
Medicare

Provider Reimbursement Manual

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

Department of Health &
Human Services (DHHS)

Centers for Medicare &
Medicaid Services (CMS)

Transmittal 14

Date: April 2006

HEADER SECTION NUMBERS

PAGES TO INSERT

PAGES TO DELETE

3500.2 – 3504.2 (Cont.)	35-7 – 35-10.2 (6 pp.)	35-7 – 35-10.2 (6 pp.)
3508 – 3509.1 (Cont.)	35-13 – 35-18.1 (7 pp)	35-13 – 35-18 (6 pp)
3514.4 – 3515.2	35-24.3 – 35-24.6 (4 pp)	35-24.3 – 35-24.6 (4 pp)
3534.3 (Cont.) - 3534.4	35-73 – 35-76 (4 pp)	35-73 – 35-76 (4 pp)
3560.2 – 3560.2 (Cont.)	35-109 – 35-110.1 (3 pp)	35-109 – 35-110.1 (3 pp)
3590 (Cont.) – 3590 (Cont.)	35-303 – 35-304 (2 pp)	35-303 – 35-304 (2 pp)
	35-312.3 – 35-312.4 (2 pp)	35-312.3 – 35-312.4 (2 pp)
	35-355 – 35-356 (2 pp)	35-355 – 35-356 (2 pp)
3595 (Cont) – 3595 (Cont.)	35-503 – 35-504 (2 pp)	35-503 – 35-504 (2 pp)
	35-513 – 35-516.1 (5 pp)	35-513 – 35-516 (4 pp)
	35-518.1 – 35-518.2 (2 pp)	35-518.1 – 35-518.2 (2 pp)
	35-533 – 35-534 (2 pp)	35-533 – 35-534 (2 pp)
	35-539 – 35-548 (10 pp)	35-539 – 35-548 (10 pp)
	35-561 – 35-569 (9 pp)	35-561 – 35-569 (9 pp)

NEW/REVISED MATERIAL--EFFECTIVE DATE:

This transmittal updates Chapter 35 – Skilled Nursing Facility Cost Report Form CMS 2540-96. Provisions in section 3508 establish the use of a code for “Core Based Statistical Area” (CBSA), and is effective for services rendered on and after October 1, 2005. Provisions in section 3514.4 introduce additional RUGS for reimbursement, and are effective for services rendered on and after January 1, 2006. Section 3534.03 implements the reduction of bad debts, and is effective for cost reporting periods beginning on and after October 1, 2005.

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

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
<i>CBSA</i>	-	<i>Core-Based Statistical Area</i>
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
<i>DRA</i>	-	<i>Deficit Reduction Act of 2005</i>
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

<u>Step No.</u>	<u>Worksheet</u>	
1	S-2	Read §3508. Complete entire worksheet.
2	S-3, Parts I, II AND III	Read §3509. Complete entire worksheet.
<i>3</i>	<i>S-7</i>	<i>Read §3514.4. Complete Part IV</i>
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.

Step No.	Worksheet	
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 <u>separate</u> 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	<i>E-1</i>	<i>Complete lines 1-4.</i>
3	E, Part II	Read §§3534-3534.2. Complete through line 17 of this worksheet for title XVIII for each applicable provider.
4	<i>E-1</i>	<i>Complete lines 1-4.</i>
5	E, Part III	Read §§3534-3534.3. Complete through line 7 for Part A and lines 23 through 29 for Part B services.
6	<i>E-1</i>	<i>Complete lines 1-4.</i>
7	E, Part I	Complete remainder of this worksheet for each applicable health care component for each applicable provider component.

Step No.	Worksheet	
8	E, Part II	Complete remainder of this worksheet for each applicable health care component for each applicable provider component.
9	E, Part III	Complete the remainder of this worksheet.
10	S-4	Read §3511. Complete this worksheet when applicable.
11	H-1	Read §3540. Complete this worksheet when applicable.
12	H-2	Read §3541. Complete this worksheet when applicable.
13	H-3	Read §3542. Complete this worksheet when applicable.
14	H	Read §3539. Complete this worksheet where applicable.
15	H-6, Part I	Read §§3545-3545.1. Complete this worksheet when applicable.
16	H-6, Part II	Read §§3545-3545.2. Complete this worksheet when applicable.
17	S-5	Read §3512. Complete this worksheet when applicable.
18	I-1 through I-3	Read §§3556-3560.2. Complete these worksheets when applicable.
19	I-5	Read §3563. Complete this worksheet when applicable.
20	J-3	Read §3553. Complete this worksheet when applicable. A separate copy of this worksheet must be completed for each component.
21	S-8	Read §3515. Complete this worksheet when Applicable.
22	K-1	Read §3566. Complete this worksheet when applicable.
23	K-2	Read§3567. Complete this worksheet when applicable.

<u>Step No</u>	<u>Worksheet</u>	
24	K-3	Read §3568. Complete this worksheet when applicable.
25	K	Read §3565. Complete this worksheet when Applicable.
26	K-4	Read §3569. Complete this worksheet when Applicable.
27	K-5	Read §3570. Complete this worksheet when Applicable.
28	K-6	Read §3571. Complete this worksheet.
29	G	Read §3536. This step is completed by all providers maintaining fund type accounting records. Non-proprietary providers which do not maintain fund type records complete the General Fund column only.
30	G-1	Read §§3536.1. Complete entire worksheet.
31	G-2, Parts I & II	Read §§3536.2. Complete entire worksheet.
32	S, Parts I & II	Read §§3506-3506.2. Complete Part II entirely. Then complete Part I.

