Medicare

Department of Health and Human Services (DHHS)

Provider Reimbursement Manual

Centers for Medicare and Medicaid Services (CMS)

Part 2, Provider Cost Reporting Forms and Instructions, Chapter 29, Form CMS 222-92

Transmittal 10 **Date: NOVEMBER 2011**

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
2906 - 2906 (Cont.)	29-7 - 29-8 (2 pp.)	29-7 - 29-8 (2 pp.)
2908.2 (Cont.) - 2908.2 (Cont.)	29-11 - 29-11.1 (2 pp.)	29-11 (1 p.)
2990 (Cont.) - 2990 (Cont.)	29-309 - 29-312 (4 pp.)	29-309 - 29-312 (4 pp.)
2995 (Cont.) - 2995 (Cont.)	29-503 - 29-504 (2 pp.)	29-503 - 29-504 (2 pp.)
	29-517 - 29-518.1 (3 pp.)	29-517 - 29-518 (2 pp.)
	29-527 - 29-528 (2 pp.)	29-527 - 29-528 (2 pp.)

NEW/REVISED MATERIAL--EFFECTIVE DATE: Cost Reporting Periods Ending on or After January 1, 2011.

This transmittal updates Chapter 29, Independent Rural Health Clinic (RHC) /Freestanding Federally Qualified Health Center (FQHC) Cost Report, (Form CMS-222-92). This transmittal also reflects further clarification and makes corrections to existing instructions.

Significant Revisions:

- Worksheet B, Part I - Added lines 7.01 (Medical Nutrition Therapist) and 7.02 (Diabetes Self Management Training) as new position categories to facilitate the collection of full time equivalent (FTE) and visit data for RHCs and FQHCs.
- Worksheet C, Part II - Added lines 18.01 through 18.06 to implement section 4104 of ACA which eliminates coinsurance and deductible for preventive services furnished by RHCs and FQHCs, effective for dates of service on or after January 1, 2011.
- Added a new edit: 1000C.

REVISED ELECTRONIC SPECIFICATIONS EFFECTIVE DATE: Changes to the electronic reporting specifications are effective for cost reporting periods ending on or after January 1, 2011.

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

Lines 38 through 48.--Enter the expenses related to the administration and management of the clinic.

Line 49.--Enter the sum of the amount on lines 38 through 48.

Line 50.--Enter the sum of lines 37 and 49. Transfer the total amount in column 7 to Worksheet B, Part II, line 14.

Lines 51 through 56.--Enter the cost centers applicable to services other than RHC/FQHC services (excluding overhead).

Line 57.--Enter the sum of the amounts on lines 51 through 56.

Lines 58 through 60.--Enter the cost of services that are not reimbursable under Medicare.

Line 61.--Enter the sum of the amounts on lines 58 through 60.

Line 62.--This is the total cost of the facility. It is the sum of the amounts on lines 25, 50, 57, and 61.

2905. WORKSHEET A-1 - RECLASSIFICATION

This worksheet provides for the reclassification of certain amounts to effect the proper cost allocation. The cost centers affected must be specifically identifiable in your accounting records. Use reclassifications in instances in which the expenses applicable to more than one of the cost centers listed on Worksheet A are maintained in your accounting books and records in one cost center. For example, if a physician performs administrative duties, the appropriate portion of his/her compensation, payroll taxes and fringe benefits must be reclassified from "Facility Health Care Staff Cost" to "Facility Overhead", line 38 for the office salaries and line 45 for the benefits and taxes.

2906. WORKSHEET A-2 - ADJUSTMENTS TO EXPENSES

This worksheet provides for adjusting the expenses listed on Worksheet A, column 5. Make these adjustments, which are required under the Medicare principles of reimbursement, on the basis of cost, or amount received. Enter the total amount received (revenue) only if the cost (including the direct cost and all applicable overhead) cannot be determined. However, if total direct and indirect cost can be determined, enter the cost. Once an adjustment to an expense is made on the basis of cost, you may not, in future cost reporting periods determine the required adjustment to the expense on the basis of revenue. Enter the following symbols in column 1 to indicate the basis for adjustments: "A" for costs and "B" for amount received. Line descriptions indicate the more common activities which affect allowable costs or result in costs incurred for reasons other than patient care and, thus, require adjustments.

Types of items to be entered on this worksheet are (1) those needed to adjust expenses incurred, (2) those items which constitute recovery of expenses through sales, charges, fees, etc, and (3) those items needed to adjust expenses in accordance with the Medicare principles of reimbursement. (See CMS Pub. 15-1, §2328.)

