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 16 **Date: OCTOBER 2008**

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
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3511.3 – 3511.3 (Cont.)	35-22.1– 35-22.2 (2pp.)	35-22.1– 35-22.2 (2pp.)
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NEW/REVISED MATERIAL--*EFFECTIVE DATE:*

This transmittal updates Chapter 35, Skilled Nursing Facility Complex Cost Report, Form CMS 2540-96, to reflect further clarification to existing instructions. The effective date effective for instructional changes is April 30, 2008.

Significant Revisions:

Worksheet S-2 – One of the changes in Transmittal 15 required the reporting of a National Provider Identifier (NPI) in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Worksheet S-2 was revised to provide for the reporting of this NPI, and the last test case included this change. However due to an internal change of direction concerning this reporting, the NPI is now NOT required to be entered on the Worksheet S-2. Transmittal 16 reverses the change in Transmittal 15 concerning the reporting of the NPI.

Worksheet S-2 - lines 53 through 56- Are added to record information concerning any related organizations or home office costs as defined in CMS Pub.15-1, Chapter 10. These lines include reporting provider name, address, and fiscal intermediary or contractor information.

Worksheet S-4 - Subscript column 1 of lines 16 and 17, to report CBSA. For services on and after 01/01/2006 MSA data is no longer applicable.

Worksheet E-III - Where an intermediary is required to list an adjustment on the settlement worksheet (Worksheet E, Part III), Lines 16 and 36 may be further subscripted beginning with 16.20 and 36.20.

Worksheet H-6 Part II - Specs are added to require that the proper amount as identified on line 20 is entered on line 20.

Worksheets K through K-5 - Effective for FYE on and after 06/30/2006 the following cost centers should be added on subscripted lines as follows:

"Nursing Care-Continuous Home Care" – Line 10.20

"HH Aide & Homemaker- Cont. Home Care" – Line 18.20

"Analgesics" – Line 20.30

"Sedatives/Hypnotics" – Line 20.31

"Other – Specify" – Line 20.32

Specs are being revised to require capturing the actual time stamp (i.e. 14.52) of the ECR file.

REVISED ELECTRONIC SPECIFICATIONS EFFECTIVE DATE: Changes to the electronic reporting specifications are effective for cost reporting periods ending on and after September 30, 2008.

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

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 1st 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.-- Did this facility report less than 1500 Medicare days in its previous year's cost report? Enter "Y" for yes or "N" for no. If a new provider is filing a first year cost report, and qualifies to file a "simplified" SNF cost report, do not enter "Y" or "N".

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

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

Line 53.—Are there any related organizations or home office costs as defined in CMS Pub 15-1, chapter 10 in this cost report? Enter "Y" for yes, or "N" for no in column 1. If yes, and there are related organization or home office costs, enter the related organization or home office provider number in column 2. Also, 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.

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

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

Column Descriptions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Line 10.--Enter the amount from Worksheet A, column 1, line 49.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Lines 16 and 17. – Enter the total number of Metropolitan Statistical Areas (MSAs), and*/or Community Based Statistical Area (CBSA),* served by this provider for this cost reporting period. List each MSA *and CBSA* code on line 17. *Effective for services on and after 01/01/2006, do not use column 1.For 01/01/2006 and after, Worksheet S-4, column 1 should be subscripted to column 1.01 for lines 16 and 17 to report the number of CBSAs, and CBSA codes serviced during this cost reporting period.*

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

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

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

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

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

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

Less than a full Episode of Care--

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

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

When a beneficiary experiences a Significant Change in Condition (SCIC) and subsequently, but within the same 60 day episode, elects to transfer to another provider, a SCIC within a PEP occurs. A SCIC adjustment occurs when a beneficiary experiences a significant change in condition, either improving or deteriorating, during the 60 day episode that was not envisioned in the original plan of care. The SCIC adjustment reflects the proportional payment adjustment for the time both before and after the beneficiary experienced the significant change in condition during the 60 day episode.

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

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

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

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

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

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

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

Line 18.-- Enter in columns 1 through 6 for each episode of care payment category, respectively, the total non-routine medical supply charges for services relating to episodes of care rendered and concluded in the provider's fiscal year.

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

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

Line 12.--Enter the program's share of any recovery of excess depreciation applicable to prior years resulting from provider termination or a decrease in program utilization. (See §§136-136.16.)

Line 13.--Enter the program's share of any net depreciation adjustment applicable to prior years resulting from the gain or loss on the disposition of depreciable assets. (See §§132 - 132.4.) Enter in parentheses ( ) the amount of any excess depreciation taken.

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

Line 14.—For cost reporting periods beginning prior to October 1, 2005, enter the sum of lines 3, 7, 10 and 11, minus lines 12, 8 & 9, plus line 13. For cost reporting periods beginning on and after October 1, 2005 enter the sum of lines 3, 7, line 10.03 for title XVIII, plus lines 11and 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 from Worksheet E-1, column 2.

