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 and Medicaid Services (CMS)

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NEW/REVISED MATERIAL--*EFFECTIVE DATE:*

This transmittal revises Chapter 35 - Skilled Nursing Facility Cost Report Form CMS 2540-96 for implementation of a Prospective Payment System (PPS) for a SNF- based Home Health Agency (HHA) in accordance with §1895 of the Social Security Act effective for HHA services rendered on and after October 1, 2000.

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.

CHAPTER 35

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX COST REPORT FORM HCFA 2540-96

SKILLED NURSING FACILITY AND SKILLED NURSING
FACILITY HEALTH CARE COMPLEX COST REPORT
FORM HCFA 2540-96

3500. GENERAL

The Paperwork Reduction Act of 1995 requires that the private sector be informed as to why information is collected and what the information is used for by the government. In accordance with §§1815(a) and 1861(v)(1)(A)(ii) of the Act, providers of service participating in the Medicare program are required to submit annual information to achieve settlement of costs for health care services rendered to Medicare beneficiaries. Also, 42 CFR 413.20 requires cost reports from providers on an annual basis. In accordance with these provisions, Form CMS 2540-96 must be completed by all skilled nursing facilities (SNFs) and SNF health care complexes in determining program reimbursement. Besides determining program reimbursement, the data submitted on the cost report supports management of the Federal programs, e.g., data extraction in developing cost limits. In completing Form CMS 2540-96, the information reported must conform to the requirements and principles set forth in the Provider Reimbursement Manual, Part I (CMS Pub. 15-1). The filing of the cost report is mandatory and failure to do so results in all payments to be deemed overpayment, and 100 percent of these payments are withheld until the cost report is received. See chapter 1 of CMS PRM 15-2. The instructions contained in this chapter are effective for cost reporting periods ending on or after **June 30, 1996**. However, changes implemented by Transmittals 4, 5, 6, 7, 8, 9, 10 and 11 have various effective dates, listed as follows:

Home Health Agencies must make per visit limitation comparisons based on the applicable Metropolitan Standard Area (MSA) for cost reporting periods beginning on and after October 1, 1997. Effective for services rendered on or after October 1, 2000, all home health agencies, including SNF-based HHA's will be reimbursed on a Prospective Payment System (PPS).

Outpatient physical therapy services require a 10% reasonable cost reduction for services rendered on and after January 1, 1998.

All SNF's will be reimbursed under the Prospective Payment System (PPS) for cost reporting periods beginning on and after July 1, 1998.

Worksheet S-8, and Worksheets K through K-6 are effective for cost reporting periods beginning on and after April 1, 1999.

42 CFR §413.321 allows a SNF to use the "simplified" method of reimbursement. SNF's with less than 1500 Medicare days, who have no subproviders attached, and filed their previous year's cost report using the "simplified" method (originally developed on Form HCFA 2540S), will now file their cost reports on Form CMS 2540-96, completing ONLY the worksheets identified in §3504.2

Effective for cost reporting periods ending on and after March 31, 2000, the electronic cost report (ECR) file will be considered the official means of cost report submissions. The submission of the hard copy cost report will no longer be required, except for providers that use the Centers for Medicare & Medicaid (formerly Health Care Financing Administration) supplied free software. Those providers must continue to submit the manually completed hard copy cost report to their fiscal intermediary (along with the corresponding ECR file) due to an inability of the free software to create a print image file. The free software generated ECR file will, however, be considered the official copy.

NOTE: This form is not used by SNFs that are hospital-based. Instead, they continue to use Form CMS 2552.

You may submit computer prepared forms in lieu of the forms provided by CMS. These computer prepared forms are acceptable if the forms are reviewed and accepted for provider use by CMS before being placed into use. (See §108 for the use of computer prepared cost reporting forms.)

If computer prepared cost reporting forms have been reviewed and accepted for provider use, they must be revised and resubmitted for review and acceptance whenever changes in the law, regulations, or program instructions are adopted which have an impact on Medicare cost reporting.

In addition to Medicare reimbursement, these forms also provide for the computation of reimbursable costs applicable to titles V and XIX. Complete the worksheets and portions of worksheets applicable to titles V and XIX only when reimbursement is being claimed from these respective programs and only to the extent these forms are required by the State program.

Public reporting burden for this collection of information is estimated to average 187 hours per response, and record keeping burden is estimated to average 132 hours per response. This includes time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to:

Centers for Medicare and Medicaid Services
7500 Security Boulevard
Mail Stop N2-14-26
Baltimore, Md. 21244

3500.1 Rounding Standards For Fractional Computations.--Throughout the Medicare cost report, required computations result in the use of fractions. The following rounding standards must be employed for such computation.

1. Round to 2 decimal places:
   a. Percentages (e.g., capital reduction, outpatient cost reduction)
   b. Averages, standard work week, payment rates, and cost limits
   c. Full time equivalent employees
   d. Per diem
   e. Hourly rates

2. Round to 3 decimal places:
   a. PCR Rates

3. Round to 5 decimal places:
   a. Sequestration (e.g., 2.092 percent is expressed as .02092)
   b. Payment reduction

4. Round to 6 decimal places:
   a. Ratios (e.g., unit cost multipliers, cost/charge ratios)

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

3500.2 Acronyms and Abbreviations.--Throughout the Medicare cost report and instructions, a number of acronyms and abbreviations are used. For your convenience, commonly used acronyms and abbreviations are summarized below.

A&G	-	Administrative and General
AHSEA	-	Adjusted Hourly Salary Equivalency Amount
ASC	-	Ambulatory Surgical Center
BBA	-	Balanced Budget Act of 1997 (PL105-33)
CAPD	-	Continuous Ambulatory Peritoneal Dialysis
CAP-REL	-	Capital-Related
CCPD	-	Continuous Cycling Peritoneal Dialysis
CCU	-	Coronary Care Unit
CFR	-	Code of Federal Regulations
CMHC	-	Community Mental Health Center
CMS	-	Centers for Medicare and Medicaid Services (Formerly HCFA - Health Care Financing Administration)
COL	-	Column
CORF	-	Comprehensive Outpatient Rehabilitation Facility
CRNA	-	Certified Registered Nurse Anesthetist
CTC	-	Certified Transplant Center
DMERC	-	Durable Medical Equipment Regional Carrier
DRG	-	Diagnostic Related Group
EKG		Electrocardiogram
ESRD		End Stage Renal Disease
FQHC		Federally Qualified Health Center
FR		Federal Register
GME		Graduate Medical Education
HCFA Pub.*		Health Care Financing Administration Publication
HIPPS		Health Insurance Prospective Payment System
HHA		Home Health Agency
HMO		Health Maintenance Organization
HSPC		Hospice
I&Rs		Interns and Residents
ICF/MR		Intermediate Care Facility for the Mentally Retarded
ICU		Intensive Care Unit
IME		Indirect Medical Education
INPT		Inpatient
LCC		Lesser of Reasonable Cost or Customary Charges
LUPA		Low Utilization Payment Adjustment
MDH		Medicare Dependent Hospitals
MED-ED		Medical Education
MSA		Metropolitan Statistical Area
NHCMQ		Nursing Home Case Mix and Quality Demonstration
NF		Nursing Facility
OBRA		Omnibus Budget Reconciliation Act
OLTC		Other Long Term Care
OOT		Outpatient Occupational Therapy
OPO		Organ Procurement Organization
OPT		Outpatient Physical Therapy
OSP		Outpatient Speech Pathology
PBP		Provider-Based Physician
PEP		Partial Episode Payment
PPS		Prospective Payment System
PRM		Provider Reimbursement Manual
PRO		Professional Review Organization

PS&R	Provider Statistical and Reimbursement System
PT	Physical Therapy
RCE	Reasonable Compensation Equivalent
RHC	Rural Health Clinic
RPCH	Rural Primary Care Hospitals
ROE	Return on Equity Capital
RT	Respiratory Therapy
RUG	Resource Utilization Group
SCH	Sole Community Hospitals
SCIC	Significant Change in Condition
SNF	Skilled Nursing Facility
TEFRA	Tax Equity and Fiscal Responsibility Act of 1982
WKST	Worksheet

NOTE: In this chapter, TEFRA refers to §1886(b) of the Act and not to the entire Tax Equity and Fiscal Responsibility Act.

All references to "HCFA" (Forms, Pub. Etc.) are now "CMS" (Forms, Pub. Etc.)

3504 RECOMMENDED SEQUENCE FOR COMPLETING A SNF COST REPORT

3504.1 Recommended Sequence for Completing an SNF or SNF Health Care Complex - Full Cost Report.--

Part I - Departmental Cost Adjustments and Cost Allocation

Step No.	Worksheet	
1	S-2	Read §3508. Complete entire worksheet.
2	S-3, Parts I, II AND III	Read §3509. Complete entire worksheet.
3	S-7	Read §3514.3. Complete Part IV only.
4	A	Read §3516. Complete columns 1 through 3, lines 1 through 75.
5	A-6	Read §3517. Complete, if applicable.
6	A	Read §3516. Complete columns 4 and 5, lines 1 through 75.
7	A-7	Read §3518. Complete line 1 only.
8	A-8-1	Read §3520. Complete Part A. If the answer to Part A is "Yes", complete Parts B and C.
9	A-8-3	Read §§3522-3522.7. Complete, if applicable.
10	A-8-4	Read §§3523-3523.5. Complete, if applicable.
11	A-8-5	Read §§3564-3564.7. Complete, if applicable.
12	A-8	Read §3519. Complete entire worksheet.
13	A	Read §3516. Complete columns 6 and 7, lines 2 through 75.
14	B (Parts I and II), B-1, and B-2	Read §§3524 and 3526. Complete all worksheets entirely.

Part II - Departmental Cost Distribution and Cost Apportionment

Step No.	Worksheet	
1	C	Read §3527. Complete entire worksheet.
2	D	Read §3530. Complete entire worksheet. A separate copy of this worksheet must be completed for each applicable health care program for each SNF and nursing facility (NF).
3	D-1	Read §3531. A separate worksheet must be completed for each applicable health care program for each SNF and NF.
4	H-4, Parts I and II	Read §§3543-3543.2. Complete, if applicable.
5	J	Read §§3551-3554. Complete, if applicable.

Part III - Calculation of Reimbursement Settlement

Step No.	Worksheet	
1	E, Part I	Read §§3534-3534.1. Complete through line 22 of this worksheet for each applicable health care program for each applicable provider component.
2	E, Part II	Read §§3534-3534.2. Complete through line 17 of this worksheet for title XVIII for each applicable provider.
3	E, Part III	Read §§3534-3534.3. Complete through line 7 for Part A and lines 23 through 29 for Part B services.
4	E, Part I	Complete remainder of this worksheet for each applicable health care component for each applicable provider component.
5	E, Part II	Complete remainder of this worksheet for each applicable health care component for each applicable provider component.
6	E, Part III	Complete the remainder of this worksheet.
7	S-4	Read §3511. Complete this worksheet when applicable.
8	H-1	Read §3540. Complete this worksheet when applicable.
9	H-2	Read §3541. Complete this worksheet when applicable.
10	H-3	Read §3542. Complete this worksheet when applicable.

Step No.	Worksheet	
11	H	Read §3539. Complete this worksheet when applicable.
12	H-6, Part I	Read §§3545-3545.1. Complete this worksheet when applicable.
13	H-6, Part II	Read §§3545-3545.2. Complete this worksheet when applicable.
14	S-5	Read §3512. Complete this worksheet when applicable.
15	I-1 through I-3	Read §§3556-3560.2. Complete these worksheets when applicable.
16	I-5	Read §3563. Complete this worksheet when applicable.
17	J-3	Read §3553. Complete this worksheet when applicable. A separate copy of this worksheet must be completed for each component.
18	S-8	Read §3515. Complete this worksheet when Applicable.
19	K-1	Read §3566. Complete this worksheet when applicable.
20	K-2	Read§3567. Complete this worksheet when applicable.
21	K-3	Read §3568. Complete this worksheet when applicable.
22	K	Read §3565. Complete this worksheet when Applicable.
23	K-4	Read §3569. Complete this worksheet when Applicable.
24	K-5	Read §3570. Complete this worksheet when Applicable.
25	K-6	Read §3571. Complete this worksheet.

3505. SEQUENCE OF ASSEMBLY

The following examples of assembly of worksheets are provided so all providers are consistent in the order of submission of their annual cost report. All providers using Form CMS 2540-96 must adhere to this sequence. If worksheets are not completed because they are not applicable, do not include blank worksheets in the assembly of the cost report.

Worksheet	Part	Full Cost Report	Simplified Cost Report
S	I &II	X	X
S-2		X	X
S-3	I, II & III	X	X
S-4		X	
S-5		X	
S-6		X	
S-7	IV	X	X
S-8		X	
A		X	X
A-6		X	X
A-7		X	X
A-8		X	X
A-8-1		X	
A-8-2		X	
A-8-3		X	
A-8-4		X	
A-8-5		X	
B	I	X	
B	II	X	
B	III		X
B-1	I	X	
B-I	II		X

Worksheet	Part	Full Cost Report	Simplified Cost Report
B-2		X	
C		X	X
D		X	X
D-1		X	
D-2		X	
E	I	X	
E	II	X	
E	III	X	X
E-1		X	X
G		X	X
G-1		X	X
G-2		X	X
G-3		X	X
H Through H-7		X	
I Through I-5		X	
J-I Through J-4		X	
K Through K-6		X	

3511. WORKSHEET S-4 - SNF-BASED HOME HEALTH AGENCY STATISTICAL DATA

In accordance with 42 CFR 413.413(a), 42 CFR 413.24(a), and 42 CFR 413.24(c), you are required to maintain statistical records for proper determination of costs payable under the Medicare program. The statistics required to be reported on this worksheet pertain to an SNF-based home health agency. The data needed to be maintained, depending on the services provided by the agency, include number of program visits, total number of agency visits, number of program home health aide hours, total agency home health aide hours, program unduplicated census count and total unduplicated census count, program patient count, and total agency patient count. In addition, FTE data is required by employee staff, contracted staff, and total staff. Complete a separate Worksheet S-4 for each SNF-based home health agency.

All data required on this worksheet, as well as in the entire HHA cost report for a given fiscal year must only be associated with services rendered during episodes of care that conclude during that fiscal year. (See §3511.3 for a further discussion of episodes.)

Home Health Agency Visits.--Use lines 1 through 8 to identify the number of service visits and corresponding number of patients. The patient count in columns 2, 5, and 8 includes each individual who received each type of service. The sum of the patient count in columns 3 and 6 may not equal the amount in column 9 for each line. Also, the total of all of the lines does not equal line 9, unduplicated census count, since many patients receive more than one service.

Columns 1, 2, and 3.--Enter data pertaining to title XVIII patients only. Enter in column 2 the title XVIII visits for each discipline for services rendered through September 30, 2000 for reporting periods which overlap October 1, 2000. For reporting periods which begin on or after October 1, 2000 enter in column 2 all visits rendered during entire cost reporting period . Enter in column 3 the patient count applicable to the title XVIII visits in column 2 for each line description. See Home Health Agency Manual (CMS Pub. 11), §322 for patient count determination. Enter the sum of lines 1 through 6 in column 2 on line 8 (total visits). The sum of lines 1 through 6 in column 3 does not equal the unduplicated census count on line 9 because a beneficiary could be receiving more than one type of service.

Columns 4, 5, and 6.--Enter data pertaining to all other patients. Enter in column 5 the count of all the agency visits except title XVIII visits for each discipline. Enter in column 6 the total agency patient count, except title XVIII, applicable to the agency visits entered in column 5. Enter the sum of lines 1 through 7 in column 5 on line 8 (total visits). The sum of lines 1 through 7 in column 6 does not equal the unduplicated census count on line 9 because a patient could be receiving more than one type of service.

Columns 7, 8, and 9.--The amounts entered in column 8 are the sum of columns 2 and 5 for each discipline for cost reporting periods ending on or before September 30, 2000. For cost reporting periods which overlap October 1, 2000, enter in column 8 the total visits rendered during the entire reporting period. For cost reporting periods which overlap October 1, 2000 the amounts entered in column 8 may not equal the sums of columns 2 and 5 for each discipline. For cost reporting periods beginning on or after October 1, 2000, column 8 will again equal the sum of columns 2 and 5. The amounts entered in column 9 may not be the sum of columns 3 and 6 for each discipline. The unduplicated census count on line 9, column 9, does not necessarily equal the sum of title XVIII unduplicated census count (line 9, column 3) plus the "Other" unduplicated census count (line 9, column 6) . For example, if a patient receives both covered services and non-covered services, he or she is counted once as title XVIII (for covered services), once as other (for non-covered services), and only once as total. (See Mr. Washington example below.)

3511.1 Part I - Home Health Agency Visits.--

Lines 1 through 6.--These lines identify the type of home health services which are reimbursable by title XVIII. These lines reflect the number of visits furnished and the number of patients receiving a particular type of service.

EXAMPLE: Mr. Washington become a patient of First Home Health Agency on March 21, 1996. While he is a patient, he received skilled nursing and physical therapy services which are covered under title XVIII and home delivered meals service which are not covered under title XVIII. Mr. Washington is discharged June 22, 1996. Mr. Washington is readmitted to the First Home Health Agency on October 25, 1996, and received only skilled nursing services covered under title XVIII. The First Home Health Agency is a calendar year provider. Count Mr. Washington twice as a patient for skilled nursing services in column 3, line 1, once as a physical therapy patient in column 3, line 2, and once on the "All Other Services" line in column 6, line 7, for the home delivered meals service. In addition, count Mr. Washington once on the unduplicated census count for title XVIII (column 3, line 9), once on the unduplicated census count for "Other" (column 6, line 9), and once on the unduplicated census count for "Total" (column 9, line 9).

Line 6.--Enter the number of hours applicable to home health aide services in columns 1, 4, and 7.

Line 7.--Enter in columns 5 and 8 the total of all other visits. Enter in columns 6 and 9 the patient count applicable to visits furnished by the agency but which are not reimbursable by title XVIII.

Line 8.--Enter in column 2, line 8 the sum of lines 1 through 6. Enter in column 5, line 8 the sum of lines 1 through 7. Enter in column 8, line 8 the sum of columns 2 and 5.

Line 9.--Enter on line 9 in the appropriate column the unduplicated count of all patients receiving home visits or the care provided by employees of the agency or under contracted services for the entire reporting period. Enter on line 9.01 in the appropriate column the unduplicated count of all patients receiving home visits or other care provided prior to October 1, 2000, by employees of the agency or under contracted services during the reporting period. Enter on line 9.02in the appropriate column the unduplicated count of all patients receiving home visits or other care provided on or after October 1, 2000, by employees of the agency or under contracted services during the reporting period. (Beneficiaries who receive services before and after October 1, 2000, must be included in both unduplicated census counts before and after October 1, 2000. The sum of lines 9.01 and 9.02 may not necessarily equal line 9.) For cost reporting periods beginning on or after October 1, 2000, do not subscript line 9 as all unduplicated census count data is entered online 9. Count each individual only once. However, because a patient may be covered under more than one health insurance program, the total census count may not be equal the sum of the Title XVIII and all other census counts. For the purpose of calculating the unduplicated census count, if a beneficiary has received health care in more than one Metropolitan Statistical Area (MSA), you must prorate the unduplicated census count based on the ratio of visits provided in an MSA to the total visits furnished to the beneficiary so as to not exceed a total of (1). For example, if an HHA furnishes 100 visits to an individual beneficiary in one MSA during the cost reporting period, and the same individual received a total of 400 visits (the other 300 visits were furnished in other MSAs during the cost reporting period), the reporting HHA would count the beneficiary as a .25 (100 divided by 400) in the unduplicated census count for Medicare patients for the cost reporting period. Round the result to two decimal places, e.g., .2543 is rounded to .25. **A provider is also to query the beneficiary to determine if he or she has received health care from another provider during the year, e.g., Maryland versus Florida for beneficiaries with seasonal residence.**

3511.2 Part II - Employment Data.--

Lines 1 through 15 --Lines 1 through 15 provide statistical data related to the human resources of the HHA. The human resources statistics are required for each of the job categories specified in lines 1 through 15. Enter any additional categories needed on lines 13 to 15.

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

Report in column 1 the full time equivalent (FTE) employees on the HHA's payroll. These are staff for which an IRS Form W-2 is issued.

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

Compute staff FTEs for column 1 as follows. Divide the sum of all hours for which employees were paid by 2080 hours. Round to two decimal places, e.g., round .62244 to .62. Compute contract FTEs for column 2 as follows. Divide the sum of all hours for which contracted and consultant staff worked by 2080 hours.

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

Lines 16 and 17. - Enter the total number of Metropolitan Statistical Areas (MSAs) served by this provider for this cost reporting period. List each MSA code on line 17.

3511.3 Part III – Compilation of PPS Activity Data.--

In accordance with 42 CFR §413.20 and §1895 of the Social Security Act, home health agencies are mandated to transition from a cost based reimbursement system to a prospective payment system (PPS) effective for home health services rendered on or after October 1, 2000.

The statistics required on this worksheet pertain to home health services furnished on or after October 1, 2000. The data to be maintained, depending on the services provided by the agency, includes the number of aggregate program visits furnished in each episode of care payment category for each covered discipline, the corresponding aggregate program charges imposed in each episode of care payment category for each covered discipline, total visits and total charges for each episode of care payment category, total number of episodes and total number of outlier episodes for each episode of care payment category, and total medical supply charges for each episode of care payment category.

All data captured in Part III of this worksheet must be associated only with episodes of care which terminate during the current fiscal year for payment purposes. Similarly, when an episode of care is initiated in one fiscal year and concludes in the subsequent fiscal year, all data required in Part III of this worksheet associated with that episode will appear in the fiscal year on the PS&R in which the episode of care terminates.

HHA Visits.--See Part I of this section for the definition of an HHA visit.

Episode of Care.--Under home health PPS, the 60 day episode is the basic unit of payment where the episode payment is specific to one individual beneficiary. Beneficiaries are covered for an unlimited number of non-overlapping episodes. The duration of a full length episode is 60 days. An episode begins with the start of care date and must end by the 60th day from the start of care.

Less that a full Episode of Care.--

When 4 or fewer visits are provided by the HHA in a 60 day episode period, the result is a Low Utilization Payment Adjustment (LUPA). In this instance, the HHA is reimbursed based on a standardized per visit payment.

An episode may end before the 60th day in the case of a beneficiary elected transfer, or a discharge and readmission to the same HHA (including for an intervening inpatient stay). This type of situation results in a Partial Episode Payment (PEP) adjustment.

When a beneficiary experiences a Significant Change in Condition (SCIC) and subsequently, but within the same 60 day episode, elects to transfer to another provider, a SCIC within a PEP occurs.

A SCIC adjustment occurs when a beneficiary experiences a significant change in condition, either improving or deteriorating, during the 60 day episode that was not envisioned in the original plan of care. The SCIC adjustment reflects the proportional payment adjustment for the time both before and after the beneficiary experienced the significant change in condition during the 60 day episode.

Use lines 1 through 12 to identify the number of visits and the corresponding visit charges for each discipline for each episode payment category. Lines 13 and 14 identify the total number of visits and the total corresponding charges, respectively, for each episode payment category. Line 15 identifies the total number of episodes completed for each episode payment category. Line 16 identifies the total number of outlier episodes completed for each episode payment category. Outlier episodes do not apply to 1) Full Episodes without Outliers 2) LUPA Episodes. Line 17 identifies the total medical supply charges incurred for each episode payment category. Column 7 displays the sum total of data for columns 1 through 6. The statistics and data required on this worksheet are obtained from the provider statistical and reimbursement (PS&R) report and pertain only to services rendered on or after October 1, 2000.

Columns 1 through 6.--Enter data pertaining to Title XVIII patients only for services furnished on or after October 1, 2000. Enter, as applicable, in the appropriate columns 1 through 6, lines 1 through 12, the number of aggregate program visits furnished in each episode of care payment category for each covered discipline and the corresponding aggregate program visit charges imposed for each covered discipline for each episode of care payment category. The visit counts and corresponding charge data are mutually exclusive for all episode of care payment categories. For example, visit counts and the corresponding charges that appear in column 4 (PEP only episodes) will not include any visit counts or corresponding charges that appear in column 5 (SCIC within a PEP) and vise versa. This is true for all episode of care payment categories in columns 1 through 6.

Line 13.--Enter in columns 1 through 6 for each episode of care payment category, respectively, the sum total of visits from lines 1, 3, 5, 7, 9, and 11.

Line 14—Enter in columns 1 through 6 for each episode of care payment category, respectively, the sum total other of charges for all unspecified services reimbursed under PPS.

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

Line 16.--Enter in columns 1 through 6 for each episode of care payment category, respectively, the total number of episodes of care rendered and concluded in the provider's fiscal year.

Line 17.--Enter in columns 2 and 4 through 6 for each episode of care payment category identified, respectively, the total number of episodes of care rendered and concluded in the provider's fiscal year. Outlier episodes do not apply to columns 1 and 3 (Full Episodes without Outliers and LUPA Episodes, respectively).

Line 18.-- Enter in columns 1 through 6 for each episode of care payment category, respectively, the total visit charges for services rendered and concluded in the provider's fiscal year.

Column 7.-- Enter on lines 1 through 18, respectively, the sum total of amounts from columns 1 through 6.

3512. WORKSHEET S-5 - SKILLED NURSING FACILITY-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA

In accordance with 42 CFR 413.20(a), 42 CFR 413.24(a), and 42 CFR 413.24(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 provider-based rural health clinics (RHCs) and provider-based Federally Qualified Health Centers (FQHCs). If you have more than one of these clinics, complete a separate worksheet for each facility.

Lines 1 and 2.--Enter the full address of the RHC/FQHC.

Line 3.--For FQHCs only, enter your appropriate designation (U = urban or R =rural). See §505.2 of the RHC/FQHC Manual, CMS Pub. 27, for information regarding urban and rural designations. If you are uncertain of your designation, contact your intermediary. RHCs do not complete this line.

Lines 4 through 9.--In column 1, enter the applicable grant award number(s). In column 2, enter the date(s) awarded.

