
Medicare

Department of Health and
Human Services (DHHS)

Provider Reimbursement Manual Part 2, Provider Cost Reporting Forms and Instructions, Chapter 41, Form CMS-2540-10

Centers for Medicare and
Medicaid Services (CMS)

Transmittal 2

Date: September 2011

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NEW/REVISED MATERIAL--*EFFECTIVE DATE*: Cost Reporting Periods Beginning on or After December 1, 2010.

This transmittal corrects clerical errors in Chapter 41 Transmittal 1, Skilled Nursing Facility and Skilled Nursing Facility Complex Cost Report, Form CMS-2540-10.

For automated cost report software purposes transmittals 1 and 2 will be merged and implemented simultaneously.

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/revise information only, and not the entire table of contents.

Pub 15-2-41

SKILLED NURSING FACILITY AND SKILLED NURSING
FACILITY HEALTH CARE COMPLEX COST REPORT
FORM CMS-2540-10

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4103. WORKSHEET S - SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

Check the appropriate box to indicate whether you are filing electronically or manually. For electronic filing, indicate on the appropriate line the date and time corresponding to the creation of the electronic file. This date and time remains as an identifier for the file by the contractor and is archived accordingly. This file is your original submission and is not to be modified.

4103.1 Part I – Cost Report Status.--*This section is to be completed by the provider and contractor as indicated on the worksheet.*

Lines 1 through 3--The provider must check the appropriate box to indicate on line 1 or 2, column 1, whether this cost report is being filed electronically or manually. For electronic filing, indicate on line 1, column 2 the date and on line 1, column 3 the time corresponding to the creation of the electronic file. This date and time remains as an identifier for the file by the contractor and is archived accordingly. This file is your original submission and is not to be modified. If this is an amended cost report, enter on line 3, column 1 the number of times the cost report has been amended.

Line 4, Column 1--The contractor must enter the Healthcare Cost Report Information System (HCRIS) cost report status code that corresponds to the filing status of the cost report: 1=As submitted; 2=Settled without audit; 3=Settled with audit; 4=Reopened; or 5=Amended.

Line 5, Column 1--Enter the date (mm/dd/yyyy) an accepted cost report was received from the provider.

Line 6, Column 1--Enter the 5 position Contractor Number.

Lines 7 and 8, Column 1--If this is an initial cost report, enter “Y” for yes in the box on line 7. If this is a final cost report, enter “Y” for yes in the box on line 8. If neither, leave both lines 7 and 8 blank. An initial report is the very first cost report for a particular provider CCN. A final cost report is a terminating cost report for a particular provider CCN.

Line 9, Column 1--Enter the Notice of Program Reimbursement (NPR) date (mm/dd/yyyy). The NPR date must be present if the cost report status code is 2, 3 or 4.

Line 10, Column 1--If this is a reopened cost report (response to line 4, column 1 is “4”), enter the number of times the cost report has been reopened.

Line 11, Column 1--Enter the software vendor code for the software used by the contractor to process this cost report. Use the format “X99”, where X is the alpha character representing a specific cost report transmittal and 99 is the two digit software vendor code.

4103.2 Part II - Certification.--This certification is read, prepared, and signed after the cost report has been completed in its entirety.

4103.3 Part III - Settlement Summary.--Enter the balance due to or due from the applicable program for each applicable component of the program. Transfer settlement amounts as follows:

| <u>Skilled Nursing Facility Component</u> | <u>Title V</u> | <u>From</u> | | <u>Title XIX</u> |
|--------------------------------------------------------|------------------------------------------------------------|------------------------------------------|------------------------------------------|---------------------------------------------------|
| | | <u>Title XVIII Part A</u> | <u>Title XVIII Part B</u> | |
| Skilled Nursing Facility Line 1 33 | Wkst. E, Part II, Line 33 | Wkst. E, Part I, Line 15 | Wkst. E, Part I, Line 29 | Wkst. E, Part II, Line |
| Nursing Facility Line 2 | Wkst. E, Part II Line 33 | N/A | N/A | Wkst. E, Part II, Line 33 |
| ICF/MR Line 3 | N/A | N/A | N/A | Wkst. E, Part II, Line 33 |
| SNF-Based Home Health Agency Line 4 Cols. 34 | Wkst. H-4, Part II, Sum of Cols. 1&2, Line 34 | Wkst. H-4, Part II, Col. 1 Line 34 | Wkst. H-4, Part II, Col. 2 Line 34 | Wkst. H-4, Part II, Sum of 1&2, Line |
| SNF-Based RHC Line 5 | Wkst. I-3, Line 28 | N/A | Wkst. I-3, Line 28 | Wkst. I-3, Line 28 |
| SNF-Based FQHC Line 6 | Wkst. I-3, Line 28 | N/A | Wkst. I-3, Line 28 | Wkst. I-3, Line 28 |
| SNF-Based CMHC Line 7 | Wkst. J-3, Col. 1, Line 20 | N/A | Wkst. J-3, Col. 1, Line 20 | Wkst J-3, Col. 1, Line 20 |

4104. **WORKSHEET S-2 - PART I SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX IDENTIFICATION DATA**

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

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

Line 3.--Indicate your county in column 1. Enter in column 2 the Core Based Statistical Area (CBSA) code. Enter in column 3, a "U" or "R" designating urban or rural.

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

Line 4.--This is an institution or distinct part of an institution that meets the requirements set forth in 42 CFR section 483.5 that has been issued a separate identification number indicating that it meets the requirements of §1819 of the Social Security Act. Skilled Nursing Facility cost reports, reimbursed under title XVIII must use the Prospective Payment System.

Line 5.--This is an institution or distinct part of an institution that meets the requirements set forth in 42 CFR section 483.5 that has been issued a separate identification number indicating that it meets the requirements of §1919 of the Social Security Act.

Line 6.--This is an institution or distinct part of an institution that meets the requirements set forth in 42 CFR section 483.5 that has been issued a separate identification number indicating that it meets the requirements of §1905 of the Social Security Act.

Line 7.--This is a SNF based HHA that has been issued an identification number and which meets the requirements of §§1861(o) and 1891 of the Act. If you have more than one SNF based HHA, subscript this line and report the required information for each HHA.

Lines 8 & 9.--This is a SNF-based RHC/FQHC that meets the requirements of §1861(aa) of the Act.

Line 10.--This is a SNF-based community mental health center that has been issued a separate identification number. See section 1861(ff) of the Social Security Act.

Line 11.--This is any other SNF-based facility not listed above. The beds in this unit are not certified for titles V, XVIII, or XIX.

Line 12.--This is a SNF-based Hospice that meets the requirements of §1861(dd) of the Social Security Act.

Line 13.--For any component type not identified on lines 4 through 12, enter the required information in the appropriate column. *Subscript this line accordingly to accommodate multiple CORFs (lines 13.00-13.09), OPTs (lines 13.10-13.19), OOTs (lines 13.20-13.29) and OSPs (lines 13.30-13.39).*

Line 14.--Enter the inclusive dates covered by this cost report. In accordance with 42 CFR 413.24(f), you are required to submit periodic reports of operations which generally cover a consecutive 12-month period of operations. (See §§102.1 - 102.3 for situations when you may file a short period cost report.)

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

When you voluntarily or involuntarily cease to participate in the health insurance program or experience a change of ownership, a cost report is due no later than 5 months following the effective date or termination of your agreement or change of ownership.

Line 15.--Enter *in column 1*, a number from the list below which indicates the type of ownership or auspices under which the SNF is conducted.

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

* Where an "other" item is selected, please specify *in column 2*.

Lines 16 through 18.--These lines provide for furnishing certain information concerning the provider. All applicable items must be completed.

Line 19.--If this is a low Medicare utilization cost report, *indicate with a "Y", for yes, or "N" for No.*

Line 19.01.--If line 19 is yes, does this cost report meet your contractor's criteria for filing a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for No.

Lines 20 through 23.--These lines provide for furnishing certain information concerning depreciation. All applicable items must be completed. (See CMS Pub. 15-1, Chapter 1, regarding depreciation.)

Lines 20, 21, and 22.--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 23.--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 25 through 28.--Indicate a "Yes" or "No" answer to each question on these lines.

Lines 29 through 36.--Indicate for each component the type of service that qualifies for the exception.

Line 37.--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 38.--Malpractice insurance, sometimes referred to as professional liability insurance, is insurance purchased by physicians and SNF's to cover the cost of being sued for malpractice.

Line 39.-- A claims-made insurance policy covers claims first made (reported or filed) during the year the policy is in force for any incidents that occur that year or during any previous period during which the insured was covered under a "claims-made" contract. The Occurrence policy covers an incident occurring while the policy is in force regardless of when the claim arising out of that incident is filed. If the policy is claims-made, enter 1. If the policy is occurrence, enter 2.

Line 40.--A liability limit refers to the maximum sum of money an insurance company will pay per lawsuit and per policy year. For example, a standard liability limit for physician professional liability is \$1 million in damages per lawsuit and a total of \$3 million for all lawsuits during the policy year (often referred to as \$1 million/\$3 million).

Line 41.--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 42.--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.

Malpractice insurance premiums are money paid by the provider to a commercial insurer to protect the provider against potential negligence claims made by their patients/clients. Malpractice paid losses is money paid by the healthcare provider to compensate a patient/client for professional negligence. Malpractice self-insurance is money paid by the provider where the healthcare provider acts as its own insurance company (either as a sole or part-owner) to financially protect itself against professional negligence – often providers will manage their own funds or purchase a policy referred to as captive insurance, which protects providers for excess protection that may be unavailable or cost-prohibitive at the primary level.

Line 43.--Are there any related organizations or home office costs as defined in CMS Pub. 15-1, Chapter 10? Enter "Y" for yes, or "N" for no, in column 1

Line 44.--If yes, and there are home office costs, enter the home office chain number. If this facility is part of a chain organization; enter the name and address of the home office on lines 45, 46 and 47.

Line 45, columns 1, 2 and 3.--Enter the name of the home office in column 1, and enter the name of the contractor of the home office in column 2. Enter the contractor number in column 3.

Line 46, columns 1 and 2.--Enter the street address in column 1, or the post office box number in column 2.

Line 47, columns 1, 2 and 3.--Enter the city, State and zip code in columns 1, 2, and 3.

4104.1 Part II – Skilled Nursing Facility and Skilled Nursing Facility Health Care Complex Reimbursement Questionnaire.-- The information required on Part II of this worksheet (formerly Form CMS-339) must be completed by all providers submitting cost reports to the Medicare contractor under Title XVIII of the Social Security Act (hereafter referred to as “The Act”). Its purpose is to assist you in preparing an acceptable cost report, to minimize the need for direct contact between you and your contractor, and to expedite review and settlement of the cost report. It is designed to answer pertinent questions about key reimbursement concepts displayed in the cost report and to gather information necessary to support certain financial and statistical entries on the cost report. The questionnaire is a tool used in arriving at a prompt and equitable settlement of your cost report.

Where the instructions for this worksheet direct you to submit documentation/information, mail or otherwise transmit to the contractor immediately, after submission of the ECR. The contractor has the right under §§1815(a) and 1883(e) of the Act to request any missing documentation required to complete the desk review.

To the degree that the information in the questionnaire constitutes commercial or financial information which is confidential and/or is of a highly sensitive personal nature, the information will be protected from release under the Freedom of Information Act. If there is any question about releasing information, the contractor should consult with the CMS Regional Office.

NOTE: The responses on all lines are Yes or No unless otherwise indicated. If in accordance with the following instructions, you are requested to submit documentation, indicate the line number for each set of documents you submit.

Line Descriptions

Lines 1 through 18 are required to be completed by all Skilled Nursing Facilities.

Line 1--Indicate whether the provider has changed ownership. Enter “Y” for yes or “N” for no in column 1. If column 1 is “Y”, enter the date the change of ownership occurred in column 2. Also, submit the name and address of the new owner and a copy of the sales agreement with the cost report.

Line 2--Indicate whether the provider has terminated participation in the Medicare program. Enter “Y” for yes or “N” for no in column 1. If column 1 is “Y”, enter the date of termination in column 2, and “V” for voluntary or “I” for involuntary in column 3.

Line 3--Indicate whether the provider is involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships. Enter “Y” for yes or “N” for no in column 1. If column 1 is “Y”, submit a list of the individuals, the organizations involved, and a description of the transactions with the cost report.

NOTE A related party transaction occurs when services, facilities, or supplies are furnished to the provider by organizations related to the provider through common ownership or control. (See CMS Pub. 15-1, Chapter 10 and 42 CFR §413.17)

Line 4--Indicate whether the financial statements were prepared by a Certified Public Accountant. Enter "Y" for yes or "N" for no in column 1. If you answer "Y" in column 1, enter "A" for audited, "C" for compiled, or "R" for reviewed in column 2. Submit a complete copy of the financial statements (i.e., the independent public accountant's opinion, the statements themselves, and the footnotes) with the cost report. If the financial statements are not available for submission with the cost report enter the date they will be available in column 3.

If you do not engage public accountants to prepare your financial statements, submit a copy of the financial statements you prepared, and written statements of significant accounting policy and procedure changes affecting Medicare reimbursement which occurred during the cost reporting period. You may submit the changed accounting or administrative procedures manual in lieu of written statements.

Line 5--Indicate whether the total expenses and total revenues reported on the cost report differ from those on the filed financial statements. Enter "Y" for yes or "N" for no in column 1. If you answer "Y" in column 1, submit reconciliation with the cost report.

Line 6--Indicate whether costs were claimed for Nursing School. Enter "Y" for yes, or "N" for no in column 1. If you answer "Y" in column 1, enter "Y" for yes or "N" for no in column 2 to indicate whether the provider is the legal operator of the program.

Line 7--Indicate whether costs were claimed for Allied Health Programs. Enter "Y" for yes, or "N" for no in column 1. If you answer "Y" in column 1, submit a list of the program(s) with the cost report and annotate for each, whether the provider is the legal operator of the program.

NOTE: For purposes of lines 6 and 7, the provider is the legal operator of a nursing school and/or allied health program if it meets the criteria in 42 CFR §413.85(f)(1) or (f)(2).

Line 8--Indicate whether approvals and/or renewals were obtained during the cost reporting period for Nursing School and/or Allied Health programs. Enter "Y" for yes, or "N" for no in column 1. If you answer "Y" in column 1, submit a list of the program(s), and copies of the approvals and/or renewals with the cost report.

Line 9--Indicate whether you are seeking reimbursement for bad debts resulting from Medicare deductible and coinsurance amounts which are uncollectible from Medicare beneficiaries. (See 42 CFR §413.89ff and CMS Pub. 15-1, §§306-324 for the criteria for an allowable bad debt.) Enter "Y" for yes or "N" for no in column 1. If you answer "Y" in column 1, submit a completed Exhibit 1 or internal schedules duplicating the documentation requested on Exhibit 1 to support the bad debts claimed. If you are claiming bad debts for inpatient and Part B SNF services, complete a separate Exhibit 1 or internal schedule for each category. Also, complete a separate Exhibit 1, as applicable, for bad debts of each sub provider.

Exhibit 1 displayed at the end of this section requires the following documentation:

Columns 1, 2, 3 - Patient Names, Health Insurance Claim (HIC) Number, Dates of Service (From - To)--The documentation required for these columns is derived from the beneficiary's bill. Furnish the patient's name, health insurance claim number and dates of service that correlate to the filed bad debt. (See CMS Pub. 15-1, §314 and 42 CFR §413.89)

Column 4--Indigency/Welfare Recipient--If the patient included in column 1 has been deemed indigent, place a check in this column. If the patient in column 1 has a valid Medicaid number, also include this number in this column. See the criteria in CMS Pub. 15-1, §§312 and 322 and 42 CFR §413.89 for guidance on the billing requirements for indigent and welfare recipients.