3504.2 Recommended Sequence for Completing an SNF Cost Report Under the Simplified Method - Less Than 1500 Medicare Days.--

<u>Step No.:</u>	<u>Worksheet</u>	
1	S-2	Read §3508. Complete lines 1 through 6, 13, 14, 20, 23 through 32, 43, 45 through 48, 50, 51 and 52.
2	S-3, Part I	Read §3509. Complete lines 1, 3 and 9.
3	S-3, Part II	Complete lines 1, 2, 3, 5 through 8, and 14 through 24.
4	S-3, Part III	Complete lines 1 through 11, 13 and 14.
5	S-7, Part IV	Read §3514.3 Complete Part IV only.

<u>Step No.:</u>	<u>Worksheet</u>	
6	A	Read §3516. Complete columns 1, 2 and 3. Complete lines 1 through 9, 16, 18, 19, 21 through 33, 54, 56, 59, 63 and 75..
7	A-6	Read §3517. Complete, if applicable.
8	A-7	Read §3518. Complete, if applicable.
9	A	Read §3516. Complete columns 4 and 5.
10	A-8-1	Read §3520. Complete Part A. If the answer to Part A is "Yes", complete Parts B and C.
11	A-8-3	Read §§3522-3522.7. Complete, if applicable.
12	A-8	Read §3519. Complete entire worksheet.
13	A	Read §3516. Complete columns 6 and 7.
14	B, Part III	Read §3525.1. Complete entire worksheet.
15	B-1, Part II	Read §3525.1. Complete entire worksheet.
16	C	Read §§3527. Complete lines 21 through 33, and line 75.
17	D, Part I	Read §3530. Complete lines 21 through 33, and line 75. A separate copy of this worksheet must be completed for each applicable health care program for each SNF and nursing facility (NF).
18	<i>E-1</i>	<i>Complete lines 1 - 4.</i>
19	E, Part III, Part A	Read §3534.3. Complete lines 7 through 18.
20	E, Part III, Part B	Read §3534.3. Complete lines 19, 20, 22, 23, 25 through 28, 31, and 33 through 38.
21	G	Read §3536. This step is completed by all providers maintaining fund type accounting records. Non-proprietary providers which do not maintain fund type records complete the General Fund column only.
22	G-1	Read §§3536.1. Complete entire worksheet.
23	G-2	Read §§3536.2. Complete entire worksheet.
24	G-3	Read §§3536.3. Complete entire worksheet.
25	S, Parts I & II	Read §3506.2. Complete Part II entirely. Then complete Part I.

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

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

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

Line 3.--Indicate the county *in column 1. Sub-script column 2. Enter in column 2* the MSA Code of this SNF. *Enter in column 2.01, the Core Based Statistical Area (CBSA) code. Enter in column 3,* a "U" or "R" designating urban or rural.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subscript line 15 in the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Line 48—*Use Worksheet S-2, line 48 columns 1 and 2 for the Limit and Fee amount respectively, and subscript line 48 for the time periods.* If line 47 column 1 is Y, and column 2 is N, enter on line 48 column 1 the payment limit provided from your fiscal intermediary. If your fiscal year is OTHER than a year beginning on October 1st, enter in column 1 the payment limit for the period prior to October 1, and enter in column 2 the payment limit for the period beginning October 1st. The per trip rate is updated October 1st of each year. Subscript this line as needed.

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

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

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

Line 50.-- Did this facility report less than 1500 Medicare days in its previous year’s cost report? Enter “Y” for yes or “N” for no. If a new provider is filing a first year cost report, and qualifies to file a “simplified” SNF cost report, do not enter “Y” or “N”.

Line 51.--If line 50 is yes, did you file your previous year’s cost report using the “simplified” step-down method of cost finding? (See §3500.) Enter “Y” for yes or “N” for no. If a new provider is filing a first year cost report, and qualifies to file a “simplified” SNF cost report, do not enter “Y” or “N”.

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

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

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

Column Descriptions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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.

NOTE: Effective for services on and after January 1, 2006, nine new RUGs are introduced into the reimbursement calculation on this worksheet. These new RUGs are: "RUX", "RUL", "RVX", "RVL", "RHX", "RHL", "RMX", "RML", and "RLX".

Subscript the lines on Worksheet S-7, Part IV to accommodate the following. Line 3.01 for "RUX", Line 3.02 for "RUL", Line 6.01 for "RVX", Line 6.02 for "RVL", Line 9.01 for "RHX", Line 9.02 for "RHL", Line 12.01 for "RMX", Line 12.02 for "RML", and Line 14.01 for "RLX". 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.

Instructions from this point to the end of the section are not applicable after January 1, 2006.

All SNF's which have elected the 100 percent Federal rate, or those that are on the 100 percent rate via the fourth transition year (or forward), should enter all days in column 3.01 with no calculations indicated. The amount previously indicated on line 46, column 5 is now to be entered on Worksheet E, Part III, line 7 as an input. However, this may not apply to SNF's in MSA's # 1123, 3810, and 7520, for cost reporting periods that overlap 12/01/01. Complete column 3.01.

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 *days* 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 October 1st to September 30th 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 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 follows:

Medicare Days (90 & 45 & 29) Patient (A, B & C)	164 days
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.

primary payer payment is not credited toward the beneficiary's deductible and coinsurance (situations 4 and 5). Primary payer payments that are credited toward the beneficiary's deductible and coinsurance are not entered on line 9.

Line 9.--Enter the Part A coinsurance billed to Medicare beneficiaries. Include any primary payer payments applied to Medicare beneficiaries' coinsurance in situations where the primary payer payments do not fully satisfy the obligation of the beneficiary to the provider. Do not include any primary payer payments applied to Medicare beneficiaries' coinsurance in situations where the primary payer payment fully satisfies the obligation of the beneficiary to the provider. DO NOT INCLUDE coinsurance billed to program patients for physicians' professional services.

