
Medicare

Provider Reimbursement Manual

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

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

Transmittal 18

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NEW/REVISED MATERIAL--EFFECTIVE DATE: See below

This transmittal updates Chapter 35, Skilled Nursing Facility Complex Cost Report, and Form CMS 2540-96, to reflect further clarification to existing instructions. This transmittal introduces 23 additional RUGs (RUG-IV) required for reimbursement for services on and after October 1, 2010. Worksheet S-7 is included in this Transmittal to provide a sample of the subscribed lines needed to implement RUG-IV. Line 45 will be subscribed as lines 45.01 through 45.23 to accommodate the 23 additional RUGs. The effective date for these instructional changes is October 1, 2010.

42 CFR §413.321 allowed a SNF to use the “simplified” method of reimbursement for cost reporting periods beginning prior to July 1, 1998. After that date, SNF’s may not use the “Simplified” method to file a cost report. A full cost report is required.

Worksheet B, Part III, and Worksheet B-1, Part II are eliminated. A full cost report is required, and the annotations on Worksheet A that identify only the cost centers that were used under the simplified cost allocation method are not applicable.

Changes to the electronic reporting specifications are effective for cost reporting periods ending on and after October 1, 2010.

3500. GENERAL

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

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

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

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

42 CFR Subpart I §413.321 allowed a SNF to use the "simplified" method of reimbursement for cost reporting periods beginning prior to July 1, 1998. Therefore, SNF cost reports, are not allowed to be filed using the "simplified" method after that date.

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

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

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

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

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

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

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

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

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

1. Round to 2 decimal places:
 - a. Percentages (e.g., capital reduction, outpatient cost reduction)
 - b. Averages, standard work week, payment rates, and cost limits
 - c. Full time equivalent employees
 - d. Per diem
 - e. Hourly rates
2. Round to 3 decimal places:
 - a. PCR Rates
3. Round to 5 decimal places:
 - a. Sequestration (e.g., 2.092 percent is expressed as .02092)
 - b. Payment reduction
4. Round to 6 decimal places:
 - a. Ratios (e.g., unit cost multipliers, cost/charge ratios)

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

<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.—

NOTE: This section is not applicable for cost reporting periods beginning on and after July 1, 1998.

<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.

Step No.:	Worksheet	
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 <u>separate</u> copy of this worksheet must be completed for each applicable health care program for each SNF and nursing facility (NF).
18	E-1	Complete lines 1 - 4.
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.

3505. SEQUENCE OF ASSEMBLY

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

NOTE: The simplified method is not applicable for cost reporting periods beginning on and after July 1, 1998.

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

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

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.

NOTE: Do not complete lines 48 and 48.01 for cost reporting periods beginning on and after 01/01/2006.

Line 48.— If line 47 column 1 is Y, and column 2 is N, enter on line 48 column 1 the payment limit provided from your fiscal intermediary, and for services on or after 04/01/2002, enter in column 2, the Fee Amount from the PS&R. Use Worksheet S-2, line 48 (and subscripts) columns 1 and 2 for the Limit and Fee amount respectively. If your fiscal year is OTHER than a year beginning on October 1st, enter in Line 48, column 1, the payment limit for the period prior to October 1, and enter in column 2 the Fee Amount. Subscript line 48 for the applicable time periods, and enter in column 1 the Limit; enter in column 2 the Fee Amount. 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 - 48.03.— Use lines 48.01-48.03 if your fiscal year is OTHER than a year beginning on October 1^s. Ambulance services will be based on a blend until 100 percent 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.—*This line is not completed for cost reporting periods beginning on and after July 1, 1998.*

Line 51.-- *This line is not completed for cost reporting periods beginning on and after July 1, 1998.*

Line 52.-- *This line is not completed for cost reporting periods beginning on and after July 1, 1998.*

Line 53.—Are there any related organizations or home office costs as defined in CMS Pub 15-1, chapter 10. Enter "Y" for yes, or "N" for no, in column 1. If yes, and there are home office costs, enter the home office provider number. If this facility is part of a chain organization, enter the name and address of the home office on lines 54, 55 and 56.

