
Medicare

Provider Reimbursement Manual - Part 2, Provider Cost Reporting Forms and Instructions, Chapter 18, Form CMS-2088-92

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

Transmittal 8

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<u>HEADER SECTION NUMBERS</u>	<u>PAGES TO INSERT</u>	<u>PAGES TO DELETE</u>
1810.1 (Cont.) - 1813 (Cont.)	18-25 - 18-28 (4 pp.)	18-25 - 18-28 (4 pp.)
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NEW/REVISED MATERIAL--EFFECTIVE DATE: Not Applicable

This transmittal updates Chapter 18, Outpatient Rehabilitation Provider Cost Report for Community Mental Health Centers, (Form CMS-2088-92) to clarify and correct the existing instructions, incorporate a select legislative provision, and comply with an Executive order. The effective dates vary due to various implementation dates.

Significant Revisions:

- Worksheet D - line 11.02 is added to Implement section 3201(c) of the Middle Class Tax Relief and Job Creation Act of 2012 which reduces bad debts by 12 percent for cost reporting periods that begin on or after October 1, 2012, 24 percent for cost reporting periods that begin on or after October 1, 2013, and 35 percent for cost reporting periods that begin on or after October 1, 2014.
 - Line 17.01 is added to apply the 2 percent Medicare sequestration adjustment, as indicated in the Office of Management and Budget Report to the Congress on the sequestration for fiscal year 2013 required by section 251A of the Balanced Budget and Emergency Deficit Control Act, as amended by the Joint Committee. The sequestration adjustment is effective for portions of cost reporting periods that overlap April 1, 2013 through September 30, 2013.
- Electronic Reporting Specifications - Incorporates the time stamp into the electronic cost report file.

REVISED ELECTRONIC SPECIFICATIONS EFFECTIVE DATE: Changes to the electronic reporting specifications are effective for cost reporting periods beginning on or after October 1, 2012.

DISCLAIMER: 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.

Medicare is not the primary payer under the following situations:

1. If the items of services have been, or can reasonably be expected to be paid under a worker's compensation law of a State or of the United States, including the Federal Black Lung Program;
2. If the items of services have been, or can reasonably be expected to be paid by automobile medical or no-fault insurance, or any liability insurance;
3. If the beneficiary is entitled to Medicare solely on the basis of end stage renal disease (ESRD) and is covered by an employer group health plan (EGHP), Medicare is the secondary payer for the first 18 months (See §1862(b)(1)(C) of the Act);
4. If the beneficiary is age 65 or over and either employed, or the spouse of an employed individual of any age, and the beneficiary is thereby covered by an EGHP; and
5. If the beneficiary is under age 65 and disabled and is covered by a large group health plan (LGHP) as a current employee, self-employed individual, or family member of such an employee, or self-employed individual.

When payment by the primary payer satisfies the total liability of the beneficiary, the services are treated as if they were non-Medicare services. The patient charges are included in total patient charges but are not included in Medicare charges, and no primary payer payment is entered on line 2.

If the primary payment does not satisfy the beneficiary's liability, include the covered charges in Medicare charges, and include the total charges in total charges for cost apportionment purposes. Enter the primary payment on line 2 to the extent the primary payer payment is not applied to the beneficiary's deductible and coinsurance.

Any part of the payment by the primary payer that satisfies some or all of the beneficiary's Medicare deductible and coinsurance is applied against the deductible and coinsurance. Do not enter primary payer payments that are applied against the deductible or the coinsurance on line 2. The providers must familiarize themselves with primary payer situations because they have a legal responsibility to attempt to recover their costs from the primary payer before seeking payment from Medicare. The primary payer rules are more fully explained in 42 CFR 411.

Line 3--For cost based CMHC services rendered prior to August 1, 2000, enter in the applicable column the total expenses for CMHC services by subtracting line 2 from line 1. Enter in the applicable column the total PPS payment for CMHC services furnished on or after August 1, 2000, by adding lines 1.01 and 1.05 minus line 2. CORFs and OPTs enter the result of line 1 plus line 1.1 minus line 2.

Line 4--Enter the total amount of deductibles billed to program patients.

Line 6--CMHCs (only the portion of the reporting period reimbursed under cost during the beginning transition year) enter in the applicable column the amount from line 29 of Part II. For CMHCs with cost reporting periods beginning on or after August 1, 2000, do not complete this line as PPS reimbursed services are not subject to LCC. CORFs, and other providers enter in column 1 the amount from line 29 of Part II.