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

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

Part B Line Descriptions.-

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

Line Descriptions

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

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

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

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

Line 26.--Enter the amounts paid or payable by workmen's compensation and other primary payers when program liability is secondary to that of the primary payer. There are six situations under which Medicare payment is secondary to a primary payer:

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

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

However, if the payment by the primary payer does not satisfy the beneficiary's obligation, the program pays (in situations 1, 2, and 3) the amount it otherwise pays (absent primary payer payment) less the primary payer payment and any applicable deductible and coinsurance. In situations 1, 2, and 3, primary payer payment is not credited toward the beneficiary's deductibles and coinsurance. In situations 4 and 5, the program pays the lesser of (a) the amount it otherwise pays (without regard to the primary payer payment or deductibles and coinsurance) less the primary payer payment; or (b) the amount it otherwise pays (without regard to primary payer payment or deductibles and coinsurance) less applicable deductible and coinsurance. In situations 4 and 5, primary payer payment is credited toward the beneficiary's deductible and coinsurance obligation.

If the primary payment does not satisfy the beneficiary's liability, include the covered days and charges in program days and charges and include the total days and charges in total days and charges for cost apportionment purposes. Enter the primary payer payment on line 26 to the extent that primary payer payment is not credited toward the beneficiary's deductible and coinsurance. Primary payer payments that are credited toward the beneficiary's deductible and coinsurance are not entered on line 27.

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

Line 28.--Enter program reimbursable bad debts for deductibles and coinsurance (from your records), excluding deductibles and coinsurance for physicians' professional services and net of bad debt recoveries.

Line 31.--Enter the program's share of any recovery of excess depreciation applicable to prior years resulting from provider termination or a decrease in Medicare utilization. (See CMS Pub. 15-I, §§136 - 136.16.)

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

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

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

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

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

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

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

Line 36.20.--Enter *OTHER adjustments from Worksheet E-1, column 4.*

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

Line 38.--Enter the program reimbursement effect of protested items. Estimate the reimbursement effect of the nonallowable items by applying reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See §115.2.) Attach a worksheet showing the details and computations for this line.

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

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

Line Descriptions

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

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

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

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

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

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

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

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

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

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

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

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

Line 8 - Inpatient - Respite Care.--This cost center includes costs applicable to patients who receive this level of care on an intermittent, nonroutine, and occasional basis. The costs included on this line are those direct costs of furnishing routine and ancillary services associated with inpatient respite care for which other provisions are not made on this worksheet. Costs incurred by the hospice in furnishing direct patient care services to patients receiving inpatient respite care either directly by the hospice or under a contractual arrangement in an inpatient facility are to be included in visiting service costs section.

For a hospice that maintains its own inpatient beds, these costs include (but are not limited to) the costs of furnishing 24 hours nursing care within the facility, patient meals, laundry and linen services and housekeeping. Plant operation and maintenance costs are recorded on line 3.

For a hospice that does not maintain its own inpatient beds, but furnishes inpatient respite care through a contractual arrangement with another facility, record contracted/purchased costs on Worksheet K-3. Do not include any costs associated with providing direct patient care. These costs are recorded in the visiting service costs section**.**

Line 9 - Physician Services.--In addition to the palliation and management of terminal illness and related conditions, hospice physician services also include meeting the general medical needs of the patients to the extent that these needs are not met by the attending physician. The amount entered on this line includes costs incurred by the hospice or amounts billed through the hospice for physicians direct patient care services.

Line 10 - Nursing Care.--Generally, nursing services are provided as specified in the plan of care by or under the supervision of a registered nurse at the patient's residence.

Line 10.20 - Nursing Care–Continuous Home Care.--Enter the continuous home care portion of costs for nursing services provided by a registered nurse, licensed practical nurse, or licensed vocational nurse as specified in the plan of care by or under the supervision of a registered nurse at the patient's residence.

Line 11 - Physical Therapy.--Physical therapy is the provision of physical or corrective treatment of bodily or mental conditions by the use of physical, chemical, and other properties of heat, light, water, electricity, sound massage, and therapeutic exercise by or under the direction of a registered physical therapist as prescribed by a physician. Therapy and speech-language pathology services may be provided for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

Line 12 - Occupational Therapy.--Occupational therapy is the application of purposeful goal-oriented activity in the evaluation, diagnostic, for the persons whose function is impaired by physical illness
or injury, emotional disorder, congenital or developmental disability, and to maintain health. Therapy and speech-language pathology services may be provided for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

Line 13 - Speech/Language Pathology.--These are physician-prescribed services provided by or under the direction of a qualified speech-language pathologist to those with functionally impaired communications skills. This includes the evaluation and management of any existing disorders of the communication process centering entirely, or in part, on the reception and production of speech and language related to organic and/or nonorganic factors. Therapy and speech-language pathology services may be provided for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

Line 14 - Medical Social Services.--This cost center includes only direct expenses incurred in providing medical social services. Medical social services consist of counseling and assessment activities which contribute meaningfully to the treatment of a patient's condition. These services must be provided by a qualified social worker under the direction of a physician.