Columns 5 & 6--Date First Bill Sent to Beneficiary & Date Collection Efforts Ceased--This information should be obtained from the provider's files and should correlate with the beneficiary name, HIC number, and dates of service shown in columns 1, 2 and 3 of this exhibit. The dates in column 6 represents the date that the unpaid account is deemed worthless, whereby all collection efforts, both internal and by an outside entity, ceased and there is no likelihood of recovery of the unpaid account. (See CFR 413.89(f), and CMS Pub. 15-1, §§308, 310, and 314)

Column 7--Remittance Advice Dates--Enter in this column the remittance advice dates that correlate with the beneficiary name, HIC No., and dates of service shown in columns 1, 2, and 3 of this exhibit.

Columns 8 & 9--Deductibles & Coinsurance--Record in these columns the beneficiary's unpaid deductible and coinsurance amounts that relate to covered services.

Column 10--Total Medicare Bad Debts--Enter on each line of this column, the sum of the amounts in columns 8 and 9. Calculate the total bad debts by summing up the amounts on all lines of Column 10. This "total" must agree with the bad debts claimed on the cost report. Attach additional supporting schedules, if necessary, for bad debt recoveries.

NOTE: The information in Exhibit 1 is not captured in the ECR file. Therefore, this exhibit must be completed and submitted either manually (hard copy), or in electronic media format (e.g. diskette, or CD).

Line 10--Indicate whether your bad debt collection policy changed during the cost reporting period. Enter "Y" for yes or "N" for no in column 1. If you answer "Y" in column 1, submit a copy of the policy with the cost report.

Line 11--Indicate whether patient deductibles and/or coinsurance are waived. Enter "Y" for yes or "N" for no in column 1. If you answer "Y" in column 1, ensure that they are not included on the bad debt listings (i.e., Exhibit 1 or your internal schedules) submitted with the cost report.

Line 12--Indicate whether total available beds have changed from the prior cost reporting period. Enter "Y" for yes or "N" for no in column 1. If you answer "Y" in column 1, provide a copy of the approval from the Regional Office for a change in bed size required under CMS Pub. 15-1, §2337.2.

NOTE: For purposes of line 12, available beds are provider beds that are permanently maintained for lodging inpatients. They must be available for use and be housed in patient rooms or wards (i.e., do not include beds in corridors or temporary beds). (See 42 CFR §412.105(b) and CMS Pub. 15-1, §2200.2.C.)

Line 13--Indicate whether the cost report was prepared using the Provider Statistical & Reimbursement Report (PS&R) only. Use columns 1 and 2 for Part A and columns 3 and 4 for Part B. Enter "Y" for yes or "N" for no in columns 1 and 3. If either column 1 or 3 is "Y" enter the paid through date of the PS&R in columns 2 and/or 4. Also, submit a crosswalk between revenue codes and charges found on the PS&R to the cost center groupings on the cost report. This crosswalk will reflect a cost center to revenue code match only.

Line 14--Indicate whether the cost report was prepared using the PS&R for totals and provider records for allocation. Use columns 1 and 2 for Part A and columns 3 and 4 for Part B. Enter "Y" for yes or "N" for no in columns 1 and 3. If either column 1 or 3 is "Y" enter the paid through date of the PS&R in columns 2 and/or 4. Also, submit a detailed crosswalk between revenue codes, departments and charges on the PS&R to the cost center groupings on the cost report. This crosswalk must include which revenue codes were allocated to each cost center. Supporting workpapers must accompany this crosswalk to provide sufficient documentation as to the accuracy of the provider records.

Line 15--If you entered "Y" on either line 13 or 14, columns 1 and/or 3, indicate whether adjustments were made to the PS&R data for additional claims that have been billed but not included on the PS&R used to file this cost report. Enter "Y" for yes or "N" for no in columns 1 and 3. If either column 1 or 3 is "Y", include a schedule which supports any claims not included on the PS&R. This schedule should include totals consistent with the breakdowns on the PS&R, and should reflect claims that are unprocessed or unpaid as of the cut-off date of the PS&R used to file the cost report.

Line 16--If you entered "Y" on either line 13 or 14, columns 1 and/or 3, indicate whether adjustments were made to the PS&R data for corrections of other PS&R information. Enter "Y" for yes or "N" for no in columns 1 and 3. If either column 1 or 3 is "Y", submit a detailed explanation and documentation which provides an audit trail from the PS&R to the cost report.

Line 17--If you entered "Y" on either line 13 or 14, columns 1 and/or 3, indicate whether other adjustments were made to the PS&R data. Enter "Y" for yes or "N" for no in columns 1 and 3. If either column 1 or 3 is "Y", include a description of the other adjustments and documentation which provides an audit trail from the PS&R to the cost report.

Line 18--Indicate whether the cost report was prepared using provider records only. Enter "Y" for yes or "N" for no in columns 1 and 3. If either column 1 or 3 is "Y", submit detailed documentation of the system used to support the data reported on the cost report. If detail documentation was previously supplied, submit only necessary updated documentation with the cost report.

The minimum requirements are:

- Copies of input tables, calculations, or charts supporting data elements for PPS operating rate components and other PRICER information covering the cost reporting period.
- Internal records supporting program utilization statistics, charges, prevailing rates and payment information broken into each Medicare bill type in a consistent manner with the PS&R.
- Reconciliation of remittance totals to the provider's internal records.
- Include the name of the system used and indicate how the system was maintained (vendor or provider). If the provider maintained the system, include date of last software update.

Note: Additional information may be supplied such as narrative documentation, internal flow charts, or outside vendor informational material to further describe and validate the reliability of your system.

EXHIBIT 1
LISTING OF MEDICARE BAD DEBTS AND APPROPRIATE SUPPORTING DATA

PROVIDER _____
NUMBER _____
FYE _____

PREPARED BY _____
DATE PREPARED _____
SNF INPATIENT _____ SNF Part B _____
Subprovider _____

| (1) Patient Name | (2) HIC. NO. | (3) DATES OF SERVICE | | (4) INDIGENCY & WEL. RECIP. (CK IF APPL) | | (5) DATE FIRST BILL SENT TO BENEFICIARY | (6) DATE COLLECTION EFFORTS CEASED | (7) REMITTANCE ADVISE DATES | (8)* DEDUCT | (9)* CO-INS | (10) TOTAL |
|------------------------|-----------------|----------------------------|----|---------------------------------------------------|--------------------|--------------------------------------------------|------------------------------------------------|--------------------------------------|----------------|----------------|---------------|
| | | FROM | TO | YES | MEDICAID NUMBER | | | | | | |
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* THESE AMOUNTS MUST NOT BE CLAIMED UNLESS THE PROVIDER BILLS FOR THESE SERVICES WITH THE INTENTION OF PAYMENT.
SEE INSTRUCTIONS FOR COLUMN 4 - INDIGENCY/WELFARE RECIPIENT, FOR POSSIBLE EXCEPTION

4105. WORKSHEET S-3 - SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX STATISTICAL DATA

In accordance with 42 CFR 413.20(a), and 42 CFR 413.24(a), 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, NF, ICF/MR, HHA, CMHC, OLTC and hospice. The data to be maintained, depending on the services provided by the component, include the number of beds, the number of bed days available, the number of inpatient days/visits, the number of discharges, the average length of stay, the number of admissions, 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.

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.

NOTE: An institution or institutional complex may only change the bed size of its SNF and/or its NF up to two times per cost reporting year. The two changes may occur as follows; once on the first day of the beginning of its cost reporting year; and again on the first day of a single cost reporting quarter within that same cost reporting year, in order to effect *one* of the combinations set forth in §2337.2.

Columns 3 through 6--Enter the number of inpatient days/visits for all classes of patients for each component by program.

Column 7--Enter the total number of inpatient days for each component. The total in column 7 must equal the sum of columns 3 through 6.

Columns 8 through 11--Enter the number of discharges, including deaths, 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, 2 & 7 | Column 3 divided by column 8 |
| b. | Column 14, lines 1 & 7 | Column 4 divided by column 9 |
| c. | Column 15, lines 1, 2, 3, & 7 | Column 5 divided by column 10 |
| d. | Column 16, lines 1, 2, 3, & 7 | Column 7 divided by column 12 |
| e. | <i>Column 16, line 8</i> | <i>Column 7 (line 8 minus line 4) divided by column 12</i> |

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 2.

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.

4105.1 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 a 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 100.

Line 2.--Enter physician salaries paid to employees which are included on Worksheet A, column 1, line 100.

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.--If you are a member of a chain or other related organization, as defined in CMS Pub. 15-1, §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 5.--Enter the sum of lines 2 through 4.

Line 6.--Subtract line 5 from line 1 and enter the result.

Line 7.--Enter the total of Worksheet A, column 1, line 33. This amount represents other long term care.

Line 8.--Enter the total of Worksheet A, column 1, line 70. If this line is subscripted to accommodate more than one HHA, also enter the total of the subscripted lines.

Line 9.--Enter the amount from Worksheet A, column 1, line 73

Line 10.--Enter the amount from Worksheet A, column 1, line 83.

Line 11.--Enter the amount from Worksheet A, column 1, lines 14, 72, 74, 84, and lines 90 through 95.

Line 12.--Enter the sum of lines 7 through 11.

Line 13.--Line 6 minus line 12 and enter the result.

Line 14.--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. For example, you have a contract with a nursing service to supply nurses for the general routine service area on weekends. 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. 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 officer, 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.

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.

Line 15.--Enter from your records the amount paid under contract for physician services for Part A only related directly to the SNF and/or NF. This includes Part A physician services from the home office allocation and/or from related organizations.

Line 16.--Enter the salaries and wage related costs (as defined on lines 17 and 18 below) paid to personnel who are affiliated with a home office and/or related organization, who provide services to the SNF and/or NF, and whose salaries are not included on Worksheet A, column 1. In addition, add the home office salaries excluded on line 4. This figure is based on recognized methods of allocating an individual's home office salary to the SNF and/or NF. If no home office/related organization exists or if you cannot accurately determine the hours associated with the home office/related organization salaries that are allocated to the SNF and/or NF, then enter a zero in column 1. All costs for any related organization must be shown as the cost to the related organization.

NOTE: All wage-related costs, including amounts related to excluded areas and physician services should be included on lines 17 and 18.

Line 17.--Enter the total core wage related costs as described in Part IV. Only the total cost of the wage related costs that are considered fringe benefits may be directly charged to each cost center provided the costs are reported in column 2 and not column 1 of Worksheet A. For purposes of determining the wage related costs for the wage index, a facility must use generally accepted accounting principles (GAAP). Continue to use Medicare payment principles on all other areas to determine allowable fringe benefits.

4108. WORKSHEET S-6 - SKILLED NURSING FACILITY BASED COMMUNITY MENTAL HEALTH CENTER STATISTICAL DATA

In accordance with 42 CFR 413.20(a), 42 CFR 413.24(a), and 42 CFR 413.24(c), you are required to maintain statistical records for proper determination of costs payable under the Medicare program. The statistics required to be reported on this worksheet pertain to a skilled nursing facility-based community mental health center (CMHCs), comprehensive outpatient rehabilitation facilities (CORFs), or outpatient rehabilitation facilities (ORFs) which generally furnish outpatient physical therapy (OPT), outpatient occupational therapy (OOT), or outpatient speech pathology (OSP). If you have more than one skilled nursing facility-based component complete a separate worksheet for each component.

Additionally, only CMHCs are required to complete the corresponding Worksheet J series. However, all CMHCs, CORFs, ORFs, OPTs, OOTs, and OSPs must complete the Worksheet A accordingly for the purpose of overhead allocation.

Lines 1 through 19.--These lines provide statistical data related to the human resources of the skilled nursing facility-based component. The human resources statistics are required for each of the job categories specified on lines 1 through 17. Enter any additional categories needed on lines 18 and 19.

Enter the number of hours in your normal work week in the space provided above line 1.

Report in column 1 the full time equivalent (FTE) employees on the skilled nursing facility-based component's payroll. These are staff for which an IRS Form W-2 is issued.

Report in column 2 the FTE contracted and consultant staff of the skilled nursing facility-based component.

Staff FTEs are computed for column 1 as follows: sum of all hours for which employees were paid divided by 2080 hours, round to two decimal places, e.g., round .4452 to .45. Contract FTEs are computed for column 2 as follows: sum of all hours for which contracted and consultant staff worked divided by 2080 hours, and round to two decimal places.

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

4109. WORKSHEET S-7 PROSPECTIVE PAYMENT FOR SKILLED NURSING FACILITIES 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. Public Law 105-33 (Balanced Budget Act of 1997) requires that all SNFs be reimbursed under PPS for cost reporting periods beginning on and after July 1, 1998. Use this form to report the Medicare days of the provider by Resource Utilization Group (RUG).

Column Descriptions

Column 1--The M3PI revenue code designations are already entered in this column.

Column 2 - The only data required to be reported are the days associated with each RUG. These days should be reported in column 2. The calculation of the total payment for each RUG is not required. All payment data is reported as a total amount paid under the RUG PPS payment system on Worksheet E, Part I, line 4, and is generated from the PS&R or your records. The total *days* on line 100 must agree with the amount on Worksheet S-3, Part I, column 4, line 1.

Lines 101 through 106 --These lines provide for furnishing certain information concerning the provider. All applicable items must be completed.

Enter in column 1 the direct patient care expenses and related expenses for each category. Enter in column 2 the ratio, expressed as a percentage, of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 1, column 3. For each line, indicate in column 3 whether the increased RUG payments received reflects increases associated with direct patient care and related expenses by responding "Y" for yes. Indicate "N" for no if there was no increase in spending in any of these areas. *If column 2 is zero, enter N/A in column 3.* If the increased spending is in an area not previously identified in areas one through four, identify on the "Other (Specify)" line(s), the cost center(s) description and the corresponding information as indicated above.

4115. WORKSHEET A-7 - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES

This part enables the Medicare program to analyze the changes that occurred in your capital asset balances during the current reporting period. This worksheet is completed only once for the entire SNF complex.

The analysis of changes in capital asset balances during the cost reporting period must be completed by all SNFs and SNF health care complexes. Do not reduce the amount entered by any accumulated depreciation reserves.

Columns 1 and 6.--Enter the balance recorded in your books of accounts at the beginning of your cost reporting period (column 1) and at the end of your cost reporting period (column 6).

Columns 2 through 4.--Enter the cost of capital assets acquired by purchase (including assets transferred from another provider, noncertified health care unit, or nonhealth care unit) in column 2 and the fair market value at date acquired of donated assets in column 3. Enter the sum of columns 2 and 3 in column 4.

Column 5.--Enter the cost or other approved basis of all capital assets sold, traded, or transferred to another provider, a noncertified health care unit, or nonhealth care unit or retired or disposed of in any other manner during your cost reporting period.

The sum of columns 1 and 4 minus column 5 equals column 6.

Column 7.--Enter the initial acquisition cost of fully depreciated assets for each category. An asset that is fully depreciated and continues to be used in the facility must be recorded in this column. There will be no depreciation expense recorded after the asset is fully depreciated.