Line 54, columns 1, 2, and 3.— Enter the name of the home office in column 1, and enter the name of the fiscal intermediary or contractor of the home office in column 2. Enter the fiscal intermediary or contractor number in column 3.

Line 55, columns 1, and 2.—Enter the street address in column 1, or the post office box number in column 2.

Line 56, columns 1, 2 and 3.—Enter the city, State and zip code in columns 1, 2, and 3.

Column 4.01.--Enter the number of demonstration inpatient days applicable to each group associated with the rate in effect January 1 through the end of your fiscal year. Enter the total on line 46.

Add the amounts on line 46, columns 3.01 and 4.01, and enter the result on Worksheet E, Part V, line 2.

Column 5.--Calculate the total for each revenue group by multiplying the rate by the days covered by that rate. Where you must report two rates and two sets of days for each group, multiply the rate in column 3 by the days in column 3.01. Multiply the second rate in column 4 by the days in column 4.01. For each line (group), add the product of column 3 multiplied by the 3.01 plus the product of columns 4 multiplied by 4.01, and enter the result in column 5 on the same line. Add lines 1 through 45, column 5, and enter the total on line 46. Transfer column 5, line 46, to Worksheet E, Part V, line 6.

3514.2 Part II - PPS Statistical Data. --Complete this part for cost reporting periods beginning on and after July 1, 1998. Use this part to report the Medicare days of the provider by RUG. The total on line 46 must agree with the amount on Worksheet S-3, column 4, line . This part has been revised with the issuance of Transmittal # 5. As of the issuance of Transmittal # 5, Part II has been replaced with Part III, and should not be completed.

3514.3 Part III - PPS Statistical Data.-- **Complete Part III for cost reporting periods beginning on or after July 1, 1998.** Use this part to report the Medicare days of the provider by RUG. Do not use Part III for cost reporting periods ending on and after February 28, 2001.

Transition Period.--Indicate the applicable transition period. Your fiscal intermediary will provide you with this status. Example: If your cost report year begins on July 1, 1998, check the box for year number 1. For the next fiscal year beginning on July 1, 1999, check the box for year number 2. For the following fiscal year beginning on July 1, 2000, check the box for year number 3. For the last fiscal year in the transition period beginning on July 1, 2001, check the box for year number 4.

EXCEPTION: THE TRANSITION PERIOD PAYMENT METHOD WILL NOT APPLY TO A SNF THAT (1) ELECTED FOR IMMEDIATE TRANSITION TO FEDERAL RATE UNDER SECTION 102 OF THE BALANCED BUDGET REFINEMENT ACT OF 1999, OR (2) FIRST RECEIVED MEDICARE PAYMENTS (INTERIM OR OTHERWISE) ON OR AFTER OCTOBER 1, 1995 UNDER PRESENT OR PREVIOUS OWNERSHIP. THESE FACILITIES WILL BE PAID BASED ON ONE HUNDRED PERCENT (100%) OF THE FEDERAL RATE. Enter this rate in column 5.

For the first year of the provider's transition period, the PPS rate will be twenty-five percent (25%) of the Federal Case Mix Rate and seventy-five percent (75%) of the Facility Specific Rate. In the second year of the Provider's transition period, the PPS rate will be fifty percent (50%) of the Federal Case Mix Rate and fifty percent (50%) of the Facility Specific Rate. For the third year of the Provider's transition period, the PPS rate will be seventy-five percent (75%) of the Federal Case Mix Rate and twenty-five percent (25%) of the Facility Specific Rate. For the fourth and final year of the Provider's transition period, the PPS rate will be one hundred percent (100%) of the Federal Case Mix Rate. See columns 9 and 10 below.

Column 2.--Enter the Federal Specific Rate on each applicable RUG line.

Column 3.--Enter the Federal Case Mix rate applicable to each RUG for services from the beginning of the fiscal year through September 30.