If an adjustment to an expense affects more than one cost center, record the adjustment to each cost center on a separate line on this worksheet.

Line Descriptions

Line 1.--Investment income on restricted and unrestricted funds which are commingled with other funds must be applied together against the total interest expense included in allowable costs. (See CMS Pub. 15-1, §202.2.)

Apply the investment income on restricted and unrestricted funds which are commingled with other funds against the Administrative, Depreciation - Buildings and Fixtures, Depreciation - Equipment, and any other appropriate cost centers on the basis of the ratio that interest expense charged to each cost center bears to the total interest expense charges to all of your cost centers.

Line 5.--Enter the allowable home office costs which have been allocated to the facility. Use additional lines to the extent that various facility cost centers are affected. (See CMS Pub. 15-1, chapter 21.)

Line 6.--Obtain the amount to be entered on this line from Supplemental Worksheet A-2-1, Part II, column 6, line 5. Note that Worksheet A-2-1, Part II, lines 1 through 4, represent the detail of the various cost centers to be adjusted on Worksheet A.

Line 8.--Enter the amount which represents the allowable cost of the services furnished by National Health Service Corp (NHSC) personnel. Obtain this amount from your intermediary.

Lines 9 and 10.--If depreciation expense computed in accordance with Medicare principles of reimbursement differs from depreciation expenses per your books, enter the difference on lines 9 and/or 10.

2907. WORKSHEET B - VISITS AND OVERHEAD COST FOR RHCs/FQHCs

Worksheet B is used by the RHC/FQHC to summarize (1) the visits furnished by your health care staff and by physicians under agreements with you, and (2) the overhead costs incurred by you which apply to RHC/FQHC services.

2907.1 Part I - Visits and Productivity.--Use Part I to summarize the number of facility visits furnished by the health care staff and to calculate the number of visits to be used in the rate determination. Productivity standards established by CMS are applied as a guideline that reflects the total combined services of the staff. Apply a level of 4200 visits for each physician and a level of 2100 visits for each nonphysician practitioner.

Lines 1 through 9 *(and applicable subscripts)* of Part I list the types of practitioners (positions) for whom facility visits must be counted and reported.

Line 1--Enter the number of FTEs and total visits furnished to facility patients by staff physicians working at the facility on a regular ongoing basis. Also include on this line, physician data (FTEs and visits) for services furnished to facility patients by staff physicians working under contractual agreement with you on a regular ongoing basis in the RHC/FQHC facility. These physicians are subject to productivity standards. See 42 CFR 491.8.

Column 1.--Record the number of all full time equivalent (FTE) personnel in each of the applicable staff positions in the facility practice (See CMS Pub. 27, §503 for a definition of FTEs).

Column 2.--Record the total visits actually furnished to all patients by all personnel in each of the applicable staff positions in the reporting period. Count visits in accordance with instructions in 42 CFR 405.2401(b) defining a visit.

Column 3.--This is the number of visits required by productivity standards. No entry is required.

Line 12.--Enter the subtotal of Medicare cost. This cost is determined by multiplying the rate per visit on line 10 by the number of visits on line 11 (the total number of covered Medicare beneficiary visits for RHC/FQHC services during the reporting period).

Line 13.--Enter the number of Medicare covered visits subject to the outpatient mental health services limitation from your intermediary records.

Line 14.--Enter the Medicare covered cost for outpatient mental health services by multiplying the rate per visit on line 10 by the number of visits on line 13.

Line 15.--Enter the limit adjustment. In accordance with MIPPA 2008, section 102, the outpatient mental health treatment service limitation applies as follows: For services rendered through December 31, 2009, the limitation is 62.50 percent; services from January 1, 2010, through December 31, 2011, the limitation is 68.75 percent; services from January 1, 2012, through December 31, 2012, the limitation is 75 percent; services from January 1, 2013, through December 31, 2013, the limitation is 81.25 percent; and services on or after January 1, 2014, the limitation is 100 percent. This is computed by multiplying the amount on line 14 by the corresponding outpatient mental health treatment service limit percentage. This limit applies only to therapeutic services not initial diagnostic services.

Line 16.--Enter the total Medicare cost. This is equal to the sum of the amounts on lines 12 and 15.

Line 17.--Enter the amount credited to the RHC's Medicare patients to satisfy their deductible liabilities on the visits on lines 11 and 13 as recorded by the intermediary from clinic bills processed during the reporting period. RHCs determine this amount from the interim payment lists provided by the intermediaries. FQHCs enter zero on this line as deductibles do not apply.