Line 8--CORFs, OPTs, and CMHCs (only the portion of the reporting period reimbursed under cost during the beginning transition year), enter in the applicable column 80 percent of the amount shown on line 7. CMHCs enter 0 (zero) for services reimbursed under PPS.

Line 9--CORFs and OPTs enter in the applicable column the coinsurance amount billed to Medicare beneficiaries, but this amount may not exceed 20 percent of the customary charges as shown on line 27, Part II. For CMHCs, enter in the applicable column the gross coinsurance amount billed to Medicare beneficiaries.

Line 11.--Enter reimbursable bad debts, net of bad debt recoveries, applicable to any Medicare deductibles and coinsurance. The amount entered applicable to CMHC PPS must not exceed the discounted coinsurance applicable to Medicare beneficiaries.

Line 11.01--Enter the gross reimbursable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. These amounts must also be reported on line 11. (12/31/2004)

Line 11.02.--Enter in column 1, the result of line 11 (including negative amounts) times 88 percent for cost reporting periods that begin on or after October 1, 2012, 76 percent for cost reporting periods that begin on or after October 1, 2013, and 65 percent for cost reporting periods that begin on or after October 1, 2014.

Line 12.--CORFs, OPTs and CMHCs for cost reimbursed services only, enter in the appropriate column the result of line 11 plus the lesser of the amounts on line 8 or 10. *For cost reporting periods that begin prior to October 1, 2012, for CMHC PPS reimbursed services, enter in the appropriate column the result of line 10 plus line 11. For cost reporting periods that begin on or after October 1, 2012, for CMHC PPS reimbursed services, enter in column 1 the result of line 10 plus line 11.02.*

Line 15.--Enter the sum of columns 1 and 1.01, line 12.

Line 16.--*Do not use this line for cost reporting periods that begin on or after October 1, 2012.*

Line 16.5.--Enter any other adjustments. For example, enter an adjustment resulting from changing the recording of vacation pay from cash basis to accrual basis. (See CMS Pub. 15-1, §2146.4)

Line 17.--Subtract lines 16 and 16.5 from line 15 and enter the result.

Line 17.01.--Enter the sequestration adjustment amount as follows: [.02 times the result of the ratio of total days in the cost reporting period that overlap April 1, 2013, through September 30, 2013, to the total days in the entire cost reporting period rounded to four decimal places. Multiply that result by line 17 rounded to zero decimal places.]

Line 18.--Enter the total interim payments applicable to this cost reporting period from Worksheet S-1, line 4. For intermediary final settlement, report on line 18.5 the amount from Worksheet S-1, line 5.99.

Line 19.--Subtract the total amount entered on lines *17.01 and* 18 from the amount entered on line 17 and enter the resulting amount. This represents the amount due to or from the provider before any tentative or final settlement. Transfer this amount to Worksheet S, Part III, line 6.

1810.2 Part II - Computation of Lesser of Reasonable Cost or Customary Charges.--Part II provides for the computation of the lesser of reasonable cost as defined in 42 CFR 413.13(b)(2) or customary charges as defined in 42 CFR 413.13(b)(1).

NOTE: For CORF services rendered prior to January 1, 1998, complete lines 22 through 27 as these services are not subject to LCC but are reimbursed based on Reasonable Costs. For CORF services rendered on or after January 1, 1998, complete lines 21 through 29, as these services are subject to LCC.

Line Descriptions

Line 21.--CMHCs enter the reasonable cost of Title XVIII services as follows: Reporting periods overlapping August 1, 2000, from Part I, line 1, column 1; Reporting periods beginning on or after August 1, 2000 do not complete Part II of this worksheet. For CORFs this line represents the reasonable cost of Title XVIII services rendered on or after January 1, 1998 from line 1. OPTs enter the reasonable cost of Title XVIII services from Worksheet C, column 8, line 44.

Line 21.1.--This line is the CORF reasonable cost of Title XVIII services rendered prior to January 1, 1998 from Part I, line 1.1.

Line 22.--This line provides for the charges which relate to the reasonable cost on line 21. CMHCs with cost reporting periods which overlap August 1, 2000, enter the result of Worksheet C, column 3, line 39.02 minus column 5, line 39 and for reporting periods beginning on or after August 1, 2000 do not complete Part II of this worksheet. OPTs enter the amount from Worksheet C, column 3, line 44.02. Do not include the charges for any services that are reimbursed under any method other than cost reimbursement. CORFs enter the total charges for Medicare services provided on or after January 1, 1998 from Worksheet C, column 5, line 28.