4116. WORKSHEET A-8 - ADJUSTMENTS TO EXPENSES

In accordance with 42 CFR 413.9(c)(3), if your operating costs include amounts not related to patient care (specifically not reimbursable under the program) or amounts flowing from the provision of luxury items or services (i.e., those items or services substantially in excess of or more expensive than those generally considered necessary for the provision of needed health services), such amounts are not allowable.

This worksheet provides for the adjustment in support of those listed on Worksheet A, column 6. These adjustments, which are required under the Medicare principles of reimbursement, are made on the basis of cost or amount received (revenue) only if the cost (including direct cost and all applicable overhead) cannot be determined. If the total direct and indirect cost can be determined, enter the cost. Submit with the cost report a copy of any workpapers used to compute a cost adjustment. Once an adjustment to an expense is made on the basis of cost, you may not determine the required adjustment to the expense on the basis of revenue in future cost reporting periods. Enter the following symbols in column 1 to indicate the basis for adjustment: "A" for cost, and "B" for amount received. Line descriptions indicate the more common activities which affect allowable costs or which result in costs incurred for reasons other than patient care and, thus, require adjustments.

The types of adjustments entered on this worksheet are (1) those needed to adjust expenses to reflect actual expenses incurred; (2) those items which constitute recovery of expenses through sales, charges, fees, grants, gifts; (3) those items needed to adjust expenses in accordance with the Medicare principles of reimbursement; and (4) those items which are provided for separately in the cost apportionment process.

If an adjustment to an expense affects more than one cost center, record the adjustment to each cost center on a separate line on Worksheet A-8.

Line 1.--Enter the investment income to be applied against interest expense. (See CMS Pub. 15-1, §202.2 for an explanation.)

Line 5.--For patient telephones, either make an adjustment on this line or establish a nonreimbursable cost center. When line 5 is used, base the adjustment on cost. Revenue cannot be used. (See CMS Pub. 15-1, §2328.)

Line 8.--Enter the adjustment amount from Worksheet A-8-2, column 18. Amounts paid to SNF-based physicians for general SNF services rendered are not included in these adjustments. (See CMS Pub. 15-1, §§2108 - 2108.11.)

Line 9.--Enter allowable home office costs which have been allocated to the SNF and which are not already included in your cost report. Use additional lines to the extent that various SNF cost centers are affected. (See CMS Pub. 15-1, §§2150 - 2153.)

Line 11.--Obtain the amount from your records.

Line 12.--Obtain the amount from Part I, column 6 of Worksheet A-8-1. Note that Worksheet A-8-1 represents the detail of the various cost centers on Worksheet A, which must be adjusted.

Line 13.--An adjustment is required for nonallowable patient personal laundry.

Line 14.--Enter the amount received from the sale of meals to employees. This income offsets the dietary expense.

Line 5.--For a full cost report, enter the total general inpatient routine service costs from Worksheet B, Part I, column 18, SNF from line 30, NF from line 31, or ICF/MR from line 32.

EXCEPTION: When the SNF 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 enter the general inpatient routine service costs from lines 30 and 31.

Line 6.--Enter the total charges for general inpatient routine services for the SNF, the SNF-based NF, or the SNF-based ICF/MR as applicable. These charges agree with the amounts on Worksheet G-2, column 1, lines 1, 2, and 3. See exception after line 5 above.

Line 7.--Enter the general inpatient routine cost/charge ratio (rounded to six decimal places, e.g., .102589241 is rounded to .102589) by dividing the total inpatient general routine service costs (line 5) by the total inpatient general routine service charges (line 6).

Line 8.--Enter the private room charges from your records.

Line 9.--Enter the average per diem charge (rounded to two decimal places) for private room accommodations by dividing the total charges for private room accommodations (line 8) by the total number of days of care furnished in private room accommodations (line 2).

Line 10.--Enter the semi-private room charges from your records.

Line 11.--Enter the average per diem charge (rounded to two decimal places) for semi-private accommodations by dividing the total charges for semi-private room accommodations (line 10) by the total number of days of care furnished in semi-private room accommodations (line 1 – line 2).

Line 12.--Subtract the average per diem charge for all semi-private accommodations (line 11) from the average per diem charge for all private room accommodations (line 9) to determine the average per diem private room charge differential. If a negative amount results from this computation, enter zero.

Line 13.--Multiply the average per diem private room charge differential (line 12) by the inpatient general routine cost/charge ratio (line 7) to determine the average per diem private room cost differential (rounded to two decimal places).

Line 14.--Multiply the average per diem private room cost differential (line 13) by the private room accommodation days (line 2) to determine the total private room accommodation cost differential adjustment.

Line 15.--Subtract the private room cost differential adjustment (line 14) from the general inpatient routine service cost (line 5) to determine the adjusted general inpatient routine service cost net of private room accommodation cost differential adjustment.

Line 16.--Determine the adjusted general inpatient routine service cost per diem by dividing the amount on line 15 by inpatient days (including private room days) shown on line 1.

Line 17.--Determine the routine service cost by multiplying the program inpatient days (including the private room days) shown on line 3 by the amount on line 16.

Line 18.--Determine the medically necessary private room cost applicable to the program by multiplying line 4 by the amount on line 13.

Line 19.--Add the amounts on lines 17 and 18 to determine the total program general inpatient routine service cost.

Line 20.--Enter the capital-related cost allocated to the general inpatient service cost center from Worksheet B, Part II, column 18, SNF from line 30, NF from line 31, or ICF/MR from line 32. See exception after line 5 above.

Line 21.--Determine the per diem capital-related cost by dividing line 20 by inpatient days on line 1.

Line 22.--Determine the program capital-related cost by multiplying line 21 by line 3.

Line 23.--Determine the inpatient routine service cost by subtracting the amount on line 22 from the amount on line 19.

Line 24.--Obtain the aggregate charges to beneficiaries for excess costs from your records.

Line 25.--Obtain the total program routine service cost for comparison to the cost limitation by subtracting the amount on lines 24 from the amount on line 23.

Line 26.--This line is not applicable for title XVIII, but may be currently used for title V and or title XIX. Enter the per diem limitation applicable to the respective title.

Line 27.--This line is not applicable for title XVIII, but may be currently used for title V and or title XIX. Obtain the inpatient routine service cost limitation by multiplying the number of inpatient days shown on line 3 by the cost limit for inpatient routine service cost applicable to you for the period for which the cost report is being filed. This amount is provided by your contractor and is entered in the space provided in the line description.

Line 28.--*This line is not applicable for title XVIII, but may be currently used for title V and or title XIX.* Enter the amount of reimbursable inpatient routine service cost which is determined by adding line 22 to the lesser of lines 25 or 27. Transfer this amount to the appropriate Worksheet E, Part II, line 4.

4125.2 Part II - Calculation of Inpatient Nursing & Allied Health Cost for PPS Pass through.

Line 1.--Enter the total inpatient days from Worksheet S-3, Part I, column 7, line 8, less lines 4 and 7.

Line 2.--Enter the program inpatient days from Worksheet S-3, Part I, column 3, 4, or 5 lines 1 or 2.

Line 3.--Enter the program Nursing & Allied Health cost from Worksheet B, Part I, column 14, line 14.

Line 4.--Calculate the ratio of program days to total days. Divide line 2 by line 1.

Line 5.--Calculate the Nursing & Allied Health pass through cost. Multiply the amount on line 3 times the amount on line 4. Transfer this amount to Worksheet E, Part I, line 2, for title XVIII, or Worksheet E, Part II, line 2 for titles V or XIX.

Line 41--Due to Other Funds--There are four funds: General Fund, Specific Purpose Fund, Endowment Fund and Plant Fund. These are in columns 1 through 4 respectively. Amounts are reported in the fund owing the amount. Each amount recorded as “due to” must also be reported on Worksheet G, line 10 (Due From Other Funds).

The sum of the amounts on line 10, columns 1 through 4 must equal the sum of the amounts on line 41, columns 1 through 4.

Line 42--Other Current Liabilities--This line is used to record any current liabilities not reported on lines 35 through 41.

Line 43--Total Current Liabilities--Enter the sum of lines 35 through 42.

Line 44--Mortgage Payable--This amount reflects the long-term financing obligation used to purchase real estate/property.

Line 45--Notes Payable--These amounts reflect liabilities of the SNF to vendors, banks and other, evidenced by promissory notes due and payable longer than one year.

Line 46--Unsecured Loans--These amounts are not loaned on the basis of collateral.

Line 48--Other Long-Term Liabilities--This line is used to record any long-term liabilities not reported on lines 46 through 48.

Line 50--Total Long-Term Liabilities--Enter the sum of lines 44 through 49.

Line 51--Total Liabilities--Enter the sum of lines 43 and 50.

Line 52--General Fund Balance--This represents the difference between the total of General Fund assets and General Fund Liabilities in column 1. This amount usually equals the end of period fund balance on Worksheet G-1, column 2, line 19.

Line 53--Specific Purpose Fund--This represents the difference between the total of Specific Purpose Fund assets and Specific Purpose Fund Liabilities in column 2.

Line 54--Donor Created - Endowment Fund Balance - Restricted--The sum of the amounts on lines 54, 55 and 56, represent the difference between the total of Endowment Fund assets and Endowment Fund Liabilities in column 3.

Line 55--Donor Created - Endowment Fund Balance - Unrestricted.

Line 56--Governing Body Created - Endowment Fund Balance.

Line 57--Plant Fund Balance - Invested in Plant--The sum of the amounts on lines 57 and 58, represent the difference between the total of Plant Fund assets and Plant Fund Liabilities in column 4.

Line 58--Plant Fund Balance - Reserves for Plant Improvement, Replacement and Expansion--
The credit balances of the restricted funds reported on lines 54 through 56, represent the net amount of each restricted fund's assets available for its designated purpose. The accounts should be credited for all income earned on restricted fund assets, as well as gains on the disposal of such assets. If, however, such items are treated as General Fund income (considering legal requirements and donor intent), the restricted Fund Balance account is charged, and the Due to General Fund account credited, for such income.

For Investor-Owned Corporations, the accounts on lines 53 through 58 include stock, paid in capital and retained earnings. For Investor-Owned Partnerships, the amounts on lines 53 through 58 include capital and partner's draw. For Investor-Owned - Division of a Corporation, the amounts on lines 53 through 58 include the division's or subsidiary's stock, paid in capital and divisional equity.

Line 59--Total Fund Balances--Enter the sum of lines 52 through 58.

Line 60--Total Liabilities and Fund Balances--Enter the sum of lines 51 and 59.

For each Fund, the amount on line 34 equals the amount on line 60.

4140.2 Worksheet G-1 - Statement of Changes in Fund Balances--

Columns 1 and 2--General Fund.

Columns 3 and 4--Specific Purpose Fund--These accounts are used for funds held for specific purposes such as research and education.

Columns 5 and 6--Endowment Fund--These accounts are for amounts restricted for endowment purposes.

Columns 7 and 8--Plant Fund--These accounts are for amounts restricted for the replacement and expansion of the plant.

Line 1--Fund Balance at Beginning of Period--The fund balance at the beginning of the period comes from the prior year cost report Worksheet G-1, line 19, columns 2, 4, 6 and 8, respectively.

Line 2--Net Income--Transfer to column 2, the amount from Worksheet G-3, line 31. Columns 1, 3, 4, 5, 6, 7 and 8 are not completed.

Line 3--Total--For column 2, enter the sum of lines 1 and 2. Leave columns 1, 3, 5 and 7 blank. For columns 4, 6 and 8, bring down the amount on line 1.

Lines 5 through 9--Additions--Most income is included in the net income reported on line 2. Any increases affecting the fund balance not included in net income are reported on these lines. A description (not exceeding 36 characters) is entered for each entry on lines 5 through 9.

Line 10--Total Additions--In columns 2, 4, 6 and 8, enter the sum of lines 5 through 9 columns 1, 3, 5 and 7, respectively.

Line 11--Subtotals--Enter the sum of lines 3 and 10 for columns 2, 4, 6 and 8. Leave columns 1, 3, 5 and 7 blank.

Lines 13 through 17--Deductions--Most expenses are included in the net income reported on line 2. Any decreases affecting the fund balance not included in net income are reported on these lines. A description (not exceeding 36 characters) is entered for each entry on lines 13 through 17.

Line 18--Total Deductions--In columns 2, 4, 6 and 8, enter the sum of lines 13 through 17, columns 1, 3, 5 and 7, respectively.

Line 19--Fund Balance at the end of Period per Balance Sheet--Enter the result of line 11 minus line 18 for columns 2, 4, 6 and 8. Leave columns 1, 3, 5 and 7 blank. The amount in line 19, column 2 must agree with Worksheet G, line 52, column 1. The amount on line 19, column 4 must agree with Worksheet G, line 53, column 2. The amount on line 19, column 6 must agree with the sum of Worksheet G, column 3, lines 54 through 56. The amount on line 19, column 8 must agree with the sum of Worksheet G, column 4, lines 57 and 58.

These amounts will also be used to start next year's Worksheet G-1.

4140.3 Worksheet G-2, Parts I & II - Statement of Patient Revenues and Operating Expenses--The worksheets require the reporting of total patient revenues for the entire facility and operating expenses for the entire facility. If cost report total revenues and total expenses differ from those on your filed financial statement, submit a reconciliation report with the cost report submission. If you have more than one SNF-based HHA and/or more than one outpatient rehabilitation provider, subscript the appropriate lines on Worksheet G-2, Part I, to report the revenue for each multiple based facility separately.

Part I - Patient Revenues--Enter total patient revenues associated with the appropriate cost centers on lines 1 through 4, and 6 through 13.

Line 1--SNF--Enter revenues generated by the SNF component of the complex. Obtain these amounts from your accounting books and/or records.

Line 2--Nursing Facility--Enter the nursing facility revenue from your accounting books and/or records.

Line 3--ICF/MC--Enter the ICF/MC revenue from your accounting books and/or records.

Line 4--Other Long Term Care-- Enter the revenue generated from other long term care sub providers from your accounting books and/or records. Subscript this line as necessary.

Line 5--Total General Inpatient Routine Care--Sum of lines 1 through 4.

Line 6--Ancillary Services--Enter in the appropriate column revenue from inpatient ancillary services and outpatient ancillary services from your accounting books and/or records.

Line 7--Clinic--Enter in the appropriate column revenue from clinic services from your accounting books and/or records.

Line 8--Home Health Agency-- Enter home health agency revenue from your accounting books and/or records. If there is more than one home health agency, include the revenues for all home health agencies on this line.

Line 9--Ambulance Services--Enter from your accounting books and/or records the revenue relative to the ambulance service cost reported on Worksheet A, line 71.

Line 10—RHC/FQHC--Enter in column 2 only, the revenue generated from RHC/FQHC.

Line 11--CMHC--Enter in column 2 only, the revenue generated from CMHC.

Line 12--Hospice--Enter from your accounting books and/or records in the appropriate column, the revenue generated from hospice services rendered. If there is more than one hospice, include the revenues for all hospices on this line.

Line 13--Other (specify).

Line 14--Total Patient Revenues--Enter the sum of lines 5 through 13.

Column 3--Enter the sum of columns 1 and 2, lines 1 – 14 respectively in column 3.

Part II - Operating Expenses--Enter the expenses incurred that arise during the ordinary course of operating the hospital complex.

Line 1--Operating Expenses--This amount is transferred from Worksheet A, line 100, column 3.

Lines 2 through 7--Add (Specify)--Identify on these lines additional operating expenses not included in line 1.