Column 4.--Enter the number of days applicable to each RUG for services from the beginning of the fiscal year through September 30.

Columns 5 and 5.01.--Enter in column 5 the Federal Case Mix (adjusted for the labor portion by the update factor specific to the provider's MSA) rate times 104 percent, applicable to each NON-High-Cost RUG for services from October 1, through the end of the fiscal year. Enter in column 5.01 the Federal Case Mix rate times 124 percent applicable to each High-Cost RUGs for services from October 1, through the end of the fiscal year.

Columns 6 and 6.01.--Enter in column 6 the number of days applicable to ALL RUGs for services from October 1 through the end of the fiscal year. Enter in column 6.01 the number of days applicable to each High-Cost RUG for services from October 1 through the end of the fiscal year (This should be the same amount that is reported in column 5 for that RUG.)

The total on line 75, columns 4 and 6 must agree with the amount on Worksheet S-3, Part I, column 4, line 1.

Do not use columns 3 and 4 for a cost report period that begins on October 1. Report the applicable Federal Case Mix rates in column 5 for each NON-High-Cost RUG. Report Medicare days for ALL RUG's in column 6. Report the applicable High-Cost Rates in column 5.01, and the High-Cost Days in column 6.01. (This should be the same amount that is reported in column 5 for that RUG.)

Column 7.--Multiply the rates in column 3 times the days in column 4. Round to zero places. Multiply the rates in column 3.01 times the days in column 4.01. Round to zero places. Multiply the rates in column 5 times the days in column 6. Round to zero places. Multiply the rates in column 5.01 times the days in column 6.01. Round to zero places. Add the results from column 4, 4.01, 6, and 6.01. Enter the combined total on each line. Round each line in column 7 to zero decimal places.

Column 8.--Multiply the facility specific rate times the total program annual days (sum of columns 4, 4.01, and 6) for each RUG, and enter the product in column 8.

Columns 9.--Multiply the Federal amount in column 7 times your transition period percentage. I.e. year # 1 is 25 percent year # 2 is 50 percent year # 3 is 75 percent, a year # 4 and forward is 100 percent. Enter the results on the appropriate line for each RUG. Enter the sum of lines 1 through 45 on line 75.

Column 10.--Multiply the facility specific amount 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 75. Add the amount in column 9, line 75, plus the amount in column 10, line 75, together, and transfer this total to Worksheet E, Part III, line 7.

SPECIAL INSTRUCTIONS TO CALCULATE THE INCREASE FOR CERTAIN HIGH COST PATIENTS, EFFECTIVE FOR SERVICES FURNISHED ON AND AFTER APRIL 1, 2000.

Section 101 of the Balanced Budget Refinement Act of 1999 (BBRA, P.L. 106-113, Appendix F) provides for a temporary, 20 percent increase in payment for 15 specified RUGs (listed below). The BBRA provides that this 20 percent increase becomes effective for services furnished beginning on April 1, 2000, and remains in effect until the date that *CMS* implements a refined case-mix classification system. The following is a list of the affected RUGs along with the corresponding line on Worksheet S-7, Part III.

HIGH - COST RUGS

RUG	Line #	RUG	Line #	RUG	Line #
RHC	7	RMC	10	RMB	11
SE3	15	SE2	16	SE1	17
SSC	18	SSB	19	SSA	20
CC2	21	CC1	22	CB2	23
CB1	24	CA2	25	CA1	26

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.