Lines 15-17 - Counseling.--Counseling services must be available to both the terminally ill individual and family members or other persons caring for the individual at home. Counseling, including dietary counseling, may be provided both for the purpose of training the individual's family or other care giver to provide care, and for the purpose of helping the individual and those caring for him or her to adjust to the individual's approaching death. This includes dietary, spiritual, and other counseling services provided while the individual is enrolled in the hospice. Costs associated with such counseling are accumulated in the appropriate counseling cost center. Costs associated with bereavement counseling are recorded on line 30.

Line 18 - Home Health Aide and Homemaker.--Enter the cost of a home health aide and homemaker services. Home health aide services are provided under the general supervision of a registered professional nurse and may be provided by only individuals who have successfully completed a home health aide training and competency evaluation program or competency evaluation program as required in 42 CFR 484.36.

Home health aides may provide personal care services. Aides may also perform household services to maintain a safe and sanitary environment in areas of the home used by the patient, such as changing the bed or light cleaning and laundering essential to the comfort and cleanliness of the patient.

Homemaker services may include assistance in personal care, maintenance of a safe and healthy environment, and services to enable the individual to carry out the plan of care.

Line 18.20 - Home Health Aide and Homemaker-Continuous Home Care.--Enter the continuous care portion of cost for home health aide and/or homemaker services provided as specified in the plan of care and under the supervision of a registered nurse.

Line 19 - Other.--Enter on this line any other visiting cost which cannot be appropriately identified in the services already listed.

Line 20 - Drugs, Biological and Infusion Therapy.--Only drugs as defined in §1861(t) of the Act and which are used primarily for the relief of pain and symptom control related to the individual's terminal illness are covered. The amount entered on this line includes costs incurred for drugs or biologicals provided to the patients while at home. If a pharmacist dispenses prescriptions and provides other services to patients while the patient is both at home and in an inpatient unit, a reasonable allocation of the pharmacist cost must be made and reported respectively on line 20 (Drugs and Biologicals) and line 7 (Inpatient General Care) or line 8 (Inpatient Respite Care) of Worksheet K.

A hospice may, for example, use the number of prescriptions provided in each setting to make that allocation, or may use any other method that results in a reasonable allocation of the pharmacist's cost in relation to the service rendered.

Infusion therapy may be used for palliative purposes if you determine that these services are needed for palliation. For the purposes of a hospice, infusion therapy is considered to be the therapeutic introduction of a fluid other than blood, such as saline solution, into a vein.

Line 20.30 - Analgesics.- Enter the cost of analgesics.

Line 20.31 - Sedatives/Hypnotics. - Enter the cost of sedatives/hypnotics.

Line 20.32 - Other Specify. - Specify the type and enter the cost of any other drugs which cannot be appropriately identified in the drug cost center already listed.

Line 21 - Durable Medical Equipment/Oxygen.--Durable medical equipment as defined in 42 CFR 410.38 as well as other self-help and personal comfort items related to the palliation or management

of the patient's terminal illness are covered. Equipment is provided by the hospice for use in the patient's home while he or she is under hospice care.

Line 22 - Patient Transportation.--Enter all of the cost of transportation except those costs previously directly assigned in column 3. This cost is allocated during the cost finding process.

Line 23 - Imaging Services.--Enter the cost of imaging services including MRU.

Line 24 - Labs and Diagnostics.--Enter the cost of laboratory and diagnostic tests.

Line 25 - Medical Supplies.--The cost of medical supplies reported in this cost center are those costs which are directly identifiable supplies furnished to individual patients.

These supplies are generally specified in the patient's plan of treatment and furnished under the specific direction of the patient's physician.

Line 26 - Outpatient Services.--Use this line for any outpatient services costs not captured elsewhere. This cost can include the cost of an emergency room department.

Lines 27-28 - Radiation Therapy and Chemotherapy.--Radiation, chemotherapy, and other modalities may be used for palliative purposes if you determine that these services are needed for palliation. This determination is based on the patient's condition and your care giving philosophy.

Line 29 - Other (Specify).--Enter any additional costs involved in providing visiting services which have not been provided for in the previous lines.

Lines 30-33 - Non Reimbursable Costs.--Enter in the appropriate lines the applicable costs. Bereavement program costs consists of counseling services provided to the individual's family after the individual's death. In accordance with §1814 (I)(1) (A) of the Social Security Act, bereavement counseling is a required hospice service, but it is not reimbursable.

Line 34 - Total.--Line 34 column 10, must agree with Worksheet A, line 55, column 7.

3566. WORKSHEET K-1 – HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Enter all salaries and wages for the hospice on this worksheet for the actual work performed within the specific area or cost center in accordance with the column headings. For example, if the administrator also performs visiting services which account for 55 percent of that person's time, then enter 45 percent of the administrator's salary on line 6 (A&G) and 55 percent of the administrator's salary enter on line 10 (Nursing Care).

The records necessary to determine the split in salary between two or more cost centers must be maintained by the hospice and must adequately substantiate the method used to split the salary. These records must be available for audit by the intermediary, and the intermediary can accept or reject the method used to determine the split in salary. When approval of a method has been requested in writing and this approval has been received prior to the beginning of a cost reporting period, the approved method remains in effect for the requested period and all subsequent periods until you request in writing to change to another method or until the intermediary determines that the method is no longer valid due to changes in your operations.