Line 10.--Subscript line 10 as needed to list all physicians furnishing services at the RHC/FQHC. Enter the physician's name in column 1, and the physician's Medicare billing number in column 2.

Line 11.--Subscript line 11 as needed to list all supervisory physicians. Enter the physician's name in column 1, and the number of hours the physician spent in supervision in column 2.

Line 12--If the facility operates as other than an RHC or FQHC, answer yes to this question and indicate the number of other operations in column 2. List other types of operations and hours on subscripts of line 13.

Line 13.--Enter the starting and ending hours for each applicable day(s) in the columns for the clinic services provided. If the facility provides other than RHC or FQHC services (e.g., laboratory or physician services), subscript line 13 and enter the type of operation on each of the subscripted lines. Enter in each column the starting and ending hours for the applicable day(s) that a facility is available to provide other than RHC/FQHC services.

NOTE: Line 13 must still be completed even if the facility answers NO to the question on line 12.

Line 15. --Is this a consolidated cost report? If yes, enter the provider names, addresses and provider numbers for all providers included in this cost report. (See CMS Pub.27 §508.D.)

Line 16. --Did you provide all or substantially all of the direct GME training costs for services on or after October 1, 1997? If yes, you must separately identify allowable and non-allowable costs on Worksheet I-1 and enter in column 2 the number of Medicare visits performed by Interns and Residents.

Subscript columns 3 and 4 of this worksheet to columns 3.01 and 4.01 respectively. Identify column 3.01 as "Federal Rate – High Cost Add-On", (for services between April 1, 2000 and September 30, 2000). Identify column 4.01 as " Add-On Days" (for services between April 1, 2000 and September 30, 2000). Enter in column 3.01 for each of the 15 lines identified above, 20 percent of the amount on the corresponding line in column 3. Enter in column 4.01 the days applicable to services, for the 15 lines listed above, from April 1, 2000 through September 30, 2000 or the end of the fiscal year. Where the fiscal year ends between April 2, 2000 and September 30, 2000 the provider should report in column 6.01 only the days applicable for April 1 through the end of the fiscal year. The days from the beginning of the next fiscal year through September 30, 2000 will be reported in column 4.01 of the subsequent cost report.

Section 101 of the BBRA also provides for an additional 4 percent increase in payment for ALL services furnished during fiscal years (FYs) 2001 and 2002. Therefore, for services furnished after September 30, 2000, and before October 1, 2002, columns 5 and 6 of this worksheet should be subscripted to columns 5.01 and 6.01, respectively. Identify column 5.01 as " Federal Rate – High Cost Add-On" (for services after September 30), and identify column 6.01 as " Add-On Days" (for services after September 30). Enter in column 5.01 for each line identified above, 20 percent of the Federal Case Mix Rate. Enter in column 6.01 the days applicable to services associated with the high cost RUGs (as listed above), from October 1, 2000 to the end of the provider's fiscal year.

All of the RUG rates will be increased by 4 percent. Enter in column 5, the Federal Case Mix Rate times 104 percent.

3514.4 Part IV - PPS Statistical Data for Electronic Filing.--Use Part IV for cost reporting periods ending on and after February 28, 2001. Use this part to report the Medicare days of the provider by RUG.

For cost reporting periods beginning on and after July 1, 2001, the only data required to be reported are the days associated with each RUG. These days can be reported in column 3.01, and do not have to be split between "before and after" October 1. The calculation of the total payment for each RUG is no longer required. All payment data is reported as a total amount paid under the RUG PPS payment system on Worksheet E, Part III, line 7,and is generated from the PS&R or your records. The total on line 46 must agree with the amount on Worksheet S-3, column 4, line 1. DO NOT COMPLETE columns 3, 4, 4.01, 4.05 or 5.

Column Descriptions

Column 1--The case mix group designations are already entered in this column.

Column 2--The M3PI revenue code designations are already entered in this column.

Columns 3 and 4.--Enter the rate assigned to the provider for each applicable RUG, and period. This rate is updated annually effective October 1. Providers with fiscal years other than October 1 to September 30 may have two rates to report. Enter the rate prior to October 1 in column 3 and the rate on or after October 1 in column 4. Providers with a fiscal year 10/01 to 09/30 use column 4 only. This Federal rate is adjusted for the labor portion by the update factor specific to the provider's MSA. This update factor is reported on Worksheet S-2, line 3.2 columns 1 and 2.

Columns 3.01 and 4.01.--Enter in column 3.01 the days, for each RUG, of the period before October 1 and in column 4.01 for the days on and after October 1. Enter the total on line 46.

Column 4.05.--For cost reporting periods that end prior to April 1, 2000, do not complete this column. For services rendered on and after April 1, 2000, through September 30, 2000, enter the days associated with the high cost RUGs at an increase of 20 percent.

Column 5.--Multiply columns 3 and 4 times columns 3.01 and 4.01 (column 4 times column 4.01 for cost reporting periods beginning October 1) respectively, rounded to zero and add the two results. This becomes the Federal amount. Multiply the Federal amount by the appropriate transition period percentage, i.e. 25 percent, 50 percent, 75 percent, or 100 percent identified on Worksheet S-2 line 3.1, column 2. Add to the Federal amount the result of the calculation of (total days from columns 3.01 and 4.01 multiplied by the facility specific rate (that result rounded to zero) identified on worksheet S-2, line 3.1, column 1) times the reciprocal percentage applied to the Federal rate, i.e., 75 percent, 50 percent, 25 percent, or 0 percent. Enter the result on the appropriate line for each RUG. Enter the sum of lines 1 through 45 on line 46, and transfer this total to Worksheet E, Part III, line 7

3515. WORKSHEET S-8 - HOSPICE IDENTIFICATION DATA

In accordance with 42 CFR 418.310, hospice providers of service participating in the Medicare program are required to submit information for health care services rendered to Medicare beneficiaries. 42 CFR 413.20 requires cost reports from providers on an annual basis. The data submitted on the cost reports supports management of Federal programs. The statistics required on this worksheet pertain to a SNF-based hospice. Complete a separate Worksheet S-8 for each SNF-based hospice.

3515.1 Part I - Enrollment Days Based on Level of Care.

Lines 1--4.--Enter on line 1 through 4 the enrollment days applicable to each type of care. Enrollment days are unduplicated days of care received by a hospice patient. A day is recorded for each day a hospice patient receives one of four types of care. Where a patient moves from one type of care to another, count only one day of care for that patient for the last type of care rendered. For line 5, an inpatient care day may be reported only where the hospice provides or arranges to provide the inpatient care.

For the purposes of the Medicare and Medicaid hospice programs, a patient electing hospice can receive only one of the following four types of care per day:

Line 1.--**Continuous Home Care Day** - A continuous home care day is a day on which the hospice patient is not in an inpatient facility. A day consists of a minimum of 8 hours and a maximum of 24 hours of predominantly nursing care. Convert continuous home care hours into days so that a true accountability can be made of days provided by the hospice.

Line 2.--**Routine Home Care Day -** A routine home care day is a day on which the hospice patient is at home and not receiving continuous home care.

Line 3.--**Inpatient Respite Care Day** - An inpatient respite care day is a day on which the hospice patient receives care in an inpatient facility for respite care.

Line 4.--**General Inpatient Care Day** - A general inpatient care day is a day on which the hospice patient receives care in an inpatient facility for pain control or acute or chronic symptom management which cannot be managed in other settings.

Column Descriptions

Column 1.--Enter only the unduplicated Medicare days applicable to the four types of care. Enter on line 5 the total unduplicated Medicare days.

Column 2.--Enter only the unduplicated Medicaid days applicable to the four types of care. Enter on line 5 the total unduplicated Medicaid days.

Column 3.--Enter only the unduplicated days applicable to the four types of care for all Medicare hospice patients residing in a skilled nursing facility. Enter on line 5 the total unduplicated days.

Column 4.--Enter only the unduplicated days applicable to the four types of care for all Medicaid hospice patients residing in a nursing facility. Enter on line 5 the total unduplicated days.

Column 5.--Enter in column 5 only the days applicable to the four types of care for all other non Medicare or non Medicaid hospice patients. Enter on line 5 the total unduplicated days.

Column 6.--Enter the total days for each type of care, (i.e., sum of columns 1, 2, and 5). The amount entered in column 6 line 5 represents the total days provided by the hospice.

NOTE: Convert continuous home care hours into days so that column 6 line 5 reflects the actual total number of days provided by the hospice.

3515.2 Part II --Census Data

Line 6.--Enter on line 6 the total number of patients receiving hospice care within the cost reporting period for the appropriate payer source.

The total under this line equals the actual number of patients served during the cost reporting period for each program. Thus, if a patient's total stay overlapped two reporting periods, the stay is counted once in each reporting period. The patient who initially elects the hospice benefit, is discharged or revokes the benefit, and then elects the benefit again within a reporting period is considered to be a new admission with a new election and is counted twice.

A patient transferring from another hospice is considered to be a new admission and is included in the count. If a patient entered a hospice under a payer source other than Medicare and then subsequently elects Medicare hospice benefit, count the patient once for each pay source.

The difference between line 6 and line 9 is that line 6 equals the actual number of patients served during the reporting period for each program, whereas under line 9, patients are counted once, even if their stay overlaps more than one reporting period.

Line 7.--Enter the total Title XVIII unduplicated continuous care hours billable to Medicare. when computing the unduplicated continuous care hours, count only one hour regardless of the number of services or therapies provided simultaneously within that hour.

Line 8.--Enter the average length of stay for the reporting period. Include only the days for which a hospice election was in effect. The average length of stay for patients with a payer source other than Medicare and Medicaid is not limited to the number of days under a hospice election.

The statistics for a patient who had periods of stay with the hospice under more than one program is included in the respective columns. For example, patient A enters the hospice under Medicare hospice benefit, stays 90 days, revokes the election for 70 days (and thus goes back into regular Medicare coverage), then reelects the Medicare hospice benefits for an additional 45 days, under a new benefit period and dies (patient B). Medicare patient C was in the program on the first day of the year and died on January 29 for a total length of stay of 29 days. Patient D was admitted with private insurance for 27 days, then their private insurance ended and Medicaid covered an additional 92 days. Patient E, with private insurance, received hospice care for 87 days. The average length of stay (LOS) (assuming these are the only patients the hospice served during the cost reporting period) is computed as follow:

Medicare Days (90 & 45 & 29)	164 days	
Patient (A, B & C)		
Medicare Patients	/3	

Average LOS Medicare	54.67 Days	
Medicaid Days Patient D (92)	92 Days	
Medicaid Patient	1	
Average LOS Medicaid	92 Days	
Other Payments (D & E)		2
Average LOS (Other)		54 Days
All Patients (90+45+29+92+87+27)		370 Days
Total number of patients	6	
Average LOS for all patients		61.67 Days

Enter the hospice's average length of stay, without regard to payer source, in column 6, line 8.

Line 9.--Enter the unduplicated census count of the hospice for all patients initially admitted and filing an election statement with the hospice within a reporting period for the appropriate payer source. Do not include the number of patients receiving care under subsequent election periods (see HCFA Pub. 21 '204). However, the patient who initially elects the hospice benefit, is discharged or revokes the benefits, and elects the benefit again within the reporting period is considered a new admission with each new election and is counted twice.

The total under this line equals the unduplicated number of patients served during the reporting period for each program. Thus, you do not include a patient if their stay was counted in a previous cost reporting period. If a patient enters a hospice source other than Medicare and subsequently becomes eligible for Medicare and elects the Medicare hospice benefit, then count that patient only once in the Medicare column, even though he/she may have had a period in another payer source prior to the Medicare election. A patient transferring from another hospice is considered to be a new admission and is included in the count.

3516. WORKSHEET A - RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

In accordance with 42 CFR 413.20, the methods of determining costs payable under title XVIII involve making use of data available from the institution's basic accounts, as usually maintained, to arrive at equitable and proper payment for services. Worksheet A provides for recording the trial balance of expense accounts from your accounting books and records. It also provides for the necessary reclassification and adjustments to certain accounts. The cost centers on this worksheet are listed in a manner which facilitates the transfer of the various cost center data to the cost finding worksheets (e.g., on Worksheets A, B, C, and D, the line numbers are consistent, and the total line is set at number 75). All of the cost centers listed do not apply to all providers using these forms. An "X" on the cost center line identifies ONLY those cost centers which may be used for the Simplified Method cost report.

Do not include on this worksheet items not claimed in the cost report because they conflict with the regulations, manuals, or instructions but which you wish nevertheless to claim and contest. Enter amounts on the appropriate settlement worksheet (Worksheet E, Part I, line 37; Worksheet E, Part II, line 29; Worksheet E, Part III, Part A, line 18, Part B, line 38; Worksheet H-6, Part II, line 23; Worksheet J-3, line 25; or Worksheet I-3, line 27).

If the cost elements of a cost center are separately maintained on your books, you must maintain a reconciliation of the costs per the accounting books and records to those on this worksheet. The reconciliation is subject to review by the intermediary.

Standard (i.e., preprinted) CMS line numbers and cost center descriptions cannot be changed. If you need to use additional or different cost center descriptions, you may do so by adding additional lines to the cost report. When an added cost center description bears a logical relationship to a standard line description, the added label must be inserted immediately after the related standard line description. Identify the added line as a numeric (only) subscript of the immediately preceding line. That is, if two lines are added between lines 5 and 6, identify them as lines 5.01 and 5.02. If additional lines are added for general service cost centers, add corresponding columns for cost finding on Worksheets B, B-1, J-1, and K-5.

If you checked yes on Worksheet S-2, line 52, indicating that you wish to file this cost report under 42 CFR 413.321 (the simplified cost report method), certain cost centers on Worksheet A will not be used. Section 3504.2, step # 6 identifies the cost centers that will be allowed under this method. Worksheet A, Column C also identifies the cost centers that may be used under the simplified cost reporting method. Column C is not applicable to the "full" SNF cost report, and as such, is not required to be printed (via the PI file) on the "full" SNF cost report. This column may be printed (via the PI file) on the "simplified" SNF cost report, but is not required. Overhead cost centers, nursing administration, central supply, pharmacy, medical records & library, and social service are combined into one category, and is reported on line 9.

Submit the working trial balance of the facility with the cost report. A working trial balance is a listing of the balances of the accounts in the general ledger to which adjustments are appended in supplementary columns and used as a basic summary for financial statements.

Cost center coding is a methodology for standardizing the meaning of cost center labels as used by health care providers on the Medicare cost reports. Form CMS 2540-96 provides for preprinted cost center descriptions on Worksheet A. The preprinted cost center labels are automatically coded by CMS approved cost reporting software. These cost center descriptions are hereafter referred to as the standard cost centers. Nonstandard cost center descriptions have been identified through analysis of frequently used labels.

The use of this coding methodology allows providers to continue to use labels for cost centers that have meaning within the individual institution. The four digit cost center codes that are associated with each provider label in their electronic file provide standardized meaning for data analysis. You are required to compare any added or changed label to the descriptions offered on the standard or nonstandard cost center table # 5, in §3595.

Columns 1, 2, and 3.--The expenses listed in these columns must be in accordance with your accounting books and records. List on the appropriate lines in columns 1, 2, and 3 the total expenses incurred during the cost reporting period. Detail the expense between salaries (column 1) and other than salaries (column 2). The sum of columns 1 and 2 must equal column 3. Record any needed reclassification and/or adjustments in columns 4 and 6, as appropriate.

Column 4.--Enter any reclassification among the cost center expenses in column 3 which are needed to effect proper cost allocation.

Worksheet A-6 reflects the reclassification affecting the cost center expenses. This worksheet need not be completed by all providers but must be completed only to the extent that the reclassification are needed and appropriate in the particular provider's circumstances. Show reductions to expenses in parentheses ( ).

The net total of the entries in column 4 must equal zero on line 75.

Column 5.--Adjust the amounts entered in column 3 by the amounts in column 4 (increase or decrease) and extend the net balances to column 5. The total of column 5 must equal the total of column 3 on line 75.

Column 6.--Enter on the appropriate lines in column 6 of Worksheet A the amounts of any adjustments to expenses indicated on Worksheet A-8, column 2. The total on Worksheet A, column 6, line 75 must equal Worksheet A-8, column 2, line 32.

Column 7.--Adjust the amounts in column 5 by the amounts in column 6 (increases or decreases) and extend the net balances to column 7. Transfer the amounts in column 7 to the appropriate lines on Worksheet B, Part I, column 0, or Worksheet B, Part III, column 0.

Line Descriptions

The trial balance of expenses is broken down into general service, inpatient routine service, ancillary service, outpatient service, other reimbursable, special purpose, and nonreimbursable cost center categories to facilitate the transfer of costs to the various worksheets. For example, the categories "Ancillary Cost Centers" and "Outpatient Cost Centers" appear on Worksheet D using the same line numbers as on Worksheet A.

NOTE: The category titles do not have line numbers. Only cost centers, data items, and totals have line numbers.

Lines 1 and 2.--These cost centers include depreciation, leases, and rentals for the use of facilities and/or equipment, interest incurred in acquiring land or depreciable assets used for patient care, insurance on depreciable assets used for patient care, and taxes on land or depreciable assets used for patient care. Do not include in these cost centers costs incurred for the repair or maintenance of equipment or facilities, amounts included in rentals or lease payments for repair and/or maintenance agreements, interest expense incurred to borrow working capital or for any purpose other than the acquisition of land or depreciable assets used for patient care, general liability insurance or any other form of insurance to provide protection other than the replacement of depreciable assets, or taxes other than those assessed on the basis of some valuation of land or depreciable assets used for patient care.

Many providers incur costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control. 42 CFR 413.17 and CMS Pub. 15-I, chapter 10, require that the reimbursable cost of the provider include the costs for these items at the cost to the supplying organization (unless the exception provided in 42 CFR 413.17(d) and CMS Pub. 15-I, §1010 is applicable). However, if the price in the open market for comparable services, facilities, or supplies is lower than the cost to the supplier, the allowable cost to you may not exceed the market price.

The rationale behind this policy is that when you are dealing with a related organization, you are essentially dealing with yourself. Therefore, your costs are considered equal to the cost to the related organization.

If you include on the cost report costs incurred by a related organization, the nature of the costs (i.e., capital-related or operating costs) do not change. Treat capital-related costs incurred by a related organization as your capital-related costs.

However, if the price in the open market for comparable services, facilities, or supplies is lower than the cost to the supplying related organization, your allowable cost may not exceed the market price. Unless the services, facilities, or supplies are otherwise considered capital-related cost, no part of the market price is considered capital-related cost. Also, if the exception in 42 CFR 413.17(d) and CMS Pub.15-I, §1010 applies, no part of the cost to you of the services, facilities, or supplies is considered capital-related cost unless the services, facilities, or supplies are otherwise considered capital-related.

If the supplying organization is not related to you within the meaning of 42 CFR 413.17, no part of the charge to you may be considered a capital-related cost (unless the services, facilities, or supplies are capital-related in nature) unless:

- The capital-related equipment is leased or rented by you;
- The capital-related equipment is located on your premises or is located offsite and is on real estate owned, leased, or rented by you; and
- The capital-related portion of the charge is separately specified in the charge to you.

Under certain circumstances, costs associated with minor equipment may be considered capital-related costs. CMS Pub. 15-I, §106 discusses methods for writing off the cost of minor equipment. Three methods are presented in that section. Amounts treated as expenses under method (a) are not capital-related costs because they are treated as operating expenses. Amounts included in expense

under method (b) are capital-related costs because such amounts represent the amortization of the cost of tangible assets over a projected useful life. Amounts determined under method (c) are capital-related costs because method (c) is a method of depreciation.

Line 9.--This cost center normally includes only the cost of nursing administration. The salary cost of direct nursing services (including the salary cost of nurses who render direct service in more than one patient care area) are directly assigned to the various patient care cost centers in which the services were rendered. Direct nursing services include gross salaries and wages of head nurses, registered nurses, licensed practical and vocational nurses, aides, orderlies, and ward clerks.

However, if your accounting system fails to specifically identify all direct nursing services to the applicable patient care cost centers, then the salary cost of all direct nursing service is included in this cost center.

Line 12.--This cost center includes the direct cost of the medical records cost center including the medical records library. The general library and the medical library must not be included in this cost center. Report them in the administrative and general cost center.

Line 14.--Use this line to record the cost of intern and residents if the SNF maintains an intern and residents program.

Lines 16 through 20.--These lines are for the inpatient routine service cost centers.

Line 19.--This cost center accumulates the direct costs incurred in maintaining long term care services not specifically required to be included in other cost centers. A long term care unit refers to a unit where the average length of stay for all patients is 25 days or more. The beds in this unit are not certified for titles V, XVIII, or XIX.

Line 20.--No data should be entered on this line for cost reports ending on and after November 30, 1999.

Lines 21 through 33.--These lines are for the ancillary cost centers.

Line 32.--The support surfaces which are classified as ancillary are those listed under the durable medical equipment regional carrier's (DMERC) level 2 and level 3 support surfaces categories. For example, support surfaces which qualify under DMERC's level 2 support surface criteria are low air loss mattress replacement and overlay systems. An example of support surfaces which qualify under DMERC's level 3 support surface criteria is air fluidized beds.

NOTE: Items listed in the DMERC level 1 support surface criteria do not qualify for this category because they are inexpensive and common enough to be considered routine services in all cases.

Lines 34, 35, and 36.--These lines are for outpatient cost centers.

Lines 37 through 51.--These lines are for other reimbursable cost centers.

Lines 37 through 47.--These lines are provided to accumulate costs which are specific to HHA services.

Line 37.--This cost center accumulates the direct costs attributable to HHA administrative and general costs.

Provider-based HHAs are operated and managed in a variety of ways within the context of the health care complexes of which they are components. In some instances, there are discrete management and administrative functions pertaining to the HHA, the cost of which is readily identifiable from the books and records.

In other instances, the administration and management of the provider-based HHA is integrated with the administration and management of the health care complex to such an extent that the cost of administration and management of the home health agency can be neither identified nor derived from the books and records of the health care complex. In other instances, the cost of administration and management of the HHA is integrated with the administration and management of the health care complex, but the cost of the HHA administration and management can be derived through cost finding. However, in most cases, even where the cost of HHA administration and management can be either identified or derived, the extent to which the costs are applicable to the services furnished by the provider-based HHA is not readily identifiable.

Even when the costs of administration and management of a provider-based HHA can be identified or derived, such costs do not generally include all of the general service costs (i.e., overhead costs) applicable to the HHA. Therefore, allocation of general service costs through cost finding is necessary for the determination of the full costs of the provider-based HHA.

If the provider-based HHA can identify discrete management and administrative costs from its books and records, include these costs on line 37.

Similar situations occur for services furnished by the provider-based HHA. For example, in some instances, physical therapy services are furnished by a discrete HHA physical therapy department. In other instances, physical therapy services are furnished to the patients of the provider-based HHA by an integrated physical therapy department of an SNF health care complex in such a manner that the direct costs of furnishing the physical therapy services to the patients of the provider-based HHA cannot be readily identified or derived.

In still other instances, physical therapy services are furnished to patients of the provider-based HHA in an integrated physical therapy department of an SNF health care complex in such a manner that the costs of physical therapy services furnished to patients of the provider-based HHA can be readily identified or derived.

If you maintain a separate therapy department for the HHA apart from the SNF therapy department furnishing services to other patients of the health care complex or are able to reclassify costs from an integrated therapy department to an HHA therapy cost center, then make a reclassification entry on Worksheet A-6 to the appropriate HHA therapy cost center. Make a similar reclassification to the appropriate line for other ancillaries when the HHA costs are readily identifiable.

NOTE: This cost report provides separate HHA cost centers for all therapy services. If services are provided to HHA patients from a shared SNF ancillary cost center, make the cost allocation on Worksheet B.

Line 38.--This cost center includes the direct patient care costs incurred for skilled nursing care to patients who are normally at their place of residence.

Lines 39 through 41.--These lines provide for Physical Therapy - HHA, Occupational Therapy - HHA, and Speech Pathology - HHA cost centers when only HHA patients are serviced from them.

Line 42.--This cost center includes the direct patient care cost incurred for counseling and assessment activities which contribute meaningfully to the treatment of a patient§s condition within the context of home health care.

Line 43.--This cost center includes the direct patient care costs incurred for services performed by specially trained personnel who assist individuals in carrying out physicians§ instructions under an established plan of care.

Line 44.--Enter the cost of durable medical equipment (DME) rented to home health patients. (See CMS Pub. 11, §206.)

Line 45.--Enter the cost of DME sold to home health patients.

Line 46.--Enter the cost of a home delivered meals program. This service is not reimbursable under title XVIII. However, it may be reimbursable by a State program, and, as such, identify the cost for that purpose.

Line 47.--This cost center includes the direct costs of noncovered home health services for Medicare cost reporting purposes. Noncovered services include homemaker services, home dialysis aide services, private duty nursing, health promotion activities, and day care programs. Report "telemedicine" services rendered on and after October 1, 2000, on a subscript line of line 47. Transfer this amount to Worksheet H, line 23.50.

Line 48.--Enter on this line the ambulance cost where the ambulance is owned and operated by the facility.

Line 49.--Use this line if your SNF operates an intern and resident program not approved by Medicare.

Line 50.--This cost center accumulates the direct costs attributable to an outpatient rehabilitation facility. This line should be subscripted to accommodate the following: comprehensive outpatient rehabilitation facility (CORF) should use line 50.00, community mental health center (CMHC) should use line 50.10, outpatient physical therapy (OPT) should use line 50.20, outpatient occupational therapy (OOT) should use line 50.30, and outpatient speech therapy (OSP) should use line 50.40. Direct costs normally include such cost categories as are listed on the applicable Worksheet J-1, lines 1 through 21.

Lines 52 through 56.--These lines are for special purpose cost centers.

Line 52.--This cost center includes the costs of malpractice insurance premiums and self insurance fund contributions. Also, include the cost if you pay uninsured malpractice losses incurred either through deductible or coinsurance provisions, as a result of an award in excess of reasonable coverage limits, or as a governmental provider. After reclassification in column 4 and adjustments in column 6, the balance in column 7 must equal zero.