Effective for services provided on and after October 1, 2010, the following RUG-IV group is added to Worksheet S-7 for the reimbursement calculation. The default line designation is changed to “AAA”. Subscript line 45 to lines 45.01 through 45.23 as follows:

<i>Line:</i>	<i>RUG</i>	<i>Line:</i>	<i>RUG</i>	<i>Line</i>	<i>RUG</i>
<i>45.01</i>	<i>ES3</i>	<i>45.02</i>	<i>ES2</i>	<i>45.03</i>	<i>ES1</i>
<i>45.04</i>	<i>HE2</i>	<i>45.05</i>	<i>HE1</i>	<i>45.06</i>	<i>HD2</i>
<i>45.07</i>	<i>HD1</i>	<i>45.08</i>	<i>HC2</i>	<i>45.09</i>	<i>HC1</i>
<i>45.10</i>	<i>HB2</i>	<i>45.11</i>	<i>HB1</i>	<i>45.12</i>	<i>LE2</i>
<i>45.13</i>	<i>LE1</i>	<i>45.14</i>	<i>LD2</i>	<i>45.15</i>	<i>LD1</i>
<i>45.16</i>	<i>LC2</i>	<i>45.17</i>	<i>LC1</i>	<i>45.18</i>	<i>LB2</i>
<i>45.19</i>	<i>LB1</i>	<i>45.20</i>	<i>CE2</i>	<i>45.21</i>	<i>CE1</i>
<i>45.22</i>	<i>CD2</i>	<i>45.23</i>	<i>CD1</i>		

If your cost reporting period does not end on September 30, 2010, but overlaps that date, complete Column 3.01 for lines 1 through 45 for services provided prior to October 1, 2010, and lines 45.01 through 45.23 for services provided after September 30, 2010. The total on line 46 column 3.01 must agree with the amount on Worksheet S-3, column 4 line 1

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)		164 days
Patient (A, B & C)		
Medicare Patients		/3

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Line Descriptions

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

the 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 percent 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 10.04—Recovery of reimbursable bad debts for dual eligible beneficiaries, *for statistical purposes only*.

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, and 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 16.20.--Enter OTHER adjustments. *Enter negative amounts in parentheses ().*

Line 17.--Enter the amount on line 14 minus the sum of lines 15, 16, and 16.01, *plus the amount on line 16.20.* 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 36.20.--Enter OTHER adjustments *Enter negative amounts in parentheses ()*

Line 37.--Enter the amount on line 34 minus the sum of lines 35, 36, and 36.01, *plus the amount on Line 36.20*. 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 step-down 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.

Line 10.--Enter the total general service cost allocation for physical therapy. Obtain this amount from Worksheet B, Part I, column 18, line 25

Line 11.--Enter the total general service cost allocation for occupational therapy. Obtain this amount from Worksheet B, Part I, column 18, line 26.

Line 12.--Enter the total general service cost allocation for speech therapy. Obtain this amount from Worksheet B, Part I, column 18, line 27.

Line 13.--Enter the direct cost for physical therapy. Obtain this amount from Worksheet B, Part I, column 0, line 25.

Line 14.--Enter the direct cost for occupational therapy. Obtain this amount from Worksheet B, Part I, column 0, line 26.

Line 15.--Enter the direct cost for speech therapy. Obtain this amount from Worksheet B, Part I, column 0, line 27.

Line 16.--Enter the amount on line 10, less the amount on line 13. This is the physical therapy indirect cost for the entire reporting unit.

Line 17.--Enter the amount on line 11, less the amount on line 14. This is the occupational therapy indirect cost for the entire reporting unit.

Line 18.--Enter the amount on line 12, less the amount on line 15. This is the speech therapy indirect cost for the entire reporting unit.

Line 19.--Enter the charge to charge ratio for physical therapy. To obtain this figure, divide the amount on Worksheet D, column 2, line 25 by the amount on Worksheet C, column 2, line 25.

Line 20.--Enter the charge to charge ratio for occupational therapy. To obtain this figure, divide the amount on Worksheet D, column 2, line 26 by the amount on Worksheet C, column 2, line 26.

Line 21.--Enter the charge to charge ratio for speech therapy. To obtain this figure, divide the amount on Worksheet D, column 2, line 27 by the amount on Worksheet C, column 2, line 27.

Line 22.--Calculate the physical therapy demonstration indirect cost by multiplying the amount on line 16 by the amount on line 19.