Line 18.--Enter the net Medicare cost. This is equal to the result of subtracting the amount on line 17 from the amount on line 16. Enter in column 3 the sum of the amounts in columns 1 and 2.

NOTE: *Section 4104 of ACA eliminates coinsurance and deductible for preventive services, effective for dates of service on or after January 1, 2011. RHCs and FQHCs must provide detailed healthcare common procedure coding system (HCPCS) coding for preventive services to ensure coinsurance and deductible are not applied. Providers must maintain this documentation in order to apply the appropriate reductions on lines 18.03 and 18.04. For cost reporting periods that overlap or begin on or after January 1, 2011, providers must complete lines 18.01 through 18.06.*

Line 18.01.--Enter the total Medicare charges from the contractor's records (PS&R report). For cost reporting periods that overlap January 1, 2011, do not complete the column associated with services rendered prior to January 1, 2011, and enter total program charges in the column associated with services rendered on or after January 1, 2011. For cost reporting periods beginning on or after January 1, 2011, enter total program charges in each column, as applicable.

Line 18.02.--Enter the total Medicare preventive charges from the provider's records. For cost reporting periods that overlap January 1, 2011, do not complete the column associated with services rendered prior to January 1, 2011, and enter total program preventive charges in the column associated with services rendered on or after January 1, 2011. For cost reporting periods beginning on or after January 1, 2011, enter total program preventive charges in each column, as applicable.

Line 18.03.--Enter the total Medicare preventive costs. For cost reporting periods that overlap January 1, 2011, do not complete the column associated with services rendered prior to January 1, 2011, and enter the total program preventive costs ((line 18.02 divided by line 18.01) times line 18)) in the column associated with services rendered on or after January 1, 2011. For cost reporting periods beginning on or after January 1, 2011, enter the total program preventive costs ((line 18.02 divided by line 18.01) times line 18)) in each column, as applicable.

Line 18.04.--Enter the total Medicare non-preventive costs. For cost reporting periods that overlap January 1, 2011, do not complete the column associated with services rendered prior to January 1, 2011, and enter the total program non-preventive costs ((line 18 minus line 18.03) times .80)) in the column associated with services rendered on or after January 1, 2011. For cost reporting periods beginning on or after January 1, 2011, enter the total program non-preventive costs ((line 18 minus line 18.03) times .80)) in each column, as applicable.

Line 18.05.--Enter the net Medicare costs. For cost reporting periods that overlap January 1, 2011, enter total program costs (line 18 times .80) in column 1, and enter the sum of lines 18.03 and 18.04, in column 2, as applicable. For cost reporting periods beginning on or after January 1, 2011, enter the sum of lines 18.03 and 18.04, in each column, as applicable.

Line 18.06.--Enter the coinsurance amount applicable to the RHC or FQHC for program patient visits on lines 11 and 13 as recorded by the contractor from clinic bills processed during the reporting period. This line is captured for informational and statistical purposes only. This line does not impact the settlement calculation.

Line 19.--Enter 80 percent of the amount on line 18, column 3. ***Do not use this line for cost reporting periods that overlap or begin on or after January 1, 2011.***

Line 20.--Enter the Medicare cost of pneumococcal and influenza vaccines and their administration from Worksheet B-1, line 16.

Line 21.--Enter the total reimbursable Medicare cost. *For cost reporting periods ending before 1/1/2011, enter* the sum of the amounts on lines 19 and 20. *For cost reporting periods that overlap or begin on or after January 1, 2011, enter the sum of the amounts on lines 18.05 and 20.*

Line 22.--Enter the total payments made to you for covered services furnished to Medicare beneficiaries during the reporting period (from intermediary records).

Line 23.--This is equal to the result of subtracting the amount on line 21 from the amount on line 22.

Line 24.--Enter your total reimbursable bad debts, net of recoveries, from your records.

Line 24.01.--Enter the gross reimbursable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. These amounts also are included on line 24. (4/1/2004b)

Line 24.02.--FOR INTERMEDIARY/CONTRACTOR USE ONLY--Enter intermediary/contractor tentative and final settlements on this line.

Line 25.--Enter the total amount due to/from the Medicare program (sum of lines 23 and 24 *plus or minus line 24.02*). This is the amount of the payment reconciliation.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-222-92
TABLE 1 - RECORD SPECIFICATIONS

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

The medium for transferring cost reports submitted electronically to fiscal intermediaries is 3½" diskette. These disks must be in IBM format. The character set must be ASCII. You must seek approval from your fiscal intermediary regarding alternate methods of submission to ensure that the method of transmission is acceptable.