Line 53.--After reclassification in column 4 and adjustments in column 6, the balance in column 7 must equal zero.

Line 54.--Only include utilization review costs of the SNF. Either reclassify or adjust all costs depending on the scope of the review. If the scope of the review covers all patients, reclassify all allowable costs in column 4 to administrative and general expenses (line 4). If the scope of the review covers only Medicare patients or Medicare, title V, and title XIX patients, then (1) in column 4, reclassify to administrative and general expenses all allowable costs other than physician compensation and (2) deduct, in column 6, the compensation paid to the physicians for their personal services on the utilization review committee. After reclassification in column 4 and adjustments in column 6, the balance in column 7 must equal zero.

Line 55.--This cost center accumulates the direct costs attributable to a hospice.

Lines 58 through 63.--Use these lines to record the costs applicable to nonreimbursable cost centers to which general service costs apply. If additional lines are needed for nonreimbursable cost centers than those shown, add a subscript consisting of a numeric subscript code to one or more of these lines. The subscripted lines must be appropriately labeled to indicate the purpose for which they are being used. However, if the expense (direct and all applicable overhead) attributable to any nonallowable cost area is so insignificant as not to warrant establishment of a nonreimbursable cost center and the sum total of all such expenses is so insignificant as not to warrant the establishment of a composite nonreimbursable cost center, adjust these expenses on Worksheet A-8. (See CMS Pub. 15-I, §2328.)

Line 60.--Establish a nonreimbursable cost center to accumulate the cost incurred by the provider for services related to the physicians' private practice. Examples of such costs include depreciation costs for the space occupied, movable equipment used by the physicians' offices, administrative services, medical records, housekeeping, maintenance and repairs, operation of plant, drugs, medical supplies, and nursing services.

This nonreimbursable cost center does not include costs applicable to services which benefit the general population or for direct patient services rendered by SNF-based physicians.

3517. WORKSHEET A-6 - RECLASSIFICATIONS

This worksheet provides for the reclassification of certain costs to effect proper cost allocation under cost finding. Submit, with the cost report, copies of any workpapers used to compute reclassification affected on this worksheet.

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

Examples of reclassification that may be needed are:

1. Capital-related costs that are not included in one of the capital-related cost centers on Worksheet A, column 3. Examples include insurance on buildings and fixtures and movable equipment, rent on buildings and fixtures and movable equipment, interest on funds borrowed to purchase buildings and fixtures and movable equipment, personal property taxes, and real property taxes. Interest on funds borrowed for operating expenses is not included in capital related costs. It must be allocated with administrative and general expenses.

2. Employee benefits expenses (e.g., personnel department, employee health service, hospitalization insurance, workmen's compensation, employee group insurance, social security taxes, unemployment taxes, annuity premiums, past service benefits and pensions) included in the administrative and general cost center.

3. Insurance expense included in the administrative and general cost center and applicable to buildings and fixtures and/or movable equipment.

4. Interest expense included on Worksheet A, column 3, line 53 and applicable to funds borrowed for administrative and general purposes (e.g., operating expenses) or for the purchase of buildings and fixtures or movable equipment.

5. Rent expenses included in the administrative and general cost center and applicable to the rental of buildings and fixtures and to movable equipment from other than related organizations. (See the instructions for Worksheet A-8-1 for treatment of rental expenses for related organizations.)

6. Any taxes (real property taxes and/or personal property taxes) included in the administrative and general cost center and applicable to buildings and fixtures and/or movable equipment.

7. Utilization review costs. Administrative costs related to utilization review and the costs of professional personnel other than physicians are allowable costs and are apportioned among all users of the SNF, irrespective of whether utilization review covers the entire patient population. Reclassify these costs from Worksheet A, column 3, line 54 to administration and general costs.

This reclassification includes the costs of physician services in utilization review only if a valid allocation between Medicare and the other programs is not supported by documentation. Otherwise, the costs of physician services in utilization review are in accordance with the instructions for Worksheet A-8 relating to utilization review.

Make the appropriate adjustment for physician compensation on Worksheet A-8. For further explanations concerning utilization review in SNFs, see CMS Pub. 15-I, §2126.2.

8. Any dietary cost included in the dietary cost center and applicable to any other cost centers, e.g., gift, flower, coffee shop, and canteen.

9. Any direct expense included in the central service and supply cost center and directly applicable to other cost centers, e.g., intravenous therapy, oxygen (inhalation) therapy.

10. Any direct expenses included in the laboratory cost center and directly applicable to other cost centers, e.g., electrocardiology.

11. Any direct expenses included in the radiology cost center and directly applicable to other cost centers, e.g., electrocardiology.

12. When you purchase services (e.g., physical therapy) under arrangements for Medicare patients but do not purchase such services under arrangements for non-Medicare patients, your books reflect only the cost of the Medicare services. However, if you do not use the grossing up technique for purposes of allocating your overhead and if you incur related direct costs applicable to all patients, Medicare and non-Medicare (e.g., paramedics or aides who assist a physical therapist in performing physical therapy services), such related costs are reclassified on Worksheet A-6 from the ancillary service cost center and ARE allocated as part of administrative and general expense.

However, when you purchase therapy services that include performing administrative functions such as completion of medical records, training etc. as discussed in CMS Pub 15-I, §1412.5, the bundled charge for therapies provided under arrangements includes the provision of these services. Therefore for cost reporting purposes, these related services are NOT reclassified to A&G.

3531. WORKSHEET D-1 - COMPUTATION OF INPATIENT ROUTINE COSTS

This worksheet provides for the computation of SNF inpatient operating cost in accordance with 42 CFR 413.53 (determination of cost of services to beneficiaries) and 42 CFR 413.30 (limitations on reimbursable costs). This worksheet applies to all Title V, Title XVIII, and Title XIX inpatient routine costs.

A separate copy of this worksheet must be completed for the SNF, NF, and ICF/MR. Also, a separate copy of this worksheet must be completed for each health care program under which inpatient operating costs are computed. Report separately the required statistics for the SNF, NF, and ICF/MR.

3531.1 Part I - Calculation of Inpatient Routine Costs.

At the top of each page, indicate by checking the appropriate box the health care program and provider component for which the page is prepared.

Line Descriptions

Line 1.--Enter the following data depending on the health care program and provider component for which the page is completed:

Description	Inpatient Days From
SNF	Worksheet S-3, Part I, column 7, line 1, including private room days for title XVIII
NF	Worksheet S-3, Part I, column 7, line 3 for titles V and XIX
ICF/MR	Worksheet S-3, Part I, column 7, line 3.1 for title XIX

EXCEPTION: When the SNF is located in a State that licenses the provider as an SNF regardless of the level of care given for titles V and XIX patients, enter the days from Worksheet S-3, column 7, sum of lines 1 and 3.

Line 2.--Enter the total private room days. (From provider's records.)

Line 3.--Enter the following data depending on the health care program and provider component for which the page is completed:

Description	Inpatient Days From
SNF	Worksheet S-3, Part I, column 4, line 1, for title XVIII
NF	Worksheet S-3, Part I, column 3, line 3 for title V and Worksheet S-3, Part I, column 5, line 3 for title XIX
ICF/MR	Worksheet S-3, Part I, column 5, line 3.1 for title XIX

EXCEPTION: When the SNF 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, enter the program inpatient days from Worksheet S-3, column 3, lines 1 and 3 for title V and from Worksheet S-3, column 5, lines 1 and 3 for title XIX.

Line 4.--Enter the total medically necessary private room days applicable to each health care program and each provider component.

Line 5.--For a full cost report, enter the total general inpatient routine service costs from Worksheet B, Part I, column 18, SNF from line 16, NF from line 18, or ICF/MR from line 18.1. For a simplified cost report, enter the total general inpatient service costs from Worksheet B, Part III, column 5, SNF line 16, NF from line 18, or ICF/MR from line 18.1.

EXCEPTION: When the SNF 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, enter the general inpatient routine service costs from lines 16 and 18.

Line 6.--Enter the total charges for general inpatient routine services for the SNF, the SNF-based NF, or the SNF-based ICF/MR as applicable. These charges agree with the amounts on Worksheet G-2, column 1, lines 1, 3, and 3.1. See exception after line 5 above.

Line 7.--Enter the general inpatient routine cost/charge ratio (rounded to six decimal places) by dividing the total inpatient general routine service costs (line 5) by the total inpatient general routine service charges (line 6).

Line 8.--Enter the private room charges from your records.

Line 9.--Enter the average per diem charge (rounded to two decimal places) for private room accommodations by dividing the total charges for private room accommodations by the total number of days of care furnished in private room accommodations.

Line 10.--Enter the semi-private room charges from your records.

Line 11.--Enter the average per diem charge (rounded to two decimal places) for semi-private accommodations by dividing the total charges for semi-private room accommodations by the total number of days of care furnished in semi-private room accommodations.

Line 12.--Subtract the average per diem charge for all semi-private accommodations (line 11) from the average per diem charge for all private room accommodations (line 9) to determine the average per diem private room charge differential. If a negative amount results from this computation, enter zero.

Line 13.--Multiply the average per diem private room charge differential (line 12) by the inpatient general routine cost/charge ratio (line 7) to determine the average per diem private room cost differential (rounded to two decimal places).

Line 14.--Multiply the average per diem private room cost differential (line 13) by the private room accommodation days (line 2) to determine the total private room accommodation cost differential adjustment.

Line 15.--Subtract the private room cost differential adjustment (line 14) from the general inpatient routine service cost (line 5) to determine the adjusted general inpatient routine service cost net of private room accommodation cost differential adjustment.

Line 16.--Determine the adjusted general inpatient routine service cost per diem by dividing the amount on line 15 by inpatient days (including private room days) shown on line 1.

Line 17.--Determine the routine service cost by multiplying the program inpatient days (including the private room days) shown on line 3 by the amount on line 16.

Line 18.--Determine the medically necessary private room cost applicable to the program by multiplying line 4 by the amount on line 13.

Line 19.--Add the amounts on lines 17 and 18 to determine the total program general inpatient routine service cost.

Line 20.--Enter the capital-related cost allocated to the general inpatient service cost center from Worksheet B, Part II, column 18, SNF from line 16, NF from line 18, or ICF/MR from line 18.1. See exception after line 5 above.

Line 21.--Determine the per diem capital-related cost by dividing line 20 by inpatient days on line 1.

Line 22.--Determine the program capital-related cost by multiplying line 20 by line 3.

Line 23.--Determine the inpatient routine service cost by subtracting the amount on line 21 from the amount on line 19.

Line 24.--Obtain the aggregate charges to beneficiaries for excess costs from your records.

Line 25.--Obtain the total program routine service cost for comparison to the cost limitation by subtracting the amount on lines 24 from the amount on line 23.

Line 26.--Enter the per diem limitation. This line will not be used for cost reporting periods beginning on and after July 1, 1998.

Line 27. --Obtain the inpatient routine service cost limitation by multiplying the number of inpatient days shown on line 3 by the cost limit for inpatient routine service cost applicable to you for the period for which the cost report is being filed. This amount is provided by your intermediary and is entered in the space provided in the line description. Line 27 will not be calculated for PPS cost reports with fiscal years beginning on and after July 1, 1998

Line 28.--Enter the amount of reimbursable inpatient routine service cost which is determined by adding line 22 to the lesser of lines 25 or 27. Transfer this amount to the appropriate Worksheet E, Part I, line 4. For PPS cost reports with fiscal years beginning on and after July 1, 1998, enter the amount from line 19. No amount will be transferred for title XVIII to Worksheet E, Part I.

3531.2 Part II - Calculation of Inpatient Intern and Resident Cost for PPS Passthrough.--This part is applicable for cost reporting periods beginning on and after July 1, 1998.

Line 1. --Enter the total inpatient days from Worksheet S-3, Part I, column 7, line 9, less the hospice days on line 8.

Line 2. --Enter the title XVIII inpatient days from Worksheet S-3, Part I, column 4, line 1.

Line 3. --Enter the program intern and resident cost from Worksheet B, Part I, column 14, line 14.

Line 4. --Calculate the ratio of program days to total days. Divide line 2 by line 1.

Line 5. --Calculate the intern and resident pass through cost. Multiply the amount on line 3 times the amount on line 4. Transfer this amount to Worksheet E, Part III, line 2.

3532. WORKSHEET D-2 - APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS

3532.1 Part I - Not in Approved Teaching Program.--Use this part only if you have interns and residents who are not in an approved teaching program. (See CMS Pub. 15-I, chapter 4.)

Column 1.--Enter the percentage of time that interns and residents are assigned to each of the indicated patient care areas on lines 2 through 11, 13, and 14 (from your records).

Column 2.--Enter on line 1 the total cost of services rendered in all patient care areas from Worksheet B, Part I, column 18, line 49. Multiply the percent in column 1 for each line by the total cost in column 2, line 1. Enter the resulting amounts on the appropriate line in column 2.

A. Inpatient.--

Column 3.--Enter the total inpatient days applicable to the various patient care areas of the complex:

Description	Enter in Col. 3	Inpatient Days From
SNF	line 2	Worksheet S-3, Part I, col. 7, line 1
SNF PPS	line 2	Worksheet S-3, Part I col. 7, line 1
NF	line 4	Worksheet S-3, Part I col. 7, line 3
ICF/MR	Line 4.1	Worksheet S-3, Part I col. 7, line 3.1

Column 4.--Divide the allocated expenses in column 2 by the inpatient days in column 3 to arrive at the average per diem cost for each cost center.

Columns 5, 6, and 7.--Enter in the appropriate column the health care program inpatient days for each patient care area.

Titles V and XIX

Description	Enter in column 5 for title V or column 7 for title XIX	From
SNF	line 2	Worksheet D-1, line 3
NF	line 4	Worksheet D-1, line 3
ICF/MR	Line 4.1	Worksheet D-1, line 3

Title XVIII.--Enter in column 6, line 2 the total number of days in which beneficiaries were inpatients of the provider and had Medicare Part B coverage. Determine such days without regard to whether Part A benefits were available. Submit a reconciliation with the cost report demonstrating the computation of Medicare Part B inpatient days. The following reconciliation format is recommended.

3539. WORKSHEET H - ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

This worksheet provides for recording of direct HHA costs such as salaries, fringe benefits, transportation, and contracted services, as well as other costs, to arrive at the identifiable agency cost in column 6. This data is required by 42 CFR 413.20. Obtain these direct costs from your records. The cost centers on this worksheet are listed in a manner which facilitates the sequential listing of accounts and array of expense accounts for transfer of the various cost center data from Worksheets H-1, H-2, and H-3. All of the cost centers listed do not apply to all agencies using these forms. Therefore, use only those cost centers applicable to your HHA.

NOTE: For cost reporting periods beginning on and after October 1, 2000, Worksheets H-1, H-2, and H-3 are not required to be filed. Obtain the information for columns 1, 2 and 4 below from your records.

Column 1.--Obtain the expenses listed in this column from your records.

Column 2.--Obtain the expenses listed in this column from your records.

Column 3.--Enter on each line (other than line 4) the cost of public transportation or the amount paid to employees for the use of private vehicles only when these costs can be identified and directly assigned to a particular cost center.

Where the agency owns (or rents) its vehicles, enter this cost on line 4 in the transportation cost center.

Report the transportation cost in this manner so that the identifiable costs can be recorded where applicable. Allocate unidentifiable costs during cost finding through the administrative and general cost center.

Column 4.--Obtain the expenses listed in this column from your records.

Column 5.--Enter on the applicable lines in column 5 all other identifiable agency costs which have not been reported in columns 1 through 4 from your books and records.

NOTE: Lines 12 through 14.--Costs for enteral and parenteral nutrition therapy (EPNT) items are not considered routine in conjunction with patient visits and must be included on lines 12 through 14, as appropriate, to be billed separately.

EPNT items, which are considered prosthetic devices and furnished by an SNF-based 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 total charges but excluded from the Title XVIII charge statistic in the apportionment of DME and medical supply costs on Worksheet H-5, lines 8, 9, and 10.

Column 6.--Add the amounts in columns 1 through 5 for each cost center and enter the totals in column 6.

Line 23.50 -- Create this subscripted line to accumulate cost associated with “telemedicine” services rendered on and after October 1, 2000.

3540. WORKSHEET H-1 - COMPENSATION ANALYSIS - SALARIES AND WAGES

DO NOT COMPLETE THIS WORKSHEET FOR COST REPORTING PERIODS BEGINNING ON AND AFTER OCTOBER 1, 2000.

A detailed analysis of salaries and wages is required to explain data entered on Worksheet H, column 1. This data is required by 42 CFR 413.20.

Enter all salaries and wages for the HHA on this worksheet for the actual work performed within the specific work area or cost center in accordance with the column headings. For example, if the administrator spends 100 percent of his/her time in the HHA, and of this time, performs skilled nursing care which accounts for 25 percent of that person's time, then enter 75 percent of the administrator's salary and any employee related benefits on line 5 (Administrative and General-HHA), and enter 25 percent of the administrator's salary (and any employee-related benefits) on line 6 (skilled nursing care).

Maintain the records necessary to determine the split in salary (and employee related benefits) between two or more cost centers and adequately substantiate the method used to split the salary and employee related benefits. These records must be available for audit by the intermediary. The intermediary can accept or reject the method used to determine the split in salary. Any deviation or change in methodology to determine splits in salary and employee benefits must be requested in writing and approved by the intermediary before any change is effectuated. Where approval of a method has been requested in writing and this approval has been received (prior to the beginning of the cost reporting period), the approved method remains in effect for the requested period and all subsequent periods until you request in writing to change to another method or until the intermediary determines that the method is no longer valid due to changes in your operations.

Definitions

Salary.--This is gross salary paid to the employee before taxes and other items are withheld, including deferred compensation, overtime, incentive pay, and bonuses. (See CMS Pub. 15-I, chapter 21.)

Administrators (Column 1)

Possible Titles: President, Chief Executive Officer

Duties: This position is the highest occupational level in the agency. This individual is the chief management official in the agency. He/she develops and guides the organization by taking responsibility for planning, organizing, implementing, and evaluating. He/she is responsible for the application and implementation of established policies. He/she may act as a liaison among the governing body, the medical staff, and any departments. He/she provides for personnel policies and practices that adequately support patient care and maintains accurate and complete personnel records. He/she implements the control and effective utilization of the physical and financial resources of the provider.

Directors (Column 2)

Possible Titles: Medical, Nursing, or Executive Director

Duties: The Medical Director is responsible for helping to establish and assure that the quality of medical care is appraised and maintained. This individual advises the chief executive officer on medical and administrative problems and investigates and studies new developments in medical practices and techniques.

The Nursing Director is responsible for establishing the objectives for the

3541. WORKSHEET H-2 - COMPENSATION ANALYSIS - EMPLOYEE BENEFITS (PAYROLL-RELATED)

DO NOT COMPLETE THIS WORKSHEET FOR COST REPORTING PERIODS BEGINNING ON AND AFTER OCTOBER 1, 2000.

A detailed analysis of employee benefits compensation is required to explain data entered on Worksheet H, column 2. This data is required by 42 CFR 413.20.

Enter all payroll-related employee benefits for the HHA on this worksheet. See CMS Pub. 15-I, §§2144 - 2145 for definition of fringe benefits. Make entries using the same basis as that used for reporting salaries and wages on Worksheet H-1. Therefore, using the example above, enter 75 percent of the administrator's payroll-related fringe benefits on line 5 (Administrative and General-HHA), and enter 25 percent of the administrator's payroll-related fringe benefits on line 6 (skilled nursing care).

Report payroll-related employee benefits in the cost center that the applicable employee's compensation is reported. Perform this assignment based on an actual basis or upon the following basis:

A. FICA (actual expense by cost center);

B. Pension and retirement and health insurance (nonunion) (gross salaries of participating individuals by cost center);

C. Union health and welfare (gross salaries of participating union members by cost center); or

D. All other payroll-related benefits (gross salaries by cost center).

Include non payroll-related employee benefits in the Administrative and General - HHA cost center. Include costs for such items as personal education, recreation activities, and day care in the Administrative and General - HHA cost center.

Add the amounts of each cost center, columns 1 through 8, and enter the total in column 9.

Add the amounts in each column, lines 1 through 24, and enter this total on line 25 for each column. Transfer the totals in column 9 to Worksheet H, column 2, lines as applicable. To facilitate transferring amounts from Worksheet H-2 to Worksheet H, the same cost centers with corresponding line numbers are listed on both worksheets.

3542. WORKSHEET H-3 - COMPENSATION ANALYSIS - CONTRACTED SERVICES/PURCHASED SERVICES

DO NOT COMPLETE THIS WORKSHEET FOR COST REPORTING PERIODS BEGINNING ON AND AFTER OCTOBER 1, 2000.

A detailed analysis of contracted or purchased services is required to explain data entered on Worksheet H, column 4. This data is required by 42 CFR 413.20.

All provider-based agencies must enter on this worksheet all costs for contracted and/or purchased services for the HHA. Enter the contracted/purchased cost on the appropriate cost center line within the column heading which best describes the type of services purchased. For example, where physical therapy services are purchased, enter the contract cost of the therapist in column 6, line 7. If a contracted/purchased service covers more than one cost center, then include the amount applicable to each cost center on each affected cost center line. Add the amounts of each cost center, columns 1 through 8, and enter the total in column 9. Add the amounts in each column, lines 1 through 24, and enter the total on line 25. Transfer the total in column 9 to Worksheet H, column 4, lines as applicable. To facilitate transferring amounts from Worksheet H-3 to Worksheet H, the same cost centers with corresponding line numbers are listed on both worksheets.

3544. WORKSHEET H-5 - APPORTIONMENT OF PATIENT SERVICE COSTS

This worksheet provides for the apportionment of home health patient service costs. Complete a separate worksheet for each applicable title, Title V, Title XVIII, and Title XIX.

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

These services are reimbursable under Part B only and will be entered on lines 18 through 20, columns 3 through 6.

Payment on Basis of Location of Service.--Section 4604 of the Balanced Budget Act (BBA) of 1997, appends §1891(g) of the Social Security Act, effective for cost reporting periods beginning on or after October 1, 1997, requiring home health agencies to submit claims for payment for home health services under title XVIII on the basis of geographic location at which the service is furnished. This requires home health agencies to make Medicare program cost limitation comparisons based on the geographic location (Metropolitan Statistical Area (MSA) or Non-MSA) of services furnished to program beneficiaries. To accomplish this, Worksheet H-5, Part I, the aggregate cost per visit computation, must be completed only one time for the entire home health agency. Complete Worksheet H-5, Part II, computation of the lesser of aggregate Medicare cost or the aggregate of the Medicare limitation computation, once for each MSA where Medicare covered services were furnished during the cost reporting period.

3544.1 Part I - Aggregate Agency Cost Per Visit Computation.--This part provides for the computation of the average home health agency cost per visit used to derive each MSA's total allowable cost attributable to Medicare patient care visits. Complete this part once for the entire home health agency. This computation is required by 42 CFR 413.53 and 42 CFR 413.30.

Cost Per Visit Computation

Column Descriptions

Column 2.--Enter the cost for each discipline from Worksheet H-4, Part I, column 5, lines as indicated.

Column 3.--Enter the total agency visits from statistical data (Worksheet S-4, column 8, lines 1 through 6) for each type of discipline on lines 1 through 6.

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

3544.2 Part II - Computation of Aggregate Medicare Cost and the Aggregate of the Medicare Limitation.--This part provides for the computation of the cost of Medicare patient care visits and the corresponding reasonable cost limitation for Medicare services provided in the MSA identified. Complete this part one time for each MSA where Medicare beneficiary visits where provided during the cost reporting period. Lines 1 through 6 and column 11 are subscripted to isolate pre October 1, 2000, costs to facilitate the application of the lesser of aggregate cost or aggregate visit limits. Enter the MSA/Non-MSA code from Worksheet S-4, line 17, for which Medicare services were furnished.

Lines 1 through 7-

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

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

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

Columns 5 and 6, lines1.01, 2.01, 3.01, 4.01, 5.01, 6.01.--Enter in column 5 the Medicare Part A visits furnished to program beneficiaries on or after October 1, 2000. Enter in column 6 the Medicare Part B visits not subject to deductibles and coinsurance furnished to program beneficiaries on or after October 1, 2000.

NOTE: The sum of Worksheets H-5, Part II, columns 5 and 6, lines 1.01, 2.01, 3.01, 4.01, 5.01 and 6.01, respectively, may not necessarily equal the corresponding amounts on Worksheet S-4, Part III, column 7, lines 1, 3, 5, 7, 9 and 11, respectively, due to the difference between visits contained in episodes terminating in the current fiscal year (Worksheet S-4, Part III), and visits rendered through the fiscal year end (Worksheet H-5, Part III.

Columns 7 and 10--**DO NOT USE THESE COLUMNS**, for cost reporting periods beginning on and after October, 1, 1997.

NOTE: For reporting periods overlapping October 1, 2000, the sum of all Worksheets H-5, Part II, Medicare program visits, sums of line 1-6 (excluding subscripts) for columns 5 must be equal to or less than the sum of the visits shown on Worksheet S-4, Part I, Column 2, lines1 through 6.

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

Column Descriptions for Cost Limitation Computation

Lines 8 through 14-

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

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

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

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

Columns 7 and 10--**DO NOT USE THESE COLUMNS**, for cost reporting periods beginning on and after October, 1, 1997.

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

3544.3 Part III - Supplies and Drugs Cost Computation.--Certain items covered by Medicare and furnished by an HHA are not included in the visit for apportionment purposes. Since an average cost per visit and the cost limit per visit do not apply to these items, the ratio of total cost to total charges is developed and applied to Medicare charges to arrive at the Medicare cost for these items. Enteral/parenteral nutrition therapy (EPNT) items which are considered prosthetic devices furnished by an HHA on or after March 14, 1986, are reimbursed on a reasonable charge basis through billings submitted to the DMERC. (As a prosthetic device, such services are reimbursable only 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 medical supply costs on Part IV, line 15. Lines 15 and 16 are subscripted to isolate pre October 1, 2000, costs to facilitate the flow of these costs to Worksheet H-6 in order to apply LCC.

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

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

NOTE: Injectable drugs are a Part B service only.