Definitions

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

Administrator (Column 1).--

Possible Titles: President, Chief Executive Officer.

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

Director (Column 2).--

Possible Titles: Medical Director, Director of Nursing, or Executive Director.

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

The nursing director is responsible for establishing the objectives for the department of nursing. This individual administers the department of nursing and directs and delegates management of professional and ancillary nursing personnel.

Medical Social Worker (Column 3).--This individual is a person who has at least a bachelor's degree from a school accredited or approved by the council of social work education. These services must be under the direction of a physician and must be provided by a qualified social worker.

Supervisors (Column 4).--Employees in this classification are primarily involved in the direction, supervision, and coordination of the hospice activities.

When a supervisor performs two or more functions, e.g., supervision of nurses and home health aides, the salaries and wages must be split in proportion with the percentage of the supervisor's time spent in each cost center, provided the hospice maintains the proper records (continuous time records) to support the split. If continuous time records are not maintained by the hospice, enter the entire salary of the supervisor on line 6 (A&G) and allocate to all cost centers through step-down. However, if the supervisor's salary is all lumped in one cost center, e.g., nursing care, and the supervisor's title coincides with this cost center, e.g., nursing supervisor, no adjustment is required.

Total Therapists (Column 6).--Include in column 6, on the line indicated, the cost attributable to the following services:

Physical therapy	-	line 11
Occupational therapy	-	line 12
Speech pathology	-	line 13

Therapy and speech-language pathology may be provided to control symptoms or to enable the individual to maintain activities of daily living and basic functional skill.

Physical therapy is the provision of physical or corrective treatment of bodily or mental conditions by the use of physical, chemical, and other properties of heat, light, water, electricity, sound, massage, and therapeutic exercise by or under the direction of a registered physical therapist as prescribed by a physician.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 2540-96

TABLE 1 - RECORD SPECIFICATIONS

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

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

The following are requirements for all records:

