):				
Title V payment system	4, 6, 8, 10-11	4	1	X
Title XVIII payment system	4, 8, 10- 11	5	1	X
Title XIX payment system	4, 6, 8, 10-11	6	1	X
Cost reporting period beginning date (MM/DD/YYYY)	13	1	10	X
Cost reporting period ending date (MM/DD/YYYY)	13	2	10	X
Type of control (See Table 3B.)	14	1	2	9
Is this an entirely participating skilled nursing facility? (Y/N)	15	1	1	X
<p style="color: red;">A notice published in the Federal Register Vol. 68 N. 149 which provided for an increase in the Rug payments for services beginning 10/01/2003. This increase is expected to be used for direct patient care and related expenses.</p>				
<p style="color: red;">Enter the percentage of total expenses for each of the following categories to total SNF revenue from inpatient care service</p>				
Staffing	15.01	1	4	9.99
Recruitment	15.02	1	4	9.99
Retention of employees	15.03	1	4	9.99
Training	15.04	1	4	9.99
<p style="color: red;">Is the increases spending associated with direct patient care and related expenses reflects each of the following categories (Y/N)</p>				
Staffing	15.01	2	1	X
Recruitment	15.02	2	1	X
Retention of employees	15.03	2	1	X
Training	15.04	2	1	X

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 2540-96
 TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

<u>DESCRIPTION</u>	<u>LINE(S)</u>	<u>COLUMN(S)</u>	<u>FIELD SIZE</u>	<u>USAGE</u>
WORKSHEET S-2 (Continued)				
Other (Specify)	15.05-15.20	0	36	X
Enter the percentage of total expenses for Other to total SNF revenue from inpatient care service	15.05	1	4	9.99
Is the increases spending associated with direct patient care and related expenses reflects Other (Y/N)	15.05	2	1	X
Is this a partially participating skilled nursing facility? (Y/N)	16	1	1	X
Is this skilled nursing facility unit of a domiciliary institution? (Y/N)	17	1	1	X
Is this skilled nursing facility unit of a rehabilitation center? (Y/N)	18	1	1	X
Text as needed for blank line	19	0	36	X
Other type (Y/N)	19	1	1	X
If this is a low or no Medicare utilization cost report, enter "L" for low or "N" for no Medicare utilization. (L/N)	20	1	1	X
If this is an all-inclusive provider, enter the method used. (See Table 3B.)	21	1	1	X
Is the difference between total interim payments and the net cost covered service included in the balance sheet? (Y/N)	22	1	1	X
Enter the amount of depreciation reported in this SNF for the method indicated:				
Straight Line	23	1	9	9
Declining Balance	24	1	9	9
Sum of the Years' Digits	25	1	9	9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 2540-96
 TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN
 DESIGNATIONS

<u>DESCRIPTION</u>	<u>LINE(S)</u>	<u>COLUMN(S)</u>	<u>FIELD SIZE</u>	<u>USAGE</u>
WORKSHEET S-2 (Continued)				
If depreciation is funded, enter the balance as of the end of the period.	27	1	9	9
Were there any disposals of capital assets during the cost reporting period? (Y/N)	28	1	1	X
Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? (Y/N)	29	1	1	X
Was accelerated depreciation claimed on assets acquired on or after August 1, 1970? (Y/N)	30	1	1	X
Did you cease to participate in the Medicare program at the end of the period to which this cost report applies? (Y/N)	31	1	1	X
Was there a substantial decrease in health insurance proportion of allowable cost from prior cost reporting periods? (Y/N)	32	1	1	X

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 2540-96
TABLE 3A - WORKSHEETS REQUIRING NO INPUT

Worksheet S, Part I
 Worksheet A-8-3, Parts II, III, and IV
 Worksheet A-8-4, Parts II and III
 Worksheet J-1, Part II
 Worksheet H-4, Part I

TABLE 3B - TABLES TO WORKSHEET S-2

Table I: Type of Control

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

Table II: All-inclusive provider methods (see CMS Pub. 15-I, §2208.2).

Method A	=	Departmental statistical data
Method D	=	Comparable SNF data
Method E	=	Percentage of average cost per diem

**TABLE 3C - LINES THAT CANNOT BE SUBSCRIBED
 (BEYOND THOSE PREPRINTED)**

<u>Worksheet</u>	<u>Lines</u>
S, Part II	1, 3, 7
S-2	1-4, 6, 6.10, 7, 13,14, 16-35, 41-46
S-3, Part I	1, 3, 4
S-3, Parts II & III	All
S-4, Part I	1-8
S-4, Part II	1-12
S-5	1-8, 14, 16
S-6	1-17

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 2540-96
TABLE 3C - LINES THAT CANNOT BE SUBSCRIBED
(BEYOND THOSE PREPRINTED) (CONTINUED)

<u>Worksheet</u>	<u>Lines</u>
S-7, Parts I, II, III, and IV	All
S-8	All
A	16, 19, 48, 49, 52-54, 75 (lines 17 and 20 may not be used)
A-6	All
A-7	All
A-8 - full cost report	Lines 2, through 20, 28 and 32
A-8 - simplified cost report	All except lines 23 and 31
A-8-1, Part A	All
A-8-1, Part B	1-8
A-8-1, Part C	1-9
A-8-2	All
A-8-3	All (except lines 5, 6, 12, 13, 28-38, 51, 59, 62, and 64)
A-8-4	All
A-8-5	All (except lines 5, 6, 12, 12.01, 13, 13.01, 66-70, 77-81)
B, Parts I & II	16, 19, 48, 49, 52-54, 65, and 75 (lines 17 and 20 may not be used)
B, Part III	15.1, 16, 17, 18, 18.1, 19, 21-33, 59, 63 (Lines 17 and 20 may not be used)
B-1	16, 19, 48, 49, and 52-54 (lines 17 and 20 may not be used)
B, Part II	15.1, 16, 17, 18, 18.1, 19, 21-33, 59, 63 (Lines 17 and 20 may not be used)
C	75
D, Part I	75
D-1	All
D-2	2, 4-5, and 17 (lines 3, 7, 11, 18, and 19 may not be used)
E, Part I	All (except line 30)
E, Part II	All (except line 22)
E, Part III	All (except line 32)

To download the Forms associated with this instruction, click [here](#).