The following are requirements for all records:

1. All alpha characters must be in upper case.

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

3. No record may exceed 60 characters.

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

```
          1         2         3         4         5         6
12345678901234567890123456789012345678901234567890123456789012345678901234567890
1             1    213975200909120100904A99P00120101202009274
1             2         14:30
```

Record #1: This is a cost report file submitted by Provider 213975 for the period from April 1, 2009 (2009091) through March 31, 2010 (2010090). It is filed on FORM CMS-222-92. It is prepared with vendor number A99's PC based system, version number 1. Position 38 changes with each new test case and/or approval and is alpha. Positions 39 and 40 remain constant for approvals issued after the first test case. This file is prepared by the independent rural health clinic facility on April 30, 2010 (2010120). The electronic cost report specification dated October 1, 2009 (2009274) is used to prepare this file.

FILE NAMING CONVENTION

Name each cost report file in the following manner:

RFNNNNNN.YYL, where

1. RF (Independent Rural Health Clinic or Federally Qualified Health Center Electronic Cost Report) is constant;
2. NNNNNN is the 6 digit Medicare independent rural health clinic or federally qualified health center provider number;
3. YY is the year in which the provider's cost reporting period ends; and
4. L is a character variable (A-Z) to enable separate identification of files from independent RHC/FQHC facility with two or more cost reporting periods ending in the same calendar year.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-222-92
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.	RHC/FQHC 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 "4" (for FORM CMS-222-92)
10.	Vendor Code	3	X	38-40	To be supplied upon approval. Refer to page 32-503.
11.	Vendor Equipment	1	X	41	P = PC; M = Main Frame
12.	Version Number	3	X	42-44	Version of extract software, e.g., 001=1st, 002=2nd, etc. or 101=1st, 102=2nd. The version number must be incremented by 1 with each recompile and release to client(s).
13.	Creation Date	7	9	45-51	YYYYDDD – Julian date; date on which the file was created (extracted from the cost report)
14.	ECR Spec. Date	7	9	52-58	YYYYDDD – Julian date; date of electronic cost report specifications used in producing each file. Valid for cost reporting periods ending on or after *2011001 (1/1/2011)*. Prior approval(s) 2005090 *and 2009274*.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 222-92
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
SUPPLEMENTAL WORKSHEET A-2-1 (Continued)				
If type is G, specify description of relationship	1-4	0	36	X
Name of related individual or organization	1-4	2	36	X
Percentage of ownership	1-4	3	6	9 (3).99
Name of related individual or organization	1-4	4	36	X
Percentage of ownership of provider	1-4	5	6	9(3).99
Type of business	1-4	6	15	X
WORKSHEET B-PART I				
Position by department:				
Number of Full Time Equivalent Personnel	1-3,5-7	1	6	9(3).99
Total Visits	1-3,5-7,9	2	11	9
Productivity Standard (see instructions)	1-3	3	11	9
Greater of columns 2 or 4	4	5	11	9
WORKSHEET C-PART I				
Maximum Rate Per Visit	8	1,2,2.01	6	9(3).99
WORKSHEET C-PART II				
Medicare Covered Visits Excluding Mental Health Services	11	1,2,2.01	11	9
Medicare Covered Visits For Mental Health Services	13	1,2,2.01	11	9
Beneficiary Deductibles	17	1,2,2.01	11	9
Total Program Cost	*18*	*1,2,2.01*	*11*	*9*
Total Program Charges	*18.01*	*1,2,2.01*	*11*	*9*
Total Program Preventative Charges	*18.02*	*1,2,2.01*	*11*	*9*
Total Net Program Cost	*18.05*	*1,2,2.01*	*11*	*9*
Beneficiary Coinsurance	*18.06*	*1,2,2.01*	*11*	*9*

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 222-92
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
WORKSHEET C-PART II				
Payments to RHC/FQHC during Reporting Period	22	3	11	9
Total Reimbursable Bad Debts, Net of Recoveries	24	3	11	9
Total Gross Reimbursable Bad Debts for Dual Eligible Beneficiaries	24.01	3	11	9
Total Amount Due To/From The Medicare Program	25	3	11	9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-222-92
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

SUPPLEMENTAL WORKSHEET B-1

Ratio of Pneumococcal and Influenza Vaccine Staff Time to Total Health Care Staff Time	2	1,2,2.01,2.02	8	9.9(6)
Medicare supplies cost-Pneumococcal and Influenza Vaccine (From Your Records)	4	1,2,2.02	11	9
Total Number of Pneumococcal and Influenza injections (From Provider Records)	11	1,2,2.01,2.02	11	9
Number of Pneumococcal and Influenza Vaccine Injections Administered to Medicare Beneficiaries allowable cost	13	1,2,2.01,2.02	11	9