Line 22.1.--This line provides for CORF charges prior to January 1, 1998, which relate to the reasonable cost on line 21.1. Enter the result of Worksheet C, column 3, line 28.02 minus Worksheet C, column 5, line 28. Do not include the charges for any services that are reimbursed under any method other than cost reimbursement.

Lines 23 through 27.--These lines provide for the reduction of Medicare charges when you do not actually impose such charges in the case of most patients liable for payment for services on a charge basis or when you fail to make reasonable efforts to collect such charges from those patients. If you impose these charges and make reasonable efforts to collect the charges from patients liable for payment for services on a charge basis, you are not required to complete lines 24 through 26, but enter on line 27 the amount from line 22 and enter on line 27.1 the amount from line 22.1. See 42 CFR 413.13(b). In no instance may the customary charges on line 27 exceed the actual charges on line 22, or the customary charges on line 27.1 exceed the actual charges on line 22.1.

1812. WORKSHEET G - STATEMENT OF REVENUE AND EXPENSES

Worksheet G is prepared from your accounting books and records. Additional worksheets may be supplied if necessary.

Worksheet G is completed by all providers.

You may substitute your own forms for Worksheet G. However, you must provide the minimum detail contained in Worksheet G.

1813. SUPPLEMENTAL WORKSHEET A-8-2 - PROVIDER-BASED PHYSICIAN ADJUSTMENTS

In accordance with 42 CFR 413.9, 42 CFR 405.480, 42 CFR 405.481, 42 CFR 405.482, and 42 CFR 405.550(e), you may claim as allowable cost only those costs which you incur for physician services that benefit the general patient population of the provider. 42 CFR 405.482 imposes limits on the amount of physician compensation which may be recognized as a reasonable provider cost.

Supplemental Worksheet A-8-2 provides for the computation of the allowable provider-based physician cost incurred. 42 CFR 405.481 provides that the physician compensation paid by you must be allocated between services to individual patients (professional services), services that benefit your patients generally (provider services), and nonreimbursable services, e.g., research. Only provider services are reimbursable to you through the cost report. If you are a CORF, see 42 CFR 410.100(a) for an explanation of which services constitute provider services. This worksheet also provides for the computation of the reasonable compensation equivalent (RCE) limits required by 42 CFR 405.482. The methodology used in this worksheet is to apply the RCE limit to the total physician compensation attributable to provider services that are reimbursable on a reasonable cost basis.

NOTE: Where several physicians work in the same department, see CMS Pub. 15-I, §2182.6C for a discussion of applying the RCE limit in the aggregate for the department versus on an individual basis to each of the physicians in the department.

Column Descriptions

Columns 1 and 10.--Enter the line numbers from Worksheet A for each cost center that contained compensation for physicians subject to RCE limits. Enter the line numbers in the same order as displayed on Worksheet A.

Columns 2 and 11.--Enter (on the same line as the cost center) the description of the cost center used on Worksheet A.

When RCE limits are applied on an individual basis to each physician in a department, each physician must be listed on successive lines below the cost center. Each physician must be listed using an individual identifier which is not necessarily either the name or social security number of the individual (e.g., Dr. A, Dr. B). However, the identity of the physician must be made available to the fiscal intermediary upon audit.

When RCE limits are applied on a departmental basis, insert the word "aggregate" instead of the physician identifiers on the line below the cost center description.

Columns 3 through 9 and 12 through 18.--When the aggregate method is used, enter the data for each of these columns on the aggregate line for each cost center. When the individual method is used, enter the data for each column on the individual physician identifier lines for each cost center.

Column 3.--Enter the total physician compensation paid by the provider for each cost center. Physician compensation is monetary payments, fringe benefits, deferred compensation, costs of physician membership in professional societies, continuing education, malpractice and any other items of value (excluding office space or billing and collection services) that a provider or other organization furnishes a physician in return for the physician's services. (See 42 CFR 405.481(a).) Include the compensation in column 3 of Worksheet A or, if necessary, through appropriate reclassifications or as a cost paid by a related organization through Worksheet A-3-1.

Column 4.--Enter the amount of total remuneration included in column 3 which is applicable to the physician's services to individual patients (professional component). These services are reimbursed on a reasonable charge basis by the Part B carrier in accordance with 42 CFR 405.550(b). The written allocation agreement between you and the physician specifying how the physician spends his or her time is the basis for this computation. (See 42 CFR 405.481(f).)