Line 8--Total Additions--Enter on line 8, column 2, the sum of lines 2 through 7, column 1.

Lines 9 through 13--Deduct (specify)-- Identify on these lines deductions from operating expenses not included in line 1.

Line 14--Total Deductions--Enter on line 14, column 2, the sum of lines 9 through 13, column 1.

Line 15--Total Operating Expenses--Enter in column 2, the result of line 1, column 2 plus line 8, column 2, less line 14, column 2.

Line Descriptions

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

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

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

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

Line 14.--Enter the limit adjustment. This limit applies only to therapeutic services, not initial diagnostic services. 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; for services from January 1, 2010, through December 31, 2011, the limitation is 68.75 percent; for services from January 1, 2012, through December 31, 2012, the limitation is 75 percent; for services from January 1, 2013, through December 31, 2013, the limitation is 81.25 percent; and for services on and after January 1, 2014, the limitation is 100 percent. This is computed by multiplying the amount on line 13 by the corresponding outpatient mental health service limit percentage. This limit applies only to therapeutic services, not initial diagnostic services.

Line 15.--Enter the total program cost. *Enter the sum of the amounts on lines 11 and 14, in columns 1 and 2 respectively.*

***NOTE:** Section 4104 of the Affordable Care Act (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 HCPCS coding for preventive services to ensure coinsurance and deductible are not applied. Providers will need to maintain this documentation in order to apply the appropriate reductions on lines 15.03 and 15.04.*

Line 15.01.--*Enter the total program charges from the contractor's records. For cost reporting periods that overlap January 1, 2011, do not complete column 1; enter total program charges for services rendered on or after January 1, 2011 in column 2. For cost reporting periods beginning on or after January 1, 2011, enter total program charges in columns 1 and 2, accordingly.*

Line 15.02.--*Enter the total program preventive charges from the provider's records. For cost reporting periods that overlap January 1, 2011, do not complete column 1; enter total program preventive charges for services rendered on or after January 1, 2011 in column 2. For cost reporting periods beginning on or after January 1, 2011, enter total program preventive charges in columns 1 and 2, accordingly.*

Line 15.03.--*Enter the total program preventive costs. For cost reporting periods that overlap January 1, 2011, do not complete column 1; enter the total program preventive costs ((line 15.02 divided by line 15.01) times line 15)) for services rendered on or after January 1, 2011, in column 2. For cost reporting periods beginning on or after January 1, 2011, enter the total program preventive costs ((line 15.02 divided by line 15.01) times line 15)) in columns 1 and 2, accordingly.*

Line 15.04.--Enter the total program non-preventive costs. For cost reporting periods that overlap January 1, 2011, do not complete column 1; enter the total program non-preventive costs ((line 15 minus line 15.03) times .80)) for services rendered on or after January 1, 2011, in column 2. For cost reporting periods beginning on or after January 1, 2011, enter the total program non-preventive costs ((line 15 minus line 15.03) times .80)) in columns 1 and 2, accordingly.

Line 15.05.--Enter the total program costs. For cost reporting periods that overlap January 1, 2011, enter total program costs (line 15 times .80) in column 1, and enter the sum of lines 15.03 and 15.04, in column 2. For cost reporting periods beginning on or after January 1, 2011, enter the sum of lines 15.03 and 15.04, in columns 1 and 2, accordingly.

Line 16.--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 16.

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

Line 18.--Enter the coinsurance amount applicable to the RHC or FQHC for program patients for visits on lines 10 and 12 as recorded by the contactor from clinic bills processed during the reporting period. *Informational only.*

Line 19.-- Enter the net program cost, excluding vaccines. This is equal to the result of subtracting the amounts on lines 16 *and 17, from the amounts on line 15.05, columns 1 and 2.*

Line 20.--Enter the total reimbursable program cost of vaccines and their administration from Worksheet I-4, line 16.

Line 21.--Enter the total reimbursable program cost (line 19 plus line 20).

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

Line 23.--Enter the gross reimbursable bad debts for full-benefit dual eligible individuals. This amount must also be included in the amount on line 22.

Line 24.--Enter any other adjustment. Specify the adjustment in the space provided.

Line 25.--This is the sum of lines 21 plus line 22, plus or minus line 24.

Line 26.--Enter the total interim payments made to you for covered services furnished to program beneficiaries during the reporting period (from contractor records). Transfer amount from Worksheet I-5, line 4.

Line 27.--Your contractor will enter the tentative adjustment from Worksheet I-5, line 5.99.

Line 28.--Enter the total amount due to/from the program, line 25 minus lines 26 and 27. Transfer this amount to Worksheet S, Part III, columns 1, 3, or 4 as applicable, line 5 or line 6 accordingly.

Line 29.--Enter the program reimbursement effect of protested items. The reimbursement effect of non-allowable items is estimated by applying reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See CMS Pub. 15-2 §115.2)

4151. WORKSHEET I-4 - COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

The cost and administration of pneumococcal and influenza vaccine to Medicare beneficiaries are 100 percent reimbursable by Medicare. This worksheet provides for the computation of the cost of these vaccines for services rendered on and after August 1, 2000. Use this worksheet only for vaccines rendered to patients who at the time of receiving the vaccine(s) were not inpatients or outpatients of the parent provider. If a patient simultaneously received vaccine(s) with any Medicare covered services as an inpatient or outpatient, those vaccine costs are reimbursed through the parent provider and cannot be claimed by the RHC and FQHC.

Effective for services rendered on and after September 1, 2009, in accordance with CR 6633, dated August 27, 2009, the administration of influenza A (H1N1) vaccines furnished by RHC's and FQHC's is cost reimbursed. However, no cost will be incurred for the H1N1 vaccine as this is provided free of charge to providers/suppliers

This worksheet must be completed for services furnished on and after October 1, 2009. The administrative cost of influenza vaccines to Medicare beneficiaries is 100 percent reimbursable by Medicare. This worksheet provides for the computation of these services rendered on and after October 1, 2009.

Line 1.--Enter the health care staff cost from Worksheet I-1, column 7, line 10.

Line 2.--Enter the ratio of the estimated percentage of time involved in administering pneumococcal and influenza vaccine injections to the total health care staff time. Do not include physician service under agreement time in this calculation.

Line 3.--Multiply the amount on line 1 by the amount on line 2 and enter the result.

Line 4.--Enter the cost of pneumococcal and influenza vaccine medical supplies from your records.

Line 5.--Enter the sum of lines 3 and 4.

Line 6.--Enter the amount on Worksheet I-1, column 7, line 22. This is your total direct cost of the facility.

Line 7.--Enter the amount from Worksheet I-2, line 18.

Line 8.--Divide the amount on line 5 by the amount on line 6 and enter the result.

Line 9.--Multiply the amount on line 7 by the amount on line 8 and enter the result.

Line 10.--Enter the sum of the amounts on lines 5 and 9.

Line 11.--Enter the total number of pneumococcal and influenza vaccine injections from your records.

Line 12.--Enter the cost per pneumococcal and influenza vaccine injection by dividing the amount on line 10 by the number on line 11 and entering the result.

Line 13.--Enter the number of pneumococcal and influenza vaccine injections administered to Medicare beneficiaries from your records.

Line 14.--Enter the Medicare cost for vaccine injections by multiplying the amount on line 12 by the amount on line 13.

Line 15.--Enter the total cost of pneumococcal and influenza vaccine and its (their) administration by entering the sum of the amount in column 1, line 10 and the amount in column 2, line 10. Transfer this amount to Worksheet I-3, Part I, line 2.

Line 16.--Enter the Medicare cost of pneumococcal and influenza vaccine and its (their) administration. This is equal to the sum of the amount in column 1, line 14 and column 2, line 14. Transfer the result to Worksheet I-3, Part II, line 20.

After the unit cost multiplier has been applied to all the cost centers receiving the services, the total cost (line 22, Part I) must equal the total cost on line 23, Part II.

Perform the preceding procedures for each general service cost center.

In column 16, Part I, enter the total of columns 3A through 15.

In column 17, Part I, if Worksheet B, Part I, column 17, excluded costs, column 17 on this worksheet must also exclude these costs.

In column 18, Part I, enter the sum of columns 16 and 17.

In Part I, compute the unit cost multiplier for allocation of the components' administrative and general costs as follows.

Line 22.--Enter the sum of lines 1 through 21.

In column 20, line 23, calculate the unit cost multiplier for component administrative and general costs. Divide column 18, line 1 by the result of column 18, line 22 minus line 1 and round to six decimal places.

In column 19, for lines 2 through 21, multiply the amount in column 18 by the unit cost multiplier in column 20, line 23, and enter the result in this column. On line 22, enter the total of the amounts on lines 2 through 21. The total on line 22 equals the amount on column 18, line 1.

In column 20, enter on lines 2 through 21 the sum of the amounts in columns 18 and 19. The total in column 20, line 22 must equal the total in column 18, line 22.

4154. WORKSHEET J-2 - COMPUTATION OF CMHC REHABILITATION COSTS

Use this worksheet if you operate a SNF-based CMHC. Complete a separate worksheet for each provider.

4154.1 Part I - Apportionment of CMHC Cost Centers.--

Column 1.--Enter on each line the total cost for the cost center as previously computed on Worksheet J-1, Part I, column 20. To facilitate the apportionment process, the line number designations are the same on both worksheets.

Column 2.--Enter the charges for each cost center. Obtain the charges from your records.

Column 3.--For each cost center, enter the ratio derived by dividing the cost in column 1 by the charges in column 2.

Columns 4, 6, and 8.--For each cost center, enter the *CMHC* charges from your records for title V *in column 4*, and title XIX *in column 8*. *Do not complete column 6 for CMHC title XVIII charges as they are reimbursed under OPPS.* Not all facilities are eligible to participate in all programs.

Columns 5, 7, and 9.--For each cost center, enter the costs obtained by multiplying the charges in columns 4, 6 and 8 respectively, by the ratio in column 3.

Line 22.--Enter the totals for columns 1, 2, and 4 through 9.

4154.2 Part II - Apportionment of Cost of CMHC Services Furnished by Shared Departments.-
-Use this part only when the SNF complex maintains a separate department for any of the cost centers listed on this worksheet, and the department provides services to patients of the skilled nursing facility's outpatient *CMHC* facility.

Column 3.--For each of the cost centers listed; enter the ratio of cost to charges that are shown on Worksheet C, column 3, from the appropriate line for each cost center.

Columns 4, 6, and 8.-- For each cost center, enter the *CMHC* charges from your records for title V, *in column 4*, and title XIX, *in column 8*. *Do not complete column 6 for CMHC title XVIII charges as they are reimbursed under OPPS.*

Columns 5, 7, and 9.--For each cost center, enter the costs obtained by multiplying the charges in columns 4, 6, and 8 respectively by the ratio in column 3.

Line 30.--Enter the totals for columns 4 through 9.

Line 31. -- Add the amount from Part I, columns 5, 7, and 9, line 22 and Part II, columns 5, 7, and 9, line 30, respectively.

4155. WORKSHEET J-3 - CALCULATION OF REIMBURSEMENT SETTLEMENT OF COMMUNITY MENTAL HEALTH CENTER SERVICES

Line 1--Enter the cost of rehabilitation services from Worksheet J-2, Part II, line 31 from columns 5 or 9, respectively for Titles V and XIX.

Line 2--Enter the gross PPS payments received for *title XVIII* services rendered during the cost reporting period excluding outliers. Obtain this amount from the PS&R and/or your records.

Line 3--Enter the total outliers payments received. Obtain this amount from the PS&R and/or your records.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2540-10
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**ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2540-10
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 3 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 contractors is a 3½” diskette, compact diskettes (CDs), or a flash drive. The file must be in IBM format. The character set must be ASCII. Providers should seek approval from their contractor regarding method 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 | | 6 |
| 12345678901 | 2345678901 | 2345678901 | 2345678901 | 2345678901 | 2345678901 | 2345678901 | 2345678901 | 2345678901 | 2345678901 | 2345678901 | 2345678901 |
| 1 | 1 | 015123201033520113343A99P00120121112010335 | | | | | | | | | |
| 1 | 7 | 14:30 | | | | | | | | | |

Record #1: This is a cost report file submitted by CCN 015123 for the period from December 1, 2010 (2010335) through November 30, 2011, (2011334). It is filed on Form CMS-2540-10. 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 an alpha character. 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 April 20, 2012, (2012111). The electronic cost report specification, dated December 1, 2010, (2010335), is used to prepare this file. This is the original cost report filed for this fiscal year.

**ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2540-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE,
AND COLUMN DESIGNATIONS**

WORKSHEET S

| <u>DESCRIPTION</u> | <u>LINE(S)</u> | <u>COLUMN(S)</u> | <u>FIELD SIZE</u> | <u>USAGE</u> |
|----------------------------------------------------------------------------------------------------------------------------------|----------------|------------------|-----------------------|--------------|
| Part I: Cost report Status | | | | |
| Provider Use Only | | | | |
| Electronically filed cost report | 1 | 1 | 1 | X |
| Manually submitted cost report | 2 | 1 | 1 | X |
| <i>If this is an amended cost report enter the number of times the provider resubmitted this cost report = (0-9)</i> | <i>3</i> | <i>1</i> | <i>1</i> | <i>9</i> |
| <i>Creation Date (MM/DD/YYYY)</i> | <i>3</i> | <i>2</i> | <i>10</i> | <i>X</i> |
| <i>Creation Time (XX:XX:XX XX)</i> | <i>3</i> | <i>3</i> | <i>11</i> | <i>X</i> |
| Contractor Use Only | | | | |
| <i>Cost Report Status</i> | <i>4</i> | <i>1</i> | <i>1</i> | <i>9</i> |
| <i>Date Received</i> | <i>5</i> | <i>1</i> | <i>10</i> | <i>X</i> |
| <i>Contractor Number</i> | <i>6</i> | <i>1</i> | <i>5</i> | <i>9</i> |
| <i>First Cost Report for Provider CCN</i> | <i>7</i> | <i>1</i> | <i>1</i> | <i>X</i> |
| <i>Last Cost Report for Provider CCN</i> | <i>8</i> | <i>1</i> | <i>1</i> | <i>X</i> |
| <i>NPR Date: (MM/DD/YYYY)</i> | <i>9</i> | <i>1</i> | <i>10</i> | <i>X</i> |
| <i>If line 4, column 1 is "4", enter number of times reopened = (0-9)</i> | <i>10</i> | <i>1</i> | <i>1</i> | <i>9</i> |
| <i>Enter the Contractor's vendor code</i> | <i>11</i> | <i>1</i> | <i>3</i> | <i>X</i> |
| Part III: Balances due provider or program: | | | | |
| Title V | 1, 2, 4-7 | 1 | 9 | -9 |
| Title XVIII, Part A | 1, 4 | 2 | 9 | -9 |
| Title XVIII, Part B | 1, 4-7 | 3 | 9 | -9 |
| Title XIX | 1-7 | 4 | 9 | -9 |
| In total | 100 | 1-4 | 9 | -9 |

WORKSHEET S-2, Part I

For the skilled nursing facility only:

| | | | | |
|----------|---|---|----|---|
| Street | 1 | 1 | 36 | X |
| P.O. Box | 1 | 2 | 9 | X |
| City | 2 | 1 | 36 | X |

**ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2540-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE,
AND COLUMN DESIGNATIONS**