TABLE 3A - WORKSHEETS REQUIRING NO INPUT

Worksheet B, Part II

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

Worksheet	Lines
S, Part I	1-5,9,10,13,14
S, Part III	1-6,9,10
A	1-8,12-14,16-20,24-33,37-42,44,49-53,57,61,62
A-1	ALL
A-2	1-10
A-2-1, Part I	1
A-2-1, Part II	1-3,5
A-2-1, Part III	1-3
B-Part I	1-9
B-Part II	10-16
C, Part I	1-9
C, Part II	10-25
B-1	1-16

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-222-92
TABLE 6 – EDITS

Reject Code	Condition
1025A	For each line on Worksheet A-1, if there is an entry in columns 3, 4, 6, or 7, there must be an entry in column 1. There must be an entry on each line of column 4 for each entry in column 3 (and vice versa), and there must be an entry on each line of column 7 for each entry in column 6 (and vice versa). [3/31/2005]
1040A	For Worksheet A-2 adjustments on lines 1-5, and 7-10, if either columns 2 or 4 has an entry, then both columns 2 and 4 must have entries, and if any one of columns 0, 1, 2, or 4 for line 11 and subscripts thereof has an entry, then all columns 0, 1, 2, and 4 must have entries. Only valid line numbers may be used in column 4. [3/31/2005]
1045A	If there are any transactions with related organizations as defined in CMS Pub. 15-I, chapter 10 (Worksheet A-2-1, Part I, column 1, line 1 is "Y"), Worksheet A-2-1, Part II, columns 4 or 5, sum of lines 1-4 must be greater than zero; and Part C, column 1, any one of lines 1-4 must contain any one of alpha characters A through G. Conversely, if Worksheet A-2-1, Part I, column 1, line 1 is "N", Worksheet A-2-1, Parts II and III must not be completed. [3/31/2005]
1050A	If the following amounts on Worksheet A are greater than zero, then the corresponding FTEs and total visits on worksheet B, Part I must also be greater than zero and vise versa: Worksheet A, column 7, Line: 1, 2, 3, 4, 6, 7 Worksheet B, Part I, columns 1& 2, Line: 1, 2, 3, 5, 6, 7 [3/31/2005]
1055A	If the amount on Worksheet A, column 7, line 13 (Physician Services Under Agreement) is greater than zero, then the corresponding total visits on worksheet B, Part I, column 2, line 9 must also be greater than zero and vise versa. [3/31/2005]
1000B	Total visits on Worksheet B, Part I (sum of column 2, lines 1-3, 5-7, & 9), must be greater than or equal to the sum of the total Medicare covered visits on Worksheet C, Part II, lines 11 &13, columns 1, 2, & 2.01. [3/31/2005]
1000C	*The sum of Worksheet C, Part II, line 18.02, columns 1 and 2, must be less than or equal to the sum of line 18.01, columns 1 and 2. [1/1/2011s].*

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-222-92
TABLE 6 – EDITS

II. Level II Edits (Potential Rejection Errors)

These conditions are usually, but not always, incorrect. These edit errors should be cleared when possible through the cost report. When corrections on the cost report are not feasible, 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). [3/31/2005]
2005	Only elements set forth in Table 3, with subscripts as appropriate, are required in the file. [3/31/2005]
2010	The cost center codes (positions 21-24) (type 2 records) must be a code from Table 5, and each cost center code must be unique. [3/31/2005]
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. [3/31/2005]
2020	All standard cost center codes must be entered on the designated standard cost center line and subscripts thereof as indicated in Table 5. [3/31/2005]
2025	Only nonstandard cost center codes within a cost center category may be placed on standard cost center lines of that cost center category. [3/31/2005]
2030	The standard cost centers listed below must be reported on the lines as indicated and the corresponding cost center codes may only appear on the lines as indicated. No other cost center codes may be placed on these lines or subscripts of these lines, unless indicated herein. [3/31/2005]

Cost Center	Line	Code
Physician	1	0100
Physician Assistant	2	0200
Nurse Practitioner	3	0300
Visiting Nurse	4	0400
Other Nurse	5	0500
Clinical Psychologist	6	0600
Clinical Social Worker	7	0700
Laboratory Technician	8	0800
Physician Services Under Agreement	13	1300
Physician Supervision Under Agreement	14	1400
Medical Supplies	17	1700
Transportation (Health Care Staff)	18	1800