Line 23.--Calculate the occupational therapy demonstration indirect cost by multiplying the amount on line 17 by the amount on line 20.

Line 24.--Calculate the speech therapy demonstration indirect cost by multiplying the amount on line 18 by the amount on line 21.

Line 25.--Providers in Phase II, enter the sum of lines 5, 6, and 9. Transfer this amount to Worksheet E, Part III, line 7. Providers in Phase III, enter the sum of lines 5, 6, 9, 22, 23, and 24. Transfer this amount to Worksheet E, Part III, line 7.

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	PROVIDER NO.:	PERIOD: FROM: TO:	WORKSHEET S-7 PART IV
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	GROUP (1) 1	M3PI REVENUE CODE 2	SERVICES PRIOR TO October 1		SERVICES ON OR AFTER October 1		HIGH COST RUGs (2) DAYS 4.05	TOTAL (see instructions) 5	
			RATE 3	DAYS 3.01	RATE 4	DAYS 4.01			
1	RUC								1
2	RUB								2
3	RUA								3
4	RVC								4
5	RVB								5
6	RVA								6
7	RHC								7
8	RHB								8
9	RHA								9
10	RMC								10
11	RMB								11
12	RMA								12
13	RLB								13
14	RLA								14
15	SE3								15
16	SE2								16
17	SE1								17
18	SSC								18
19	SSB								19
20	SSA								20
21	CC2								21
22	CC1								22
23	CB2								23
24	CB1								24
25	CA2								25
26	CA1								26
27	IB2								27
28	IB1								28
29	IA2								29
30	IA1								30
31	BB2								31
32	BB1								32
33	BA2								33
34	BA1								34
35	PE2								35
36	PE1								36
37	PD2								37
38	PD1								38
39	PC2								39
40	PC1								40
41	PB2								41
42	PB1								42
43	PA2								43
44	PA1								44
45	AAA								45

(1) The RUG III category represents the PPS period. Enter in column 3.01 the days prior to October 1st and in column 4.01 the days on or after October 1st.
 (2) Enter in column 4.05 those days which are contained in either column 3.01 or 4.01 which cover the period of 4/1/2000 through 9/30/2000.
 These RUGs receive a 20% payment increase added to the total in column 5.

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA			PROVIDER NO.:		PERIOD: FROM: TO:		WORKSHEET S-7 PART IV CONTINUED	
Line 45 Sub- script	GROUP (1)	M3PI REVENUE	SERVICES PRIOR TO October 1		SERVICES ON OR AFTER October 1		HIGH COST RUGs (2)	TOTAL (see instructions)
		CODE	RATE	DAYS	RATE	DAYS	DAYS	
	1	2	3	3.01	4	4.01	4.05	5
45.01	ES3							45.01
45.02	ES2							45.02
45.03	ES1							45.03
45.04	HE2							45.04
45.05	HE1							45.05
45.06	HD2							45.06
45.07	HD1							45.07
45.08	HC2							45.08
45.09	HC1							45.09
45.10'	HB2							45.10'
45.11	HB1							45.11
45.12	LE2							45.12
45.13	LE1							45.13
45.14	LD2							45.14
45.15	LD1							45.15
45.16	LC2							45.16
45.17	LC1							45.17
45.18	LB2							45.18
45.19	LB1							45.19
45.20'	CE2							45.20'
45.21	CE1							45.21
45.22	CD2							45.22
45.23	CD1							45.23
46	TOTAL							46

RUG-IV groups were published in the "Federal Register", Vol. 74.No. 153/August 11, 2009, page 40288- FY 2010 SNF Final Rule. These RUGs are effective for services on and after 10/01/2010.

RUG-IV groups are added for reimbursement on Worksheet S-7, Part IV, and are displayed above. Subscript line 45 as shown above to accommodate this addition.

NOTE: The default line code designation has been changed to "AAA".