WORKSHEET S-2, Part I (Continued)

| <u>DESCRIPTION</u> | <u>LINE(S)</u> | <u>COLUMN(S)</u> | <u>FIELD SIZE</u> | <u>USAGE</u> |
|----------------------------------------------------------------------------------------------------------------------|-----------------|------------------|-----------------------|--------------|
| State | 2 | 2 | 2 | X |
| Zip Code | 2 | 3 | 10 | X |
| County | 3 | 1 | 36 | X |
| CBSA Code (XXXXXX) | 3 | 2 | 5 | X |
| Urban/Rural | 3 | 3 | 1 | X |
| For the skilled nursing facility and SNF-based components: | | | | |
| Component name | 4-13 | 1 | 36 | X |
| Provider CCN (XXXXXXX) | 4-10, 12, 13 | 2 | 6 | X |
| For the skilled nursing facility and SNF-based components (continued): | | | | |
| Date certified (MM/DD/YYYY) | 4-10, 12, 13 | 3 | 10 | X |
| Title V payment system | 4, 5, 7-10 | 4 | 1 | X |
| Title XVIII payment system | 4, 7-10 | 5 | 1 | X |
| Title XIX payment system | 4-10 | 6 | 1 | X |
| Cost reporting period beginning date (MM/DD/YYYY) | 14 | 1 | 10 | X |
| Cost reporting period ending date (MM/DD/YYYY) | 14 | 2 | 10 | X |
| Type of control (See Table 3B.) | 15 | 1 | 2 | 9 |
| <i>Type of control (Other description)</i> | <i>15</i> | <i>2</i> | <i>36</i> | <i>X</i> |
| Is this a distinct part skilled nursing facility that meets the requirements of 42CFR section 483.5? (Y/N) | 16 | 1 | 1 | X |
| Is this a composite distinct part skilled nursing facility that meets the requirements of 42CFR section 483.5? (Y/N) | 17 | 1 | 1 | X |
| Are there any costs included in Worksheet A which resulted from transactions with related organizations? (Y/N) | 18 | 1 | 1 | X |

**ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2540-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE,
AND COLUMN DESIGNATIONS**

WORKSHEET S-2, Part I (Continued)

| <u>DESCRIPTION</u> | <u>LINE(S)</u> | <u>COLUMN(S)</u> | <u>FIELD SIZE</u> | <u>USAGE</u> |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|------------------|-----------------------|--------------|
| <i>If this is a low Medicare utilization cost report, "Y" for yes, or "N".</i> | 19 | 1 | 1 | X |
| <i>If line 19 is yes, does this cost report meet your contractor's criteria for filing a low utilization cost report? (Y/N)</i> | 19.01 | 1 | 1 | X |
| Enter the amount of depreciation reported in this SNF for the method indicated: | | | | |
| Declining Balance | 21 | 1 | 9 | 9 |
| Sum of the Years' Digits | 22 | 1 | 9 | 9 |
| Did you cease to participate in the Medicare program at the end of the period to which this cost report applies? (Y/N) | 27 | 1 | 1 | X |
| Was there a substantial decrease in health insurance proportion of allowable cost from prior cost reports? (Y/N) | 28 | 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 | 29 | 1-2 | 1 | X |
| Nursing Facility | 30 | 3 | 1 | X |
| I C F - M R | 31 | 3 | 1 | X |
| SNF-Based HHA | 32 | 1-2 | 1 | X |
| SNF-Based RHC | 33 | 2 | 1 | X |
| SNF-Based FQHC | 34 | 2 | 1 | X |
| SNF-Based CMHC | 35 | 2 | 1 | X |
| SNF-Based OLTC | 36 | N/A | N/A | N/A |
| Is the skilled nursing facility located in a state that certifies the provider as a SNF regardless of the level of care given for titles V and XIX patients? (Y/N) | 37 | 1 | 1 | X |

**ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2540-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE,
AND COLUMN DESIGNATIONS**

WORKSHEET S-2, Part I (Continued)

| <u>DESCRIPTION</u> | <u>LINE(S)</u> | <u>COLUMN(S)</u> | <u>FIELD SIZE</u> | <u>USAGE</u> |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|------------------|-----------------------|--------------|
| Are you legally-required to carry malpractice insurance? (Y/N) | 38 | 1 | 1 | X |
| Is the malpractice a "claims-made:", or "occurrence" policy? If the policy is "claims-maid", enter 1. If policy is "occurrence", enter 2. | 39 | 1 | 1 | 9 |
| What is the liability limit for the malpractice policy? Enter in column 1 the monetary limit per lawsuit. Enter in column 2 the monetary limit per policy year. | 40 | 1-2 | 9 | 9 |
| List malpractice premiums in column 1, paid losses in column 2, and self-insurance in column 3 | 41 | 1-3 | 9 | 9 |
| Are malpractice premiums and paid losses reported in other than the Administrative and General cost center? Enter Y or N. If yes, check box, and submit supporting schedule listing cost centers and amounts. | 42 | 1 | 1 | X |
| Are there any related organizations or home office costs as defined in CMS Pub. 15-1, chapter 10? | 43 | 1 | 1 | X |
| If yes, and there are costs, for the home office, enter the applicable Provider CCN. | 44 | 1 | 9 | 9 |
| If this facility is part of a chain organization, enter the name and address of the home office on the lines below | | | | |
| Name | 45 | 1 | 36 | X |
| Contractor Name | 45 | 2 | 36 | X |
| Contractor Number | 45 | 3 | 5 | X |
| Street | 46 | 1 | 36 | X |
| P.O. Box | 46 | 2 | 9 | X |
| City | 47 | 1 | 36 | X |
| State | 47 | 2 | 2 | X |
| Zip Code | 47 | 3 | 10 | X |

**ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2540-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE,
AND COLUMN DESIGNATIONS**

WORKSHEET S-2, PART II (Continued)

| <u>DESCRIPTION</u> | <u>LINE(S)</u> | <u>COLUMN(S)</u> | <u>FIELD SIZE</u> | <u>USAGE</u> |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|------------------|-----------------------|--------------|
| If column 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in column 4. | 14 | 4 | 10 | X |
| If line 13 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? (Y/N) | 15 | 1 | 1 | X |
| If line 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? (Y/N) | 15 | 3 | 1 | X |
| If line 13 "Y", then were adjustments made to PS&R data for corrections of other PS&R information. (Y/N) | 16 | 1 | 1 | X |
| If line 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Information. (Y/N) | 16 | 3 | 1 | X |
| <i>Describe the "Other Adjustments"</i> | <i>17</i> | <i>0</i> | <i>36</i> | <i>X</i> |
| If line 13 is "Y", then were adjustments made to PS&R data for Other?(Y/N) | 17 | 1 | 1 | X |
| If line 14 is "Y", then were adjustments made to PS&R data for Other? (Y/N) | 17 | 3 | 1 | X |
| Was the cost report prepared only using the provider's records? (Y/N) | 18 | 1 | 1 | X |
| Was the cost report prepared only using the provider's records? (Y/N) | 18 | 3 | 1 | X |

**ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2540-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE,
AND COLUMN DESIGNATIONS**

WORKSHEET S-3, PART I

| <u>DESCRIPTION</u> | <u>LINE(S)</u> | <u>COLUMN(S)</u> | <u>FIELD SIZE</u> | <u>USAGE</u> |
|-------------------------------------------|----------------|------------------|-----------------------|--------------|
| Number of beds | 1-3, 5, 7 | 1 | 9 | 9 |
| Bed days available | 1-3, 5, 7 | 2 | 9 | 9 |
| Title V inpatient days | 1, 2, 4, 7 | 3 | 9 | 9 |
| Title XVIII inpatient days | 1, 4, 7 | 4 | 9 | 9 |
| Title XIX inpatient days | 1-4, 7 | 5 | 9 | 9 |
| Other inpatient days | 1-5, 7 | 6 | 9 | 9 |
| Total inpatient days | 1-5, 7 | 7 | 9 | 9 |
| Title V discharges | 1, 2, 7 | 8 | 9 | 9 |
| Title XVIII discharges | 1, 7 | 9 | 9 | 9 |
| Title XIX discharges | 1-3, 7 | 10 | 9 | 9 |
| Other discharges | 1-3, 5, 7 | 11 | 9 | 9 |
| Total discharges | 1-3, 5, 7 | 12 | 9 | 9 |
| Title V average length of stay | 1-2, 7 | 13 | 9 | 9(6).99 |
| Title XVIII average length of stay | 1, 7 | 14 | 9 | 9(6).99 |
| Title XIX average length of stay | 1-3, 7 | 15 | 9 | 9(6).99 |
| Total average length of stay | 1-3, 7 | 16 | 9 | 9(6).99 |
| Title V admissions | 1, 2, 7 | 17 | 9 | 9 |
| Title XVIII admissions | 1, 7 | 18 | 9 | 9 |
| Title XIX admissions | 1-3, 7 | 19 | 9 | 9 |
| Other admissions | 1-3, 5, 7 | 20 | 9 | 9 |
| Total admissions | 1-3, 5, 7 | 21 | 9 | 9 |
| Full time equivalent employees on payroll | 1-7 | 22 | 9 | 9(6).99 |
| Full time equivalent nonpaid Workers | 1-7 | 23 | 9 | 9(6).99 |

**ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2540-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE,
AND COLUMN DESIGNATIONS**

WORKSHEET S-3, PART II

| <u>DESCRIPTION</u> | <u>LINE(S)</u> | <u>COLUMN(S)</u> | <u>FIELD SIZE</u> | <u>USAGE</u> |
|---------------------------------------------|----------------|------------------|-----------------------|--------------|
| Reported salaries | 1-11, 14-21 | 1 | 9 | 9 |
| Reclassification of salaries from Wkst. A-6 | 1-11, 14-21 | 2 | 9 | -9 |
| Paid hours related to salary | 1-11, 14-16 | 4 | 10 | 9(7).99 |
| Average hours related to salary | 1-11, 14-16 | 5 | 10 | 9(7).99 |

WORKSHEET S-3, PART III

| <u>DESCRIPTION</u> | <u>LINE(S)</u> | <u>COLUMN(S)</u> | <u>FIELD SIZE</u> | <u>USAGE</u> |
|-------------------------------------------------|----------------|------------------|-----------------------|--------------|
| Reclassification of salaries from Worksheet A-6 | 1-11, 13 | 2 | 9 | -9 |
| Paid hours related to salary | 1-11, 13 | 4 | 10 | 9(7).99 |

WORKSHEET S-3, PART IV

| | <u>LINE(S)</u> | <u>COLUMN(S)</u> | <u>FIELD SIZE</u> | <u>USAGE</u> |
|------------------------------------------------------|----------------|------------------|-----------------------|--------------|
| 401K Employer Contributions | 1 | 1 | 9 | 9 |
| Tax Sheltered Annuity (TSA) Employer Contribution | 2 | 1 | 9 | 9 |
| Qualified and Non-Qualified Pension Plan Cost | 3 | 1 | 9 | 9 |
| Prior Year Pension Service Cost | 4 | 1 | 9 | 9 |
| 401K/TSA Plan Administration fees | 5 | 1 | 9 | 9 |
| Legal/Accounting/Management Fees- Pension Plan | 6 | 1 | 9 | 9 |
| Employee Managed Care Program Administration Fees | 7 | 1 | 9 | 9 |
| Health Insurance (Purchased or Self Funded) | 8 | 1 | 9 | 9 |

**ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2540-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE,
AND COLUMN DESIGNATIONS**

WORKSHEET S-3, PART IV (Cont.)

| | <u>LINE(S)</u> | <u>COLUMN(S)</u> | <u>FIELD SIZE</u> | <u>USAGE</u> |
|----------------------------------------------------------------------------------------------------------------------------|----------------|------------------|-----------------------|--------------|
| Prescription Drug Plan | 9 | 1 | 9 | 9 |
| Dental, Hearing and Vision Plan | 10 | 1 | 9 | 9 |
| Life Insurance (If employee is owner or beneficiary) | 11 | 1 | 9 | 9 |
| Accidental Insurance (If employee is owner or beneficiary) | 12 | 1 | 9 | 9 |
| Disability Insurance (If employee is owner or beneficiary) | 13 | 1 | 9 | 9 |
| Long-Term Care Insurance (If employee is owner or beneficiary) | 14 | 1 | 9 | 9 |
| Workers' Compensation Insurance | 15 | 1 | 9 | 9 |
| Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106 Non cumulative portion) | 16 | 1 | 9 | 9 |
| FICA-Employers Portion Only | 17 | 1 | 9 | 9 |
| Medicare Taxes - Employers Portion Only | 18 | 1 | 9 | 9 |
| Unemployment Insurance | 19 | 1 | 9 | 9 |
| State or Federal Unemployment Taxes | 20 | 1 | 9 | 9 |
| Executive Deferred Compensation | 21 | 1 | 9 | 9 |
| Day Care Cost and Allowances | 22 | 1 | 9 | 9 |
| Tuition Reimbursement | 23 | 1 | 9 | 9 |
| Total Wage Related cost (Sum of lines 1 23) | 24 | 1 | 9 | 9 |
| Other Wage Related Costs (description) | 25 | 0 | 36 | X |
| Other Wage Related Costs | 25 | 1 | 9 | 9 |

**ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2540-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE,
AND COLUMN DESIGNATIONS**

This space intentionally left blank – reserved for future data.

WORKSHEET S-4

| <u>DESCRIPTION</u> | <u>LINE(S)</u> | <u>COLUMN(S)</u> | <u>FIELD SIZE</u> | <u>USAGE</u> |
|-------------------------------------------------------|----------------|------------------|-----------------------|--------------|
| County | 1 | 1 | 36 | X |
| Home health aide hours: | 2 | 1-5 | 11 | 9 |
| Unduplicated census count: | 3 | 1-5 | 11 | 9(8).99 |
| Enter the number of hours in your normal work week | 4 | 1 | 6 | 9(3).99 |

**ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2540-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE,
AND COLUMN DESIGNATIONS**

WORKSHEET S-4 (Cont.)

| <u>DESCRIPTION</u> | <u>LINE(S)</u> | <u>COLUMN(S)</u> | <u>FIELD SIZE</u> | <u>USAGE</u> |
|-------------------------------------------|----------------|------------------|-------------------|--------------|
| Other (specify) | 20 | 0 | 36 | X |
| Number of full time equivalent employees: | | | | |
| Staff | 5-20 | 1 | 6 | 9(3).99 |
| Contract | 5-20 | 2 | 6 | 9(3).99 |

HOME HEALTH AGENCY CBSA CODES

| | | | | |
|--------------------------------------------------------------------------------------------------------------------------|----|---|---|---|
| How many CBSAs in column 1 did you provide services to during this cost reporting period? | 21 | 1 | 2 | 9 |
| List those CBSA code(s) in column 1 serviced during this cost reporting period (<i>line 22</i> contains the first code) | 22 | 1 | 5 | 9 |

PPS ACTIVITY DATA - Applicable for Medicare Services Rendered on or after October 1, 2000

| | | | | |
|-------------------|--------------------|-----|----|---|
| PPS Activity Data | 23-34, 36 38-40 | 1-4 | 11 | 9 |
|-------------------|--------------------|-----|----|---|

WORKSHEET S-5

| <u>DESCRIPTION</u> | <u>LINE(S)</u> | <u>COLUMN(S)</u> | <u>FIELD SIZE</u> | <u>USAGE</u> |
|------------------------------------------------------------|----------------|------------------|-------------------|--------------|
| RHC/FQHC Identification: | | | | |
| Street | 1 | 1 | 36 | X |
| County | 1 | 2 | 36 | X |
| City | 2 | 1 | 36 | X |
| State | 2 | 2 | 2 | X |
| Zip Code | 2 | 3 | 10 | X |
| Designation for FQHC's only "R" for rural or "U" for urban | 3 | 1 | 1 | X |
| Source of Federal funds: | | | | |
| Other (specify) | 9 | 0 | 36 | X |

**ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2540-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE,
AND COLUMN DESIGNATIONS**

WORKSHEET S-5 (Cont.)

| <u>DESCRIPTION</u> | <u>LINE(S)</u> | <u>COLUMN(S)</u> | <u>FIELD SIZE</u> | <u>USAGE</u> |
|----------------------------------------------------------------------------------------------|----------------|------------------|-------------------|--------------|
| Amount of Federal Funds: | 4-9 | 1 | 11 | 9 |
| Award Date (MM/DD/YYYY) | 4-9 | 2 | 10 | X |
| Other (specify) | 9 | 0 | 36 | X |
| | 9 | 1 | 11 | 9 |
| | 9 | 2 | 10 | X |
| Does this facility operate as other than an RHC or FQHC? | 10 | 1 | 1 | X |
| Indicate number of operation(s) | 10 | 2 | 2 | 9 |
| Facility hours of operations * | | | | |
| Clinic - Hours: from/to | 11 | 1-14 | 4 | 9 |
| Have you received an approval for an exception to the productivity standard? | 12 | 1 | 1 | X |
| Is this a consolidated cost report in accordance with IOM CMS Pub. 100-04, Chapter 9, §30.8? | 13 | 1 | 1 | X |
| Enter the number of providers included in this report. | 13 | 2 | 2 | 9 |
| Provider Name | 14 | 1 | 36 | X |
| Provider Number (CCN) | 14 | 2 | 6 | X |

* List hours of operations based on a 24 hour clock. For example 8:00 AM is 0800, 6:30 PM is 1830, and midnight is 2400.