1. All alpha characters must be in upper case.

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

3. No record may exceed 60 characters.

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

```
          1         2         3         4         5
12345678901234567890123456789012345678901234567890123456
1             1    0101231999274200030 53C99P00520000202000305
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

		Size	Usage	Loc.	Remarks
1.	Record Type	1	X	1	Constant "1"
2.	NPI	10	9	2-11	Numeric only
3.	Spaces	1	X	12	
4.	Record Number	1	X	13	Constant "1"
5.	Spaces	3	X	14-16	
6.	SNF Provider Number	6	9	17-22	Field must have 6 numeric characters
7.	Fiscal Year Beginning Date	7	9	23-29	YYYYDDD - Julian date; first day covered by this cost report
8.	Fiscal Year Ending Date	7	9	30-36	YYYYDDD - Julian date; last day covered by this cost report
9.	MCR Version	1	9	37	Constant "3" (for Form CMS 2540-96)
10.	Vendor Code	3	X	38-40	To be supplied upon approval. Refer to page 35-503.
11.	Vendor Equipment	1	X	41	P = PC; M = Main Frame
12.	Version Number	3	X	42-44	Version of extract software, e.g., 001=1st, 002=2nd, etc. or 101=1st, 102=2nd. The version number must be incremented by 1 with each recompile and release to client(s).
13.	Creation Date	7	9	45-51	YYYYDDD - Julian date; date on which the file was created (extracted from the cost report)
14.	ECR Spec. Date	7	9	52-58	YYYYDDD - Julian date; date of electronic cost report specifications used in producing each file. Valid for cost reporting periods ending on and after *2008274 (September 30, 2008).* Prior approval(s) are for cost reporting periods ending on or after 2005304 (October 31, 2005). 2002365 (12/31/02), 2001059, 2000274, 1999334, 1998273, 1997273, and 1996274.

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

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

		Size	Usage	Loc.	Remarks
1.	Record Type	1	9	1	Constant "1"
2.	Spaces	10	X	2-11	
3.	Record Number				*#2 to #6 - Reserved for future use.* *#7 – The time that the cost report is created. This is represented in military time as alpha numeric. Use position 21-25. Example 2:30PM is expressed as 14:30.* *#8 to #99 - Reserved for future use*
4.	Spaces	7	X	14-20	Spaces (optional)
5.	ID Information	40	X	21-60	Left justified to position 21.

RECORD NAME: Type 2 Records for Labels

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

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

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

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

TYPE 2 COST CENTER DESCRIPTIONS

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

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

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

Worksheets That Apply to the Hospice Complex

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

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

FOOTNOTES:

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

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

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

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

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

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

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

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

(i) Multiple Worksheets H-5, Part II for Cost Limitations Based on the MSA *or CBSA*
The fifth and sixth digits of the worksheet indicator (positions 6 and 7 or the record) is numeric from *00-29* and corresponds to the two digit subscript of line 17 on Worksheet S-4 (i.e. insert the identifier 02 for line 17.02) which identifies the 4 *character* MSA code. If services are provided in only one MSA, the default is 00. Where an HHA provides services in multiple MSA, one Worksheet H-5, Part II must be completed for each MSA.

The fifth and sixth digits of the worksheet indicator (positions 6 and 7 of the record) are numeric from 30-59 and correspond to, but are not identical with, the two digit subscript of line 29, column 1.01 on Worksheet S-4 (i.e., insert the identifier 30 for line 17.00, 31 for line 17.01, and 32 for line 17.02) which identifies the 5 character CBSA. If services are provided in only one CBSA the default is 30. Where an HHA provides services in multiple CBSAs, one Worksheet H-5, Part II must be completed for each CBSA. (The actual effective date of use for CBSAs is episodes concluding on or after January1, 2006.)

(j) Multiple SNF-Based Hospices (HSPSs)
The 3rd digit of the worksheet indicator (position 4 of the record) is numeric to identify the SNF-based hospice. If there is only one hospice, the default is 1. This affects all K series worksheets, and Worksheet S-8

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 2540-96

TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

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

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

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

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

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

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

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

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 2540-96

TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
	WORKSHEET S			
Part II: Balances due provider or program:				
Title V	1, 3-6	1	9	-9
Title XVIII, Part A	1, 4	2	9	-9
Title XVIII, Part B	1, 4-6	3	9	-9
Title XIX	1, 3-6	4	9	-9
In total	7	1-4	9	-9
	WORKSHEET S-2			
For the skilled nursing facility only:				
Street	1	1	36	X
P.O. Box	1	2	9	X
City	2	1	36	X
State	2	2	2	X
Zip Code	2	3	10	X
County	3	1	36	X
MSA Code	3	2	4	X
CBSA Code	3	2.01	5	X
Urban/Rural	3	3	1	X
Facility Specific Rate	3.1	1	11	9(8).99
Transition period	3.1	2	3	9(3)
Wage Index Adjustment Factor – Before October 1	3.2	1	6	9.9(4)
Wage Index Adjustment Factor – After September 30	3.2	2	6	9.9(4)
For the skilled nursing facility and SNF-based components:				
Component name	4, 6-8, 10-12	1	36	X
Provider number (xxxxxx)	4, 6- 8, 10-12	2	6	X