Line 10.--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.

Line 10.01—Multiply the amount (including negative amounts) on line 10 by 100% for cost reporting periods beginning before 10/01/2005.

Line 10.02—Enter the gross reimbursable bad debts for full-benefit dual eligible individuals. This amount must also be included in the amount on line 10.

Line 10.03—DRA 2005 SNF Bad Debt – For cost reporting periods beginning on or after October 1, 2005, calculate as follows: [(Line 10 – line 10.02) times .7], PLUS the amount on line 10.02. This is the adjusted SNF allowable bad debt in accordance with DRA 2005, section 5004. (10/01/2005)

Line 11.--Enter the applicable program's share of the reasonable compensation paid to physicians for services in utilization review committees applicable to the SNF. Include this amount in the amount eliminated from total costs on Worksheet A-8, line 28.

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 program utilization. (See §§136-136.16.)

Line 13.--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 §§132 - 132.4.) Enter in parentheses () the amount of any excess depreciation taken.

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 14.—For cost reporting periods beginning prior to October 1, 2005, enter the sum of lines 3, 7, 10 and 11, minus lines 12, 8 & 9, plus line 13. For cost reporting periods beginning on and after October 1, 2005 enter the sum of lines 3, 7, line 10.03 for title XVIII, plus lines 11 and 13, minus lines 8, 9, and 12.

Line 15.--Using the methodology outlined in §120, enter the sequestration adjustment.

Line 16.--Enter interim payments from Worksheet E-1.

NOTE: Include amounts received from PPS (for inpatient routine services) as well as amounts received from ancillary services.

Line 16.01.--Your fiscal intermediary will enter the Part A tentative adjustments from Worksheet E-1, column 2, line 5.99.

Line 17.--Enter the amount on line 14 minus the sum of lines 15, 16, and 16.01. Enter a negative amount in parentheses (). Transfer this amount to Worksheet S, Part II, column 2, line 1 or line 2, as applicable.

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.

Part B Line Descriptions.-

Use this part to calculate reimbursement settlement for Part B services for SNFs under title XVIII.

Line Descriptions

Line 19.--Enter the amount of Part B ancillary services furnished to Medicare patients. Obtain this amount from Worksheet D, Part I column 9, line 75.

Line 21.--Enter the intern and resident cost from Worksheet D-2, column 8, lines 16 or 20 for title XVIII

Line 23.--Report the charges applicable to the ancillary services from Worksheet D, Part I, column 3, line 75, plus Part II, line 2.

Line 24.--Enter the intern and resident charges from the provider's records.

Line 26.--Enter the amounts paid or payable by workmen's compensation and other primary payers when 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 liability of the program beneficiary, for cost reporting purposes, the services are considered non-program services. (The primary payment satisfies the beneficiary's liability when you accept that payment as payment in full. Note this on no-pay bills submitted in these situations.) The patient days and charges are included in total patient days and charges but are not included in program patient days and charges. In this situation, no primary payer payment is entered on line 26.

However, if the payment by the primary payer does not satisfy the beneficiary's obligation, the program pays (in situations 1, 2, and 3) the amount it otherwise pays (absent primary payer payment) less the primary payer payment and any applicable deductible and coinsurance. In situations 1, 2, and 3, primary payer payment is not credited toward the beneficiary's deductibles and coinsurance. In situations 4 and 5, 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 deductible and coinsurance. In situations 4 and 5, primary payer payment is credited toward the beneficiary's deductible and coinsurance obligation.

If the primary payment does not satisfy the beneficiary's liability, include the covered days and charges in program days and charges and include the total days and charges in total days and charges for cost apportionment purposes. Enter the primary payer payment on line 26 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 27.

Line 27.--Enter the Part B deductible and coinsurance billed to Medicare beneficiaries. Include any primary payer payments applied to Medicare beneficiaries' coinsurance in situations where the primary payer payments do not fully satisfy the obligation of the beneficiary to you. Do not include any primary payer payments applied to Medicare beneficiaries' coinsurance in situations where the primary payer payment fully satisfies the obligation of the beneficiary to you. **DO NOT INCLUDE** coinsurance billed to program patients for physicians' professional services.

Line 28.--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.

Line 31.--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 CMS Pub. 15-I, §§136 - 136.16.)

Line 32.--Enter any other adjustments. For example, enter an adjustment resulting from changing the recording of vacation pay from cash basis to accrual basis. (See CMS Pub. 15-I, §2146.4.) Specify the adjustment in the space provided.

Line 33.--Enter the program's share of any net depreciation adjustment applicable to prior years resulting from the gain or loss on the disposition of depreciable assets. (See CMS Pub. 15-I, §§132 - 132.4.) Enter in parentheses () the amount of any excess depreciation taken.

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 34.-- Enter the sum of the amounts on lines 25, 28, and 30, minus the amounts on lines 26, 27, and 31 plus or minus the amounts on lines 32 and 33.

Line 35.--Using the methodology outlined in §120, enter the sequestration adjustment.

Line 36.--Enter the Title XVIII interim payment from Worksheet E-1, column 4 line 4. Enter the Title V or Title XIX interim payment from your records.

Line 36.01.-- Your Fiscal Intermediary will enter the Part B tentative adjustments from Worksheet E-1, column 4, line 5.99.

Line 37.--Enter the amount on line 34 minus the sum of lines 35, 36, and 36.01. Enter a negative amount in parentheses (). Transfer this amount to Worksheet S, Part II, column 3, line 1.