WORKSHEET S-6

| <u>DESCRIPTION</u> | <u>LINE(S)</u> | <u>COLUMN(S)</u> | <u>FIELD SIZE</u> | <u>USAGE</u> |
|---------------------------------------------------|----------------|------------------|-------------------|--------------|
| Number of hours in a normal work week | 0 | 1 | 6 | 9(3).99 |
| Other (specify) | 18-19 | 0 | 36 | X |
| Number of full time equivalent employees on staff | 1-19 | 1 | 6 | 9(3).99 |
| Number of full time equivalent contract personnel | 1-19 | 2 | 6 | 9(3).99 |

**ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2540-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE,
AND COLUMN DESIGNATIONS**

WORKSHEET S-7

| <u>DESCRIPTION</u> | <u>LINE(S)</u> | <u>COLUMN(S)</u> | <u>FIELD SIZE</u> | <u>USAGE</u> |
|-------------------------|----------------|------------------|-----------------------|--------------|
| Days (see instructions) | 1-99 | 2 | 6 | 9 |

Enter in column 1 the expense for each category. Enter in column 2 the percentage of total expense for each category to total SNF revenue from Worksheet G-2, Part I, line 1, column 3. Indicate in column 3 "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category.

Enter in column 1 the direct patient care expenses and related expenses for each category.

| | | | | |
|------------------------|-----|---|----|---|
| Staffing | 101 | 1 | 9 | 9 |
| Recruitment | 102 | 1 | 9 | 9 |
| Retention of employees | 103 | 1 | 9 | 9 |
| Training | 104 | 1 | 9 | 9 |
| Other (Specify) | 105 | 0 | 36 | X |
| Other (Specify) | 105 | 1 | 9 | 9 |

Enter in column 2 the ratio, expressed as a percentage, of total expenses for each category to total SNF revenue.

| | | | | |
|------------------------|-----|---|---|---------|
| Staffing | 101 | 2 | 6 | 9(3).99 |
| Recruitment | 102 | 2 | 6 | 9(3).99 |
| Retention of employees | 103 | 2 | 6 | 9(3).99 |
| Training | 104 | 2 | 6 | 9(3).99 |
| Other (Specify) | 105 | 2 | 6 | 9(3).99 |

Does the increased RUG payments received reflect increases associated with direct patient care and related expenses (Y/N)

| | | | | |
|------------------------|-----|---|---|---|
| Staffing | 101 | 3 | 3 | X |
| Recruitment | 102 | 3 | 3 | X |
| Retention of employees | 103 | 3 | 3 | X |
| Training | 104 | 3 | 3 | X |
| Other (Specify) | 105 | 3 | 3 | X |

Enter total SNF revenue from Worksheet G-2, Part I, line 1, column 3.

| | | | | |
|--|-----|---|---|---|
| | 106 | 2 | 9 | 9 |
|--|-----|---|---|---|

**ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2540-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE,
AND COLUMN DESIGNATIONS**

WORKSHEET S-8

| <u>DESCRIPTION</u> | <u>LINE(S)</u> | <u>COLUMN(S)</u> | <u>FIELD SIZE</u> | <u>USAGE</u> |
|----------------------------------------------------|----------------|------------------|-------------------|--------------|
| <u>Part I</u> | | | | |
| Continuous Home Care | 1 | 1-5 | 9 | 9 |
| Routine Home Care | 2 | 1-5 | 9 | 9 |
| Inpatient Respite Care | 3 | 1-5 | 9 | 9 |
| General Inpatient Care | 4 | 1-5 | 9 | 9 |
| <u>Part II</u> | | | | |
| Number of Patients Receiving Hospice Care | 6 | 1-5 | 9 | 9 |
| Total number of Unduplicated Continuous Care Hours | 7 | 1 & 3 | 11 | 9(8).99 |
| Unduplicated Census Count | 9 | 1-5 | 9 | 9 |

WORKSHEET A

| | | | | |
|------------------------------------------------|------------------------------------------------|---|---|----|
| Direct salaries by department | 3-15, 30-33, 40-52, 60-63, 70-74, 82-84, 90-95 | 1 | 9 | -9 |
| Total direct salaries | 100 | 1 | 9 | 9 |
| Other direct costs by department | 1-15, 30-33, 40-52, 60-63, 70-74, 80-84, 90-95 | 2 | 9 | -9 |
| Total other direct costs | 100 | 2 | 9 | 9 |
| Net expenses for cost allocation by department | 1-15, 30-33, 40-52, 60-63, 70-74, 80-84, 90-95 | 7 | 9 | -9 |
| Total net expenses for cost allocation | 100 | 7 | 9 | 9 |

WORKSHEET A-6

For each expense reclassification:

| | | | | |
|-----------------------|------|---|----|---|
| Explanation | 1-99 | 0 | 36 | X |
| Reclassification code | 1-99 | 1 | 2 | X |

**ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2540-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE,
AND COLUMN DESIGNATIONS**

WORKSHEET A-6 (Continued)

| <u>DESCRIPTION</u> | <u>LINE(S)</u> | <u>COLUMN(S)</u> | <u>FIELD SIZE</u> | <u>USAGE</u> |
|-------------------------|----------------|------------------|-----------------------|--------------|
| Increases: | | | | |
| Worksheet A line number | 1-99 | 3 | 5 | 99.99 |
| Salary amount | 1-99 | 4 | 9 | 9 |
| Non salary amount | 1-99 | 5 | 9 | 9 |
| Decreases: | | | | |
| Worksheet A line number | 1-99 | 7 | 5 | 99.99 |
| Salary amount | 1-99 | 8 | 9 | 9 |
| Non salary amount | 1-99 | 9 | 9 | 9 |
| <i>Total Increases</i> | <i>100</i> | <i>4-5</i> | <i>9</i> | <i>9</i> |
| <i>Total Decreases</i> | <i>100</i> | <i>8-9</i> | <i>9</i> | <i>9</i> |

WORKSHEET A-7

Analysis of changes in capital assets balances
for land, land improvements, buildings and
fixtures, building improvements, fixed and
movable equipment, and in total:

| | | | | |
|---------------------------|-----|---|---|---|
| Beginning balances | 1-9 | 1 | 9 | 9 |
| Purchases | 1-9 | 2 | 9 | 9 |
| Donations | 1-9 | 3 | 9 | 9 |
| Disposals and retirements | 1-9 | 5 | 9 | 9 |
| Fully Depreciated Assests | 1-9 | 7 | 9 | 9 |

WORKSHEET A-8

| | | | | |
|---------------------------|---------------------------------------------|---|----|----|
| Description of adjustment | <i>25-99</i> | 0 | 36 | X |
| Basis (A or B) | 1-7, 9-11, <i>13-99</i> | 1 | 1 | X |
| Amount | 1-7, 9-11, <i>13-100</i> | 2 | 9 | -9 |
| Worksheet A line number | 1-7, 9-11, <i>13-21,</i> <i>25-99</i> | 4 | 5 | 9 |

**ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2540-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE,
AND COLUMN DESIGNATIONS**

WORKSHEET A-8-1

| <u>DESCRIPTION</u> | <u>LINE(S)</u> | <u>COLUMN(S)</u> | <u>FIELD SIZE</u> | <u>USAGE</u> |
|-----------------------------------------------------------------------------------------------------------------|----------------|------------------|-------------------|--------------|
| Part I-Costs incurred and adjustments required as a result of transactions with related organization(s): | | | | |
| Worksheet A line number | 1-9 | 1 | 5 | 99.99 |
| Expense item(s) | 1-9 | 3 | 36 | X |
| Amount included in Worksheet A | 1-9 | 4 | 9 | -9 |
| Amount allowable in reimbursable cost | 1-9 | 5 | 9 | -9 |
| <i>Total</i> | <i>10</i> | <i>4-6</i> | <i>9</i> | <i>9</i> |
| Part II - For each related organization: | | | | |
| Type of interrelationship (A - G) | 1-10 | 1 | 1 | X |
| If type is G, specify description of relationship | 1-10 | 0 | 36 | X |
| Name of individual or partnership with interest in provider and related organization | 1-10 | 2 | 15 | X |
| Percent of ownership of provider | 1-10 | 3 | 6 | 9(3).99 |
| Name of related organization | 1-10 | 4 | 15 | X |
| Percent of ownership of related organization | 1-10 | 5 | 6 | 9(3).99 |
| Type of business | 1-10 | 6 | 15 | X |

WORKSHEET A-8-2

| <u>DESCRIPTION</u> | <u>LINE(S)</u> | <u>COLUMN(S)</u> | <u>FIELD SIZE</u> | <u>USAGE</u> |
|---------------------------------------------------|----------------|------------------|-------------------|--------------|
| By each cost center or physician: | | | | |
| Worksheet A line number | 1-99 | 1 | 5 | 99.99 |
| Physician identifier | 1-99 | 2 | 36 | X |
| Total physicians; remuneration | 1-99 | 3 | 9 | 9 |
| Physicians' remuneration - professional component | 1-99 | 4 | 9 | 9 |
| Physicians' remuneration - provider component | 1-99 | 5 | 9 | 9 |
| RCE amount | 1-99 | 6 | 9 | 9 |

**ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2540-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE,
AND COLUMN DESIGNATIONS**

WORKSHEET A-8-2 (Cont.)

| <u>DESCRIPTION</u> | <u>LINE(S)</u> | <u>COLUMN(S)</u> | <u>FIELD SIZE</u> | <u>USAGE</u> |
|------------------------------------------------------|----------------|------------------|-----------------------|--------------|
| Number of physicians' hours - provider component | 1-99 | 7 | 9 | 9 |
| Cost of memberships and continuing education | 1-99 | 12 | 9 | 9 |
| Physician cost of malpractice insurance | 1-99 | 14 | 9 | 9 |
| In total for the facility: | | | | |
| Total physicians' remuneration | 100 | 3 | 9 | 9 |
| Physicians' remuneration - professional component | 100 | 4 | 9 | 9 |
| Physicians' remuneration - provider component | 100 | 5 | 9 | 9 |
| Number of physicians' hours - provider component | 100 | 7 | 9 | 9 |
| Cost of memberships and continuing education | 100 | 12 | 9 | 9 |
| Physician cost of malpractice insurance | 100 | 14 | 9 | 9 |

**WORKSHEETS B, PARTS I AND II; B-1; H-2, PARTS I AND II, J-1, PARTS I AND II, AND
K-5, PARTS I AND II**

| <u>DESCRIPTION</u> | <u>LINE(S)</u> | <u>COLUMN(S)</u> | <u>FIELD SIZE</u> | <u>USAGE</u> |
|-----------------------------------|----------------|------------------|-----------------------|--------------|
| Column heading (cost center name) | 1-3 * | 1-3, 4-15 | 10 | X |
| Statistical basis | 4, 5 * | 1-3, 4-15 | 10 | X |

* Refer to Table 1 for specifications and Table 2 for the worksheet identifier for column headings. There may be up to five type 2 records (3 for cost center name and 2 for the statistical basis) for each column. However, for any column that has less than five type 2 record entries, blank records or the word "blank" is not required to maximize each column record count.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2540-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE,
AND COLUMN DESIGNATIONS

WORKSHEET D, PART II

| <u>DESCRIPTION</u> | <u>LINE(S)</u> | <u>COLUMN(S)</u> | <u>FIELD SIZE</u> | <u>USAGE</u> |
|-------------------------------------------------------|----------------|------------------|-----------------------|--------------|
| Vaccine cost apportionment Program vaccine charges | 2 | 1 | 9 | 9 |

WORKSHEET D-1, *PART I*

| | | | | |
|--------------------------------------------------------|-----|---|---|---------|
| Private room days | 2 | 1 | 9 | 9 |
| Medically necessary private room days | 4 | 1 | 9 | 9 |
| General inpatient routine service charges | 6 | 1 | 9 | 9 |
| Private room charge | 8 | 1 | 9 | 9 |
| Semi private room charges | 10 | 1 | 9 | 9 |
| Aggregate charges to beneficiaries for excess costs | 24 | 1 | 9 | 9 |
| Inpatient routine service cost per diem limitation | 26* | 1 | 9 | 9(6).99 |
| Reimbursable inpatient routine service costs | 28 | 1 | 9 | 9 |

* Line 26 is not applicable for Title XVIII, but may be used for Titles V and XIX.