Column 5.--For each cost center, enter the amount of the total remuneration included in column 3 which is applicable to general services to the provider (provider component). The written allocation agreement is the basis for this computation. (See 42 CFR 405.481(f).)

NOTE: 42 CFR 405.481(b) requires that physician compensation be allocated between physician services to patients, the provider and nonallowable services such as research. A physician's nonallowable services must not be included in columns 4 or 5 above. The instructions for column 18 ensure that the compensation for nonallowable services included in column 3 is correctly eliminated on Worksheet A-3.

Column 6.--Enter for each line of data, as applicable, the reasonable compensation equivalent (RCE) limit applicable to the physician's compensation included in that cost center. The amount entered is the limit applicable to the physician specialty as published in the **Federal Register** before any allowable adjustments.

The RCE limits are updated annually on the basis of updated economic index data. A notice is published in the **Federal Register**, which sets forth the new limits. The RCE applicable to the various specialties is obtained from that notice. If the physician specialty is not identified in the table, use the RCE for the total category in the table. The beginning date of the cost reporting period determines which calendar year (CY) RCE is used. Your location governs which of the three geographical categories are applicable (non metropolitan areas, metropolitan areas less than one million, or metropolitan areas greater than one million).

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2088-92
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 three types of records. The first group (type one 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 two 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 3½" diskette. These disks must be in IBM format. The character set must be ASCII. You must 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.04-13
3. No record may exceed 60 characters.

Below is an example of a set of type 1 records with a narrative description of their meaning.

1	2	3	4	5	6
1234567890123456789012345678901234567890123456789012345678901234567890					
1	1	144600200400120043662A99P00120050312004366			

Record #1: This is a cost report file submitted by Provider 144600 for the period from January 1, 2004 (2004001) through December 31, 2004 (2004366). It is filed on FORM CMS-2088-92. It is prepared with vendor number A99'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 remain constant for approvals issued after the first test case. This file is prepared by the community mental health center on January 31, 2005 (2005031). The electronic cost report specification dated December 31, 2004 (2004366) is used to prepare this file.

FILE NAMING CONVENTION

Name each cost report file in the following manner:

CMNNNNNN.YYL, where

1. CM (Community Mental Health Center Electronic Cost Report) is constant;
2. NNNNNN is the 6 digit Medicare community mental health center 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 community mental health centers with two or more cost reporting periods ending in the same calendar year.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2088-92
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.	CM 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 "2" (for FORM CMS-2088-92)
10.	Vendor Code	3	X	38-40	To be supplied upon approval. Refer to page 18-503.
11.	Vendor Equipment	1	X	41	P = PC; M = Main Frame
12.	Version Number	3	X	42-44	Version of extract software, e.g., 001=1st, 002=2nd, etc. or 101=1st, 102=2nd. The version number must be incremented by 1 with each recompile and release to client(s).
13.	Creation Date	7	9	45-51	YYYYDDD – Julian date; date on which the file was created (extracted from the cost report)
14.	ECR Spec. Date	7	9	52-58	YYYYDDD – Julian date; date of electronic cost report specifications used in producing each file. Valid for cost reporting periods <i>beginning</i> on or after <i>2012275 (10/01/2012)</i> . <i>Prior approval(s)</i> 2004366 (12/31/2004).

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 2088-92
TABLE 1 - RECORD SPECIFICATIONS

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

		<u>Size</u>	<u>Usage</u>	<u>Loc.</u>	<u>Remarks</u>
1.	Record Type	1	9	1	Constant "1"
2.	Spaces	10	X	2-11	
3.	Record Number	2	9	12-13	<i>#2 - The time that the ECR file is created. This is represented in military time as alphanumeric. Use positions 21-25. Example 2:30PM is expressed as 14:30.</i> #3-99 - Reserved for future use.
4.	Spaces	7	X	14-20	Spaces (optional)
5.	ID Information	40	X	21-60	Left justified to position 21.

RECORD NAME: Type 2 Records for Labels

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

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

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

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 2088-92
TABLE 1 - RECORD SPECIFICATIONS

Column headings for the General Service cost centers on Worksheets B and B-1 are supplied once. They consist of one to three records. Each statistical basis shown on Worksheet B-1 is also to be reported. The statistical basis consists of one or two records (lines 4-5). Statistical basis code is supplied only to Worksheet B-1 columns and is recorded as line 6. The statistical code must agree with the statistical bases indicated on lines 4 and 5, i.e., code 1 = square footage, code 2 = dollar value, and code 3 = all others. Refer to Table 2 for the special worksheet identifier to be used with column headings and statistical basis and to Table 3 for line and column references.