Line 38.--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.

3534.4 Part V - Reimbursement Under NHCMQ Demonstration.--Use this part to calculate reimbursement if you are a part of the NHCMQ demonstration project. This Part will not be completed for cost reporting periods beginning on and after July 1, 1998.

Use Part A to calculate payment for title XVIII services furnished by NHCMQ demonstration participants. Only facilities in Kansas, Maine, Mississippi, New York, South Dakota, and Texas are eligible to participate in the NHCMQ demonstration.

Line Descriptions

Line 1.--Enter the number of total title XVIII inpatient days. Obtain this figure from Worksheet S-3, column 4, line 1.

Line 2.--Enter the number of demonstration program days. Obtain this figure from Worksheet S-7, sum of columns 3.01 and 4.01, line 46 .

Lines 3 through 5 calculate the net non-NHCMQ demonstration Part A inpatient ancillary services. These include radiology, laboratory, intravenous therapy, oxygen, electrocardiology, medical supplies charged to patients, and drugs charged to patients and others.

Line 3.--Enter the total Part A ancillary program costs. Obtain this figure from Worksheet D, column 4, line 75.

Line 4.--Complete this line for phase 3 only. Enter the physical, occupational, and speech therapy ancillary program costs. Enter the sum of lines 25, 26, and 27 from Worksheet D, column 4.

Line 5.--Subtract the amount on line 4 from line 3, and enter the difference. This amount represents the net ancillary services not applicable to the NHCMQ demonstration.

Line 6.-- Enter the NHCMQ demonstration inpatient routine/ancillary PPS amount paid. Obtain this figure from Worksheet S-7, column 5, line 46.

Line 7.-- Do not make any entries on this line.

Lines 8 and 9 calculate the program inpatient capital costs. The capital costs are not part of the PPS calculation. Instead the capital costs flow through the cost finding stepdown process on Worksheet B.

Line 8.--Enter the per diem capital related cost from the title XVIII SNF Worksheet D-1, line 21.

Line 9.-- Calculate the program capital related cost by multiplying the amount on line 8 by the amount on line 1.

Lines 10 through 24 calculate the indirect cost component of the demonstration ancillary services. The indirect cost component of the demonstration ancillary services is not part of the PPS calculation. Instead the indirect costs are passed through from cost finding on the cost report. For participants in the demonstration, ancillary services will be calculated as part of the PPS payment beginning in phase 3. Thus lines 10 through 24 are completed only for phase 3.

3560. WORKSHEET I-3 - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

This worksheet provides for the reimbursement calculation of Rural Health Clinics and Federal Qualified Health Clinics. Use this worksheet to determine the interim all inclusive rate of payment and the total Medicare payment due you for the reporting period.

3560.1 Part I - Determination of Rate For RHC/FQHC Services.--Part I calculates the cost per visit for RHC/FQHC services and applies the screening guideline established by CMS on your health care staff productivity.

Line Descriptions

Line 1.--Enter the total allowable cost from Worksheet I-2, Part II, line 20.

Line 2.--Enter zero on this line. Worksheet I-4 has been eliminated. Do not enter any amount cost of pneumococcal and influenza vaccine.

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

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

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

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

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

Lines 8 and 9.—*The limits are updated every January 1, (except calendar year 2003 updates that occurred January 1 and March 1 (See PM A-03-21)). Complete columns 1, 2 and 3 of lines 8 and 9, if applicable (add a column 3 for lines 8-14 if the cost reporting overlaps 3 limit update periods) to identify costs and visits affected by different payment limits during a cost reporting period. If only one payment limit is applicable during the cost reporting period, complete column 2 only.*

Line 8.--Enter the maximum rate per visit that can be received by you. Obtain this amount from CMS Pub. 27, §505 or from your intermediary.

Line 9.--Enter the lesser of the amount on line 7 or line 8. For periods with cost reporting periods beginning on or after January 1, complete column 2 only. For cost reporting periods beginning prior to January 1, amounts will be entered in columns 1 and 2.

3560.2 Part II - Calculation of Settlement.--Use Part II to determine the total payment based on specific title due you for covered RHC/FQHC services furnished to program beneficiaries during the reporting period.

Complete columns 1 and/or 2 of lines 10 through 14 to identify costs and visits affected by different payment limits during a cost reporting period. If the provider's cost reporting period begins on or after January 1, then only column 2 is completed. For all other cost reporting periods beginning prior to January 1, both columns 1 and 2 must be completed.

Line Descriptions

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

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

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

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

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

Line 15. --Enter the total allowable GME pass-through costs. To determine the direct GME cost, divide the program visits performed by Interns and Residents from Worksheet S-5, line 16, column 2, by the total visits from Worksheet I-3, line 6. Multiply the result by the total allowable GME costs from Worksheet I-1, column 7, line 20. Add the applicable overhead costs associated with GME, from Worksheet I-2, line 15. Add the provider facility overhead applicable to GME, from Worksheet B, Part I, column 14, line 35. Enter the result on this line. (If there are no allowable GME pass-through costs, this line is zero.)

Line 16.--Enter the total program cost. This is equal to the sum of the amounts on lines 11 and 14, columns 1 and 2, *(and column 3 if applicable)*, plus the GME pass through costs on line 15.

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

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

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

Line 20.--Enter zero on this line. Worksheet I-4 has been eliminated.

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

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

Line 23.--Enter any other adjustment. For example, if you change the recording of vacation pay from the cash basis to the accrual basis (See CMS Pub 15-1, § 2146.4), enter the adjustment. Specify the adjustment in the space provided.

Line 24.--This is the sum of lines 21 and 22 plus or minus line 23.