WORKSHEET E, PART I

Part A - Inpatient service PPS provider
computation of reimbursement Title XVIII

| | | | | |
|------------------------------------------------------------------|----------|----------|----------|----------|
| Inpatient PPS amount (see instructions) | 1 | 1 | 9 | 9 |
| Primary payer amounts | 4 | 1 | 9 | 9 |
| Coinsurance | 5 | 1 | 9 | 9 |
| Reimbursable bad debts | 6 | 1 | 9 | -9 |
| Reimbursable bad debts dual eligible | 7 | 1 | 9 | -9 |
| <i>Recovery of bad debts – for statistical records only.</i> | <i>9</i> | <i>1</i> | <i>9</i> | <i>9</i> |
| Utilization review | 10 | 1 | 9 | 9 |
| Other adjustments (specify) | 14 | 0 | 36 | X |
| Other adjustments | 14 | 1 | 9 | -9 |
| Protested amounts | 16 | 1 | 9 | -9 |

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2540-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE,
AND COLUMN DESIGNATIONS

WORKSHEET E, PART I (Cont.)

| <u>DESCRIPTION</u> | <u>LINE(S)</u> | <u>COLUMN(S)</u> | <u>FIELD SIZE</u> | <u>USAGE</u> |
|----------------------------------------------------------------------------------------------------------------|----------------|------------------|-----------------------|--------------|
| <u>Part B</u> - Ancillary service computation of reimbursement of lesser of cost or charges (Title XVIII only) | | | | |
| Primary payer amounts | 22 | 1 | 9 | 9 |
| Coinsurance and deductibles | 23 | 1 | 9 | 9 |
| Reimbursable bad debts | 24 | 1 | 9 | 9 |
| Other adjustments (specify) | 28 | 0 | 36 | X |
| Other adjustments | 28 | 1 | 9 | -9 |
| Protested Amounts | 30 | 1 | 9 | -9 |

WORKSHEET E, PART II (Titles V and XIX)

| | | | | |
|-----------------------------------------------|----|---|----|----|
| Utilization review – physicians' compensation | 5 | 1 | 9 | 9 |
| Charge differential | 7 | 1 | 9 | 9 |
| Inpatient primary payer amount | 9 | 1 | 9 | 9 |
| Inpatient ancillary service charges | 11 | 1 | 9 | 9 |
| Outpatient service charges | 12 | 1 | 9 | 9 |
| Inpatient routine service charges | 13 | 1 | 9 | 9 |
| Charge differential | 14 | 1 | 9 | 9 |
| Aggregate amount collected | 16 | 1 | 9 | 9 |
| Amount collectible | 17 | 1 | 9 | 9 |
| Deductibles (Title V and Title XIX only) | 21 | 1 | 9 | 9 |
| Coinsurance | 23 | 1 | 9 | 9 |
| Reimbursable bad debt | 25 | 1 | 9 | 9 |
| Unrefunded excess charges | 27 | 1 | 9 | 9 |
| Recovery of excess depreciation | 28 | 1 | 9 | 9 |
| Other adjustments (specify) | 29 | 0 | 36 | X |
| Other adjustments (see instructions) | 29 | 1 | 9 | -9 |

**ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2540-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE,
AND COLUMN DESIGNATIONS**

WORKSHEET G-2

| <u>DESCRIPTION</u> | <u>LINE(S)</u> | <u>COLUMN(S)</u> | <u>FIELD SIZE</u> | <u>USAGE</u> |
|------------------------------------------------------------|----------------|------------------|-----------------------|--------------|
| CMHC | 11 | 2 | 9 | 9 |
| SNF based Hospice | 12 | 1, 2 | 9 | 9 |
| Other (specify) | 13 | 1, 2 | 9 | 9 |
| Total patient revenues | 14 | 1-3 | 9 | 9 |
| <u>Part II:</u> Blank lines (specify) | 2-7, 9-13 | 0 | 36 | X |
| Increases to operating expenses Reported on Worksheet A | 2-7 | 1 | 9 | 9 |
| Decreases to operating expenses Reported on Worksheet A | 9-13 | 1 | 9 | 9 |
| Total operating expenses | 15 | 2 | 9 | 9 |

WORKSHEET G-3

| | | | | |
|--------------------------------------------------------------|-----------|---|----|----|
| Contractual allowance and discounts on patients' accounts | 2 | 1 | 9 | 9 |
| Other revenues | 6-24 | 1 | 9 | 9 |
| Other expenses | 27-29 | 1 | 9 | 9 |
| Blank lines (specify) | 24, 27-29 | 0 | 36 | X |
| Net income (loss) | 31 | 1 | 9 | -9 |

WORKSHEET H

| | | | | |
|-------------------------------|------|---|----|---|
| Salaries | 3-24 | 1 | 9 | 9 |
| Employee Benefits | 3-24 | 2 | 9 | 9 |
| Transportation costs | 1-24 | 3 | 9 | 9 |
| Contracted/Purchased Services | 3-24 | 4 | 9 | 9 |
| Other costs | 1-24 | 5 | 9 | 9 |
| Other (specify) | 24 | 0 | 36 | X |

**ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2540-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE,
AND COLUMN DESIGNATIONS**

WORKSHEET H-1, PARTS I & II

| <u>DESCRIPTION</u> | <u>LINE(S)</u> | <u>COLUMN(S)</u> | <u>FIELD SIZE</u> | <u>USAGE</u> |
|--------------------------------|----------------|------------------|-----------------------|--------------|
| Part I | | | | |
| Total | 25 | 1-4 | 11 | 9 |
| Cost allocation | 6-24 | 6 | 11 | 9 |
| Part II | | | | |
| Reconciliation | 5-24 | 5A | 11 | -9 |
| All cost allocation statistics | 1-24 | 1-4* | 11 | 9 |

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

WORKSHEET H-2, Parts I & II

| | | | | |
|--------------------------------------------|------|------------|----|----|
| Part I | | | | |
| Post Stepdown adjustment (including total) | 1-21 | 17 | 11 | 9 |
| Total cost after cost finding | 2-20 | 20 | 11 | 9 |
| Total cost | 21 | 0-3 & 4-15 | 11 | 9 |
| Part II | | | | |
| Centers – Statistical Basis | | | | |
| Reconciliation | 1-20 | 4A-15A | 11 | -9 |
| All cost allocation statistics | 1-20 | 1-15* | 11 | 9 |

*See note to Worksheet B-1 for treatment of administrative and general accumulated cost column. Do not include X on line 0 of accumulated cost column since this is a replica of Worksheet B-1

WORKSHEET H-3 Parts I & II

| | | | | |
|---------------------------------------------------------------|-------|-----|----|---|
| Part I | | | | |
| Total visits | 1-6 | 4 | 11 | 9 |
| Program visits | 1-6 | 6-7 | 11 | 9 |
| CBSA numbers | 8-13 | 1 | 11 | 9 |
| Program visits by discipline and CBSA | 8-13 | 2-3 | 11 | 9 |
| Total charges for DME rented and sold and medical supplies | 15-16 | 4 | 11 | 9 |
| Charges for Drugs Medicare Part B | 16 | 7-8 | 11 | 9 |
| Part II | | | | |
| Total HHA charges | 1-5 | 2 | 11 | 9 |
| Total HHA shared ancillary costs | 1-5 | 3 | 11 | 9 |

**ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2540-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE,
AND COLUMN DESIGNATIONS**

WORKSHEET I-3

| <u>DESCRIPTION</u> | <u>LINE(S)</u> | <u>COLUMN(S)</u> | <u>FIELD SIZE</u> | <u>USAGE</u> |
|---------------------------------------------------------------------------------------|----------------|------------------|-----------------------|--------------|
| Adjusted cost per visit | 7 | 1 | 6 | 9(3).99 |
| Maximum rate per visit (from your contractor) | 8 | 1 & 2 | 6 | 9(3).99 |
| Rate for program covered visits | 9 | 1 & 2 | 6 | 9(3).99 |
| <i>Program</i> covered visits excluding mental health services (from your contractor) | 10 | 1 & 2 | 11 | 9 |
| <i>Program</i> covered visits for mental health services (from your contractor) | 12 | 1 & 2 | 11 | 9 |
| <i>Total Program charges FQHC only</i> | <i>15.01</i> | <i>1</i> | <i>11</i> | <i>9</i> |
| <i>Total Program preventive charges FQHC only</i> | <i>15.02</i> | <i>1</i> | <i>11</i> | <i>9</i> |
| Primary payer amounts | 16 | 1 | 11 | 9 |
| Beneficiary deductible (from your contractor) | 17 | 1 | 11 | 9 |
| Beneficiary coinsurance (from your contractor) | 18 | 1 | 11 | 9 |
| Reimbursable bad debt | 22 | 1 | 11 | 9 |
| Reimbursable bad debt dual eligible beneficiaries | 23 | 1 | 11 | 9 |
| Other Adjustment (specify) | 24 | 0 | 36 | X |
| Other Adjustments | 24 | 1 | 11 | 9 |
| Interim payments (Title V & XIX only) | 26 | 1 | 11 | 9 |
| Protested amounts | 29 | 1 | 11 | -9 |

WORKSHEET I-4

| | | | | |
|------------------------------------------------------------------------------------------------|----|-------|----|--------|
| Ratio of pneumococcal and influenza vaccine staff time to total health care staff time | 2 | 1 & 2 | 8 | 9.9(6) |
| Medical supplies cost - pneumococcal and influenza vaccine | 4 | 1 & 2 | 11 | 9 |
| Total number of pneumococcal and influenza vaccine injections | 11 | 1 & 2 | 11 | 9 |
| Number of pneumococcal and influenza vaccine injections administered to Medicare beneficiaries | 13 | 1 & 2 | 11 | 9 |

**ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2540-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE,
AND COLUMN DESIGNATIONS**

WORKSHEET I-5

| <u>DESCRIPTION</u> | <u>LINE(S)</u> | <u>COLUMN(S)</u> | <u>FIELD SIZE</u> | <u>USAGE</u> |
|--------------------------------------------------------------|----------------|------------------|-----------------------|--------------|
| Total interim payments paid to provider | 1 | 2 | 11 | 9 |
| Interim payments payable | 2 | 2 | 11 | 9 |
| Date of each retroactive lump sum adjustment (MM/DD/YYYY) | 3.01-3.98 | 1 | 10 | X |
| Adjustment of each retroactive lump sum adjustment: | | | | |
| Program to provider | 3.01-3.49 | 2 | 11 | 9 |
| Provider to program | 3.50-3.98 | 2 | 11 | 9 |
| Date of each tentative settlement adjustment (MM/DD/YYYY) | 5.01-5.98 | 1 | 10 | X |
| Tentative settlement payment | | | | |
| Program to provider | 5.01-5.49 | 2 | 11 | 9 |
| Provider to program | 5.50-5.98 | 2 | 11 | 9 |
| FI/Contractor Name | 8 | 1 | 36 | X |
| FI Contractor Number | 8 | 2 | 5 | 9 |

WORKSHEET J-1, PARTS I & II

Part I

| | | | | |
|-------------------------------------------------|------|------------|---|----|
| Net expenses for cost allocation | 1-21 | 0 | 9 | 9 |
| Post step down adjustments (including total) | 1-22 | 17 | 9 | -9 |
| Totals (sum of lines 1-21) | 22 | 0-3 & 4-15 | 9 | 9 |

Part II

| | | | | |
|----------------------------|------|--------|---|----|
| Reconciliation | 1-21 | 4A-15A | 9 | -9 |
| Cost allocation statistics | 1-21 | 1-15 * | 9 | 9 |

*See note to Worksheet B-1 for treatment of administrative and general accumulated cost column. Do not include X on line 0 of accumulated cost column since this is a replica of Worksheet B-1.

**ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2540-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE,
AND COLUMN DESIGNATIONS**

WORKSHEET K-4, PARTS I & II

| <u>DESCRIPTION</u> | <u>LINE(S)</u> | <u>COLUMN(S)</u> | <u>FIELD SIZE</u> | <u>USAGE</u> |
|--------------------------------|----------------|------------------|-----------------------|--------------|
| Part I | | | | |
| Total | 39 | 1-5 | 11 | 9 |
| Cost allocation | 7 - 38 | 7 | 11 | 9 |
| Part II | | | | |
| Reconciliation | 6-38 | 6A | 11 | -9 |
| All cost allocation statistics | 1-38 | 1-5* | 11 | 9 |

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

WORKSHEET K-5, PARTS I & II

| | | | | |
|---------------------------------------|------|------------|----|----|
| Part I | | | | |
| Total Hospice Cost after cost finding | 2-33 | 18 | 11 | 9 |
| Total cost | 34 | 0-3 & 4-16 | 11 | 9 |
| Part II | | | | |
| Reconciliation | 1-33 | 4A-15A | 11 | -9 |
| All Cost Allocation Statistics | 1-33 | 1-15* | 11 | 9 |

*See note to Worksheet B-1 for treatment of administrative and general accumulated cost column. Do not include X on line 0 of accumulated cost column since this is a replica of Worksheet B-1.

WORKSHEET K-5, PART III

| | | | | |
|-----------------------|-----|---|----|---|
| Total Hospice Charges | 1-8 | 2 | 11 | 9 |
|-----------------------|-----|---|----|---|

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2540-10
TABLE 3A - WORKSHEETS REQUIRING NO INPUT

Worksheet D-1, Part II
 Worksheet H-1, Part I
 Worksheet J-1, Part I
 Worksheet K-5, Part I
 Worksheet K-6

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

| <u>Worksheet</u> | <u>Lines</u> |
|----------------------|---------------------------|
| <i>S, Part I</i> | <i>1-3</i> |
| S, Part III | 1-3,100 |
| S-2, Part I | 1-6, 11, 14-31, 36-47 |
| S-2, Part II | All |
| S-3, Part I | 1-3, 5, 8 |
| S-3, Part II | All |
| <i>S-3, Part III</i> | <i>1-12</i> |
| S-3, Part IV | 1-24 |
| S-4 | 1-19, 21, 23-40 |
| S-5 | 1-8, 10, 12, 13 |
| S-6 | 1-17 |
| S-7 | All except line 105 |
| S-8 | All |
| A | 30-33, 71, 80-82, 89, 100 |
| A-6 | All |
| A-7 | All |
| A-8 | 1-23, 100 |

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2540-10
TABLE 3C - LINES THAT CANNOT BE SUBSCRIBED
(BEYOND THOSE PREPRINTED) (CONTINUED)

| <u>Worksheet</u> | <u>Lines</u> |
|-------------------|--------------------------------------------------------------|
| A-8-1, Part I | 1-8, 10 |
| A-8-1, Part II | <i>1-9</i> |
| A-8-2 | All |
| B, Parts I & II | 30-33, 71, 89, 98-100 |
| B-1 | 30-33, 71, 89, 98-105 |
| B-2 | All |
| C | 71, 100 |
| D, Part I | 71, 100 |
| D, Part II | All |
| D, Part III | 100 |
| D-1 | All |
| E, Part I | All except lines 14, 28 |
| E, Part II | All except line 29 |
| E-1 | 1, 2, 3.01-3.05, 3.50-3.54, 4, 5.01- 5.03, 5.50-5.52, 6-8 |
| G | All |
| G-1 | 1-3,10,11,18,19 |
| G-2, Part I | 1-7, 9, 14 |
| G-2, Part II | 1,8,14,15 |
| G-3 | <i>1-23</i> , and 25, 26, 30, 31 |
| H | All except 24 |
| H-1, Parts I & II | All except 24 |
| H-2, Parts I & II | All except 20 |
| H-3, Parts I & II | All except lines 8-13 |
| H-4, Part I | All |
| H-4, Part II | All except 30 |
| H-5 | 1, 2, 3.01-3.05, 3.50-3.54, 4, 5.01- 5.03, 5.50-5.52, 6-8 |
| I-1 | All |
| I-2 | All |
| I-3 | All, except line 24 |
| I-4 | All |
| I-5 | 1, 2, 3.01-3.05, 3.50-3.54, 4, 5.01- 5.03, 5.50-5.52, 6-8 |
| J-1, Parts I & II | All |
| J-2, Parts I & II | All |
| J-3 | All except 16 |
| J-4 | 1, 2, 3.01-3.05, 3.50-3.54, 4, 5.01- 5.03, 5.50-5.52, 6-8 |

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2540-10
TABLE 3C - LINES THAT CANNOT BE SUBSCRIBED
(BEYOND THOSE PREPRINTED) (CONTINUED)

| <u>Worksheet</u> | <u>Lines</u> |
|---------------------|--------------|
| K | All |
| K-1 | All |
| K-2 | All |
| K-3 | All |
| K-4, Parts I & II | All |
| K-5, Parts I & II | All |
| K-5, Part III & K-6 | All |

TABLE 3D - PERMISSIBLE PAYMENT MECHANISMS

P = Prospective payment

O = Other

N = Not applicable

| <u>Component</u> | <u>Title V</u> | <u>Title XVIII</u> | <u>Title XIX</u> |
|--------------------------|----------------|--------------------|------------------|
| Skilled Nursing Facility | P or O | P | P or O |
| Nursing Facility | P or O | N | P or O |
| ICF/MR | N | N | O |
| SNF-Based HHA | P or O | P | P or O |
| SNF-Based RHC | O | O | O |
| SNF-Based FQHC | O | O | O |
| SNF-Based CMHC | O | P | O |
| SNF-Based OLTC | N | N | N |
| SNF-Based Hospice | N | N | N |
| OTHER | N | N | N |

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2540-10
TABLE 5 - COST CENTER CODING

Both the standard and nonstandard cost center descriptions along with their cost center codes are shown on Table 5. The USE column on that table indicates the number of times that a given code can be used on one cost report. Compare your added label to the descriptions shown on the standard and nonstandard tables for purposes of selecting a code. Most CMS approved software provides an automated process to present you with the allowable choices for the line/column being coded and automatically associates the code for the selected matching description with your label.