Lines 15 and 16--Enter in column 2 the total applicable HHA costs for the entire cost reporting period for each line item from Worksheet H-4, Part I, column 5, lines 10 and 11, respectively (the costs entered on lines 15 and 15.01 must be equal; the costs entered on lines 16 and 16.01 must be equal). Enter in column 3 the total HHA charges for the entire cost reporting period for each line (the charges entered on lines 15 and 15.01 must equal; the charges entered on lines 16 and 16.01 must equal) Enter in column 4 the ratio of HHA costs (column 2) to HHA charges (column 3) for each line.

Line 15--Enter in columns 5, 6, and 7 the charges for medical supplies not paid on a fee schedule for services rendered prior to October 1, 2000.

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

Line 16--Enter in column 6 the charges for pneumococcal vaccine and its administration, influenza vaccine and its administration, and hepatitis B vaccine and its administration for services rendered prior to October 1, 2000. Enter in column 7 the charge for covered osteoporosis drugs for services rendered prior to October 1, 2000. (See §1833(m)(5) of the Act.)

Line 16.01—For reporting periods which overlap October 1, 2000, enter in column 6 the charges for pneumococcal vaccine and its administration, influenza vaccine and its administration, and hepatitis B vaccine and its administration rendered on or after October 1, 2000 through the fiscal year end. Enter in column 7 the charges for covered osteoporosis drugs rendered on or after October 1, 2000, through the fiscal year end. (See§1833(m)(5) of the Act.) For reporting periods that begin on or after October 1, 2000, eliminate line 16.01 and record all charge and resulting cost data on line 16. Osteoporosis drugs will continue to be reimbursed on a cost basis for services rendered on and after October 1, 2000.

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

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

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

3544.4 Part IV - Comparison of the Lesser of Aggregate Medicare Cost, the Aggregate of the Medicare Cost Per Visit Limitation and the Aggregate Per Beneficiary Cost Limitation.--This part provides for the comparison of the reasonable cost limitation, applied to each home health agency's total allowable cost attributable to Medicare patient care visits. This comparison is required by 42 CFR 413.53 and 42 CFR 413.30. For cost reporting periods beginning on or after October 1, 1997, §1861(v)(1)(L) of the Social Security Act is amended by §4601 of BBA 1997, requiring home health agency net cost of covered services to be based on the lesser of aggregate Medicare cost, the aggregate of the Medicare limitation, or the agency specific per beneficiary annual cost limit. The per beneficiary cost limitation is derived by totaling the application of each MSA/non-MSA's unduplicated census count (two decimal places) (see§3527) to the per beneficiary cost limitation for the corresponding MSA/non-MSA. To accomplish this, the sum of all worksheets H-5, Part II, amounts in column 11, line 7, plus the applicable cost of medical supplies is compared with the sum of all worksheet H-5, Part II amounts in column 11, line 14, plus the applicable cost of medical supplies and with the amount in column 6, line 24.

Line 18--Enter in columns 3,4,and 6, respectively, the sum of the amounts from each Worksheet H-5 Part II, columns 8, 9, and 11, (exclusive of subscripts) respectively, lines 1-6, respectively, (exclusive of subscripts).

Line 19--Enter in columns 3 and 4, respectively, the cost of medical supplies from Part III, columns 8 and 9, respectively, line 15 (excluding subscripted lines). Enter in column 6 the sum of columns 3 and 4.

Line 20--Enter the sum of lines 18 and 19 for columns 3 and 4. Enter in column 6 the sum of columns 3 and 4.

Line 21--Enter the total cost per visit limitation for Medicare services which is the sum of the amounts from each Worksheet H-5, Part II, columns 8, 9, and 10 respectively, line 14.

Line 22--Enter in columns 3 and 4, respectively, the cost of medical supplies from Part III, columns 8 and 9, respectively, line 15 (excluding subscripted lines). Enter in column 6 the sum of columns 3 and 4.

Line 23--Enter the sum of lines 21 and 22 for columns 3 and 4. Enter in column 6 the sum of columns 3 and 4.

Line 24--Enter the per beneficiary cost limitation for each MSA/non-MSA area serviced by the HHA. Line 24 will have to be subscripted for each area. For each MSA/non-MSA enter the following:

Column 0--Enter the MSA/nonMSA code from Worksheet S-4, Part II, line 17, and the corresponding subscripts thereof.

Column 1--Enter the corresponding Medicare program (Title XVIII) unduplicated census count (two decimal places) from your records associated with services rendered prior to October 1 2000, (See §3511.)

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

Columns 3 and 4--(Complete column 6 prior to the completion of columns 3 and 4.) Complete columns 3 and 4 only if column 6, line 25 is less than column 6, lines 18 and 21. Enter in column 3 the result of column 3, line 18 divided by column 6, line 18 multiplied by column 6, line 25. Enter on line 25 in column 4 the result of column 4, line 18 divided by column 6, line 18 multiplied by column 6, line 25.

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

Line 25--In column 1 (two decimal places) and 6, respectively, enter the sum of lines 24 (line 24 plus all subscripted lines 24). Enter in column 3, the result of column 3, line 20 divided by column 6, line 20, multiplied by column 6, line 25. Enter on line 25 in column 4, the result of column 4, line 20, divided by column 6, line 20, multiplied by column 6, line 25. (The sum of columns 3 and 4 must equal column 6.)

NOTE: The total Medicare (Title XVIII) unduplicated census count (Worksheet S-4, column 3, line 9 (Pre October 1, 2000, Unduplicated Census Count)) must equal the sum of the unduplicated census count for all MSAs (Worksheet H-5, Part IV, column 1, line 25).

3544.5 Part V - Outpatient Therapy Reduction Computation.--This section computes the reduction in the reasonable costs of outpatient physical therapy services (which includes outpatient speech language pathology and outpatient occupational therapy) provided under arrangement for beneficiaries who are not homebound as required by §1834(k) of the Act and enacted by §4541 of BBA 1997. The amount of the reduction is 10 percent for services rendered on or after January 1, 1998. For outpatient therapy services rendered on or after January 1, 1999, §4541 of the BBA 1997 mandates a fee schedule payment basis for outpatient physical, outpatient occupational therapy, and outpatient speech pathology. Therefore, any outpatient therapy services furnished on or after January 1, 1999, **must not be included** in this section due to the application of a fee schedule for these services, but the corresponding visits must be recorded in column 5.01. These outpatient therapy services are reimbursed the lesser of the fee schedule amount or the statutory limitation which is applied on a beneficiary specific basis through the Medicare claims system. This requires no provider input on the cost report.

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

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

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

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

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

Line 29--For columns 3 through 8, enter the sum of lines 26 through 28.

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

3545. WORKSHEET H-6 - CALCULATION OF HHA REIMBURSEMENT SETTLEMENT - PART A AND PART B SERVICES

Worksheet H-6 consists of the following two parts:

Part I - Computation of the Lesser of Reasonable Cost or Customary Charges. This part provides for the reimbursement calculation of title XVIII, Part A and Part B, and title V and tile XIX. This computation is required by 42 CFR 413.9, 42 CFR 413.13, and 42 CFR 413.30. Use column 1 for Titles V and XIX.

Part II - Computation of HHA Reimbursement Settlement. Complete this part for Titles, XVIII, and XIX, as applicable.

3545.1 Part I - Computation of Lesser of Reasonable Cost or Customary Charges.--Services not paid for based on a fee schedule are paid the lesser of the reasonable cost of services furnished to beneficiaries or the customary charges made by the providers for the same services. This part provides for the computation of the lesser of reasonable cost as defined in 42 CFR 413.13(b) or customary charges as defined in 42 CFR 413.13(e). Use column 1 for Titles V and XIX.

NOTE: Nominal charge providers are not subject to the lesser of cost or charges (LCC). Therefore, a nominal charge provider completes only lines 1 and 7 of Part I. Transfer the resulting cost to line 8 of Part II.

Line Descriptions

Line 1.--This line provides for the computation of reasonable cost of Title XVIII, Part A and Part B services. Enter the cost of services from Worksheet H-5, Part IV as follows.

If the amount in column 6, line 20 is less than the amount in column 6, line 23, and the amount in column 6, line 25, transfer (aggregate Medicare cost):

To Worksheet H-6, Line 1	From Worksheet H-5
Col. 1, Part A .	Part IV, Col. 3, line 20
Col. 2, Part B..	Part III, Sum of col. 9, line 16 (excluding subscripted lines) and Part IV, col. 4, line 20
Col. 3, Part B..	Part III, Sum of col. 10, line 15 (excluding subscripted lines), 16 and 16.01 and Part V, col. 8, line 29

If the amount in column 6, line 23 is less than the amount in column 6, line 20, and the amount in column 6, line 25, transfer (aggregate Medicare limitation):

To Worksheet H-6, Line 1	From Worksheet H-5
Col. 1, Part A .	Part IV, Col. 3, line 23
Col. 2, Part B	Part III, Sum of col. 9, line 16 (excluding subscripted lines) and Part IV, col. 4, line 23
Col. 3, Part B..	Part III, Sum of col. 10, line 15 (excluding subscripted lines), 16 and line 16.01 and Part V, col. 8, line 29.

If column 6, line 25 is less than the amount in column 6, line 20, and the amount in column 6, line 23, transfer (aggregate per beneficiary limitation):

To Worksheet H-6, Line 1	From Worksheet H-5
Col. 1, Part A .	Part IV, Col. 3, line 25
Col. 2, Part B	Part III, Sum of col. 9, line 16 (excluding subscripted lines) and Part IV, col. 4, line 25
Col. 3, Part B..	Part III, Sum of col. 10, line 15 (except subscripted lines), 16 and line 16.01 and Part V, col. 8, line 29

Lines 2 through 6.--These lines provide for the accumulation of charges which relate to the reasonable cost on line 1. Do not include on these lines (1) the portion of charges applicable to the excess costs of luxury items or services (see CMS Pub. 15-I, chapter 21) and (2) provider charges to beneficiaries for excess costs as described in CMS Pub. 15-I, §2570. Where your operating costs include amounts that flow from the provision of luxury items or services, such amounts are not allowable in computing reimbursable costs.

Line 2.-- In columns 1, 2 and 3, enter from your records the charges for the applicable Medicare services rendered prior to October 1, 2000. Additionally, in columns 2 and 3, enter from your records the charges for the applicable Medicare covered drugs (see §3215.3) rendered prior to October 1, 2000.

Line 2.01--In column 3, enter from your records only the charges for applicable Medicare covered osteoporosis drugs (see 3215.3) rendered on and after October 1, 2000. LCC is applicable only for drug costs for services rendered on and after October 1, 2000. For all other services rendered on or after October 1, 2000, do not enter any charges in columns 1 and 2.

Line 7.--Enter the amounts paid or payable by workmen's compensation and other primary payers where program liability is secondary to that of the primary payer. There are six situations under which Medicare payment is secondary to a primary payer:

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

Generally, when payment by the primary payer satisfies the total liability of the program beneficiary, for cost reporting purposes only, the services are treated as if they were non-program services. (The primary payment satisfies the beneficiary's liability when you accept that payment as payment in full. This is noted 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, enter no primary payer payment on line 7. In addition, exclude amounts paid by other primary payers for outpatient dialysis services which are reimbursed under the composite rate system.

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

When the primary payment does not satisfy the beneficiary's liability, include the covered days and charges in program visits and charges, and include the total visits and charges in total visits and charges for apportionment purposes. Enter the primary payer payment on Line 9 to the extent that primary payer payment is not credited toward the beneficiary's deductible and coinsurance. Primary payer payments that are credited toward the beneficiary's deductible and coinsurance are not entered on line 7.

3545.2 Part II - Computation of HHA Reimbursement Settlement.--Check the applicable title for When the primary payment does not satisfy the beneficiary's liability, include the covered days 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 9 to the extent that primary payer payment is not credited toward the beneficiary's deductible and coinsurance. this form.

Line 8.--Enter in column 1 the lesser of the amount in column 1, line 1 or line 6 less the amount on line 7. Enter in column 2 the sum of the lesser of the amounts in column 2, line 1 or line 6, plus the lesser of the amounts in column 3, line 1 or line 6 minus the amounts on line 7, columns 2 and 3.

Lines 8.01 through 8.15—Under PPS enter only payment amounts associated with episodes completed in the current cost reporting period. Payments for episodes of care which overlap fiscal years must be recorded in the fiscal year in which the episode was completed. Enter in column 1 for lines 8.01 through 8.06, as applicable, the appropriate PPS reimbursement amount for each episode of care payment category as indicated on the worksheet. Enter in column 1 for lines 8.07 through 8.10, as applicable, the appropriate PPS outlier reimbursement amount for each episode of care payment category as indicated on the worksheet. Enter in column 1, line 8.11 the sum total of other payments. Enter in column 1, lines 8.12 through 8.14, the total DME, oxygen, prosthetics and orthotics payments, respectively. Obtain these amounts from your PS&R report.

Line 9.--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 11.--Enter all coinsurance billable to Medicare beneficiaries including amounts satisfied by primary payer payments.

NOTE: If the component qualifies as a nominal charge provider, enter 20 percent of costs subject to coinsurance. Compute this amount by subtracting Part B deductibles on line 9 and primary payment amounts on line 7, column 3 from Part B costs subject to coinsurance on line 1, column 3. The resulting amount is multiplied by 20 percent and entered on this line.

Line 13.--Enter program reimbursable bad debts for deductibles and coinsurance (from your records), excluding deductibles and coinsurance for physicians' professional services and net of bad debt recoveries.

NOTE: Effective for services rendered on or after August 5, 1997, a State is not required to provide any payment for any expenses incurred relating to payment for deductibles, coinsurance, or copayments for Medicare cost sharing to the extent that payment under

Title XVIII for the service would exceed the payment amount required to be made by the State through the State plan. For example, if the amount the State is required to pay for a Qualified Medicare Beneficiary (QMB) is less than the amount billed for deductible or coinsurance, the provider is precluded from claiming as a bad debt the balance.

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

NOTE: Section 1861 (v) (1) (O) sets a limit on the valuation of a depreciable asset that may be recognized in establishing an appropriate allowance for depreciation, and for interest on capital indebtedness after a change of ownership that occurs on or after December 1, 1997.

Line 16.--Enter the program's share of any recovery of excess depreciation applicable to prior years resulting from provider termination or a decrease in Medicare utilization. Submit the work papers which have developed this amount. (See CMS Pub. 15-I, chapter 1.)

Line 17.-- Where your cost limit is raised as a result of your request for review, amounts which were erroneously collected on the basis of the initial cost limit are required to be refunded to the beneficiary. Enter any amounts which are not refunded, either because they are less than $5 collected from a beneficiary or because you are unable to locate the beneficiary. (See CMS Pub. 15-I, §2577.)

Line 18.--Enter line 14 minus the sum of lines line 16 and 17, plus or minus the amount on line 15.

Line 18.01.--Enter any other adjustments. For example, enter an adjustment resulting from changing the recording of vacation pay from a cash basis to an accrual basis. (See CMS Pub. 15-1, §2146.4.) For purposes of reimbursing costs associated with the Outcome and Assessment Information Set (OASIS) (cost reporting periods beginning in Federal fiscal year 2000 only) report on this line in column 1, the result of multiplying the Medicare unduplicated census count on Worksheet S-4, column 2, line 9,(excluding subscripts) by $10.00, minus the interim OASIS payment made to the provider on April 1, 2000. Do not include this interim OASIS payment on Worksheet S-7, but rather attach documentation supporting the payment(s). (For intermediary use only during final settlement.)

Line 19.--Enter the applicable sequestration adjustment. (See §120 for a detailed explanation.)

Line 20—Enter the amount on line 18 plus line 18.01 minus line 19.

Line 21—Enter the interim payments from Worksheet H-7, line 4. For intermediary final settlement, report on line 21.01 the amount from Worksheet H-7, line 5.99.

Line 22.--Enter the amount on line 20 minus the amount of line 21. The amounts on this line show the balance due to you or to the program and are transferred to Worksheet S, Part II, columns 2, 3, or 4, as appropriate, line 4. Indicate overpayments by parentheses ( ).

Line 23.--Enter the Medicare reimbursement effect of protested items. Estimate the reimbursement effect of the nonallowable items by applying reasonable methodology which closely approximates the actual effect of items as if it had been determined through the normal cost finding process. (See §115.2.) Attach a schedule showing the supporting details and computation for this line.

3546. WORKSHEET H-7 - ANALYSIS OF PAYMENTS TO PROVIDER-BASED HOME HEALTH AGENCIES FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

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

The column headings designate two categories of payments: Part A and Part B.

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

Do not include any payments made for DME or medical supplies charged to patients that are paid on the basis of a fee schedule on this worksheet.

Line Descriptions

Line 1.--Enter the total Medicare interim payments paid to you for all covered services rendered prior to October 1, 2000. Additionally, for services rendered on and after October 1, 2000, enter only the total Medicare interim payments paid to the HHA for applicable Medicare covered osteoporosis drugs. The amount entered reflects the sum of all interim payments paid on individual bills (net of adjustment bills) for services rendered in this cost reporting period. The amount entered includes amounts withheld from your interim payments due to an offset against overpayments applicable to prior cost reporting periods. It does not include any retroactive lump sum adjustment amounts based on a subsequent revision of the interim rate, or tentative or net settlement amounts, nor does it include interim payments payable. If you are reimbursed under the periodic interim payment method of reimbursement, enter the periodic interim payments received for this cost reporting period. Do not include payments received for services reimbursed on a fee schedule basis

Also, enter in column 1, as applicable for HHA services furnished on or after October 1, 2000, the total Medicare PPS payments and the total PPS outlier payments paid to the HHA for all episode payment categories for related episodes completed during the current cost reporting period. The amounts entered reflects the sum of all interim PPS payments paid on individual claims (net of adjustments) for episodes completed in the current cost reporting period.

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

NOTE: Include on lines 1 and 2 the appropriate amounts applicable for respite care services.

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

Line 4.--Enter the total amount of the interim payments (sum of lines 1, 2, and 3.11). Transfer these totals to the appropriate column on Worksheet H-6, Part II, line 21.

DO NOT COMPLETE THE REMAINDER OF WORKSHEET H-7. THE REMAINDER OF THE WORKSHEET IS COMPLETED BY YOUR INTERMEDIARY.

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

Line 6.--Enter in column 2 the amount on Worksheet H-6, Part II, column 1, line 22. Enter in column 4 the amount on Worksheet H-6, Part II, column 2, line 22.

Line 7.--Enter the net settlement amount (balance due to you or balance due to the program) for the NPR, or, if this settlement is after a reopening of the NPR, for this reopening. Enter the total of the amount on line 6 plus or minus the total amount on line 5.99. Enter amounts due the program in parentheses ( ).

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

3551. WORKSHEET J-1 - ALLOCATION OF GENERAL SERVICE COSTS TO OUTPATIENT REHABILITATION PROVIDER COST CENTERS

Use this worksheet if you operate a SNF-based CORF, a SNF-based CMHC, a SNF-based OPT, a SNF-based OOT, or a SNF-based OSP. Complete a separate worksheet for each provider. For other than CMHC's If all services are paid under established fee schedules for CORF, OPT, OOT, and OSP these worksheets no longer need to be completed for cost reporting periods ending on or after June 30, 2001.

3551.1 Part I - Allocation of General Service Costs to Outpatient Rehabilitation Provider Cost Centers.-- 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. Obtain the total direct expenses (column 0, line 18) from Worksheet A, column 7, line 50. Obtain the cost center allocation (column 0, lines 1 through 21) from your records.

3551.2 Part II - Computation of Unit Cost Multiplier for Allocation of Outpatient Rehabilitation Provider Administrative and General Costs.--

3551.3 Part III - Allocation of General Service Costs to Outpatient Rehabilitation Provider Cost Centers -Statistical Basis.--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 Worksheet J-1, Part I.

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

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

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

Lines 1 through 21.--On 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 22.--Enter the total of lines 1 through 21 for each column. The total in each column must be the same as shown for the corresponding column on Worksheet B-1, line 50.

Line 23.--Enter the total expenses of the cost center to be allocated. Obtain this amount from Worksheet B, Part I, line 50, from the same column used to enter the statistical base on Worksheet J-1, Part III (e.g., in the case of capital-related cost buildings and fixtures, this amount is on Worksheet B, Part I, column 1, line 50).

Line 24.--Enter the unit cost multiplier which is obtained by dividing the cost entered on line 23 by the total statistic entered in the same column on line 22. Round the unit cost multiplier to six decimal places.

Multiply the unit cost multiplier by that portion of the total statistics applicable to each cost center receiving the services. Enter the result of each computation on Worksheet 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 22, Part I) must equal the total cost on line 23, Part III.

Perform the preceding procedures for each general service cost center.

In column 16, Part I, enter the total of columns 3a through 15.

In Part II, compute the unit cost multiplier for allocation of the components' administrative and general costs as follows.

Line 1.--Enter the amount from Part I, column 18, line 22.

Line 2.--Enter the amount from Part I, column 18, 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 19, Part I, for lines 2 through 21, multiply the amount in column 18 by the unit cost multiplier on line 4, Part II, and enter the result in this column. On line 22, enter the total of the amounts on lines 2 through 21. The total on line 22 equals the amount on column 18, line 1.

In column 20, Part I, enter on lines 2 through 17 the sum of the amounts in columns 18 and 19. The total in column 20, line 22 must equal the total in column 18, line 22.

3552. WORKSHEET J-2 - COMPUTATION OF COMPONENT COSTS

Use this worksheet if you operate a SNF-based CORF, a SNF-based CMHC, a SNF-based OPT, a SNF-based OOT, or a SNF-based OSP. Complete a separate worksheet for each provider.

3552.1 Part I - Apportionment of Outpatient Rehabilitation Provider Cost Centers.--

Column 1.--Enter on each line the total cost for the cost center as previously computed on Worksheet J-1, Part I, column 20. To facilitate the apportionment process, the line number designations are the same on both worksheets.

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

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

Columns 4, 6, 8 and 8.01.--For each cost center, enter the charges from your records for title V, title XVIII, and title XIX patients, respectively. Not all facilities are eligible to participate in all programs. For cost reporting periods which overlap August 1, 2000, you must subscript column 8, and column 9, to report CMHC charges and costs. Charges before August 1, 2000 are reported in column 8. Charges on or after August 1, 2000 are reported in column 8.01 to accommodate the

implementation of prospective payment. For cost reporting periods beginning on or after August 1, 2000 no subscripting is required.

Columns 5, 7, 9 and 9.01.--For each cost center, enter the costs obtained by multiplying the charges in columns 4, 6, 8, and 8.01 respectively, by the ratio in column 3.

Line 22.--Enter the totals for columns 1, 2, and 4 through 9.

Column 10, lines 3, 4, 5, 24, 25 and 26. --For each cost center, enter the title XVIII charges (from your records) for services rendered on and after January 1, 1998.

Column 11, lines 3, 4, 5, 24, 25 and 26. --Determine the title XVIII cost for services rendered on or after January 1, 1998 by multiplying the charges in column 10 by the ratio in column 3, and enter the result.

Column 12, lines 3, 4, 5, 24, 25 and 26. --Determine the reduction amount by multiplying the cost in column 11 by the ten percent cost reduction, and enter the result.

Column 13, lines 3, 4, 5, 24, 25 and 26. --Determine the title XVIII cost net of applicable cost reduction by subtracting the amount in column 12 from the amount in column 9. For lines 2, 6 through 21, 23, and 27 through 29, enter the cost from column 9.

3552.2 Part II - Apportionment of Cost of Outpatient Rehabilitation Services Furnished by Shared Skilled Nursing Facility Departments.--Use this part only when the SNF complex maintains a separate department for any of the cost centers listed on this worksheet, and the department provides services to patients of the skilled nursing facility's outpatient rehabilitation facility.

Column 3.--For each of the cost centers listed, enter the ratio of cost to charges that is shown on Worksheet C, column 3, from the appropriate line for each cost center.

Columns 4, 6, and 8.--For each cost center, enter the charges from your records for title V, title XVIII, and title XIX patients, respectively.

Columns 5, 7, and 9.--For each cost center, enter the costs obtained by multiplying the charges in columns 4, 6, and 8 respectively by the ratio in column 3.

Line 30.--Enter the totals for columns 4 through 7, 9 and 13.

3552.3 Part III - Total Rehabilitation Costs-- Use This Section to Determine the Applicable Facilities Rehabilitation Costs.--

Line 31. --Enter the amounts from Part I, column 13, line 22 and the amount from Part II, column 13, line 30. Add the amount from Part I, line 22 and Part II, line 30 for columns 8 through 11.

3553. WORKSHEET J-3 - CALCULATION OF REIMBURSEMENT SETTLEMENT OF REHABILITATION SERVICES

3553.1 Part I - Calculation of Reimbursement Settlement for SNF-Based Providers Not Subject to the Computation of the Lesser of Reasonable Costs or Customary Charges.--

This worksheet is to be completed if you operate a SNF-based CMHC, a SNF-based OPT, SNF-based OSP, and/or SNF-based OOT.

Line 1.--Enter the cost of rehabilitation services from Worksheet J-2, Part III, line 31 from columns 5, 7, 9 for title XVIII services prior to 8/1/2000, and 9.01 for services on and after 8/1/2000, or 13, as applicable (column 5 for title V, column 7 for title XIX, and columns 9, 9.01 or 13 for title XVIII).

NOTE: Subscript column 2, lines 1 through 10, for cost reporting periods which overlap August 1, 2000. Enter in column 2 data applicable to the CMHC prior to August 1, 2000. Enter in column 2.01 data applicable to the CMHC on and after August 1, 2000.

Lines 1.01 through 1.06 are to be completed by CMHCs for title XVIII, for services on or after August 1, 2000.

Line 1.01. Enter the cost of the health services for services rendered on or after August 1, 2000, from Worksheet J-2, Part II, column 9.01 (column 9 for cost reporting periods beginning after August 1, 2000.

Line 1.02.--Enter the PPS payments received including outliers.

Line 1.03.--Enter the 1996 SNF specific payment to cost ration provided by your intermediary. If you did not file a cost report in 1996, you are not eligible for transition corridor payments.