National Provider Identifier	4, 6- 8, 10-12 *These lines are not completed for column 2.01*	2.01	10	9

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

WORKSHEET S-2 (Continued)

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
If depreciation is funded, enter the balance as of the end of the period.	27	1	9	9
Were there any disposals of capital assets during the cost reporting period? (Y/N)	28	1	1	X
Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? (Y/N)	29	1	1	X
Was accelerated depreciation claimed on assets acquired on or after August 1, 1970? (Y/N)	30	1	1	X
Did you cease to participate in the Medicare program at the end of the period to which this cost report applies? (Y/N)	31	1	1	X
Was there a substantial decrease in health insurance proportion of allowable cost from prior cost reporting periods? (Y/N)	32	1	1	X
If this facility contains a public or non-public provider that qualifies for an exemption from the application of the lower of costs or charges, enter "Y" for each component and type of service that qualifies for the exemption. Enter "N" for each component and type of service contained in this facility that does not qualify for the exemption.				
Skilled Nursing Facility	33	1-2	1	X
Nursing Facility	35	3	1	X
I C F - M R	35.1	3	1	X
SNF-Based OLTC	36	1-2	1	X
SNF-Based HHA	37	1-2	1	X
SNF-Based Outpatient Rehabilitation Providers	39	2	1	X
SNF-Based RHC	40	2	1	X
Is this nursing facility exempt from the cost limits? (Y/N)	42	1	1	X

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

WORKSHEET S-2 (Continued)

Is the skilled nursing facility located in a State that certifies the provider as an SNF regardless of the level of care given for titles V and XIX patients? (Y/N)	43	1	1	X
Did the provider participate in the NHCMQ Demonstration during the cost reporting period? (Y/N)	44	1	1	X
If yes, enter phase number.	44	0	2	9
List malpractice premium and paid losses				
Premium:	45	1	11	9
Paid Losses:	45	2	11	9
Self Insurance:	45	3	11	9
Are malpractice premiums and paid losses reported in other than the Administrative and General cost Center? If yes, check box, and submit supporting schedules listing cost centers and amounts contained therein.	46	1	1	X
Are you claiming ambulance costs? Enter Y or N in column 1. If column 1 is Y, and this is your first year of operation for rendering ambulance services, enter Y in column 2. If it is not enter N.	47	1 & 2	1	X
If line 47 column 1 is Y, and column 2 is N, enter on line 48 column 1 the payment limit provided from your fiscal intermediary, and for services on or after 04/01/2002	*48*	*1*	*9*	*9(8).99*
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.	*48*	*2*	*9*	*9*
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.	*48.01*	*1&2*	*9*	*9(8).99*

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

WORKSHEET S-2 (Continued)

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Enter in column 1 the subsequent ambulance payment limit as required. Subscript if more than 2 limits apply.	*48.02 48.03*	*1*	*9*	*9(8).99*
Enter in column 2, the fee schedule amounts for the initial or subsequent period as applicable.	*48.02 48.03*	*2*	*9*	*9*
Did you operate an Intermediate Care Facility for the Mentally Retarded (ICF/MR) under title XIX?	49	1	1	X
Did this facility report less than 1500 Medicare days in its previous year's cost report?	50	1	1	X
If line 50 is yes, did you file your previous year's cost report using the "simplified" step-down method of cost finding?	51	1	1	X
Is this cost report being filed under 42CFR 413.321, the simplified cost report?	52	1	1	X
Are there any related organizations or home office costs as defined in CMS Pub. 15-1, chapter 10?	*53*	*1*	*1*	*X*
If yes, and there are related organization or home office costs, enter the related organization or home office provider number.	*53*	*2*	*6*	*X*
Name	*54*	*1*	*36*	*X*
FI or Contractor name	*54*	*2*	*36*	*X*
FI or Contractor number	*54*	*3*	*6*	*X*
Street	*55*	*1*	*36*	*X*
P.O. Box	*55*	*2*	*9*	*X*
City	*56*	*1*	*36*	*X*
State	*56*	*2*	*2*	*X*
Zip Code	*56*	*3*	*10*	*X*

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

WORKSHEET S-4, PART I

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Number of HHA visits, by discipline:				
Program	1-6	2	9	9
Non-Program	1-7	5	9	9
Total	1-8	8	9	9
Patient count, by discipline:				
Program	1-6	3	9	9
Non-Program	1-7	6	9	9
Total	1-7	9	9	9
Home health aide hours:				
Program	6	1	9	9
Non-Program	6	4	9	9
Total	6	7	9	9
Unduplicated census count:				
Program	9	3	9	9.99
Non-Program	9	6	9	9.99
Total	9	9	9	9.99
Unduplicated census count Pre October 1, 2000:				
Program	9.01	3	9	9.99
Non-Program	9.01	6	9	9.99
Total	9.01	9	9	9.99
Unduplicated census count Post September 30, 2000				
Program	9.02	3	9	9.99
Non-Program	9.02	6	9	9.99
Total	9.02	9	9	9.99

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

WORKSHEET S-4, PART II

Number of hours in a normal work week	0	0	6	9(3).99
Text as needed for blank lines	13-15	0	36	X
Number of full time equivalent employees:				
Staff	1-15	1	6	9(3).99
Contract	1-15	2	6	9(3).99
How many MSA's did you provide services to during this cost reporting period?	16	1	2	9
How many CBSAs did you provide services to during this cost reporting period?	*16*	*1.01*	*2*	*9*
List those MSA code(s) serviced this period.	17	1	4	X
List those CBSA code(s) serviced this period.	*17*	*1.01*	*5*	*X*

WORKSHEET S-4, Part III

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

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 2540-96

TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

WORKSHEET E, PART II

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

WORKSHEET E, PART III

Part A - Inpatient service PPS provider computation of reimbursement of lesser of cost or charges				
Intern and resident charges	5	1	9	9
Inpatient routine PPS amount (see instructions)	7	1	9	9
Primary payer amounts	8	1	9	9
Coinsurance	9	1	9	9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 2540-96

TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

WORKSHEET E, PART III (Continued)

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Reimbursable bad debts	10	1	9	-9