Line 25--Enter the total interim payments made to you for covered services furnished to program beneficiaries during the reporting period (from intermediary records). Transfer amount from Worksheet I-5, line 4.

Line 25.01—Your Fiscal Intermediary will enter the tentative adjustment from Worksheet I-5, line 5.99.

Line 26--Enter the total amount due to/from the program (line 24 minus line 25). Transfer this amount to Worksheet S, Part II, columns 1, 3, or 4 as applicable, line 6.

Line 27--Enter the program reimbursement effect of protested items. The reimbursement effect of nonallowable items is estimated by applying reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See PRM-15-1 §115.2).

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 1/2" 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
1234567890123456789012345678901234567890123456789012345678				
1	1	010123199927420003053C99P00520000202000305		

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

	<u>Size</u>	<u>Usage</u>	<u>Loc.</u>	<u>Remarks</u>
1. Record Type	1	X	1	Constant "1"
2. NPI	10	9	2-11	Numeric only
3. Spaces	1	X	12	
4. Record Number	1	X	13	Constant "1"
5. Spaces	3	X	14-16	
6. 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 <i>reporting periods beginning on and after 2005274 (October 1, 2005)</i> . Prior approval(s) are for cost reporting periods ending on or after 2002365 (12/31/02), 2001059, 2000274, 1999334, 1998273, 1997273, and 1996274.

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

<u>DESCRIPTION</u>	<u>LINE(S)</u>	<u>COLUMN(S)</u>	<u>FIELD SIZE</u>	<u>USAGE</u>
WORKSHEET S				
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	X
<i>CBSA Code</i>	<i>3</i>	<i>2.01</i>	<i>5</i>	<i>X</i>
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)

<u>DESCRIPTION</u>	<u>LINE(S)</u>	<u>COLUMN(S)</u>	<u>FIELD SIZE</u>	<u>USAGE</u>
For the skilled nursing facility and SNF-based components (continued):				
Title V payment system	4, 6, 8, 10-11	4	1	X
Title XVIII payment system	4, 8, 10- 11	5	1	X
Title XIX payment system	4, 6, 8, 10-11	6	1	X
Cost reporting period beginning date (MM/DD/YYYY)	13	1	10	X
Cost reporting period ending date (MM/DD/YYYY)	13	2	10	X
Type of control (See Table 3B.)	14	1	2	9
Is this an entirely participating skilled nursing facility? (Y/N)	15	1	1	X
A notice published in the Federal Register Vol. 68 N. 149 which provided for an increase in the Rug payments for services beginning 10/01/2003. This increase is expected to be used for direct patient care and related expenses.				
Enter the percentage of total expenses for each of the following categories to total SNF revenue from inpatient care service				
Staffing	15.01	1	4	999.99
Recruitment	15.02	1	4	999.99
Retention of employees	15.03	1	4	999.99
Training	15.04	1	4	999.99
Is the increases spending associated with direct patient care and related expenses reflects each of the following categories (Y/N)				
Staffing	15.01	2	1	X
Recruitment	15.02	2	1	X
Retention of employees	15.03	2	1	X
Training	15.04	2	1	X

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

WORKSHEET S-2 (Continued)

<u>DESCRIPTION</u>	<u>LINE(S)</u>	<u>COLUMN(S)</u>	<u>FIELD SIZE</u>	<u>USAGE</u>
Other (Specify)	15.05- 15.20	0	36	X
Enter the percentage of total expenses for Other to total SNF revenue from inpatient care service	15.05- 15.20	1	4	999.99
Is the increases spending associated with direct patient care and related expenses reflects Other (Y/N)	15.05- 15.20	2	1	X
Is this a partially participating skilled nursing facility? (Y/N)	16	1	1	X
Is this skilled nursing facility unit of a domiciliary institution? (Y/N)	17	1	1	X
Is this skilled nursing facility unit of a rehabilitation center? (Y/N)	18	1	1	X
Text as needed for blank line	19	0	36	X
Other type (Y/N)	19	1	1	X
If this is a low or no Medicare utilization cost report, enter "L" for low or "N" for no Medicare utilization. (L/N)	20	1	1	X
If this is an all-inclusive provider, enter the method used. (See Table 3B.)	21	1	1	X
Is the difference between total interim payments and the net cost covered service included in the balance sheet? (Y/N)	22	1	1	X
Enter the amount of depreciation reported in this SNF for the method indicated:				
Straight Line	23	1	9	9
Declining Balance	24	1	9	9
Sum of the Years' Digits	25	1	9	9

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

WORKSHEET S-2 (Continued)

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

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

WORKSHEET S-3, PART I

<u>DESCRIPTION</u>	<u>LINE(S)</u>	<u>COLUMN(S)</u>	<u>FIELD SIZE</u>	<u>USAGE</u>
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 workers	1, 3-5, 7-9	23	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-3, PART II

<u>DESCRIPTION</u>	<u>LINE(S)</u>	<u>COLUMN(S)</u>	<u>FIELD SIZE</u>	<u>USAGE</u>
Reported salaries	2-21	1	9	9
Reclassification of salaries from Wkst. A-6	2-21	2	9	-9
<i>Adjusted Salaries</i>	<i>16&22</i>	<i>3</i>	<i>9</i>	<i>9</i>
Paid hours related to salary	1-21	4	9	9(7).99
<i>Average Hourly Wage</i>	<i>1-18,23</i>	5	9	9.99
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(7).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(7).99
Data source	24	6	36	X