Line 1.04.--Multiply line 1.01 times line 1.03.

Line 1.05.--Divide line 1.02 by line 1.04.

Line 1.06.--Enter the transition corridor payment amount calculated based on the following:

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

a. If line 1.05 is =>90 percent but <100 percent, enter 80 percent of (line 1.04 minus line 1.02).
b. If line 1.05 is =>80 percent but <90 percent, enter .71 of (line 1.04) minus .70 (line 1.02).
c. If line 1.05 is =>70 percent but <80 percent, enter .63 of (line 1.04) minus .60 (line 1.02).
d. If line 1.05 is <70 percent, enter 21 percent of line 1.04.

For services rendered on and after January 31, 2002 through December 31, 2002:

a. If line 1.05 is =>90 percent but <100 percent, enter 70 percent of (line 1.04 minus line 1.02).
b. If line 1.05 is =>80 percent but <90 percent, enter .61 of (line 1.04) minus .60 (line 1.02).
c. If line 1.05 is <80 percent, enter 13 percent of line 1.04.

For services rendered on and after January 31, 2003 through December 31, 2003:

a. If line 1.05 is =>90 percent but <100 percent, enter 60 percent of (line 1.04 minus line 1.02).
b. If line 1.05 is <90 percent, enter 6 percent of line 1.04.

If the cost reporting periods overlap any of these effective dates you must subscript the column and make a separate transitional corridor payment for the appropriate periods.

Line 2.--Enter the amounts paid and payable by workmen's compensation and other primary payers (from your records).

Line 3.--Enter in column 2, the amount obtained by subtracting line 2 from line 1. Enter in column 2.01 the amount obtained by subtracting line 2 from the sum of lines 1, 1.02 and 1.06 for CMHC. For cost reporting periods beginning on and after August 1, 2000, enter in column 2, the sum of lines 1.02 and 1.06.

Line 6.--Enter in column 2, 80 percent of line 5 for Title XVIII services prior to August 1, 2000. Make no entry in column 2.01 for services on and after August 1, 2000. Make no entry for title V or title XIX.

Line 7.--Enter the actual coinsurance billed to program patients (from your records).

Line 9.--Enter reimbursable bad debts, net of recoveries, applicable to any deductibles and coinsurance (from your records).

Line 10.--For services prior to August 1, 2000, enter in column 2 the lesser of line 6 or line 8; plus line 9. For services on and after August 1,2000, enter in column 2.01 the sum of line 8 and 9. Combine the amount in column 2 and the amount in column 2.01, and bring one amount into the calculation for line 13 below.

Line 11.--Enter the program's share of any net depreciation adjustment applicable to prior years resulting from the gain or loss on the disposition of depreciable assets. (See HCFA Pub. 15-I, §§132ff.) Enter the amount of any excess depreciation taken in parentheses ( ).

NOTE: Section 1861 (v) (1) (O) sets a limit on the valuation of a depreciable asset that may be recognized in establishing an appropriate allowance for depreciation, and for interest on capital indebtedness after a change of ownership that occurs on or after December 1, 1997.

Line 12.--Enter the program's share of any recovery of excess depreciation applicable to prior years resulting from provider termination or a decrease in Medicare utilization. (See HCFA Pub. 15-I, §§136ff.)

Line 13.--Enter the amount on line 10, plus or minus the amount on line 11, minus the amount on line 12.

Line 14.--Using the methodology explained in §120, enter the sequestration adjustment on this line.

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, unless the deficit would reach zero

For Title XVIII, reduce each payment amount 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 PL. 99-177) takes place. Section 120 outlines the methodology by which the sequestration adjustment is computed.

Line 15.--Enter the amount on line 13 minus the amount on line 14.

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

Line 17.--Enter the balance due provider/program and transfer this amount to Worksheet S, Part II, columns as appropriate, line 5.

Line 18.--Enter the program reimbursement effect of protested items. Estimate the reimbursement effect of the nonallowable items by applying reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See §115.2.) Attach a worksheet showing the details and computations for this line.

3553.2 Part II - Computation of Customary Charges for Rehab Services.--Pursuant to §4541 of BBA 1997, §1834(k) of the Social Security Act is amended to require that title XVIII services rendered in Calendar Year 1998 for CORF be subject to the lesser of charges imposed for those services or the adjusted reasonable costs.

If you have more than one SNF-based facility, a separate worksheet must be completed for each facility.

Line 1--Enter the total cost of outpatient rehabilitation services from Worksheet J-2, Part III, column 13, line 31.

Line 1.1--Enter the total reasonable cost of rehabilitation services prior to 1/1/98, from Worksheet J-2, Part II, column 9, line 31 minus the amount from column 11, line 31.

Line 1.2--Enter the total reasonable cost of rehabilitation services rendered on or after 1/1/98 by multiplying the amount from Worksheet J-2, Part II, column 11, line 31 by 90 percent.

NOTE: Line 1 must equal the sum of lines 1.1 and 1.2

Line 2--Enter (from your records) the amounts paid and payable by Workmen's Compensation and other primary payor.

Line 3--Enter the amount obtained by subtracting line 2 from line 1

Line 4--Enter the total charges from Worksheet J-2, Part III, column 8, line 31.

Lines 5, 6, 7, and 8--These lines provide for the reduction of Medicare charges where the provider does not actually impose such charges (in the case of most patients liable for payment for services on a charge basis) or fails to make reasonable efforts to collect such charges from those patients. Enter on line 8 the product of multiplying the ratio on line 7 by line 4. In no instance may the customary charges on line 8 exceed the actual charges on line 4.

Line 8.1.--Enter the customary charges for rehabilitation services rendered prior to 1/1/98 from Worksheet J-2, Part II, column 8, line 31, minus the amount from column 10, line 31.

Line 8.2.--Enter the customary charges for rehabilitation services rendered on or after 1/1/98 by multiplying the amount from Worksheet J-2, Part II, column 10 by 90 percent.

Line 8.3.--Enter on line 8.3 the excess of total customary charges (8.2) over the total reasonable cost (line 1.2). When the total charges on line 8.2 are less than the total cost on line 1.2, enter zero (0) on line 8.3.

Line 8.4.--Enter on line 8.4 the excess of total reasonable cost (line 1.2) over total customary charges (line 8.2). When the total cost on line 1.2 is less than the customary charges on line 8.2, enter zero (0) on line 8.4.

3553.3 Part III - Computation of Reimbursement Settlement of Outpatient Rehabilitation Services.--

Line 9.--Enter the cost of rehabilitation services from Part II, line 3.

Line 10.--Enter the Part B deductibles billed to program patients (from your records) excluding any coinsurance amounts.

Line 11.--Enter the amount obtained by subtracting line 10 from line 9.

Line 11.1.--Enter the amount from Part II, line 8.4.

Line 12.--Enter 80 percent of line 11.2.

Line 13.--Enter the actual coinsurance billed to program patients (from your records).

Line 14.--Enter the amount obtained by subtracting line 13 from line 11.2.

Line 15.--Enter (from your records) reimbursable bad debts, net of recoveries, applicable to any deductibles and coinsurance.

Line 16.--Enter the lesser of the amounts on line 12 or 14 plus the amount on line 15.

Line 17.--Enter the program's share of any net depreciation adjustment applicable to prior years resulting from the gain or loss on the disposition of depreciable assets. (See HCFA Pub. 15-1, §§132ff.) Enter the amount of any excess depreciation taken in parentheses. ().

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

Line 18.--Enter the program's share of any recovery of excess depreciation applicable to prior years resulting from your termination or a decrease in Medicare utilization. (See HCFA Pub. 15-I, §§136ff.)

Line 19--Enter any other adjustment. For example, if you change the recording of vacation pay from the cash basis to the accrual basis, enter the adjustment. (See HCFA Pub. 15-I, §2146.4.) Specify the adjustment in the space provided.

Line 20--Enter the amount from line 16 minus the amounts from lines 17 and 18, plus or minus the amount on line 19.

Line 21--Enter any applicable sequestration adjustment. (See §120.)

Line 23--Enter the total interim payments, if applicable. Transfer this amount from Worksheet J-4, column 2, line 4.

Line 24--Enter the balance due the provider/program and transfer this amount to Worksheet S, Part II, column 3, line 5.

Line 25--Enter the program reimbursement effect of nonallowable cost report items which you are disputing. Compute the reimbursement effect in accordance with §115.2. Attach a schedule showing the supporting details and computation.

Line 26--Do not use this line for cost reporting periods beginning on or after October 1, 1997.

3554. WORKSHEET J-4 - ANALYSIS OF PAYMENTS TO PROVIDER-BASED COMPONENT FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Complete this worksheet for Medicare interim payments only. Complete a separate worksheet for each outpatient rehabilitation provider.

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

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

Line Descriptions

Line 1.--Enter the total program interim payments paid to the component. The amount entered reflects the sum of all interim payments paid on individual bills (net of adjustment bills) for services rendered in this cost reporting period. The amount entered include amounts withheld from the component's interim payments due to an offset against overpayments to the component applicable to prior cost reporting periods. It does not include any retroactive lump sum adjustment amounts based on a subsequent revision of the interim rate or tentative or net settlement amounts. Nor does it include interim payments payable.

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

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

Line 4.--Transfer the total interim payments to the title XVIII Worksheet J-3, Part III, line 25.

DO NOT COMPLETE THE REMAINDER OF WORKSHEET J-4. LINES 5 THROUGH 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, report all settlement payments prior to the current reopening settlement.

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, 5.99, and 6 in column 2. The amount in column 2 must equal the amount on Worksheet J-3, line 17.

Multiply the unit cost multiplier by that portion of the total statistics applicable to each cost center receiving the services. Enter the result of each computation on Worksheet K-5, Part I, in the corresponding column and line.

Perform the preceding procedures for each general service cost center.

In column 18, Part I, enter the total of columns 4A through 15.

In column 17, Part I, for lines 2 through 28, multiply the amount in column 17 by the unit cost multiplier on line 30, Part I, and enter the result in this column. On line 29, enter the total of the amounts on lines 2 through 28. The total on line 29 equals the amount in column 16, line 1.

In column 18, Part I, enter on lines 2 through 28 the sum of columns 16 and 17. The total on line 29 equals the total in column 18, line 29.

3570.3 Part III- Apportionment Hospice Shared Services.--This worksheet provides for the shared therapy, drugs, or medical supplies from the SNF to the hospice.

Column Description

Columns 1 & 2.-- Enter in column 2, the cost for each discipline from Worksheet K-5, Part I, col. 18, lines as indicated in column 1.

Column 3 & 4.--Where applicable, enter in column 4 the cost to charge ratio from Worksheet C, I column 3, lines as indicated in column 3.

Column 5.--Where SNF departments provides services to the hospice, enter on the appropriate lines the charges, from the provider's records, applicable to the SNF-based hospice.

Column 6.--Multiply the amount in column 5 by the ratios in column 4 and enter the result in column 6.

Column 7.--Add the amounts in column 2 to the amounts in column 6 and enter the result in column 7 in order to compute the total shared cost.

Line 9.--Sum of column 7 lines 1 through 8.

3571. WORKSHEET K-6 - CALCULATION OF PER DIEM COST

Worksheet K-6 calculates the average cost per days in providing care for a hospice patient. It is only an average and should not be misconstrued as the absolute.

Line 1.--Total cost from Worksheet K, line 34, less line 33, column 7. This line is suppose to reflect the true cost without any non hospice related costs.

Line 2.--Total unduplicated days from Worksheet S-8, line 5, col. 6.

Line 3.--Average total cost per day. Divide the total cost from line 1 by the total number of days from line 2.

Line 4.--Unduplicated Medicare days from Worksheet S-8, line 5, column 1.

Line 5.--Average Medicare cost. Multiply the average cost from line 3 by the number of unduplicated Medicare days on line 4 to arrive at the average Medicare cost.

Line 6.--Unduplicated Medicaid days from Worksheet S-8, line 5, column 2.

Line 7.--Average Medicaid cost. Multiply the average cost from line 3 by the number of unduplicated Medicaid days on line 6 to arrive at the average Medicaid cost.

Line 8.--Unduplicated SNF days from Worksheet S-8, line 5, column 3.

Line 9.--Average SNF cost. Multiply the average cost from line 3 by the number of unduplicated SNF days on line 8 to arrive at the average SNF cost.

Line 10.--Unduplicated NF days from Worksheet S-8, line 5, column 4.

Line 11.--Average NF cost. Multiply the average cost from line 3 by the number of unduplicated NF days on line 10 to arrive at the average NF cost.

Line 12.--Unduplicated other days from Worksheet S-8, line 5, column 5.

Line 13.--Average other cost. Multiply the average cost from line 3 by the number of unduplicated other days on line 5 to arrive at the average other cost.

EXHIBIT 1 - Form CMS -2540-96 Worksheets

The following is a listing of the Form CMS 2540-96 worksheets and the page number location.

WORKSHEETS	PAGE (S)
Wkst. S, Parts I & II	35-303
Wkst. S-2	35-304 - 35-305
Wkst. S-3, Parts I, II & III	35-306 - 35-307
Wkst. S-4	35-308
Wkst. S-5	35-309
Wkst. S-6	35-310
Wkst. S-7, Parts I, II, III & IV	35-311 - 35-312.3
Wkst. S-8	35-312.4
Wkst. A	35-313 - 35-314
Wkst. A-6	35-315
Wkst. A-7	35-316
Wkst. A-8	35-317
Wkst. A-8-1	35-318
Wkst. A-8-2	35-319
Wkst. A-8-3, Parts I - VII	35-320 - 35-322
Wkst. A-8-4, Parts I - V	35-323 - 35-324
Wkst. A-8-5, Parts I - VII	35-325 - 35-328
Wkst. B, Part I	35-329 - 35-334
Wkst. B-1	35-335 - 35-340
Wkst. B, Part II	35-341 - 35-346
Wkst. B, Part III	35-346.1 - 35-346.2
Wkst. B-2	35-347
Wkst. C	35-348
Wkst. D, Parts I, II & III	35-349 - 35-350
Wkst. D-1, Parts I & II	35-351
Wkst. D-2, Parts I & II	35-352
Wkst. E, Parts I, II, III & V	35-353 - 35-356
Wkst. E-1	35-357
Wkst. G	35-358 - 35-359
Wkst. G-1	35-360
Wkst. G-2, Parts I & II	35-361
Wkst. G-3	35-362
Wkst. H	35-363
Wkst. H-1	35-364
Wkst. H-2	35-365
Wkst. H-3	35-366
Wkst. H-4, Parts I & II	35-367
Wkst. H-5, Parts I - V	35-368 - 35-370
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Wkst. H-7	35-372
Wkst. I-1	35-373
Wkst. I-2	35-374
Wkst. I-3	35-375
Wkst. I-4	35-376
Wkst. I-5	35-377

Wkst. J-1, Parts I, II & III	35-378 - 35-384
Wkst. J-2, Parts I, II & III	35-385 - 35-386
Wkst. J-3, Parts I, II & III	35-387 - 35-388
Wkst. J-4	35-389
Wkst. K	35-390
Wkst. K-1	35-391
Wkst. K-2	35-392
Wkst. K-3	35-393
Wkst. K-4, Part I & II	35-394 - 35-395
Wkst. K-5, Part I	35-396 - 35-398
Wkst. K-5, Part II	35-399 - 35-401
Wkst. K-6	35-402

To download pages 35-303 - 35-403, click here.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 2540-96
TABLE 1 - RECORD SPECIFICATIONS

Table 1 specifies the standard record format to be used for electronic cost reporting. Each electronic cost report submission (file) has four types of records. The first group (type 1 records) contains information for identifying, processing, and resolving problems. The text used throughout the cost report for variable line labels (e.g., Worksheet A) and variable column headers (Worksheet B-1) is included in the type 2 records. Refer to Table 5 for cost center coding. The data detailed in Table 3 are identified as type three records. The encryption coding at the end of the file, records 1, 1.01, and 1.02, are type 4 records.

The medium for transferring cost reports submitted electronically to fiscal intermediaries is 3? " diskette. These disks must be in IBM format. The character set must be ASCII. Seek approval from your fiscal intermediary regarding alternate methods of submission to ensure that the method of transmission is acceptable.

The following are requirements for all records:

1. All alpha characters must be in upper case.

2. For micro systems, the end of record indicator must be a carriage return and line feed, in that sequence.

3. No record may exceed 60 characters.

Below is an example of a Type 1 record with a narrative description of its meaning.

```
          1         2         3         4         5
12345678901234567890123456789012345678901234567890123456
1             1    0101231998274199927 33C99P0052000020 2000305
```

Record #1: This is a cost report file submitted by Provider 010123 for the period from October 1, 1999 (1999274) through October 31, 2000, (2000305). It is filed on Form CMS-2540-96. It is prepared with vendor number C99's PC based system, version number 1. Position 38 changes with each new test case and/or approval and is alpha. Positions 39 and 40 will remain constant for approvals issued after the first test case. This file is prepared by the skilled nursing facility on January 20, 2000, (2000020). The electronic cost report specification, dated October 31, 2000, (2000305), is used to prepare this file.

FILE NAMING CONVENTION

Name each cost report file in the following manner:

SNNNNNNN.YYL, where

1. SN (SNF electronic cost report) is constant;
2. NNNNNN is the 6 digit Medicare skilled nursing facility provider number;
3. YY is the year in which the provider's cost reporting period ends; and
4. L is a character variable (A-Z) to enable separate identification of files from skilled nursing facilities with two or more cost reporting periods ending in the same calendar year.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 2540-96
TABLE 1 - RECORD SPECIFICATIONS

RECORD NAME: Type 1 Records - Record Number 1

		Size	Usage	Loc.	Remarks
1.	Record Type	1	X	1	Constant "1"
2.	NPI	10	9	2-11	Numeric only
3.	Spaces	1	X	12	
4.	Record Number	1	X	13	Constant "1"
5.	Spaces	3	X	14-16	
6.	SNF Provider Number	6	9	17-22	Field must have 6 numeric characters
7.	Fiscal Year Beginning Date	7	9	23-29	YYYYDDD - Julian date; first day covered by this cost report
8.	Fiscal Year Ending Date	7	9	30-36	YYYYDDD - Julian date; last day covered by this cost report
9.	MCR Version	1	9	37	Constant "3" (for Form CMS 2540-96)
10.	Vendor Code	3	X	38-40	To be supplied upon approval. Refer to page 35-503.
11.	Vendor Equipment	1	X	41	P = PC; M = Main Frame
12.	Version Number	3	X	42-44	Version of extract software, e.g., 001=1st, 002=2nd, etc. or 101=1st, 102=2nd. The version number must be incremented by 1 with each recompile and release to client(s).
13.	Creation Date	7	9	45-51	YYYYDDD - Julian date; date on which the file was created (extracted from the cost report)
14.	ECR Spec. Date	7	9	52-58	YYYYDDD - Julian date; date of electronic cost report specifications used in producing each file. Valid for cost reporting periods ending on or after 2001059 (01/28/01). Prior approval(s) are 2000274, 1999334, 1998273, 1997273, and 1996274.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 2540-96
TABLE 1 - RECORD SPECIFICATIONS

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

		Size	Usage	Loc.	Remarks
1.	Record Type	1	9	1	Constant "1"
2.	Spaces	10	X	2-11	
3.	Record Number	2	9	12-13	#2 to #99 - Reserved for future use.
4.	Spaces	7	X	14-20	Spaces (optional)
5.	ID Information	40	X	21-60	Left justified to position 21.

RECORD NAME: Type 2 Records for Labels

		Size	Usage	Loc.	Remarks
1.	Record Type	1	9	1	Constant "2"
2.	Wkst. Indicator	7	X	2-8	Alphanumeric. Refer to Table 2.
3.	Spaces	2	X	9-10	
4.	Line Number	3	9	11-13	Numeric
5.	Subline Number	2	9	14-15	Numeric
6.	Column Number	3	X	16-18	Alphanumeric
7.	Subcolumn Number	2	9	19-20	Numeric
8.	Cost Center Code	4	9	21-24	Numeric. Refer to Table 5 for appropriate cost center codes.
9.	Labels/Headings				
	a. Line Labels	36	X	25-60	Alphanumeric, left justified
	b. Column Headings Statistical Basis & Code	10	X	21-30	Alphanumeric, left justified

The type 2 records contain text that appears on the pre-printed cost report. Of these, there are three groups: (1) Worksheet A cost center names (labels); (2) column headings for step-down entries; and (3) other text appearing in various places throughout the cost report. The standard cost center labels are listed below.

A Worksheet A cost center label must be furnished for every cost center with cost or charge data anywhere in the cost report. The line and subline numbers for each label must be the same as the line and subline numbers of the corresponding cost center on Worksheet A. The columns and subcolumn numbers are always set to zero.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 2540-96
TABLE 1 - RECORD SPECIFICATIONS

TYPE 2 COST CENTER DESCRIPTIONS

The following type 2 cost center descriptions must be used for all Worksheet A standard cost center lines.

Line	Used when a FULL cost report is filed	Used when a SIMPLIFIED cost report is filed
1	CAP REL COSTS - BLDGS & FIXTURES	CAP REL COSTS - BLDGS & FIXTURES
2	CAP REL COSTS - MOVEABLE EQUIPMENT	CAP REL COSTS - MOVEABLE EQUIPMENT
3	EMPLOYEE BENEFITS	EMPLOYEE BENEFITS
4	ADMINISTRATIVE & GENERAL	ADMINISTRATIVE & GENERAL
5	PLANT OPERATION, MAINT. & REPAIRS	PLANT OPERATION, MAINT. & REPAIRS
6	LAUNDRY & LINEN SERVICE	LAUNDRY & LINEN SERVICE
7	HOUSEKEEPING	HOUSEKEEPING
8	DIETARY	DIETARY
9	NURSING ADMINISTRATION	NURSING ADMINISTRATION
10	CENTRAL SERVICES & SUPPLY	
11	PHARMACY	
12	MEDICAL RECORDS & LIBRARY	
13	SOCIAL SERVICE	
14	INTERNS & RESIDENTS (APPRVD PROG)	
16	SKILLED NURSING FACILITY	SKILLED NURSING FACILITY
18	NURSING FACILITY	NURSING FACILITY
18.1	INTERMEDIATE CARE FACILITY - MENTALLY RETARDED	
19	OTHER LONG TERM CARE	OTHER LONG TERM CARE
21	RADIOLOGY	RADIOLOGY
22	LABORATORY	LABORATORY
23	INTRAVENOUS THERAPY	INTRAVENOUS THERAPY
24	OXYGEN (INHALATION) THERAPY	OXYGEN (INHALATION) THERAPY
25	PHYSICAL THERAPY	PHYSICAL THERAPY
26	OCCUPATIONAL THERAPY	OCCUPATIONAL THERAPY
27	SPEECH PATHOLOGY	SPEECH PATHOLOGY
28	ELECTROCARDIOLOGY	ELECTROCARDIOLOGY
29	MEDICAL SUPPLIES CHARGED TO PATIENTS	MEDICAL SUPPLIES CHARGED TO PATIENTS
30	DRUGS CHARGED TO PATIENTS	DRUGS CHARGED TO PATIENTS
31	DENTAL CARE - TITLE XIX ONLY	DENTAL CARE - TITLE XIX ONLY
32	SUPPORT SURFACES	SUPPORT SURFACES
34	CLINIC	
35	RURAL HEALTH CLINIC	
37	ADMINISTRATIVE & GENERAL - HHA	
38	SKILLED NURSING CARE - HHA	
39	PHYSICAL THERAPY - HHA	
40	OCCUPATIONAL THERAPY - HHA	
41	SPEECH PATHOLOGY - HHA	
42	MEDICAL SOCIAL SERVICES - HHA	
43	HOME HEALTH AIDE - HHA	
44	DME RENTED - HHA	
45	DME SOLD - HHA	
46	HOME DELIVERED MEALS - HHA	
47	OTHER HOME HEALTH SERVICES - HHA	
48	AMBULANCE	
49	INTERNS & RESIDENTS (NOT APPROVED)	
52	MALPRACTICE PREMIUMS & PAID LOSSES	
53	INTEREST EXPENSE	
54	UTILIZATION REVIEW - SNF	UTILIZATION REVIEW – SNF
55	HOSPICE	
56	OTHER SPECIAL PURPOSE COST	OTHER SPECIAL PURPOSE COST
58	GIFT, FLOWER, COFFEE SHOPS &CANTEEN	
59	BARBER & BEAUTY SHOP	BARBER & BEAUTY SHOP
60	PHYSICIANS' PRIVATE OFFICES	
61	NONPAID WORKERS	
62	PATIENTS' LAUNDRY	

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 2540-96
TABLE 1 - RECORD SPECIFICATIONS

Column headings for the General Service cost centers on Worksheets B, Parts I and II, B-1, and J-1, Part III (lines 1-3) are supplied once. They consist of one to three records. Each statistical basis shown on Worksheet B-1, Worksheet J-1, Part III, and Worksheet K-5 is also reported. The statistical basis consists of one or two records (lines 4 and 5). Statistical basis code is supplied only to Worksheet B-1 columns and is recorded as line 6. This code is applied to all general service cost centers and subscripts as applicable. The statistical code must agree with the statistical bases indicated on lines 4 and 5, i.e., code 1 = square footage; code 2 = dollar value; code 3 = other basis, as preprinted on Worksheet B-1, Worksheet J-1, and Worksheet K-5; and code 4 = other than the preprinted basis, as permitted by your fiscal intermediary. When a column is subscripted and an "other" statistical basis is used, if the basis matches the preprinted basis of the main line, use code 3. When the basis of the subscripted line does not match the preprinted basis of the main line, use code 4. Refer to Table 2 for the special worksheet identifier used with column headings and statistical basis and to Table 3 for line and column references.

For the full cost report, use the exact formatting displayed below for column headings for Worksheets B-1, B, Parts I and II, Worksheet J-1, Part III (lines 1-3), and Worksheet K-5, Part II, statistical bases used in cost allocation on Worksheet B-1 Worksheet J-1, Part III (lines 4 and 5), and Worksheet K-5, Part II, and statistical codes used for Worksheet B-1 (line 6). Type 2 records for J-1, columns 1-14, are listed below as well. The numbers at the top of the columns represent the line number of the type 2 record. The numbers running vertical to line 1 descriptions are the general service cost center line designation.