Reimbursable bad debts	10.01	1	9	-9
Reimbursable bad debts	10.02	1	9	-9
Utilization review	11	1	9	9
Recovery of excess depreciation	12	1	9	9
Amounts applicable to prior periods resulting from disposition of depreciable assets	13	1	9	-9
Sequestration adjustment (see instructions)	15	1	9	9
Other Adjustments (Specify)	*16.20 - 16.99*	*0*	*36*	*X*
Other Adjustments	*16.20 - 16.99*	*1*	*11*	*-9*
Protested amounts	18	1	9	-9
Part B - Ancillary service computation of reimbursement of lesser of cost or charges (title XVIII only)				
Intern and resident charges	24	1	9	9
Primary payer amounts	26	1	9	9
Coinsurance and deductibles	27	1	9	9
Reimbursable bad debts	28	1	9	9
Recovery of excess depreciation	31	1	9	9
Other adjustments (specify)	32	0	36	X
Other adjustments	32	1	9	-9
Amounts applicable to prior periods resulting from disposition of depreciable assets	33	1	9	-9
Sequestration adjustment	35	1	9	9
Other Adjustments (Specify	*36.20 – 36.99*	*0*	*36*	*X*
Other Adjustments	*36.20 – 36.99*	*1*	*11*	*-9*
Protested amounts	38	1	9	-9

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

WORKSHEET H-5 PART V

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Medicare visits for services rendered before 1/1/98	26-28	3	9	9
Medicare visits for services rendered on and after 1/1/98	26-28	5	9	9
Medicare visits for services rendered 1/1/99 to 9/30/00	26-28	5.01	9	9
Medicare visits for services rendered on and after 10/1/00	26-28	5.02	9	9

WORKSHEET H-6, PART I

Total charges for title XVIII - Parts A and B services	2, 2.01	1-3	9	9
Amount collected from patients	3	1-3	9	9
Amount collectible from patients	4	1-3	9	9
Primary payer payments	7	1-3	9	9

WORKSHEET H-6, PART II

PPS Reimbursement Amounts	8.01–8.14	1,2	9	9
Part B deductibles billed to Medicare patients	9	2	9	9
Coinsurance billed to Medicare patients	11	2	9	9
Reimbursable bad debts	13	1-2	9	9
Amounts applicable to prior periods	15	1-2	9	9
Recovery of excess depreciation	16	1-2	9	-9
Non-refunded excess charges to beneficiaries	17	1-2	9	9
Other adjustments	18.01	1-2	9	9
Sequestration adjustment	19	1-2	9	9
Amounts due to you after sequestration adjustment & other adjustments	*20*	*1-2*	*9*	*9*
Interim payments (titles V, XVIII, and XIX)	*21*	*1-2*	*9*	*9*
Protested amounts	23	1-2	9	-9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 2540-96

TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

WORKSHEET H-7

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Total interim payments paid to provider	1	2 & 4	9	9
Interim payments payable	2	2 & 4	9	9
Date of each retroactive lump sum adjustment (MM/DD/YYYY)	3.01-3.98	1 & 3	10	X
Amount of each lump sum adjustment				
Program to provider	3.01-3.49	2 & 4	9	9
Provider to program	3.50-3.98	2 & 4	9	9

WORKSHEET I-1

Provider based cost	1-9, 11-13, 15-20, 23-27, 29-30	1,2,4,6, & 7	11	-9

WORKSHEET I-2

Number of FTE personnel	1-3, & 5-7	1	6	9(3).99
Total visits	1-3, 5-7, & 9	2	11	9
Productivity Standards	1, 2, & 3	3	4	9
Greater of columns 2 or 4	4	5	11	9
Parent provider overhead allocated to facility (see instructions)	17	1	11	9

WORKSHEET I-3

Adjusted cost per visit	7	1	6	9(3).99
Maximum rate per visit (from your intermediary)	8	1, 2, & 3	6	9(3).99
Rate for program covered visits	9	1, 2, & 3	6	9(3).99
Medicare covered visits excluding mental health services (from your intermediary)	10	1, 2, & 3	11	9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 2540-96

TABLE 3A - WORKSHEETS REQUIRING NO INPUT

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

TABLE 3B - TABLES TO WORKSHEET S-2

Table I: Type of Control

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

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

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

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

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

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 2540-96

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

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

ELECTRONIC COST REPORTING SPECIFICATIONS FOR FORM CMS 2540-96

TABLE 6 - EDITS

Reject Code	Condition
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 4: Column 3.01 sum of lines 1 through 45 must agree with Worksheet S-3, Part I, column 4, line 1. [04/30/2008]*
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]
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]

ELECTRONIC COST REPORTING SPECIFICATIONS FOR FORM CMS 2540-96

TABLE 6 – EDITS

Reject Code	Condition
1000B	On Worksheet B-1, all statistical amounts must be greater than or equal to zero, except for reconciliation columns. [03/31/1997] (A): On Worksheet B-1, Part II, all statistical amounts must be greater than or equal to zero, except for reconciliation columns. [02/01/2001] (B)
1005B	Worksheet B, Part I, column 18, line 75 must be greater than zero. [03/31/1997]
1010B	For each general service cost center with a net expense for cost allocation greater than zero (Worksheet B-1, columns 1 through 15, line 75), the corresponding total cost allocation statistics (Worksheet B-1, column 1, line 1; column 2, line 2; etc.) must also be greater than zero. Exclude from this edit any column, including any reconciliation column, that uses accumulated cost as its basis for allocation. [03/31/1997]
1015B	For any column which uses accumulated cost as its basis of allocation (Worksheet B-1), there may not simultaneously exist on any line an amount both in the reconciliation column and the accumulated cost column, including a negative one. [03/31/1997]
1010C	On Worksheet C, all amounts in column 1 line 75 and column 2 must be greater than or equal to zero. [03/31/1997]
1000D	On Worksheet D, all amounts must be greater than or equal to zero. [03/31/1997]
1005D	*The total inpatient charges on Worksheet C, Part I, Line 30 must be greater than or equal to the sum of Worksheet D, Part I, Line 30 plus Worksheet D, Part II, Line 2. [04-30--2008]*
1000E	*On Worksheet E, Part III, line 10.02, bad debt for dual eligible beneficiaries, new amounts cannot exceed total bad debts on line 10, (eg. for Worksheet E, Part III, line 10.02, must be less than or equal to line 10, total bad debts). Do not apply this edit if the total bad debt line is negative. [04/30/2008]*