WORKSHEET S-3, PART III

<u>DESCRIPTION</u>	<u>LINE(S)</u>	<u>COLUMN(S)</u>	<u>FIELD SIZE</u>	<u>USAGE</u>
Reclassification of salaries from Worksheet A-6	1-13	2	9	-9
Paid hours related to salary	1-13	4	9	9(7).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(7).99

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

WORKSHEET E, PART II

<u>DESCRIPTION</u>	<u>LINE(S)</u>	<u>COLUMN(S)</u>	<u>FIELD SIZE</u>	<u>USAGE</u>
Primary payer amount	6	1	9	9
Inpatient ancillary service charges	8	1	9	9
Intern and resident charges	10	1	9	9
Aggregate amount collected	12	1	9	9
Amount collectible	13	1	9	9
Deductibles and coinsurance	17	1	9	9
Reimbursable bad debt	19	1	9	9
Recovery of excess depreciation	21	1	9	9
Other adjustments (specify)	22	0	36	X
Other adjustments (see instructions)	22	1	9	-9
Amounts applicable to prior periods resulting from disposition of depreciable assets	23	1	9	-9
Sequestration adjustment (see instructions)	25	1	9	9
Protested amounts	29	1	9	-9

WORKSHEET E, PART III

Part A - Inpatient service PPS provider
computation of reimbursement of lesser of
cost or charges

Intern and resident charges	5	1	9	9
Inpatient routine PPS amount (see instructions)	7	1	9	9
Primary payer amounts	8	1	9	9
Coinsurance	9	1	9	9

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

WORKSHEET E, PART III (Continued)

<u>DESCRIPTION</u>	<u>LINE(S)</u>	<u>COLUMN(S)</u>	<u>FIELD SIZE</u>	<u>USAGE</u>
Reimbursable bad debts	10	1	9	-9
<i>Reimbursable bad debts</i>	<i>10.01</i>	<i>1</i>	<i>9</i>	<i>-9</i>
<i>Reimbursable bad debts</i>	<i>10.02</i>	<i>1</i>	<i>9</i>	<i>-9</i>
Utilization review	11	1	9	9
Recovery of excess depreciation	12	1	9	9
Amounts applicable to prior periods resulting from disposition of depreciable assets	13	1	9	-9
Sequestration adjustment (see instructions)	15	1	9	9
Protested amounts	18	1	9	-9
<u>Part B</u> - Ancillary service computation of reimbursement of lesser of cost or charges (title XVIII only)				
Intern and resident charges	24	1	9	9
Primary payer amounts	26	1	9	9
Coinsurance and deductibles	27	1	9	9
Reimbursable bad debts	28	1	9	9
Recovery of excess depreciation	31	1	9	9
Other adjustments (specify)	32	0	36	X
Other adjustments	32	1	9	-9
Amounts applicable to prior periods resulting from disposition of depreciable assets	33	1	9	-9
Sequestration adjustment	35	1	9	9
Protested amounts	38	1	9	-9

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

WORKSHEET H-5 PART V

<u>DESCRIPTION</u>	<u>LINE(S)</u>	<u>COLUMN(S)</u>	<u>FIELD SIZE</u>	<u>USAGE</u>
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
Medicare visits for services rendered 1/1/99 to 9/30/00	26-28	5.01	9	9
Medicare visits for services rendered on and after 10/1/00	26-28	5.02	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	8.01– 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
Other adjustments	18.01	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

WORKSHEET H-7

<u>DESCRIPTION</u>	<u>LINE(S)</u>	<u>COLUMN(S)</u>	<u>FIELD SIZE</u>	<u>USAGE</u>
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
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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
Productivity Standards	1, 2, & 3	3	4	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, & 3	6	9(3).99
Rate for program covered visits	9	1, 2, & 3	6	9(3).99
Medicare covered visits excluding mental health services (from your intermediary)	10	1, 2, & 3	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					
DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE	
Medicare covered visits for mental health services (from your intermediary)	12	1, 2, & 3	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-4					
Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	2	1&2	8	9.9(6)	
Medical supplies cost - pneumococcal and influenza vaccine	4	1&2	11	9	
Total number of pneumococcal and influenza vaccine injections	11	1&2	11	9	
Number of pneumococcal and influenza vaccine injections administered to Medicare beneficiaries	13	1&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**

WORKSHEET J-1, PART I

<u>DESCRIPTION</u>	<u>LINE(S)</u>	<u>COLUMN(S)</u>	<u>FIELD SIZE</u>	<u>USAGE</u>
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

WORKSHEET J-3

<u>DESCRIPTION</u>	<u>LINE(S)</u>	<u>COLUMN(S)</u>	<u>FIELD SIZE</u>	<u>USAGE</u>
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	5	9.999
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	6	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**

WORKSHEET K

<u>DESCRIPTION</u>	<u>LINE(S)</u>	<u>COLUMN(S)</u>	<u>FIELD SIZE</u>	<u>USAGE</u>
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

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

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
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WORKSHEET K-5, PART III