LINE

	1	2	3	4	5	6
1	CAP REL	BUILD &	FIXTURES	SQUARE	FEET	1
2	CAP REL	MOVEABLE	EQUIPMENT	SQUARE	FEET	1
3	EMPLOYEE	BENEFITS		GROSS	SALARIES	3
4	ADMINIS-	TRATIVE &	GENERAL	ACCUM.	COST	3
5	PLANT OPER	MAINT. &	REPAIR	SQUARE	FEET	1
6	LAUNDRY	& LINEN	SERVICE	POUNDS OF	LAUNDRY	3
7	HOUSE-	KEEPING		HOURS OF	SERVICE	3
8	DIETARY			MEALS	SERVED	3
9	NURSING	ADMINIS-	TRATION	DIRECT	NURSING	3
10	CENTRAL	SERVICES &	SUPPLY	COSTED	REQUIS.	3
11	PHARMACY			COSTED	REQUIS.	3
12	MEDICAL	RECORDS &	LIBRARY	TIME	SPENT	3
13	SOCIAL	SERVICE		TIME	SPENT	3
14	INTERNS &	RESIDENTS		ASSIGNED	TIME	3

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 2540-96
TABLE 1 - RECORD SPECIFICATIONS

For the simplified cost report, use the exact formatting displayed below for column headings for Worksheets B-1, Part II, and B, Part III,. The numbers at the top of the columns represent the line number of the type 2 record. The numbers running vertical to line 1 descriptions are the general service cost center line designation.

LINE

	1	2	3	4	5	6
1	CAP REL	COST		SQUARE	FEET	1
2	EMPLOYEE	BENEFITS		GROSS	SALARIES	3
3	PATIENT	SERVICES	COST	PATIENT	DAYS	3
4	ADMINIS-	TRATIVE &	GENERAL	ACCUM.	COST	3

Cost centers included in the line one (CAP REL COST) caption are: Capital Related Costs; Plant Operation Maintenance & Repair; and Housekeeping. Cost centers included in the line three (PATIENT SERVICES COST) caption are: Laundry; Diet; Nursing Administration; Central Supply; Pharmacy; and Social Services.

Examples:

Worksheet A line labels with embedded cost center codes:

```
*    2A000000        1        0100CAP REL COSTS - BLDGS & FIXTURES
*    2A000000000000100000000101CAP REL COSTS - WEST WING
     2A000000        2        0200CAP REL COSTS - MOVABLE EQUIPMENT
     2A000000        4        0400ADMINISTRATIVE & GENERAL
     2A000000        8        0800DIETARY
     2A000000       21        2100RADIOLOGY
     2A000000       21  1     2101RADIOLOGY - DIAGNOSTIC
     2A000000       27        2700SPEECH PATHOLOGY
```

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 2540-96
TABLE 2 - WORKSHEET INDICATORS

This table contains the worksheet indicators that are used for electronic cost reporting. A worksheet indicator is provided only for those worksheets from which data are to be provided.

The worksheet indicator consists of seven digits in positions 2-8 of the record identifier. The first two digits of the worksheet indicator (positions 2 and 3 of the record identifier) always show the worksheet. The third digit of the worksheet indicator (position 4 of the record identifier) is used in several ways. First, it may be used to identify worksheets for multiple SNF-based components. Alternatively, it may be used as part of the worksheet, e.g., A81. The fourth digit of the worksheet indicator (position 5 of the record identifier) represents the type of provider, by using the keys below. Except for Worksheets A-6 and A-8 (to handle multiple worksheets), the fifth and sixth digits of the worksheet indicator (positions 6 and 7 of the record identifier) identify worksheets required by a Federal program (18 = Title XVIII, 05 = Title V, or 19 = Title XIX) or worksheet required for the facility (00 = Universal), and to identify on Worksheet H-5 the two digit identifier which corresponds to the two digit subscript of question 17 on Worksheet S-4 identifying the MSA in which the provider performed services during the cost reporting period. The seventh digit of the worksheet indicator (position 8 of the record identifier) represents the worksheet part.

Provider Type - Fourth Digit of the Worksheet Identifier

	Worksheets
Universal.....0 (Zero)	
SNF.....A	
NF.....B	
CMHC.....C	
CORF.....D	
OPT.....E	
OOT.....F	J-1, J-2, J-3, J-4, S-6
OSP.....G	
ICF/MR.....I	
HOSPICE.....K	K, K-1, K-2, K-3, K-4, K-5, K-6
FQHC.....Q	I-1, I-2, I-3, I-4, I-5, S-5
RHC.....R	I-1, I-2, I-3, I-4, I-5, S-5

Worksheets That Apply to the SNF Cost Report (Full or Simplified)

Worksheet	Worksheet Indicator - Full Cost Report	Worksheet Indicator - Simplified Cost Report
S, Part I	S000001	S000001
S, Part II	S000002	S000002
S-2	S200000	S200000
S-3, Part I	S300001	S300001
S-3, Part II	S300002	S300002
S-3, Part III	S300003	S300003

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 2540-96
TABLE 2 - WORKSHEET INDICATORS

Worksheets That Vary by Component and/or Program

Worksheet	Title V	Title XVIII	Title XIX
S-4, Part I	S410051 (a)	S410181 (a)	S410191 (a)

Worksheets That Apply to the SNF Cost Report (Full or Simplified)

Worksheet	Worksheet Indicator Fill Cost Report		Worksheet Indicator Simplified Cost Report
S-4, Part II	S410002	(a)	
S-4, Part III	S410003		
S-5	S51?000	(h)	
S-6	S61?000	(b)	
S-7, Part I	S700001		
S-7, Part II	S700002		
S-7, Part III	S700003		
S-7, Part IV	S700004		S700004
S-8	S800000		
A	A000000		A000000
A-6	A600001	(c)	A600100
A-7	A700000		A700000
A-8	A800000		A800000
A-8-1, Part A	A81000A		A81000A
A-8-1, Part B	A81000B		
A-8-1, Part C	A81000C		
A-8-2	A820010	(c)	
A-8-3	A830000	(d)	A830000
A-8-4	A840000	(d)	A840000
A-8-5	A85?000	(g)	

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 2540-96
TABLE 2 - WORKSHEET INDICATORS

Worksheets That Apply to the SNF Cost Report (Full or Simplified)

Worksheet	Worksheet Indicator Full Cost Report		Worksheet Indicator Simplified Cost Report
B-1 (For use in column headings)	B10000*		
B, Part I	B000001		
B, Part II	B000002		
B, Part III			B000003
B-1, Part I	B100000		
B-1, Part II			B100002
B-2	B200010	(c)	
C	C000000		C000000

Worksheets That Vary by Component and/or Program –

Worksheet	Title V	Title XVIII	Title XIX
D, Part I (SNF)	D00A051 (f)	D00A181	D00A191
D, Part I (NF)	D00B051		D00B191
D, Part I (ICF/MR)			D00I191
D, Part II (SNF)	D00A052 (e), (f)	D00A182	D00A192 (e), (f)
D, Part II (NF)	D00B052 (e)		D00B192 (e)
D-1 (SNF)	D10A050 (f)	D10A180	D10A190 (f)
D-1 (NF)	D10B050		D10B190
D-1 (ICF/MR)			D10I190

Worksheet That Applies to the SNF Complex – Full Cost Report

D-2	D200000	(d)

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 2540-96
TABLE 2 - WORKSHEET INDICATORS

Worksheets That Vary by Component and/or Program - Full Cost Report

Worksheet	Title V	Title XVIII	Title XIX
E, Part I (SNF)	E00A051 (f)	E00A181	E00A191 (f)
E, Part I (NF)	E00B051		E00B191
E, Part I (ICF/MR			E00I191
E, Part II		E00A182	
E, Part III	E00A053	E00A183	E00A193
E, Part V		E00A185	
E-1		E10A180	

Worksheets That Vary by Component and/or Program –Simplified Cost Report

Worksheet	Title V	Title XVIII	Title XIX
E, Part III	E00A053	E00A183	E00A193
E-1		E10A180	

Worksheet That Applies to the SNF Cost Report

	Worksheet Indicator Full Cost Report		Worksheet Indicator Simplified Cost Report
G	G000000		G000000
G-1	G100000		G100000
G-2, Part I	G200001		G200001
G-2, Part II	G200002		G200002
G-3	G300000		G300000
H	H010000	(a)	
H-1	H110000	(a)	
H-2	H210000	(a)	
H-3	H310000	(a)	
H-4, Parts I & II	H410002	(a)	
H-5, Parts III- V	H510003	(a,d)	

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 2540-96
TABLE 2 - WORKSHEET INDICATORS

Worksheet That Varies by Program – Full Cost Report

Worksheet	Title V	Title XVIII	Title XIX
H-5, Parts I & II	H510052 (a,i)	H510082 (a,i)	H510092 (a,i)
H-6, Parts I & II	H610052 (a)	H610182 (a)	H610192 (a)

Worksheets That Apply to the SNF Complex _Full Cost Report

Worksheet	Worksheet Indicator	
H-7	H710000	(a)
I-1	I11?000	(h)
I-2	I21?000	(h)
I-5	I51?000	(h)

Worksheet That Varies by Program - Full Cost Report

Worksheet	Title V	Title XVIII	Title XIX
I-3	I3?052	I31?182	I31?192
I-4	I4?052	I41?182	I41?192

Worksheets That Vary by Component and/or Program - Full Cost Report

Worksheets	Worksheet Indicator	
J-1, Part I	J11?001	(b)
J-1, Part III	J11?003	(b)
J-2	J21?000	(b)
J-3, Part I	J31?000	(b, d)

Worksheet That Varies by Program - Full Cost Report

Worksheet	Title V	Title XVIII	Title XIX
J-3, Part II	J31?052	J31?182	J31?192
J-3, Part III	J31?053	J31?183	J31?193 (b)

Worksheets That Apply to the SNF Complex - Full Cost Report

J-4	J41?000	

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 2540-96
TABLE 2 - WORKSHEET INDICATORS

Worksheets That Apply to the Hospice Complex

K	K010000	
K-1	K110000	(j)
K-2	K210000	(j)
K-3	K310000	(j)
K-4, Part I	K410001	(j)
K-4, Part II	K410002	(j)
K-5, Part I	K510001	(j)
K-5, Part II	K510002	(j)
K-5, Part III	K510003	(j)

FOOTNOTES:

(a) Multiple SNF-Based Home Health Agencies (HHAs)
The 3rd digit of the worksheet indicator (position 5 of the record) is numeric to identify the SNF-based HHA. If there is only one home health agency, the default is 1. This affects all H series worksheets, and Worksheet S-4.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 2540-96
TABLE 2 - WORKSHEET INDICATORS

FOOTNOTES:

b) Multiple Outpatient Rehabilitation Providers
The third digit of the worksheet indicator is numeric from 1 to 9 to accommodate multiple providers. If there is only one outpatient provider type, the default is 1. The fourth character of the worksheet indicator (position 5 of the record) indicates the outpatient rehabilitation provider as listed above. This affects all J series worksheets and Worksheet S-6.

(c) Multiple Worksheets for Reclassifications and Adjustments Before and After Step-down
The fifth and sixth digits of the worksheet indicator (positions 6 and 7 of the record) are numeric from 01-99 to accommodate reports with more lines on Worksheets A-6, A-8-2, and/or B-2. For reports that do not need additional worksheets, the default is 01. For reports that do need additional worksheets, the first page of each worksheet is numbered 01. The number for each additional page of each worksheet is incremented by 1.

(d) Worksheet with Multiple Parts using Identical Worksheet Indicator
Although this worksheet has several parts, the lines are numbered sequentially. This worksheet identifier is used with all lines from this worksheet regardless of the worksheet part. This differs from the Table 3 presentation which identifies each worksheet and part as they appear on the cost report. This affects Worksheets A-8-3, A-8-4, D-2, H-5, Parts III through V, and J-2.

(e) States Apportioning Vaccine Costs Per Medicare Methodology
If, for titles V and/or XIX, your state directs providers to apportion vaccine costs using Medicare's methodology, show these costs on a separate Worksheet D, Part II for each title.

(f) States Licensing the Provider as an SNF Regardless of the Level of Care
These worksheet identifiers are for providers licensed as an SNF for Titles V and XIX.

(g) Multiple Worksheet A-8-5
This worksheet is used for occupational, physical, or respiratory therapy and speech pathology services furnished by outside suppliers. The fourth digit of the worksheet indicator (position 5 of the record) is an alpha character of O for occupational therapy, P for physical therapy, R for respiratory therapy, and S for speech pathology services.

(h) Multiple Health Clinic Programs
The third digit of the worksheet indicator (position 4 of the record) is numeric from 1 to 0 to accommodate multiple providers. If there is only one health clinic provider type, the default is 1. The fourth character of the worksheet indicator (position 5 of the record) indicates the health clinic provider. Q indicates Federally qualified health center, and R indicates rural health clinic.

(i) Multiple Worksheets H-5, Part II for Cost Limitations Based on the MSA
The fifth and sixth digits of the worksheet indicator (positions 6 and 7 or the record) is numeric from 00-24 and corresponds to the two digit subscript of line 17 on Worksheet S-4 (i.e. insert the identifier 02 for line 17.02) which identifies the 4 digit MSA code. If services are provided in only one MSA, the default is 00. Where an HHA provides services in multiple MSA's, one Worksheet H-5, Part II must be completed for each MSA.

(j) Multiple SNF-Based Hospices (HSPSs)
The 3rd digit of the worksheet indicator (position 5 of the record) is numeric to identify the SNF-based hospice. If there is only one hospice, the default is 1. This affects all K series worksheets, and Worksheet S-8

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

This table identifies those data elements necessary to calculate a skilled nursing facility cost report. It also identifies some figures from a completed cost report. These calculated fields (e.g., Worksheet B, column 18) are needed to verify the mathematical accuracy of the raw data elements and to isolate differences between the file submitted by the skilled nursing facility complex and the report produced by the fiscal intermediary. Where an adjustment is made, that record must be present in the electronic data file. For explanations of the adjustments required, refer to the cost report instructions.

Table 3 "Usage" column is used to specify the format of each data item as follows:

9	Numeric, greater than or equal to zero.
-9	Numeric, may be either greater than, less than, or equal to zero.
9(x).9(y)	Numeric, greater than zero, with x or fewer significant digits to the left of the decimal point, a decimal point, and exactly y digits to the right of the decimal point.
X	Character.

Consistency in line numbering (and column numbering for general service cost centers) for each cost center is essential. The sequence of some cost centers does change among worksheets. Refer to Table 4 for line and column numbering conventions for use with complexes that have more components than appear on the preprinted Form HCFA 2540-96.

Table 3 refers to the data elements needed from a standard cost report. When a standard line is subscripted, the subscripted lines must be numbered sequentially with the first subline number displayed as "01" or "1" in field locations 14-15. It is unacceptable to format in a series of 10, 20, or skip subline numbers (i.e., 01, 03), except for skipping subline numbers for prior year cost center(s) deleted in the current period or initially created cost center(s) no longer in existence after cost finding. Exceptions are specified in this manual. For “Other (specify)” lines, i.e., Worksheet settlement series, all subscripted lines must be in sequence and consecutively numbered beginning with subscripted line “01". Automated systems must reorder these numbers where the provider skips a line number in the series.

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

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

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

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
WORKSHEET S				
Part II: Balances due provider or program:				
Title V	1, 3-6	1	9	-9
Title XVIII, Part A	1, 4	2	9	-9
Title XVIII, Part B	1, 4-6	3	9	-9
Title XIX	1, 3-6	4	9	-9
In total	7	1-4	9	-9
WORKSHEET S-2				
For the skilled nursing facility only:				
Street	1	1	36	X
P.O. Box	1	2	9	X
City	2	1	36	X
State	2	2	2	X
Zip Code	2	3	10	X
County	3	1	36	X
MSA Code	3	2	4	9
Urban/Rural	3	3	1	X
Facility Specific Rate	3.1	1	11	9(8).99
Transition period	3.1	2	3	9(3)
Wage Index Adjustment Factor - Before October 1	3.2	1	6	9.9(4)
Wage Index Adjustment Factor - After September 30	3.2	2	6	9.9(4)
For the skilled nursing facility and SNF-based components:				
Component name	4, 6, 8, 10-12	1	36	X
Provider number (xxxxxx)	4, 6, 8, 10-12	2	6	X
Date certified (MM/DD/YYYY)	4, 6, 8, 10-12	3	10	X

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

WORKSHEET S-2 (Continued)

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
If this facility contains a public or non-public provider that qualifies for an exemption from the application of the lower of costs or charges, enter "Y" for each component and type of service that qualifies for the exemption. Enter "N" for each component and type of service contained in this facility that does not qualify for the exemption.				
Skilled Nursing Facility	33	1-2	1	X
Nursing Facility	35	3	1	X
I C F - M R	35.1	3	1	X
SNF-Based OLTC	36	1-2	1	X
SNF-Based HHA	37	1-2	1	X
SNF-Based Outpatient Rehabilitation Providers	39	2	1	X
SNF-Based RHC	40	2	1	X
Is this skilled nursing facility exempt from the cost limits? (Y/N)	41	1	1	X
Is this nursing facility exempt from the cost limits? (Y/N)	42	1	1	X
Is the skilled nursing facility located in a state that certifies the provider as an SNF regardless of the level of care given for titles V and XIX patients? (Y/N)	43	1	1	X
Did the provider participate in the NHCMQ Demonstration during the cost reporting period? (Y/N)	44	1	1	X
If yes, enter phase number.	44	0	2	9

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

WORKSHEET S-2 (Continued)

DESCRIPTION	LINE(S)	COLUMN (S)	FIELD SIZE	USAGE
List malpractice premium and paid losses				
Premium:	45	1	11	9
Paid Losses:	45	2	11	9
Self Insurance:	45	3	11	9
Are malpractice premiums and paid losses reported in other than the Administrative and General cost Center? If yes, check box, and submit supporting schedules listing cost centers and amounts contained therein.	46	1	1	X
Are you claiming ambulance costs? Enter Y or N in column 1. If column 1 is Y, and this is your first year of operation for rendering ambulance services, enter Y in column 2. If it is not enter N.	47	1 & 2	1	X
If line 47 column 1 is Y, and Column 2 is N, enter in column 1 the payment limit provided from your FI. 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 1.	48	1 & 2	9	9(6).99
Did you operate an Intermediate Care Facility for the Mentally Retarded (ICF/MR) under title XIX?	49	1	1	X
Did this facility report less than 1500 Medicare days in its previous year's cost report?	50	1	1	X
If line 50 is yes, did you file your previous year's cost report using the "simplified" step-down method of cost finding?	51	1	1	X
Is this cost report being filed under 42CFR 413.321, the simplified cost report?	52	1	1	X

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

WORKSHEET S-3, PART I

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Number of beds	1, 3-4, 8-9	1	9	9
Bed days available	1, 3-4, 8-9	2	9	9
Title V inpatient days	1, 3, 8-9	3	9	9
Title XVIII inpatient days	1, 8-9	4	9	9
Ambulance trips	10	4	9	9
Title XIX inpatient days	1, 3, 8-9	5	9	9
Other inpatient days	1, 3-4, 8-9	6	9	9
Total inpatient days	1, 3-4, 8-9	7	9	9
Title V discharges	1, 3, 8-9	8	9	9
Title XVIII discharges	1, 8-9	9	9	9
Title XIX discharges	1, 3, 8-9	10	9	9
Other discharges	1, 3-4,8-9	11	9	9
Total discharges	1, 3-4, 8-9	12	9	9
Title V average length of stay	1, 3, 8-9	13	9	9(6).99
Title XVIII average length of stay	1, 8-9	14	9	9(6).99
Title XIX average length of stay	1, 3, 8-9	15	9	9(6).99
Total average length of stay	1, 3-4, 8-9	16	9	9(6).99
Title V admissions	1, 3, 8-9	17	9	9
Title XVIII admissions	1, 8-9	18	9	9
Title XIX admissions	1, 3, 8-9	19	9	9
Other admissions	1, 3-4, 8-9	20	9	9
Total admissions	1, 3-4, 8-9	21	9	9
Full time equivalent employees on payroll	1, 3-5, 7-9	22	9	9(6).99
Full time equivalent nonpaid	1, 3-5, 7-9	23	9	9(6).99

workers

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

WORKSHEET S-3, PART II

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Reported salaries	2-5,8-14,17-21	1	9	9
Reclassification of salaries from Worksheet A-6	2-5,8-14,17-21	2	9	-9
Paid hours related to salary	1-5,8-14,17,18	4	9	9(6).99
Data source	2-5, 18	6	36	X
Subtotal (see instructions):				
Reported salaries	22	1	9	9
Reclassification of salaries	22	2	9	-9
Total (see instructions):				
Reported salaries	23	1	9	9
Reclassification of salaries	23	2	9	-9
Paid hours related to salary	23	4	9	9(6).99
Contract labor: physician services - Part A:				
Reported salaries	24	1	9	9
Reclassification of salaries	24	2	9	-9
Paid hours related to salary	24	4	9	9(6).99
Data source	24	6	36	X

WORKSHEET S-3, PART III

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Reclassification of salaries from Worksheet A-6	1-13	2	9	-9
Paid hours related to salary	1-13	4	9	9(6).99
Total (sum of lines 1-13)				
Reported salaries	14	1	9	9

Reclassification of salaries	14	2	9	-9
Paid hours related to salary	14	4	9	9(6).99

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

WORKSHEET S-4, PART I

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Number of HHA visits, by discipline:				
Program	1-6	2	9	9
Non-Program	1-7	5	9	9
Patient count, by discipline:				
Program	1-6	3	9	9
Non-Program	1-7	6	9	9
Total	1-7	9	9	9
Home health aide hours:				
Program	6	1	9	9
Non-Program	6	4	9	9
Unduplicated census count:				
Program	9	3	9	9.99
Non-Program	9	6	9	9.99
In total	9	9	9	9.99
Unduplicated census count Pre October 1,2000:				
Program	9.01	3	9	9.99
Non-Program	9.01	6	9	9.99
In total	9.01	9	9	9.99
Unduplicated census count Post September 30, 2000				
Program	9.02	3	9	9.99
Non-Program	9.0	6	9	9.99
In total	9.02	9	9	9.99

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

WORKSHEET S-4, PART II

Number of hours in a normal work week	0	0	6	9(3).99
Text as needed for blank lines	13-15	0	36	X
Number of full time equivalent employees:				
Staff	1-15	1	6	9(3).99
Contract	1-15	2	6	9(3).99
How many MSA's did you provide services to during this cost reporting period?	16	1	2	9
List those MSA code(s) serviced this period.	17	1	4	X

WORKSHEET S-4, Part III

Covered Home Health Visits by Discipline for each Payment Category	1,3,5,7, 9.11	1-6	9	9
HH Charges by Discipline for each Payment Category	2,4,6,8, 10,12	1-6	9	9
Total Visits	13	1-6	9	9
Other Charges	14	1-6	9	9
Total Charges	15	1-6	9	9
Total number of episodes	16	1, 3-6	9	9
Total number of outlier episodes	17	2, 4-6	9	9
Total non-routine Medical supply charges for each payment category	18	1-6	9	9
Total HH visits by discipline for each payment category	1,3,5,7,9, 11	7	9	9
Total Medical supply charges for each payment category	2,4,6,8, 10,12	7	9	9
Total Visits	13	7	9	9
Other Charges	14	7	9	9
Total Charges	15	7	9	9
Total Number of Episodes	16	7	9	9
Total Number of Outlier Episodes	17	7	9	9
Total Medical Supply Charges	18	7	9	9

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

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
WORKSHEET S-5				
RHC/FQHC Identification:				
Street	1	1	36	X
County	1	2	36	X
City	2	1	36	X
State	2	2	2	X
Zip Code	2	3	10	X
Designation for FQHC's only "R" for rural or "U" for urban	3	1	1	X
Source of Federal funds:				
Amount of Federal Funds:	4-9	1	11	9
Award Date (MM/DD/YYYY)	4-9	2	10	X
Other (specify)	9	0	36	X
Physician(s) furnishing services at the clinic or under agreement				
Physician Name	10	1	36	X
Billing Number	10	2	36	X
Supervision				
Supervisory physician name	11	1	36	X
Number of hours of supervision during period	11	2	11	9(8).99
Does this facility operate as other than an RHC or FQHC?	12	1	1	X
Indicate number of operation(s)	12	2	2	9
Facility hours of operations *				
Clinic - Hours: from/to	13	1-14	4	9

* List hours of operations based on a 24 hour clock. For example 8:00 is 0800, 6:30pm is 1830, and midnight is 2400.

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

WORKSHEET S-5 (Continued)

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Other operations	13.01-13.10	0	36	X
Other operations - Hours: from/to	13.01-13.10	1-14	4	9
Have you received an approval for an exception to the productivity standard?	14	1	1	X
Is this a consolidated cost report in accor- dance with CMS Pub. 27, section 508D	15	1	1	X
Enter the number of providers included in this report	15	2	2	9
Provider Name	15.01-15.10	1	36	X
Provider Number	15.01-15.10	2	6	X
Have you provided all or substantially all GME cost?	16	1	1	X
Enter the number of Medicare visits performed by Interns and Residents	16	2	5	9

WORKSHEET S-6

Number of hours in a normal work week	0	0	6	9(3).99
Text as needed for blank lines	18-19	0	36	X
Number of full time equivalent employees on staff	1-19	1	6	9(3).99
Number of full time equivalent contract personnel	1-19	2	6	9(3).99

WORKSHEET S-7, PART I

Title XVIII NHCMQ Demonstration Statistical Data				
Rates (see instructions)	1-45	3, 4	6	9(3).99
Days (see instructions)	1-45	3.01, 4.01	6	9

WORKSHEET S-7, PART II

Rates (See instructions)	1-45	3,5	6	9(3).99
Medicare Days	1-45	4,6	6	9

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

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
WORKSHEET B, PART III				
Total Cost	16, 18-19, 21-33, 56, 59, 63	5	9	9
WORKSHEET B-1, PART I				
For each cost allocation using accumulated costs as the statistic, include a record containing an X.	0	4-15	1	X
All cost allocation statistics	1-16, 18-19, 21-51, 55-56, 58- 63, 66**	1-15*	9	9
Reconciliation	4-16, 18-19, 21-51, 55-56, 58-63**	4A-15A	9	-9
WORKSHEET B-1, PART II				
All cost allocation statistics	16, 18-19, 21-33, 56 59, 63	1-4	9	9
WORKSHEET B-2				
For post step-down adjustment:				
Description	1-58*	1	30	X
Worksheet B part number	1-58*	2	1	9
Worksheet A line number	1-58*	3	5	99.99
Amount of adjustment	1-58*	4	9	-9

* In each column using accumulated costs as the statistical basis for allocating costs, identify each cost center that is to receive no allocation with a negative 1 placed in the accumulated cost column. You may elect to indicate total accumulated cost as a negative amount in the reconciliation column. However, there should never be entries in both the reconciliation column and accumulated cost column simultaneously on the same line. For those cost centers that are to receive partial allocation of costs, provide only the cost to be excluded from the statistic as a negative amount on the appropriate line in the reconciliation column. If line 4 is fragmented, delete it and use subscripts of line 4.