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

<u>Line</u>	<u>Description</u>
1	CAP REL COSTS-BLDG & FIXT
2	CAP REL COSTS-MVBLE EQUIP
3	EMPLOYEE BENEFITS
4	ADMINISTRATIVE & GENERAL
5	MAINTENANCE & REPAIRS
6	OPERATION OF PLANT
7	LAUNDRY & LINEN SERVICE
8	HOUSEKEEPING
9	CAFETERIA
10	CENTRAL SERVICES & SUPPLY
11	MEDICAL RECORDS & LIBRARY
12	PRO ED & TRAINING (APPRVD)
29	DRUGS & BIOLOGICALS
30	OCCUPATIONAL THERAPY
31	PSYCHIATRIC / PSYCHOLOGICAL SERVICES
32	INDIVIDUAL THERAPY
33	GROUP THERAPY
34	INDIVIDUALIZED ACTIVITY THERAPIES
35	FAMILY COUNSELING
36	DIAGNOSTIC SERVICES
37	PATIENT TRAINING & EDUCATION
45	SHELTERED WORKSHOPS
46	RECREATIONAL PROGRAMS
47	RESIDENT DAY CAMPS
48	PRE-SCHOOL PROGRAMS
49	DIAGNOSTIC CLINICS
50	HOME EMPLOYMENT PROGRAMS
51	EQUIPMENT LOAN SERVICE
52	PHYSICIANS' PRIVATE OFFICES
53	FUND RAISING
54	COFFEE SHOPS & CANTEEN
55	RESEARCH
56	INVESTMENT PROPERTY
57	ADVERTISING
58	FRANCHISE FEES & OTHER ASSESSMENTS
59	PRO ED & TRAINING (NOT APPRVD)
61	MEALS & TRANSPORTATION
62	ACTIVITY THERAPIES
63	PSYCHOSOCIAL PROGRAMS
64	VOCATIONAL TRAINING

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2088-92
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>
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WORKSHEET B-1 (Continued)

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

WORKSHEET C

Patient charges	29-38 (all on subline .02)	1	9	9
Total patient costs	39.01	1	9	9
Total patient charges	39.02	1	9	9
Medicare program charges	29-38 (all on subline .02)	3	9	9
Total Medicare patient costs	39.01	3	9	9
Total Medicare patient charges	39.02	3	9	9
Non-Medicare program charges	29-38 (all on subline .02)	4	9	9
Total Non-Medicare program costs	39.01	4	9	9
Total Non-Medicare program charges	39.02	4	9	9
Medicare charges for services rendered on or after 8/1/2000, 1/1/2002, 1/1/2003 or 1/1/2004	29-38	5	9	9
Total Medicare program charges after transition date	39	5	9	9
Medicare cost for services rendered on or after 8/1/2000, 1/1/2002, 1/1/2003 or 1/1/2004	29-38	6	9	9
Total Medicare program costs after transition date	39	6	9	9

WORKSHEET D

Part I:

Total PPS payments for CMHC – Part A and B	1.01	1 & 1.01	9	9
1996 CMHC specific payment to cost ratio	1.02	1 & 1.01	5	9.9(3)

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2088-92
 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 D (Continued)				
Amounts paid by primary payers when Medicare liability is secondary to the primary payer	2	1 & 1.01	9	9
Deductibles billed to Medicare patients	4	1	9	9
Coinsurance billed to Medicare patients	9	1	9	9
Reimbursable bad debts	11	1	9	-9
Reimbursable bad debts <i>for dual eligible beneficiaries</i>	11.01	1	9	9
<i>Adjusted reimbursable bad debts</i>	<i>11.02</i>	<i>1</i>	<i>9</i>	<i>-9</i>
Sequestration adjustment (see instructions)	16	1	9	9
Text as needed for blank line (specify)	16.5	0	36	X
Other adjustments (see instructions)	16.5	1	9	-9

WORKSHEET G

Total patient revenues	1	2	9	9
Contractual allowances and discounts on patients' accounts	2	2	9	-9
Other income	6-22	1	9	9
Other expenses	25-30	1	9	9
Net income	32	2	9	-9
Text as needed for blank lines	20-22, 28-30	0	36	X