Total Hospice Charges	1-8	5	11	-9
Total	9	6	11	-9

35-544

Rev. 14

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

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

TABLE 3B - TABLES TO WORKSHEET S-2

Table I: Type of Control

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

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

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

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

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

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

<u>Worksheet</u>	<u>Lines</u>
S-7, Parts I, II, III	All
<i>S-7, Part IV</i>	<i>1&2, 4&5, 7&8, 10&11, 13, 15-46</i>
S-8	All
A	16, 19, 48, 49, 52-54, 75 (lines 17 and 20 may not be used)
A-6	All
A-7	All
A-8 - full cost report	Lines 2, through 20, 28 and 32
A-8 - simplified cost report	All except lines 23 and 31
A-8-1, Part A	All
A-8-1, Part B	1-8
A-8-1, Part C	1-9
A-8-2	All
A-8-3	All (except lines 5, 6, 12, 13, 28-38, 51, 59, 62, and 64)
A-8-4	All
A-8-5	All (except lines 5, 6, 12, 12.01, 13, 13.01, 66-70, 77-81)
B, Parts I & II	16, 19, 48, 49, 52-54, 65, and 75 (lines 17 and 20 may not be used)
B, Part III	15.1, 16, 17, 18, 18.1, 19, 21-33, 59, 63 (Lines 17 and 20 may not be used)
B-1	16, 19, 48, 49, and 52-54 (lines 17 and 20 may not be used)
B, Part II	15.1, 16, 17, 18, 18.1, 19, 21-33, 59, 63 (Lines 17 and 20 may not be used)
C	75
D, Part I	75
D-1	All
D-2	2, 4-5, and 17 (lines 3, 7, 11, 18, and 19 may not be used)
E, Part I	All (except line 30)
E, Part II	All (except line 22)
E, Part III	All (except lines <i>10, 16, 32, and 36</i>)

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

<u>Worksheet</u>	<u>Lines</u>
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-4	10 & 11
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	<i>All, except line 25</i>
I-4	All
J-1	All
J-2	All
J-3	<i>2 through 15, 17, & 18</i>
J-4	1, 2, 3.01-3.04, and 3.50-3.53
.	

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 2540-96
TABLE 3D - PERMISSIBLE PAYMENT MECHANISMS

P = Prospective payment

O = Other

N = Not applicable

<u>Component</u>	<u>Title V</u>	<u>Title XVIII</u>	<u>Title XIX</u>
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 COST REPORTING SPECIFICATIONS FOR FORM CMS 2540-96
TABLE 6 – EDITS

<u>Reject Code</u>	<u>Condition</u>
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
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]
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. An exception to this rule is subscripts of line 48 on Worksheet D, Part I should be excluded from this edit check. [04/01/2002]
1080	For every line used on Worksheets A, B, C, and D, there must be a corresponding type 2 record. An exception to this requirement is subscripts of line 48 on Worksheet D, Part I. These subscripted lines should be excluded from this edit check. [04/01/2002]
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

<u>Reject Code</u>	<u>Condition</u>
1000S	<i>The SNF address, city, State, zip code, and county (Worksheet S-2 lines 1, 2, and 3, columns 1, 2, and 3 respectively) must be present and valid. [12/31/02]</i>
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, 43, 46, 47, 49, and 52. If line 47 is "Y", then line 48 must have a response. 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, 28-40 46, 47, 49, and 52. If line 47 is "Y", then line 48 must have a response 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 equal "N", then line 52 must also be "N". (A) Line 52 can only be "Y" <i>when: a) lines 50 and 51 are "Y", or: b) you are a new provider, and filing the first cost report of that provider, so that lines 50 and 51 are not applicable.</i> [02/28/2001] (B)

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

<u>Reject Code</u>	<u>Condition</u>
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]
1115S	The amount on Worksheet S-3, Part II, Column 3, line 22 (total wage related costs), must be greater than 7.65 percent and less than 50.0 percent of the amount in column 3, line 16 (total salaries). [12/31/2002]
1120S	For Worksheet S-3, Part II, all values for column 5 lines 1-18, and 23 must equal or exceed \$5.15. When there are no salaries reported in column <i>three</i> , then it is okay to have zero amounts in columns 3 and 5. [12/31/2002]
1125S	The amount of total salaries reported in column 1, line 1 (Worksheet S-3, Part II) must equal Worksheet A, Column 1, line 75 [12/31/2002]

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] <i>If lines 28-30 have an entry in column 2, then column 1 of that line must have an entry.</i> [03/31/1997]
<i>1045A</i>	<i>This edit was changed to a level two edit April 2003. See edit # 2045A</i>
1050A	On Worksheet A-8-2, column 3 must be equal to or greater than the sum of columns 4 and 5. If column 5 is greater than zero, column 6, and column 7 must be greater than zero. [06/13/02]

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

<u>Reject Code</u>	<u>Condition</u>
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 hours for a 12 month cost report, (2240 hours for a 13 month cost report, 2400 hours for a 14 month cost report, or 2560 hours for a 15 month cost report). [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 (<i>Worksheet B-1, columns 1 through 15, line 75</i>), 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 <i>any column, including any reconciliation column, that</i> 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	For the home health agency, [FYs ending through 9/30/2000], the total Medicare program (Title XVIII) visits reported as the sum of all Worksheets H-5, Part II (sum of columns 5 and 6, lines 1-6, plus Worksheet H-5, Part V, columns 3, 5, and 5.01, lines 26-28) must equal the sum of the visits reported on Worksheet S-4 (column 2, sum of lines 1-6). Do not apply this edit for cost reports beginning on or after 10/01/2000. (A)
1021H	For the home health agency, [FYs which over lap 10/1/2000], the total Medicare program (Title XVIII) visits reported as the sum of all Worksheets H-5, Part II (sum of columns 5 and 6, lines 1-6 which are pre 10/1/2000 visits excluding subscripts, plus Worksheet H-5, Part V, columns 5.01 pre 10/1/2000 visits, lines 26-28) must equal the sum of the visits reported on Worksheet S-4, column 2, sum of lines 1-6. (A)
1022H	For the home health agency, [FYs beginning on or after 10/1/ 2000], the total Medicare program (Title XVIII) visits reported as the sum of all Worksheets H-5, Part II (sum of columns 5 and 6, lines 1-6, must equal the sum of the visits reported on Worksheet S-4, Part III, column 7, sum of lines 1, 3, 5, 7, 9 and 11. (A)