** Line 34 in column 8 is shaded and is not used.

* On Worksheet B-2, if there are more than 58 lines needed, use multiple worksheets. (Refer to footnote (c) in Table 2.)

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

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
WORKSHEET C				
Total cost from Worksheet B, Part I, column 18, lines 21-36	75	1	9	9
Total charges by department	21-48	2	9	9
Total charges	75	2	9	9
WORKSHEET D, PART I				
Ancillary cost apportionment				
Part A program charges by department	21-48	2**	9	9
Part B program charges by department	21-36	3 *	9	9
Title XVIII charges on and after 1/1/98	25, 26, 27	6	9	9
Total program charges	75	2, 3 *	9	9
Total program costs	75	4, 5 *	9	9
WORKSHEET D, PART II				
Vaccine cost apportionment				
Program vaccine charges	2	1	9	9

* When completing Worksheet D, Part I, for titles V and/or XIX, do not use columns 3 and 5.

** Line 48 column 2 is ONLY used by titles V and XIX.

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

	DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
	WORKSHEET G-2 (Continued)				
	Outpatient rehabilitation provider	12	2	9	9
	Text as needed for blank line	13	0	36	X
	Other	13	1, 2	9	9
	Total patient revenues	14	1,2	9	9
Part II:	Text as needed for blank lines	2-7, 9-13	0	36	X
	Increases to operating expenses Reported on Worksheet A	2-7	1	9	9
	Decreases to operating expenses Reported on Worksheet A	9-13	1	9	9
	Total operating expenses	15	2	9	9
	WORKSHEET G-3				
	Contractual allowance and discounts on patients' accounts	2	1	9	9
	Other revenues	7-25	1	9	9
	Other expenses	28-30	1	9	9
	Text as needed for blank lines	25, 28-30	0	36	X
	Net income (loss)	32	1	9	-9
	WORKSHEET H				
	Salaries	3-24	1	9	9
	Employee Benefits	3-24	2	9	9
	Transportation costs	3-24	3	9	9
	Contracted/Purchased Services	3-24	4	9	9
	Other costs	1-24	5	9	9
	Text as needed for blank lines	22-24	0	36	X

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

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
WORKSHEET H-1				
Salaries and wages by discipline	3-11, 15-24	1-2, 4-7	9	9
Other salaries and wages	3-24	8	9	9
WORKSHEET H-2				
Employee benefits by discipline	3-11, 15-24	1-2, 4-7	9	9
Other employee benefits	3-24	8	9	9
WORKSHEET H-3				
Contracted/purchased services by discipline	3-11, 15-24	1-7	9	9
Other contracted/purchased services	3-24	8	9	9
WORKSHEET H-4, PART II				
Charges for home health services furnished by shared ancillary departments	1-7	1	9	9
WORKSHEET H-5, PART II				
Medicare visits - Parts A and B	1-6 (and Subscripts)	5-6	9	9
Medicare cost limits by discipline	8-13	4	6	9(8).99
Total charges for DME rented and sold and medical supplies	15, 15.01, 16	3	9	9
Charges for medical supplies - Medicare Parts A and B	15, 15.01	5-7	9	9
Charges for drugs - Medicare Part B	16	6-7	9	9

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

DESCRIPTION	LINE(S)	COLUMN	FIELD SIZE	USAGE
WORKSHEET H-5 Part II (Continued)				
Medicare unduplicated census count for each MSA	24-24.09	1	9	9(6).99
Medicare total unduplicated census count	25	1	9	9(6).99
Per beneficiary annual cost limit for each MSA	24-24.09	2	9	9(6).99
Medicare visits for services rendered before 1/1/98	26-28	3	9	9
Medicare visits for services rendered on and after 1/1/98	26-28	5	9	9
WORKSHEET H-6, PART I				
Total charges for title XVIII - Parts A and B services	2, 2.01	1-3	9	9
Amount collected from patients	3	1-3	9	9
Amount collectible from patients	4	1-3	9	9
Primary payer payments	7	1-3	9	9
WORKSHEET H-6, PART II				
PPS Reimbursement Amounts	8 – 8.14	1,2	9	9
Part B deductibles billed to Medicare patients	9	2	9	9
Coinsurance billed to Medicare patients	11	2	9	9
Reimbursable bad debts	13	1-2	9	9
Amounts applicable to prior periods	15	1-2	9	9
Recovery of excess depreciation	16	1-2	9	-9
Non-refunded excess charges to beneficiaries	17	1-2	9	9
Sequestration adjustment	19	1-2	9	9
Interim payments (titles V and XIX only)	21	1	9	9
Protested amounts	23	1-2	9	-9

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

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
WORKSHEET H-7				
Total interim payments paid to provider	1	2 & 4	9	9
Interim payments payable	2	2 & 4	9	9
Date of each retroactive lump sum adjustment (MM/DD/YYYY)	3.01-3.98	1 & 3	10	X
Amount of each lump sum adjustment				
Program to provider	3.01-3.49	2 & 4	9	9
Provider to program	3.50-3.98	2 & 4	9	9
WORKSHEET I-1				
Provider based cost	1-9, 11-13, 15-20, 23-27, 29-30	1,2,4,6, & 7	11	-9
WORKSHEET I-2				
Number of FTE personnel	1-3, & 5-7	1	6	9(3).99
Total visits	1-3, 5-7, & 9	2	11	9
Greater of columns 2 or 4	4	5	11	9
Parent provider overhead allocated to facility (see instructions)	17	1	11	9
WORKSHEET I-3				
Adjusted cost per visit	7	1	6	9(3).99
Maximum rate per visit (from your intermediary)	8	1 & 2	6	9(3.)99
Rate for program covered visits	9	1 & 2	6	9(3).99
Medicare covered visits excluding mental health services (from your intermediary)	10	1 & 2	11	9

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

WORKSHEET I-3

Medicare covered visits for mental health services (from your intermediary)	12	1 & 2	11	9
Beneficiary deductible (from your intermediary)	17	2	11	9
Reimbursable bad debt	22	2	11	9
Interim payments	25	2	11	9
Protested amounts	27	2	11	9

WORKSHEET I-5

Total interim payments paid to provider	1	2	11	9
Interim payments payable	2	2	11	9
Date of each retroactive lump sum adjustment (MM/DD/YYYY)	3.01-3.98	1	10	X
Adjustment of each retroactive lump sum adjustment:				
Program to provider	3.01-3.49	2	11	9
Provider to program	3.50-3.98	2	11	9

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

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
WORKSHEET J-1, PART I				
Net expenses for cost allocation	1-21	0	9	9
Post step down adjustments (including total)	1-22	17	9	-9
Totals (sum of lines 1-21)	22	0-3, 4-15, 17	9	9
WORKSHEET J-1, PART III				
Reconciliation	1-21	1A-15A	9	-9
Cost allocation statistics	1-21	1-15 *	9	9

* See note to Worksheet B-1 for treatment of administrative and general accumulated cost column.

WORKSHEET J-2					
Part I:	Facility charges				
	In total	2-21	2	9	9
	Title V	2-21	4	9	9
	Title XVIII	2-21	8 & 10	9	9
	Title XIX	2-21	6	9	9
Part II:	Charges for rehabilitation services furnished by shared departments				
	Title V	23-29	4	9	9
	Title XVIII	23-29	8 & 10	9	9
	Title XIX	23-29	6	9	9

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

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
WORKSHEET J-3				
Cost of component service	1	1-3	9	9
Cost of health service	1.01	1-3	9	9
PPS payment received	1.02	1-3	9	9
1996 SNF specific payment to cost ratio	1.03	1-3	4	999.99
Line 1.01 times line 1.03	1.04	1-3	9	9
Line 1.02 divided by line 1.04	1.05	1-3	4	999.99
Transitional corridor payment	1.06	1-3	9	9
Primary payment amounts	2	1-3	9	9
Part B deductible billed to program patients	4	2	9	9
Coinsurance billed	7	1-3	9	9
Reimbursable bad debts	9	1-3	9	9
Amounts applicable to prior periods resulting from depreciable asset disposal	11	1-3	9	9
Recovery of excess depreciation	12	1-3	9	9
Sequestration adjustment	14	1-3	9	9
Interim payments for titles V and XIX (where applicable)	16	1, 3	9	9
Protested amounts	18	1-3	9	-9
WORKSHEET J-4				
Total interim payments paid to provider	1	2	9	9
Interim payments payable	2	2	9	9
Date of each retroactive lump sum adjustment (MM/DD/YYYY)	3.01-3.98	1	10	X
Amount of each lump sum adjustment				
Program to provider	3.01-3.49	2	9	9
Provider to program	3.50-3.98	2	9	9

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

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
WORKSHEET K				
Salaries	3-33	1	11	9
Employee Benefits	3-33	2	11	9
Transportation	1-33	3	11	9
Contracted Services	3-33	4	11	9
Other Costs	1-33	5	11	9
Reclassification	1-33	7	11	9
Adjustments	1-33	9	11	9
WORKSHEET K-1				
Salaries and wages	3-33	1-7	11	9
All other	3-33	8	11	9
WORKSHEET K-2				
Employee Benefits	3-33	1-7	11	9
All other	3-33	8	11	9
WORKSHEET K-3				
Contracted services/purchased services	3-33	1-7	11	9
All other	3-33	8	11	9
WORKSHEET K-4, PARTS I & II				
Part I				
Total	34	1-4 & 5	11	9
Cost allocation	6-33	6	11	9
Part II				
Reconciliation	6-33	6A	11	-9
All cost allocation statistics	1-33	1-5*	11	9
WORKSHEET K-5, PART I,				
Allocated Hospice A&G	2-28	17	11	-9
Total Hospice Cost	2-28	18	11	-9
Total cost after finding	29	18	11	-9
WORKSHEET K-5, PART II,				
All Cost Allocation Statistics	1-28	1-3, 4-15	11	-9
WORKSHEET K-5, PART III				
Total Hospice Charges & Total Hospice Cost	1-8	5 & 7	11	-9
Total	9	7	11	-9

*See note to Worksheet B-1 for treatment of administrative and general accumulation cost column

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 SUBSCRIPTED (BEYOND THOSE PREPRINTED)

Worksheet	Lines
S, Part II	1, 3, 7
S-2	1-4, 6, 6.10, 7, 13-35, 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 SUBSCRIPTED (BEYOND THOSE PREPRINTED) (CONTINUED)

Worksheet	Lines
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	8, 12, 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)

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 2540-96

TABLE 3C - LINES THAT CANNOT BE SUBSCRIPTED (BEYOND THOSE PREPRINTED) (CONTINUED)

Worksheet	Lines
E, Part V	All
E-1	1, 2, 3.01-3.04, and 3.50-3.53
G	All
G-1	1
G-2, Part I	1, 3, and 4 (line 2 may not be used)
G-2, Part II	15
G-3	2, 7-24, and 32
H	All
H-1	All
H-2	All
H-3	All
H-5	All
H-6	1 through 19, 21 through 23
H-7	1, 2, 3.01-3.04, and 3.50-3.53
I-1	All
I-2	All
I-3	All
I-4	All
J-1	All
J-2	All
J-3	2 through 18
J-4	1, 2, 3.01-3.04, and 3.50-3.53
K-5, Part III	All

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 2540-96

TABLE 3D - PERMISSIBLE PAYMENT MECHANISMS

P = Prospective payment O = Other N = Not applicable

Component	Title V	Title XVIII	Title XIX
Skilled Nursing Facility	P or O	P	P or O
Nursing Facility	P or O	N	P or O
ICF/MR	N	N	O
SNF-Based OLTC	N	N	N
SNF-Based HHA	P or O	P	P or O
SNF-Based Outpatient Rehabilitation Provider	O	O	O
SNF-Based RHC	O	O	O
SNF-Based Hospice	N	N	N

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 2540-96

TABLE 3E - CORRELATION OF SUBSCRIPTINGS AMONG THE WORKSHEETS

WKST A	WKST A-8	WKST A-8-5-PT	WKST A-8-5-RT	WKST A-8-5-OT	WKST A-8-5-SP
24 (RT-Ancillary)	24 (RT-Ancillary)	N/A	77	N/A	N/A
24.01	24.01				
24.02	24.02				
24.03	24.03				
24.04	24.04				
24.05	24.05				
24.06	24.06				
24.07	24.07				
24.08	24.08				
24.09	24.09				
25 (PT-Ancillary)	25 (PT-Ancillary)	77	N/A	N/A	N/A
25.01	25.01				
25.02	25.02				
25.03	25.03				
25.04	25.04				
25.06	25.06				
25.07	25.07				
25.08	25.08				
25.09	25.09				
26 (OT-Ancillary)	26 (OT-Ancillary)	N/A	N/A	77	N/A
26.01	26.01				
26.02	26.02				
26.03	26.03				
26.04	26.04				
26.05	26.05				
26.06	26.06				
26.07	26.07				
26.08	26.08				
26.09	26.09				
27 (SP-Ancillary)	27 (SP-Ancillary)	N/A	N/A	N/A	77
27.01	27.01				
27.02	27.02				
27.03	27.03				
27.04	27.04				
27.05	27.05				
27.06	27.06				
27.07	27.07				
27.08	27.08				
27.09	27.09				

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 2540-96

TABLE 3E - CORRELATION OF SUBSCRIPTINGS AMONG THE WORKSHEETS

WKST A	WKST A-8	WKST A-8-5-PT	WKST A-8-5-RT	WKST A-8-5-OT	WKST A-8-5-SP
50 (CORF - Reimb) 50.01	22.01, 23.01, 24.01, 25.01	67, 73, 78 67.01,73.01, 78.01	67, 73, 78 67.01, 73.01, 78.01	67, 73, 78 67.01, 73.01, 78.01	67, 73, 78 67.01, 73.01, 78.01
50.10(CMHC-Reimb) 50.11	22.10, 23.10, 24.10, 25.10	68, 74, 79 68.10,74.10 79.10	68, 74, 79 68.10, 74.10 79.10	68, 74, 79 68.10, 74.10, 79.10	68, 74, 79 68.10, 74.10, 79.10
50.20 (OPT-Reimb) 50.21	22.20, 23.20, 24.20, 25.20	69, 75, 80 69.20,74.20, 79.20	69, 75, 80, 69.20,74.20, 79.20	69, 75, 80 69.20,74.20, 79.20	69, 75, 80 69.20,74.20, 79.20
50.30 (OOT-Reimb)	22.30, 23.30 24.30, 25.30	N/A	N/A	N/A	N/A
50.40 (OSP-Reimb)	22.40, 23.40, 24.40, 25.40	N/A	N/A	N/A	N/A
39(HHA-Reimb)	22.50, 23.50, 25.50	70, 76, 81, 70.01,76.01, 81.01	N/A	70. 76, 81 70.01, 76.01, 81.01	70, 76, 81 70.01,76.01, 81.01

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 2540-96

TABLE 4 - NUMBERING CONVENTION FOR MULTIPLE COMPONENTS

This table provides line and column numbering conventions for health care complexes with more than one SNF-based component of the same kind. Table 4 is necessary to ensure that data associated with each component are consistently identified throughout the cost report. For example, if there are four additional components, component II is subline .01, component III is .02, component IV is .03, and component V is .04. For outpatient rehabilitation providers other than CORFs, i.e., CMHCs, OPTs, OOTs, and OSPs, begin at a fixed subline for each type of outpatient rehabilitation provider, and increment that subscript by .01 for each additional outpatient rehabilitation provider of that type.

I. For use in facilities with more than one home health agency

	WKST.	PART	COLUMNS	LINES	SUBLINES
HHA II-V	S	II	1-4	4	1-4
HHA II-V	S-2		1-6	8	1-4
HHA II-V	S-3	I	22-23	5	1-4
HHA II-V	A		1-2, 7	37-47	1-4
HHA II-V	A-8		1-4	22.04, 23.04, 25.04 & 25.04	1-4
HHA II-V	B	I	18	37-47	1-4
HHA II-V	B	II	18	37-47	1-4
HHA II-V	B-1		1-15	37-47	1-4
HHA II-V	D-2		1	6	1-4
HHA II-V	G-2	I	2	8	1-4

II. For use in facilities with more than one comprehensive outpatient rehabilitation facility

	WKST.	PART	COLUMNS	LINES	SUBLINES
CORF II-IX	S	II	1, 3-4	5	1-8
CORF II-IX	S-2		1-6	10	1-8
CORF II-IX	S-3	I	22-23	7	1-8
CORF II-IX	A		1-2, 7	50	1-8
CORF II-IX	A-8		1-4	22.01, 23.01, 24.01 & 25.01	1-8
CORF II-IX	B	I	18	50	1-8

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 2540-96

TABLE 4 - NUMBERING CONVENTION FOR MULTIPLE COMPONENTS

II. For use in facilities with more than one comprehensive outpatient rehabilitation facility

	WKST.	PART	COLUMNS	LINES	SUBLINES
CORF II-IX	B	II	18	50	1-8
CORF II-IX	B-1		1-15	50	1-8
CORF II-IX	D-2		1	8	1-8
CORF II-IX	G-2	I	2	12	1-8

III. For use in facilities with more than one community mental health center

CMHC I-IX	S	II	1, 3-4	5	10-18
CMHC I-IX	S-2		1-6	10	10-18
CMHC I-IX	S-3	I	22-23	7	10-18
CMHC I-IX	A		1-2, 7	50	10-18
CMHC 1-IX	A-8		1-4	22.02, 23.02, 24.02 & 25.02	10-18
CMHC I-IX	B	I	18	50	10-18
CMHC I-IX	B	II	18	50	10-18
CMHC I-IX	B-1		1-15	50	10-18
CMHC I-IX	D-2		1	8	10-18
CMHC I-IX	G-2	I	2	12	10-18

IV. For use in facilities with more than one outpatient physical therapy facility

	WKST.	PART	COLUMNS	LINES	SUBLINES
OPT I-IX	S	II	1, 3-4	5	20-28
OPT I-IX	S-2		1-6	10	20-28
OPT I-IX	S-3	I	22-23	7	20-28
OPT I-IX	A		1-2, 7	50	20-28
OPT I-IX	A-8		1-4	22.03, 23.03, 24.03 & 25.03	20-28
OPT I-IX	B	I	18	50	20-28

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 2540-96

TABLE 4 - NUMBERING CONVENTION FOR MULTIPLE COMPONENTS

IV. For use in facilities with more than one outpatient physical therapy facility

	WKST.	PART	COLUMNS	LINES	SUBLINES
OPT I-IX	B	II	18	50	20-28
OPT I-IX	B-1		1-15	50	20-28
OPT I-IX	D-2		1	8	20-28
OPT I-IX	G-2	I	2	12	20-28

V. For use in facilities with more than one outpatient occupational therapy facility

OOT I-IX	S	II	1, 3-4	5	30-38
OOT I-IX	S-2		1-6	10	30-38
OOT I-IX	S-3	I	22-23	7	30-38
OOT I-IX	A		1-2, 7	50	30-38
OOT I-IX	B	I	18	50	30-38
OOT I-IX	B	II	18	50	30-38
OOT I-IX	B-1		1-15	50	30-38
OOT I-IX	D-2		1	8	30-38
OOT I-IX	G-2	I	2	12	30-38

VI. For use in facilities with more than one outpatient speech pathology facility

	WKST.	PART	COLUMNS	LINES	SUBLINES
OSP I-IX	S	II	1, 3-4	5	40-48
OSP I-IX	S-2		1-6	10	40-48
OSP I-IX	S-3	I	22-23	7	40-48
OSP I-IX	A		1-2, 7	50	40-48
OSP I-IX	B	I	18	50	40-48
OSP I-IX	B	II	18	50	40-48
OSP I-IX	B-1		1-15	50	40-48
OSP I-IX	D-2		1	8	40-48
OSP I-IX	G-2	I	2	12	40-48

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 2540-96

TABLE 5 - COST CENTER CODING

INSTRUCTIONS FOR PROGRAMMERS

Cost center coding is required because there are thousands of unique cost center names in use by providers. Many of these names are peculiar to the reporting provider and give no hint as to the actual function being reported. By using codes to standardize meanings, practical data analysis becomes possible. The methodology to accomplish this must be rigidly controlled to enhance accuracy.

For any added cost center names (the preprinted cost center labels must be precoded), the preparers must be presented with the allowable choices for that line or range of lines from the lists of standard and nonstandard descriptions. They then select a description that best matches their added label. The code associated with the matching description, including increments due to choosing the same description more than once, is then appended to the user's label by the software.

Additional guidelines are:

- Do not allow any pre-existing codes for the line to be carried over.
- Do not precode all "Other" lines.
- For cost centers, the order of choice must be standard first, then specific nonstandard, and finally the nonstandard "Other . . ."
- For the nonstandard "Other . . .", prompt the preparer with "Is this the most appropriate choice?," and then offer the chance to answer yes or to select another description.
- Allow the preparers to invoke the cost center coding process again to make corrections.
- For the preparers' review, provide a separate printed list showing their added cost center names on the left with the chosen standard or nonstandard descriptions and codes on the right.
- On the screen next to the description, display the number of times the description can be selected on a given report, decreasing this number with each usage to show how many remain. The numbers are shown on the cost center tables.
- Do not change standard cost center lines, descriptions, and codes. The acceptable formats for these items are listed on page 35-551 of the Standard Cost Center Descriptions and Codes. The proper line number is the first two digits of the cost center code.

INSTRUCTIONS FOR PREPARERS

Cost center coding standardizes the meaning of cost center labels used by health care providers on the Medicare cost reporting forms. This coding methodology allows you to continue to use labels for cost centers that have meaning within your institution.

The four digit codes that must be associated with each label provide standardized meaning for data analysis. Normally, it is necessary to code only added labels because the preprinted standard labels are automatically coded by CMS approved cost report software.

Additional cost center descriptions are identified. These additional descriptions will hereafter be referred to as the nonstandard labels. Included with the nonstandard descriptions are "Other . . ." designations to provide for situations where no match in meaning can be found. Refer to Worksheet A, lines 15, 33, 36, 51, 56, and 63.

Both the standard and nonstandard cost center descriptions along with their cost center codes are shown on Table 5. The AUSE column on that table indicates the number of times that a given code can be used on one cost report. Compare your added label to the descriptions shown on the standard and nonstandard tables for purposes of selecting a code. Most CMS approved software provides an automated process to present you with the allowable choices for the line/column being coded and automatically associates the code for the selected matching description with your label.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 2540-96
TABLE 5 - COST CENTER CODING

Additional Guidelines

Categories

Make a selection from the proper category such as general service description for general service lines, special purpose cost center descriptions for special purpose cost center lines, etc.

Use of a Cost Center Coding Description More Than Once

Often a description from the standard or nonstandard tables applies to more than one of the labels being added or changed by the preparer. In the past, it was necessary to determine which code was to be used and then increment the code number upwards by one for each subsequent use. This was done to provide a unique code for each cost center label. Now, most approved software associate the proper code, including increments as required, once a matching description is selected. Remember to use your label. You are matching to CMS's description only for coding purposes.

Cost Center Coding and Line Restrictions

Use cost center codes only in designated lines in accordance with the classification of cost center(s), e.g., lines 58 through 63 may only contain cost center codes within the nonreimbursable services cost center category of both standard and nonstandard coding.

Multiple SNF-Based Home Health Agencies

Form CMS 2540-96 provides preprinted labels for one HHA on lines 37-47. If you must report two or more HHAs, lines 37-47 must be subscripted as needed. After your label for the first HHA is entered, the standard descriptions for HHA cost centers is selected. Then enter your label for the second HHA on subscripted lines 37.01, 38.01, etc. The appropriate description is again selected as the correct match. The standard code, e.g., 3700, incremented by one, e.g., 3701, is applied to the second HHA. Additional HHAs are handled in the same manner.

Outpatient Rehabilitation Facilities

Form CMS 2540-96 provides a preprinted labels for one outpatient rehabilitation facility on line 50. Where you must report two or more CORFs, line 50 must be subscripted as needed. After your label for the first CORF is entered, the standard description for the CORF cost center is selected. Then enter your label for the second CORF on subscripted line 50.01. The appropriate description is again selected as the correct match. The standard code, i.e. 5000, incremented by one, i.e., 5001, is applied to the second CORF. Additional CORFs are handled in the same manner.