HOSPICE IDENTIFICATION DATA	PROVIDER NO.:	PERIOD: FROM _____ TO _____	WORKSHEET S - 8
	HOSPICE NO.:		

PART I

	Enrollment Days	Title XVIII	Title XIX	Title XVIII	Title XIX	Other Unduplicated Days	Total Unduplicated Days	
		Unduplicated Medicare Days	Unduplicated Medicaid Days	Unduplicated Skilled Nursing Facility Days	Unduplicated Nursing Facility Days			
		1	2	3	4			
1	Continuous Home Care							1
2	Routine Home Care							2
3	Inpatient Respite Care							3
4	General Inpatient Care							4
5	Total Hospice Days							5

PART II

		Title XVIII	Title XIX	Title XVIII Skilled Nursing facility	Title XIX Nursing Facility	Other	Total	
		1	2	3	4			
6	Number of Patients Receiving Hospice Care							6
7	Total Number of Unduplicated Continuous Care Hours Billable to Medicare							7
8	Average Length of Stay							8
9	Unduplicated Census Count							9

FORM CMS-2540-96 (12/2000) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB 15-II, SECTION 3515)

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

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

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

The following are requirements for all records:

1. All alpha characters must be in upper case.
2. For micro systems, the end of record indicator must be a carriage return and line feed, in that sequence.
3. No record may exceed 60 characters.

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

1	2	3	4	5
12345678901	2345678901	2345678901	2345678901	23456789012345678
1	1	0101231999274	20003053C99P00520000202000305	
1	7	17:15		

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 reporting periods ending on and after <i>2010274 (October 1, 2010)</i> . Prior approval(s) are for cost reporting periods ending on or after 2008274 (September 30, 2008). 2005304 (October 31, 2005). 2002365 (12/31/02), 2001059, 2000274, 1999334, 1998273, 1997273, and 1996274.

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, sub line, column, and sub column 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 sub line 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	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]
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, <i>and 49</i> . 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 subscribed, there must be a response in the appropriate columns for each subscribed 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, <i>and 49</i> . If line 47 is “Y”, then line 48 must have a response For providers 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	<i>Lines 50, 51 and 52 are not completed for cost reporting periods beginning on and after July 1, 1998. This edit is obsolete as of that date.</i>

ELECTRONIC COST REPORTING SPECIFICATIONS FOR FORM CMS 2540-96

TABLE 6 - EDITS

<u>Reject Code</u>	<u>Condition</u>
1055S	Worksheet S-2: If the response on line 53 column 1 = "Y", then there must be a response on line 53, column 2; line 54, columns 1, 2, and 3, line 55 column 1 or column 2; line 56 columns 1, 2, and 3. If the response on line 53 column 1 = "N", then line 53 column 2, and lines 54 – 56 must be blank. [04/30/2008]
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 three, 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]
1130S	If Worksheet S-4, Part II, column 1, line 17 has data, then it must be a four character alpha numeric; or if column 1.01, line 17 has data, then it must be a five character alpha numeric.[04/30/08]

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]

ELECTRONIC COST REPORTING SPECIFICATIONS FOR FORM CMS 2540-96

TABLE 6 – EDITS

Reject Code	Condition
1225S	Worksheet S-5, Line 15: If the response in column 1 = “Y”, then column 2 must be greater than zero. If the response in column 1 = “N”, then column 2 must = zero. [04/30/2008]
1230S	Worksheet S-7 Part IV: Column 3.01 sum of lines 1 through 45, <i>including subscripts of line 45</i> , must agree with Worksheet S-3, Part I, column 4, line 1. [08/31/2010]
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] If lines 28-30 have an entry in column 2, then column 1 of that line must have an entry. [03/31/1997]
1041A	The total Utilization Review amount shown on Worksheet E, Part III, Line 11, may not be greater than the amount on Worksheet A-8, line 28.(Absolute value of line 28) [04/30/2008]
1045A	This edit was changed to a level two edit April 2003. See edit # 2045A
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] <i>Transfer only the total on line 75, column 18 to Worksheet A-8, column 2 [10/01/10]</i>
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]