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

- 1023H For the home health agency, [FYs ending through 9/30/2000], the total Medicare (Title XVIII) unduplicated census count (Worksheet S-4, Part I, column 3, line 9) must be equal to or greater than the sum of the unduplicated census count for all MSAs (Worksheet H-5, Part IV, column 1, line 25). Do not apply this edit for cost reports beginning on or after 10/01/2000. (A)
- 1024H For the home health agency, [FYs which over lap 10/1/2000], the total Medicare (Title XVIII) unduplicated census count (Worksheet S-4, Part I, column 3, line 9.01) must be equal to or greater than the sum of the unduplicated census count for all MSAs (Worksheet H-5, Part IV, column 1, line 25). (A)
- 1030H For the home health agency, [FYs ending through 9/30/2000], if Medicare visits on Worksheet S-4, column 2, lines 1-6, respectively, are greater than zero, then the corresponding cost on Worksheet H-4, Part I, Column 3, lines 2 through 7, must also be greater than zero. Do not apply this edit for cost reports beginning on or after 10/01/2000. (A)
- 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]

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.

<u>Edit</u>	<u>Condition</u>
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.
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.

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

<u>Edit</u>	<u>Condition</u>																																																																																													
2030	<p>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)</p> <table border="0" style="width: 100%;"> <thead> <tr> <th style="text-align: left;"><u>Cost Center</u></th> <th style="text-align: left;"><u>Line</u></th> <th style="text-align: left;"><u>Code</u></th> </tr> </thead> <tbody> <tr><td>CAP REL COSTS - BLDGS & FIXTURES</td><td>1</td><td>0100-0199</td></tr> <tr><td>CAP REL COSTS - MOVABLE EQUIPMENT</td><td>2</td><td>0200-0299</td></tr> <tr><td>EMPLOYEE BENEFITS</td><td>3</td><td>0300-0399</td></tr> <tr><td>SKILLED NURSING FACILITY</td><td>16</td><td>1600</td></tr> <tr><td>NURSING FACILITY</td><td>18</td><td>1800</td></tr> <tr><td>INTERMEDIATE CARE FACILITY/MENTALLY RETARDED</td><td>18.1</td><td>1810</td></tr> <tr><td>OTHER LONG TERM CARE</td><td>19</td><td>1900</td></tr> <tr><td>ADMINISTRATIVE & GENERAL - HHA</td><td>37</td><td>3700-3704</td></tr> <tr><td>SKILLED NURSING CARE - HHA</td><td>38</td><td>3800-3804</td></tr> <tr><td>PHYSICAL THERAPY - HHA</td><td>39</td><td>3900-3904</td></tr> <tr><td>OCCUPATIONAL THERAPY - HHA</td><td>40</td><td>4000-4004</td></tr> <tr><td>SPEECH PATHOLOGY - HHA</td><td>41</td><td>4100-4104</td></tr> <tr><td>MEDICAL SOCIAL SERVICES - HHA</td><td>42</td><td>4200-4204</td></tr> <tr><td>HOME HEALTH AIDE - HHA</td><td>43</td><td>4300-4304</td></tr> <tr><td>DME RENTED - HHA</td><td>44</td><td>4400-4404</td></tr> <tr><td>DME SOLD - HHA</td><td>45</td><td>4500-4504</td></tr> <tr><td>HOME DELIVERED MEALS - HHA</td><td>46</td><td>4600-4604</td></tr> <tr><td>OTHER HOME HEALTH SERVICES - HHA</td><td>47</td><td>4700-4704</td></tr> <tr><td>TELEMEDICINE</td><td>47.1</td><td>4710-4714</td></tr> <tr><td>AMBULANCE</td><td>48</td><td>4800</td></tr> <tr><td>INTERNS & RESIDENTS (NOT APPRVD)</td><td>49</td><td>4900</td></tr> <tr><td>MALPRACTICE PREMIUMS & PAID LOSSES</td><td>52</td><td>5200</td></tr> <tr><td>INTEREST EXPENSE</td><td>53</td><td>5300</td></tr> <tr><td>UTILIZATION REVIEW - SNF</td><td>54</td><td>5400</td></tr> <tr><td>HOSPICE</td><td>55</td><td>5500-5504</td></tr> <tr><td>GIFT, FLOWER, COFFEE SHOPS & CANTEEN</td><td>58</td><td>5800-5899</td></tr> <tr><td>BARBER & BEAUTY SHOP</td><td>59</td><td>5900-5999</td></tr> <tr><td>PHYSICIANS-PRIVATE OFFICES</td><td>60</td><td>6000-6099</td></tr> <tr><td>NONPAID WORKERS</td><td>61</td><td>6100-6149</td></tr> <tr><td>PATIENTS-LAUNDRY</td><td>62</td><td>6200-6299</td></tr> </tbody> </table>	<u>Cost Center</u>	<u>Line</u>	<u>Code</u>	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	TELEMEDICINE	47.1	4710-4714	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
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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]																																																																																													
2005S	<i>DELETE THIS EDIT:</i> 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]																																																																																													

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

<u>Edit</u>	<u>Condition</u>
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] <ul style="list-style-type: none"> 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]

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

<u>Edit</u>	<u>Condition</u>
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]
2165S	Worksheet S-3, Part II, column 5: line 16 must be greater than \$5.14, and less than \$50.00; line 17 must be greater than \$7.00, and less than \$75.00; and line 18 must be greater than \$5.14, and less than \$50.00;. [12/31/2002]
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).
<i>2045A</i>	<i>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. However, for each line completed in Part B, at least one line entry must be completed in Part C. 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]</i>
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.