1020H	For the home health agency, [FYs ending through 9/30/2000], the total Medicare program (Title XVIII) visits reported as the sum of all Worksheets H-5, Part II (sum of columns 5 and 6, lines 1-6, plus Worksheet H-5, Part V, columns 3, 5, and 5.01, lines 26-28) must equal the sum of the visits reported on Worksheet S-4 (column 2, sum of lines 1-6). Do not apply this edit for cost reports beginning on or after 10/01/2000. (A)
1021H	For the home health agency, [FYs which over lap 10/1/2000], the total Medicare program (Title XVIII) visits reported as the sum of all Worksheets H-5, Part II (sum of columns 5 and 6, lines 1-6 which are pre 10/1/2000 visits excluding subscripts, plus Worksheet H-5, Part V, columns 5.01 pre 10/1/2000 visits, lines 26-28) must equal the sum of the visits reported on Worksheet S-4, column 2, sum of lines 1-6. (A)

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TABLE 6 – EDITS

1022H For the home health agency, [FYs beginning on or after 10/1/ 2000], the total Medicare program (Title XVIII) visits reported as the sum of all Worksheets H-5, Part II (sum of columns 5 and 6, lines 1-6, must equal the sum of the visits reported on Worksheet S-4, Part III, column 7, sum of lines 1, 3, 5, 7, 9 and 11. (A)

1023H For the home health agency, [FYs ending through 9/30/2000], the total Medicare (Title XVIII) unduplicated census count (Worksheet S-4, Part I, column 3, line 9) must be equal to or greater than the sum of the unduplicated census count for all MSAs (Worksheet H-5, Part IV, column 1, line 25). Do not apply this edit for cost reports beginning on or after 10/01/2000. (A)

1024H For the home health agency, [FYs which over lap 10/1/2000], the total Medicare (Title XVIII) unduplicated census count (Worksheet S-4, Part I, column 3, line 9.01) must be equal to or greater than the sum of the unduplicated census count for all MSAs (Worksheet H-5, Part IV, column 1, line 25). (A)

1030H For the home health agency, [FYs ending through 9/30/2000], if Medicare visits on Worksheet S-4, column 2, lines 1-6, respectively, are greater than zero, then the corresponding cost on Worksheet H-4, Part I, Column 3, lines 2 through 7, must also be greater than zero. Do not apply this edit for cost reports beginning on or after 10/01/2000. (A)

1035H Worksheet H-6 Part II: If line 2*0*, columns 1 and 2 respectively, are greater than zero (0), then Worksheet H-7 Line 1 columns 2 and 4, respectively, must be greater than zero (0) [04/30/2008]

1000J Worksheet J-1, Part I, sum of columns 0-3, 4-15, and 17, line 22, must equal the corresponding Worksheet B, column 18, line 50 or appropriate subscript as identifies this provider type. [03/31/1997]

II. Level II Edits (Potential Rejection Errors)

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

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

ELECTRONIC COST REPORTING SPECIFICATIONS FOR FORM CMS 2540-96

TABLE 6 - EDITS

2025 Only nonstandard cost center codes within a cost center category may be placed on standard cost center lines of that cost center category.

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

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

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

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

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

2005S *DELETE THIS EDIT*: The combined amount due the provider or program (Worksheet S, Part II, line 7, sum of columns 1-4) should not equal zero. [09/30/2008]

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TABLE 6 - EDITS

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

ELECTRONIC COST REPORTING SPECIFICATIONS FOR FORM CMS 2540-96

TABLE 6 – EDITS

Edit	Condition
2160S	If Worksheet S-3, Part III, column 4, line 14 is greater than zero, then those hours should be at least 20 percent but not more than 60 percent of Worksheet S-3, Part II, column 4, line 1. [03/31/1997]
2165S	Worksheet S-3, Part II, column 5: line 16 must be greater than $5.14, and less than $50.00; line 17 must be greater than $7.00, and less than $75.00; and line 18 must be greater than $5.14, and less than $50.00;. [12/31/2002]
2000A	Worksheet A-6, column 1 (reclassification code) must be alpha characters. [03/31/1997]
2020A	Worksheet A-8-1, Part A, line 1, must contain an "X" in either column 1 or 2. [03/31/1997]
2035A	For Worksheet A-7, line 7, the sum of columns 1-3 minus column 5 must be greater than zero. [03/31/1997] Column headings (Worksheets B-1; B, Parts I and II; and J-1, Part III) are required as indicated below. (A).
2045A	If there are any transactions with related organizations or home offices as defined in CMS Pub. 15-I, chapter 10 (Worksheet A-8-1, Part A, line 1, column 1, is "X"), Worksheet A-8-1, Part B, columns 4 or 5, sum of lines 1-9 must be greater than zero; and Part C, column 1, any one of lines 1-10 must contain any one of alpha characters A through G. However, for each line completed in Part B, at least one line entry must be completed in Part C. Conversely, if Worksheet A-8-1, Part A, line 1, column 2, is "X," Worksheet A-8-1, Parts B and C must not be completed. [03/31/1997]
2000B	At least one cost center description (lines 1-3), at least one statistical basis label (lines 4-5), and one statistical basis code (line 6) must be present for each general service cost center with costs to allocate. This edit applies to all general service cost centers required and/or listed. [03/31/1997]
2005B	The column numbering among these worksheets must be consistent. For example, data in capital related costs - buildings and fixtures is identified as coming from column 1 on all applicable worksheets. [03/31/1997]
2000G	Total assets on Worksheet G (line 33, sum of columns 1-4) must equal total liabilities and fund balances (line 59, sum of columns 1-4). [03/31/1997]
2010G	Net income or loss (Worksheet G-3, column 1, line 32) should not equal zero. [03/31/1997]

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