For SNF-based outpatient rehabilitation facilities other than CORFs, you must subscript line 50 as outlined in Table 4. Select the standard description and cost center code for the appropriate cost center. For example, if you have a SNF-based outpatient physical therapy facility, enter label for the first OPT on line 50.20. Select the standard description for the OPT cost center, with the standard code 5020. Where you must report two or more OPTs, enter the label for the second OPT on line 50.21. Select the appropriate description for the OPT cost center, incrementing the standard code by one, i.e., 5021. Additional OPTs are handled in the same manner.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 2540-96

TABLE 5 - COST CENTER CODING

STANDARD COST CENTER DESCRIPTIONS AND CODES

	CODE	USE
GENERAL SERVICE COST CENTERS		
CAP REL COSTS - BLDGS & FIXTURES	0100	(100)
CAP REL COSTS - MOVABLE EQUIPMENT	0200	(100)
EMPLOYEE BENEFITS	0300	(100)
ADMINISTRATIVE & GENERAL	0400	(100)
PLANT OPERATION, MAINT. & REPAIRS	0500	(100)
LAUNDRY & LINEN SERVICE	0600	(100)
HOUSEKEEPING	0700	(100)
DIETARY	0800	(100)
NURSING ADMINISTRATION	0900	(100)
CENTRAL SERVICES & SUPPLY	1000	(100)
PHARMACY	1100	(100)
MEDICAL RECORDS & LIBRARY	1200	(100)
SOCIAL SERVICE	1300	(50)
INTERNS & RESIDENTS (APPRVD PROGRAM)	1400	(100)
INPATIENT ROUTINE SERVICE COST CENTERS		
SKILLED NURSING FACILITY	1600	(01)
NURSING FACILITY	1800	(01)
INTERMEDIATE CARE FACILITY/ MENTALLY RETARDED	1810	(01)
OTHER LONG TERM CARE	1900	(01)
ANCILLARY SERVICE COST CENTERS		
RADIOLOGY	2100	(100)
LABORATORY	2200	(100)
INTRAVENOUS THERAPY	2300	(10)
OXYGEN (INHALATION) THERAPY	2400	(10)

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 2540-96

TABLE 5 - COST CENTER CODING

STANDARD COST CENTER DESCRIPTIONS AND CODES (CONTINUED)

	CODE	USE
ANCILLARY SERVICE COST CENTERS (CONTINUED)		
PHYSICAL THERAPY	2500	(10)
OCCUPATIONAL THERAPY	2600	(10)
SPEECH PATHOLOGY	2700	(10)
ELECTROCARDIOLOGY	2800	(100)
MEDICAL SUPPLIES CHARGED TO PATIENTS	2900	(100)
DRUGS CHARGED TO PATIENTS	3000	(50)
DENTAL CARE - TITLE XIX ONLY	3100	(100)
SUPPORT SURFACES	3200	(100)
OUTPATIENT SERVICE COST CENTERS		
CLINIC	3400	(10)
RURAL HEALTH CLINIC	3500	(10)
OTHER REIMBURSABLE COST CENTERS		
ADMINISTRATIVE & GENERAL - HHA	3700	(05)
SKILLED NURSING CARE - HHA	3800	(05)
PHYSICAL THERAPY - HHA	3900	(05)
OCCUPATIONAL THERAPY - HHA	4000	(05)
SPEECH PATHOLOGY - HHA	4100	(05)
MEDICAL SOCIAL SERVICES - HHA	4200	(05)
HOME HEALTH AIDE - HHA	4300	(05)
DME RENTED - HHA	4400	(05)
DME SOLD - HHA	4500	(05)
HOME DELIVERED MEALS - HHA	4600	(05)
OTHER HOME HEALTH SERVICES - HHA	4700	(05)

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 2540-96

TABLE 5 - COST CENTER CODING

STANDARD COST CENTER DESCRIPTIONS AND CODES (CONTINUED)

	CODE	USE
OTHER REIMBURSABLE COST CENTERS (CONTINUED)		
AMBULANCE	4800	(01)
INTERNS AND RESIDENTS (NOT APPROVED)	4900	(01)
CORF	5000	(10)
CMHC	5010	(10)
OPT	5020	(10)
OOT	5030	(10)
OSP	5040	(10)
SPECIAL PURPOSE COST CENTERS		
MALPRACTICE PREMIUMS & PAID LOSSES	5200	(01)
INTEREST EXPENSE	5300	(01)
UTILIZATION REVIEW - SNF	5400	(01)
HOSPICE	5500	(03)
NONREIMBURSABLE COST CENTERS		
GIFT, FLOWER, COFFEE SHOPS & CANTEEN	5800	(100)
BARBER & BEAUTY SHOP	5900	(100)
PHYSICIANS' PRIVATE OFFICES	6000	(100)
NONPAID WORKERS	6100	(50)
PATIENTS' LAUNDRY	6200	(100)

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 2540-96

TABLE 5 - COST CENTER CODING

NONSTANDARD COST CENTER DESCRIPTIONS AND CODES

	CODE	USE
GENERAL SERVICE COST CENTERS		
Other General Service Cost Centers	1350	(50)
ANCILLARY SERVICE COST CENTERS		
Other Ancillary Service Cost Centers	3050	(50)
OUTPATIENT SERVICE COST CENTERS		
Other Outpatient Service Cost Centers	3450	(50)
OTHER REIMBURSABLE COST CENTERS		
Other Reimbursable Cost Centers	4750	(50)
SPECIAL PURPOSE COST CENTERS		
Other Special Purpose Cost Centers	5350	(50)
NONREIMBURSABLE COST CENTERS		
Other Nonreimbursable Cost Centers	6150	(50)

ELECTRONIC COST REPORTING SPECIFICATIONS FOR FORM CMS 2540-96

TABLE 6 - EDITS

Medicare cost reports submitted electronically must meet a variety of edits. These include mathematical accuracy edits, certain minimum file requirements, and other data edits. Any vendor software that produces an electronic cost report file for Medicare skilled nursing facilities must automate all of these edits. Failure to properly implement these edits may result in the suspension of a vendor's system certification until corrective action is taken. The vendor's software should provide meaningful error messages to notify the skilled nursing facility of the cause of every exception. The edit message generated by the vendor systems must contain the related 4 digit and 1 alpha character, where indicated, reject/edit code specified below. Any file submitted by a provider containing a level I edit will be rejected by the fiscal intermediary, without exception.

The edits are applied at two levels. Level I edits (1000 series reject codes) are those that test the format of the data to identify for correction those error conditions that result in a cost report rejection. These edits also test for the presence of some critical data elements specified in Table 3. Level II edits (2000 series edit codes) identify potential inconsistencies and/or missing data items. Resolve these items and submit appropriate worksheets and/or data supporting the exceptions with the cost report. Failure to submit the appropriate data with your cost report may result in payments being withheld pending resolution of the issue(s).

The vendor requirements (above) and the edits (below) reduce both intermediary processing time and unnecessary rejections. Vendors should develop their programs to prevent their client skilled nursing facilities from generating either a hard copy substitute cost report or electronic cost report file where level I edit conditions exist. Ample warnings should be given to the provider where level II edit conditions are violated.

NOTE: Dates in brackets [ ] at end of edit indicate effective date of that edit for cost reporting periods ending on or after that date.

Edits that affect only a "full" cost report (i.e., not filed under the "simplified" method) are identified with the letter "A" after the edit. Edits that affect only cost reports filed under the "simplified" method are identified with the letter "B" after the edit. Edits with neither an "A" or "B" are applicable to both the full SNF cost report and the "simplified" SNF cost report.

I. Level I Edits (Minimum File Requirements)

Reject Code	Condition
1000	The first digit of every record must be either 1, 2, 3, or 4 (encryption code only).[03/31/1998]
1005	No record may exceed 60 characters. [03/31/1997]
1010	All alpha characters must be in upper case. This is exclusive of the encryption code, type 4 record, record numbers 1, 1.01, and 1.02. [03/31/1998]
1015	For micro systems, the end of record indicator must be a carriage return and line feed, in that sequence. [03/31/1997]
1020	The skilled nursing facility provider number (record #1, positions 17-22) must be valid and numeric. [10/31/1998]
1025	All dates (record #1, positions 23-29, 30-36, 45-51, and 52-58) must be in Julian format and legitimate. [10/31/1998]

ELECTRONIC COST REPORTING SPECIFICATIONS FOR FORM CMS 2540-96
TABLE 6 - EDITS

Reject Code	Condition
1030	The fiscal year begin date (record #1, positions 23-29) must be less than or equal to the fiscal year end date (record #1, positions 30-36). [10/31/1998]
1035	The vendor code (record #1, positions 38-40) must be a valid code. [03/31/1997]
1050	The type 1 record # 1 must be correct and the first record in the file [03/31/1997]
1055	All record identifiers (positions 1-20) must be unique (HCRS # 2000).
NOTE:	The FI should attempt to correct this condition in its working copy and continue processing the cost report. If the condition is correctable, notify the provider's vendor and send a copy of the ECR file to both the vendor and CMS Central Office. CMS Central Office will require a vendor software update to resolve the condition. [03/31/1997]
1060	Only a Y or N is valid for fields which require a Yes/No response. {03/31/97]
1065	Variable column (Worksheet B, Parts I and II and Worksheet B-1) must have a corresponding type 2 record (Worksheet A label) with a matching line number. (A) [03/31/1997] Variable column (Worksheet B, Part III and Worksheet B-1, Part II) must have a corresponding type 2 record (Worksheet A label) with a matching line number. (B)
1070	All line, subline, column, and subcolumn numbers (positions 11-13, 14-15, 16-18, and 19-20, respectively) must be numeric, except as noted below for reconciliation columns. [03/31/1997]
NOTE:	If the administrative and general (A&G) cost center (Worksheet A, line 4) is fragmented into two or more cost centers, then line 4 must be deleted. Fragmented A&G lines must begin with subscripted line 4.01 and continue in sequential order. Line numbers may be skipped, but must be in sequential order, e.g., 4.01, 4.02, 4.04, etc. is permissible. Any cost center with accumulated costs as its statistic must have its Worksheet B-1 reconciliation column numbered the same as its Worksheet A line number followed by an "A" as part of the line number followed by the subline number. [03/31/1997]

Reject Code	Condition
1075	Cost center integrity for variable worksheets must be maintained throughout the cost report. For subscripted lines, the relative position must be consistent throughout the cost report. [03/31/1997]
1080	For every line used on Worksheets A, B, C, and D, there must be a corresponding type 2 record. [03/31/1997]
1090	Fields requiring numeric data (charges, costs, FTEs, etc.) may not contain any alpha character. [03/31/1997]
1100	In all cases where the file includes both a total and the parts that comprise that total, each total must equal the sum of its parts. [03/31/1997]

ELECTRONIC COST REPORTING SPECIFICATIONS FOR FORM CMS 2540-96
TABLE 6 - EDITS

Reject Code	Condition
1005S	The cost report ending date (Worksheet S-2, column 2, line 13) must be on or after 3/31/97. [03/31/1997]
1010S	All provider and component numbers displayed on Worksheet S-2, column 2, lines 4, 6-8, and 10-12, must contain six (6) alphanumeric characters. [03/31/1997]
1015S	The cost report period beginning date (Worksheet S-2, column 1, line 13) must precede the cost report ending date (Worksheet S-2, column 2, line 13). [03/31/1997]
1020S	The skilled nursing facility name, provider number, certification date, and Title XVIII payment mechanism (Worksheet S-2, line 4, columns 1, 2, 3, and 5, respectively) must be present and valid. [03/31/1997]
1030S	For each provider name reported (Worksheet S-2, column 1, lines 4, 6, 6.10, 8, and 10-12), there must be corresponding entries made on Worksheet S-2, lines 4, 6, 6.10, 8, and 10-12 for the provider number (column 2), the certification date (column 3), and the payment system for either Titles V, XVIII, or XIX (columns 4, 5, or 6, respectively) indicated with a valid code (P, O, or N). (See Table 3D.) [03/31/1997]
1035S	On Worksheet S-2, there must be a response in every file in column 1, lines 13-18, 22, 28-32, and 41-44, 46-49, and 52. For provider names reported (Worksheet S-2, column 1, lines 4, 6, 6.10, 7, 8, and 10), there must be corresponding entries made on Worksheet S-2, column 1, lines 33, 36, 37; in column 2, lines 33, 36, 37, 39, and 40; and in column 3, line 35, and 35.10. If any of lines 37, 39, or 40 have been subscripted, there must be a response in the appropriate columns for each subscripted line. [09/30/1998] (A) On Worksheet S-2, there must be a response in every file in column 1, lines 13 & 14, 28-44, and 46 & 48. For provider's name reported (Worksheet S-2, column 1, line 4,), there must be a corresponding entry made on Worksheet S-2, columns 1 and 2, line 33. (B)
1040S	If Worksheet S-2, column 1, line 47 equals "Y" and column 2, line 47 equals "N" and the provider's cost reporting period begins other than October 1st, Worksheet S-2, columns 1 and 2 line 48 must be greater than zero. However, if Worksheet S-2, column 2, line 47 equals "Y" this edit should be ignored. [11/30/1999] (A)
1045S	If Worksheet S-2, column 1, line 47 equals "Y" and column 2, line 47 equals "N" and the cost reporting period begins on October 1st, Worksheet S-2, column 1, line 48 must be greater than zero, and no entry should be made in column 2. However, if Worksheet S-2, column 2, line 47 equals "Y" this edit should be ignored. [11/30/1999] (A)
1050S	If Worksheet S-2, lines 50 and 51 equals "N" , than line 52 must also be "N". (A) Line 52 can only be "Y" if lines 50 and 51 are "Y". [02/28/2001] (B)

ELECTRONIC COST REPORTING SPECIFICATIONS FOR FORM CMS 2540-96

TABLE 6 - EDITS

Reject Code	Condition
1075S	All amounts reported on Worksheet S-3, Part I must not be less than zero. [03/31/1997]
1080S	For Worksheet S-3, Part I, the sum of the inpatient days in columns 3-6 for each of lines 1, 3, and 4 must be equal to or less than the total inpatient days in column 7 for each line. [03/31/1997]
1100S	The amount of hours reported in column 4, lines 1-13 (Worksheet S-3, Part III) must be greater than or equal to zero. [03/31/1997]
1105S	For Worksheet S-3, Part I, the sum of the discharges in columns 8-11 for each of lines 1, 3, and 4 must be equal to or less than the total discharges in column 12 for each line indicated. [03/31/1997]
1110S	Worksheet S-3, Part II, columns 1 and 4, line 23 must be greater than zero. [03/31/1997]

ELECTRONIC COST REPORTING SPECIFICATIONS FOR FORM CMS 2540-96

TABLE 6 - EDITS

Reject Code	Condition

The following Wage Index edits are to be applied against PPS SNFs only, edit number 1200S, 1205S, and 1220S.

1200S	For Worksheet S-3, Part II, sum of columns 1 and 2 each of lines 2-5, 8-14, 17-21, and subscripts as applicable must be equal to or greater than zero. [01/31/2001]
1205S	The amount of salaries reported for Interns & Residents in approved programs Worksheet S-3, Part II column 1, line 4 must be equal to or greater than the amount on Worksheet A, column 1 line 14 (including subscripts). [09/30/1998]
1220S	Worksheet S-3, Part II, sum of columns 1 & 2, line 19 must be greater than zero. [09/30/1998]
1000A	Worksheet A, columns 1 and 2, line 75 must be greater than zero. [03/31/97]
1015A	On Worksheet A, lines 52 and 53, the sum of column 2 and the corresponding reclassifications and adjustments must equal zero. On line 54, the sum of columns 1 and 2 and the corresponding reclassifications and adjustments must equal zero. [03/31/1997]
1020A	For reclassifications reported on Worksheet A-6, the sum of all increases (columns 4 and 5) must equal the sum of all decreases (columns 8 and 9). [03/31/1997]
1025A	For each line on Worksheet A-6, if there is an entry in column 3, 4, 5, 7, 8, or 9, there must be an entry in column 1. There must be an entry on each line of columns 4 and/or 5 for each entry in column 3 (and vice versa), and there must be an entry on each line of columns 8 and/or 9 for each entry in column 7 (and vice versa). All entries must be valid, for example, no salary adjustments in columns 3 and/or 7, for capital lines 1 & 2 of Worksheet A. [09/30/1998]
1040A	For Worksheet A-8 adjustments on lines 1-7, 9-11, and 13-21, if either columns 2 or 4 has an entry, then columns 1, 2, and 4 must have entries, and if any one of columns 0, 1, 2, or 4 for line 31 (and subscripts of line 31) has an entry, then all columns 0, 1, 2, and 4 must have entries. [03/31/1997]
1045A	If there are any transactions with related organizations or home offices as defined in CMS Pub. 15-I, chapter 10 (Worksheet A-8-1, Part A, line 1, column 1, is "X"), Worksheet A-8-1, Part B, columns 4 or 5, sum of lines 1-9 must be greater than zero; and Part C, column 1, any one of lines 1-10 must contain any one of alpha characters A through G. Conversely, if Worksheet A-8-1, Part A, line 1, column 2, is "X," Worksheet A-8-1, Parts B and C must not be completed. [03/31/1997]
1050A	On Worksheet A-8-2, the sum of columns 4 and 5 must equal the corresponding line of column 3 and column 6, or column 7 must be greater than zero if column 3 or 5 is greater than zero. [10/31/1998]

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Reject Code	Condition
1055A	Worksheet A-8-3, column 1, line 56 must equal the sum of column 1, lines 58 and 59. [03/31/1997]
1060A	If Worksheet A-8-5, column 5, line 47 is equal to zero, column 5, line 51 must also be equal to zero. Conversely, if Worksheet A-8-5, columns 1-4, line 47 is greater than zero, column 5, line 51 must be greater than column 5, line 47 and equal to or less than 2080 hrs. [10/31/1998]
1000B	On Worksheet B-1, all statistical amounts must be greater than or equal to zero, except for reconciliation columns. [03/31/1997] (A): On Worksheet B-1, Part II, all statistical amounts must be greater than or equal to zero, except for reconciliation columns. [02/01/2001] (B)
1005B	Worksheet B, Part I, column 18, line 75 must be greater than zero. [03/31/1997]
1010B	For each general service cost center with a net expense for cost allocation greater than zero (Worksheet A, column 7, lines 1-15), the corresponding total cost allocation statistics (Worksheet B-1, column 1, line 1; column 2, line 2; etc.) must also be greater than zero. Exclude from this edit any cost center that uses accumulated cost as its basis for allocation. [03/31/1997]
1015B	For any column which uses accumulated cost as its basis of allocation (Worksheet B-1), there may not simultaneously exist on any line an amount both in the reconciliation column and the accumulated cost column, including a negative one. [03/31/1997]
1010C	On Worksheet C, all amounts in column 1 line 75 and column 2 must be greater than or equal to zero. [03/31/1997]
1000D	On Worksheet D, all amounts must be greater than or equal to zero. [03/31/1997]
1020H	Total visits on Worksheet H-5, Part I, sum of column 3 lines 1-6 must be equal to or greater than unduplicated census count, Worksheet S-4, column 8, line 9. [10/31/1998]
1030H	The sum of Worksheet H-5, Part IV, column 1, line 25 must be equal to or greater than Worksheet S-4, column 3, line 9. [10/31/1998]
1000J	Worksheet J-1, Part I, sum of columns 0-3, 4-15, and 17, line 22, must equal the corresponding Worksheet B, column 18, line 50 or appropriate subscript as identifies this provider type. [03/31/1997]

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TABLE 6 - EDITS

II. Level II Edits (Potential Rejection Errors)

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

Edit	Condition
2000	All type 3 records with numeric fields and a positive usage must have values equal to or greater than zero (supporting documentation may be required for negative amounts).
2005	Only elements set forth in Table 3, with subscripts as appropriate, are required in the file.
2010	The cost center code (positions 21-24) (type 2 records) must be a code from Table 5, and each cost center code must be unique (HCRIS #2085).
2015	Standard cost center lines, descriptions, and codes should not be changed. (See Table 5.) This edit applies to the standard line only and not subscripts of that code.
2020	All standard cost center codes must be entered on the designated standard cost center line and subscripts thereof as indicated in Table 5.
2025	Only nonstandard cost center codes within a cost center category may be placed on standard cost center lines of that cost center category.

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Edit	Condition

2030 The following standard cost centers listed below must be reported on the lines indicated and the corresponding cost center codes may appear only on the lines indicated. No other cost center codes may be placed on these lines or subscripts of these lines, unless indicated herein. [03/31/1997] (A)

Cost Center	Line	Code
CAP REL COSTS - BLDGS & FIXTURES	1	0100-0199
CAP REL COSTS - MOVABLE EQUIPMENT	2	0200-0299
EMPLOYEE BENEFITS	3	0300-0399
SKILLED NURSING FACILITY	16	1600
NURSING FACILITY	18	1800
INTERMEDIATE CARE FACILITY/MENTALLY RETARDED	18.1	1810
OTHER LONG TERM CARE	19	1900
ADMINISTRATIVE & GENERAL - HHA	37	3700-3704
SKILLED NURSING CARE - HHA	38	3800-3804
PHYSICAL THERAPY - HHA	39	3900-3904
OCCUPATIONAL THERAPY - HHA	40	4000-4004
SPEECH PATHOLOGY - HHA	41	4100-4104
MEDICAL SOCIAL SERVICES - HHA	42	4200-4204
HOME HEALTH AIDE - HHA	43	4300-4304
DME RENTED - HHA	44	4400-4404
DME SOLD - HHA	45	4500-4504
HOME DELIVERED MEALS - HHA	46	4600-4604
OTHER HOME HEALTH SERVICES - HHA	47	4700-4704
AMBULANCE	48	4800
INTERNS & RESIDENTS (NOT APPRVD)	49	4900
MALPRACTICE PREMIUMS & PAID LOSSES	52	5200
INTEREST EXPENSE	53	5300
UTILIZATION REVIEW - SNF	54	5400
HOSPICE	55	5500-5504
GIFT, FLOWER, COFFEE SHOPS & CANTEEN	58	5800-5899
BARBER & BEAUTY SHOP	59	5900-5999
PHYSICIANS= PRIVATE OFFICES	60	6000-6099
NONPAID WORKERS	61	6100-6149
PATIENTS= LAUNDRY	62	6200-6299

2035 Administrative and general cost center code 0400-0499 may appear only on line 4 and subscripts of line 4. [03/31/1997]

2040 All calendar format dates must be edited for 10 character format, e.g., 01/01/1996 (MM/DD/YYYY). [10/31/1998]

2045 All dates must be possible, e.g., no "00", no "30" or "31" of February. [03/31/1997]

2000S Worksheet S, Part II, sum of columns 2 and 3 for line 7 (title XVIII) should not equal zero. [03/31/1997]

2005S The combined amount due the provider or program (Worksheet S, Part II, line 7, sum of columns 1-4) should not equal zero. [03/31/1997]

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TABLE 6 - EDITS

Edit	Condition
2015S	The SNF certification date (Worksheet S-2, column 3, line 4) should be on or before the cost report beginning date (Worksheet S-2, column 1, line 13). [03/31/1997]
2020S	The length of the cost reporting period should be greater than 27 days and less than 459 days. [03/31/1997]
2045S	Worksheet S-2, line 14 (type of control) must have a value of 1 through 13. [03/31/1997]
2085S	The sum of column 1, lines 2-5, 8-14, 17-21, and 24 (Worksheet S-3, Part II) must be greater than zero. [03/31/1997]
2090S	The sum of column 4, lines 2-5, 8-14, 17-18, and 24 (Worksheet S-3, Part II) must be greater than zero. [03/31/1997]
2100S	Total days for the SNF (Worksheet S-3, Part I, column 7, line 9) should be greater than zero. [03/31/1997]
2105S	If Medicare SNF inpatient days (Worksheet S-3, Part I, column 4, line 1) is greater than zero, then the following fields on Worksheet S-3, Part I, should also be greater than zero. [03/31/1997] a. Total skilled nursing facility discharges (column 12, line 9); and b. Medicare SNF discharges (column 9, line 9)
2110S	Total SNF inpatient days (Worksheet S-3, Part I, column 7, lines 1 and 3) should be less than or equal to SNF bed days available (Worksheet S-3, Part I, column 2, lines 1 and 3)[03/31/1997].
2115S	If on Worksheet S-2, either of columns 4 or 6 for line 4 equals P or O, then the corresponding columns for line 6 must be blank or equal N and vice versa. This edit flags the existence of SNF and NF simultaneously for title V and/or title XIX services. [03/31/1997]
2125S	Worksheet S-3, Part II, column 1, lines 8 through 14 must equal the sum of all related lines on Worksheet A, column 1. [03/31/1997]
2150S	If Worksheet S-3, Part II (column 4, sum of lines 8 through 14 divided by the sum of line 1 minus the sum of lines 2 through 5) is greater than 5 percent, then Worksheet S-3, Part III, column 1, line 14 must equal the sum of the amounts on Worksheet A, column 1, lines 3 through 15. [03/31/1997]
2155S	If Worksheet S-3, Part II (column 4, sum of lines 8 through 14 divided by the sum of line 1 minus the sum of lines 2 through 5) is equal to or greater than 15 percent, then Worksheet S-3, Part III, columns 1 and 4 for line 14 should be greater than zero. [03/31/1997]

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TABLE 6 - EDITS

Edit	Condition
2160S	If Worksheet S-3, Part III, column 4, line 14 is greater than zero, then those hours should be at least 20 percent but not more than 60 percent of Worksheet S-3, Part II, column 4, line 1. [03/31/1997]
2000A	Worksheet A-6, column 1 (reclassification code) must be alpha characters. [03/31/1997]
2020A	Worksheet A-8-1, Part A, line 1, must contain an "X" in either columns 1 or 2. [03/31/1997]
2035A	For Worksheet A-7, line 7, the sum of columns 1-3 minus column 5 must be greater than zero. [03/31/1997]
	Column headings (Worksheets B-1; B, Parts I and II; and J-1, Part III) are required as indicated below. (A).
2000B	At least one cost center description (lines 1-3), at least one statistical basis label (lines 4-5), and one statistical basis code (line 6) must be present for each general service cost center with costs to allocate. This edit applies to all general service cost centers required and/or listed. [03/31/1997]
2005B	The column numbering among these worksheets must be consistent. For example, data in capital related costs - buildings and fixtures is identified as coming from column 1 on all applicable worksheets. [03/31/1997]
2000G	Total assets on Worksheet G (line 33, sum of columns 1-4) must equal total liabilities and fund balances (line 59, sum of columns 1-4). [03/31/1997]
2010G	Net income or loss (Worksheet G-3, column 1, line 32) should not equal zero. [03/31/1997]

NOTE: CMS reserves the right to require additional edits to correct deficiencies that become evident after processing the data commences and, as needed, to meet user requirements.