Additional Guidelines

Categories

Make a selection from the proper category such as general service description for general service lines, special purpose cost center descriptions for special purpose cost center lines, etc.

Use of a Cost Center Coding Description More Than Once

Often a description from the standard or nonstandard tables applies to more than one of the labels being added or changed by the preparer. In the past, it was necessary to determine which code was to be used and then increment the code number upwards by one for each subsequent use. This was done to provide a unique code for each cost center label. Now, most approved software associate the proper code, including increments as required, once a matching description is selected. Remember to use your label. You are matching to CMS's description only for coding purposes.

Cost Center Coding and Line Restrictions

Use cost center codes only in designated lines in accordance with the classification of cost center(s), e.g., lines 90 through 95 may only contain cost center codes within the nonreimbursable services cost center category of both standard and nonstandard coding.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2540-10
TABLE 5 - COST CENTER CODING

STANDARD COST CENTER DESCRIPTIONS AND CODES

| | <u>CODE</u> | <u>USE</u> |
|-----------------------------------------------|-------------|------------|
| GENERAL SERVICE COST CENTERS | | |
| CAP REL COSTS - BLDGS & FIXTURES | 0100 | (50) |
| CAP REL COSTS - MOVEABLE EQUIPMENT | 0200 | (50) |
| EMPLOYEE BENEFITS | 0300 | (50) |
| ADMINISTRATIVE & GENERAL | 0400 | (50) |
| PLANT OPERATION, MAINT. & REPAIRS | 0500 | (50) |
| LAUNDRY & LINEN SERVICE | 0600 | (50) |
| HOUSEKEEPING | 0700 | (50) |
| DIETARY | 0800 | (50) |
| NURSING ADMINISTRATION | 0900 | (50) |
| CENTRAL SERVICES & SUPPLY | 1000 | (50) |
| PHARMACY | 1100 | (50) |
| MEDICAL RECORDS & LIBRARY | 1200 | (50) |
| SOCIAL SERVICE | 1300 | (50) |
| NURSING AND ALLIED HEALTH EDUCATION | 1400 | (50) |
| INPATIENT ROUTINE SERVICE COST CENTERS | | |
| SKILLED NURSING FACILITY | 3000 | (01) |
| NURSING FACILITY | 3100 | (01) |
| ICF-MENTALLY RETARDED | 3200 | (01) |
| OTHER LONG TERM CARE | 3300 | (01) |

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2540-10
TABLE 5 - COST CENTER CODING

STANDARD COST CENTER DESCRIPTIONS AND CODES (CONTINUED)

| | <u>CODE</u> | <u>USE</u> |
|----------------------------------------|-------------|------------|
| ANCILLARY SERVICE COST CENTERS | | |
| RADIOLOGY | 4000 | (50) |
| LABORATORY | 4100 | (50) |
| INTRAVENOUS THERAPY | 4200 | (10) |
| OXYGEN (INHALATION) THERAPY | 4300 | (10) |
| PHYSICAL THERAPY | 4400 | (10) |
| OCCUPATIONAL THERAPY | 4500 | (10) |
| SPEECH PATHOLOGY | 4600 | (10) |
| ELECTROCARDIOLOGY | 4700 | (50) |
| MEDICAL SUPPLIES CHARGED TO PATIENTS | 4800 | (50) |
| DRUGS CHARGED TO PATIENTS | 4900 | (50) |
| DENTAL CARE - TITLE XIX ONLY | 5000 | (50) |
| SUPPORT SURFACES | 5100 | (50) |
| OUTPATIENT SERVICE COST CENTERS | | |
| CLINIC | 6000 | (10) |
| RURAL HEALTH CLINIC | 6100 | (10) |
| FQHC | 6200 | (10) |
| OTHER REIMBURSABLE COST CENTERS | | |
| HOME HEALTH AGENCY COST | 7000 | (05) |
| AMBULANCE | 7100 | (01) |
| CMHC | 7300 | (10) |

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2540-10
TABLE 5 - COST CENTER CODING

STANDARD COST CENTER DESCRIPTIONS AND CODES (CONTINUED)

| | <u>CODE</u> | <u>USE</u> |
|-------------------------------------------------------|-------------|------------|
| SPECIAL PURPOSE COST CENTERS | | |
| MALPRACTICE PREMIUMS & PAID LOSSES | 8000 | (01) |
| INTEREST EXPENSE | 8100 | (01) |
| UTILIZATION REVIEW | 8200 | (01) |
| HOSPICE | 8300 | (10) |
| NONREIMBURSABLE COST CENTERS | | |
| GIFT, FLOWER, COFFEE SHOPS & CANTEEN | 9000 | (50) |
| BARBER AND BEAUTY SHOP | 9100 | (50) |
| PHYSICIANS PRIVATE OFFICES | 9200 | (50) |
| NONPAID WORKERS | 9300 | (50) |
| PATIENTS LAUNDRY | 9400 | (50) |
| NONSTANDARD COST CENTER DESCRIPTIONS AND CODES | | |
| GENERAL SERVICE COST CENTERS | | |
| OTHER GENERAL SERVICE COST | 1500 | (50) |
| ANCILLARY SERVICE COST CENTERS | | |
| OTHER ANCILLARY SERVICE COST | 5200 | (50) |
| OUTPATIENT SERVICE COST CENTERS | | |
| OTHER OUTPATIENT SERVICE COST | 6300 | (50) |
| OTHER REIMBURSABLE COST CENTERS | | |
| OUTPATIENT REHABILITATION PROVIDER (SPECIFY) | | |
| CORF | 7200 | (10) |
| OPT | 7210 | (10) |
| OOT | 7220 | (10) |
| OSP | 7230 | (10) |
| OTHER REIMBURSABLE COST | 7400 | (50) |
| SPECIAL PURPOSE COST CENTERS | | |
| OTHER SPECIAL PURPOSE COST | 8400 | (50) |
| NONREIMBURSABLE COST CENTERS | | |
| OTHER NONREIMBURSABLE COST | 9500 | (50) |

ELECTRONIC COST REPORTING SPECIFICATIONS FOR FORM CMS-2540-10
TABLE 6 – EDITS

| <u>Reject Code</u> | <u>Condition</u> |
|--------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1080 | In all cases where the file includes both a total and the parts that comprise that total, each total must equal the sum of its parts. [12/01/2010b] |
| 1085 | All standard cost center codes must be entered on the designated standard cost center line and subscripts thereof as indicated in Table 5. [12/01/2010b] |
| 1000S | The SNF address, city, State, zip code, and county (Worksheet S-2, Part I, lines 1, 2, and 3, columns 1, 2, and 3 respectively) must be present and valid. [12/01/2010b] |
| 1005S | The cost report ending date (Worksheet S-2, Part I, column 2, line 14) must be on or after 01/01/2011. [12/01/2010b] |
| 1010S | All provider CCN and component numbers displayed on Worksheet S-2, Part I, column 2, lines 4, through 10, 12 and 13, must contain six (6) alphanumeric characters. [12/01/2010b] |
| 1015S | The cost report period beginning date (Worksheet S-2, Part I, column 1, line 14) must precede the cost report ending date (Worksheet S-2, Part I, column 2, line 14). [12/01/2010b] |
| 1020S | The skilled nursing facility name, provider CCN, certification date, and Title XVIII payment mechanism (Worksheet S-2, Part I, line 4, columns 1, 2, 3, and 5, respectively) must be present and valid. [12/01/2010b] |
| 1025S | For each provider/component name reported (Worksheet S-2, Part I, column 1, lines 4 through 13), there must be corresponding entries made on Worksheet S-2, Part I, lines 4 through 10, 12 and 13 for the provider CCN (column 2), the certification date (column 3), and the payment system for either Titles V, XVIII, or XIX (columns 4, 5, or 6, respectively) indicated with a valid code (P, O, or N). (See Table 3D.) [12/01/2010b] |
| 1030S | For Worksheet S-2, Part I, there must be a response in every file in column 1, lines 15-18, 25-28, 37-38, and 42-43. <i>If line 15, column 1 equals "13" other, specify in column 2.</i> [12/01/2010b] |
| 1035S | For Worksheet S-2, Part I, if the response on line 38 = "Y", then there must be a response on line 39. [12/01/2010b] |
| 1040S | For each provider/component listed on Worksheet S-2, Part I, lines 7 through 10 and their subscripts, there must be corresponding entries made on Worksheet S-2, Part I, lines 32 through 35 and their subscripts, accordingly. For line 32 and its subscripts, columns 1 and 2 must be completed. For lines 33 through 35 and their subscripts, column 2 must be completed. [12/01/2010b] |
| 1045S | For Worksheet S-2, Part I, if the response on line 43 = "Y", there must be a response on line 44, column 1; line 45, columns 1, 2 and 3, line 46 column 1 or column 2; line 47 columns 1, 2 and 3. If the response on line 43 column 1 = "N", then lines 44 through 47 must be blank. [12/01/2010b] |

ELECTRONIC COST REPORTING SPECIFICATIONS FOR FORM CMS-2540-10
TABLE 6 - EDITS

| <u>Reject Code</u> | <u>Condition</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|-------------------|----------------------|---|-----------|-----|---|-----------|----------------------|--|-----------|-----|--|-----------|-----|---|-----------|---------------|--|-----------|-----|--|-----------|-----|---|-----------|----------------|--|-----------|-----|----|-----------|------|--|-----------|---|--|-----------|---|----|-----------|-------------------|
| 1050S | For Worksheet S-2, Part II, there must be a "Y" or "N" response on lines 1, through 11, column 1 and lines 13 through 18, columns 1 and 3. [12/01/2010b] | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1055S | For Worksheet S-2, Part II, if the response on lines 1, 13 or 14, column 1 = "Y", a date must be entered in column 2. If the response on line 2, column 1 = "Y", a date must be entered in column 2 and a "V" or "I" must be entered in column 3. If the response on lines 13 or 14, column 3 = "Y", a date must be entered in column 4. [12/01/2010b] | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1060S | <i>Worksheet S-2, Part I, column 2, lines as indicated below may only contain those provider numbers as indicated for that line. The type of provider is also indicated.</i> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | <table border="0" style="margin-left: 40px;"> <thead> <tr> <th style="text-align: left;"><u>Line #</u></th> <th style="text-align: left;"><u>Provider #</u></th> <th style="text-align: left;"><u>Provider Type</u></th> </tr> </thead> <tbody> <tr> <td>4</td> <td>5000-6499</td> <td>SNF</td> </tr> <tr> <td>7</td> <td>3100-3199</td> <td>Home Health Agencies</td> </tr> <tr> <td></td> <td>7000-8499</td> <td>" "</td> </tr> <tr> <td></td> <td>9000-9999</td> <td>" "</td> </tr> <tr> <td>8</td> <td>3400-3499</td> <td>SNF-Based RHC</td> </tr> <tr> <td></td> <td>3975-3999</td> <td>" "</td> </tr> <tr> <td></td> <td>8500-8999</td> <td>" "</td> </tr> <tr> <td>9</td> <td>1000-1199</td> <td>SNF-Based FQHC</td> </tr> <tr> <td></td> <td>1800-1989</td> <td>" "</td> </tr> <tr> <td>10</td> <td>1400-1499</td> <td>CMHC</td> </tr> <tr> <td></td> <td>4600-4799</td> <td>"</td> </tr> <tr> <td></td> <td>4900-4999</td> <td>"</td> </tr> <tr> <td>12</td> <td>1500-1799</td> <td>SNF-Based Hospice</td> </tr> </tbody> </table> | <u>Line #</u> | <u>Provider #</u> | <u>Provider Type</u> | 4 | 5000-6499 | SNF | 7 | 3100-3199 | Home Health Agencies | | 7000-8499 | " " | | 9000-9999 | " " | 8 | 3400-3499 | SNF-Based RHC | | 3975-3999 | " " | | 8500-8999 | " " | 9 | 1000-1199 | SNF-Based FQHC | | 1800-1989 | " " | 10 | 1400-1499 | CMHC | | 4600-4799 | " | | 4900-4999 | " | 12 | 1500-1799 | SNF-Based Hospice |
| <u>Line #</u> | <u>Provider #</u> | <u>Provider Type</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4 | 5000-6499 | SNF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7 | 3100-3199 | Home Health Agencies | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 7000-8499 | " " | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 9000-9999 | " " | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 8 | 3400-3499 | SNF-Based RHC | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 3975-3999 | " " | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 8500-8999 | " " | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 9 | 1000-1199 | SNF-Based FQHC | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 1800-1989 | " " | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10 | 1400-1499 | CMHC | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 4600-4799 | " | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 4900-4999 | " | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 12 | 1500-1799 | SNF-Based Hospice | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1090S | All amounts reported on Worksheet S-3, Part I must not be less than zero. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1095S | For Worksheet S-3, Part I, the sum of the inpatient days in columns 3-6 for each of lines 1, 2, 3, and 5 must be equal to or less than the total inpatient days in column 7 for each line. [12/01/2010b] | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1100S | For Worksheet S-3, Part I, the sum of the discharges in columns 8-11 for each of lines 1, 2, 3, and 5 must be equal to or less than the total discharges in column 12 for each line indicated. [12/01/2010b] | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1105S | The amount of total salaries reported in column 1, line 1 (Worksheet S-3, Part II) must equal Worksheet A, Column 1, line 100. [12/01/2010b] | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1110S | Worksheet S-3, Part II, column 4, sum of lines 1-11, 14-21 must be greater than zero. [12/01/2010b] | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1115S | The amount on Worksheet S-3, Part II, column 3, line 17 (total wage related costs), must be greater than 7.65 percent and less than 50.0 percent of the amount in column 3, sum of lines 1-11 (total salaries). [12/01/2010b] | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

ELECTRONIC COST REPORTING SPECIFICATIONS FOR FORM CMS-2540-10
TABLE 6 – EDITS

| <u>Reject Code</u> | <u>Condition</u> |
|--------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1120S | For Worksheet S-3, Part II, all values for column 5, lines 1-16, 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. [12/01/2010b] |
| 1125S | For Worksheet S-3, Part II, sum of columns 1 and 2 each of lines 2-4, 7-11, 14-21, as applicable must be equal to or greater than zero. [12/01/2010b] |
| 1130S | Worksheet S-3, Part II, sum of columns 1 & 2, line 13 must be greater than zero. [12/01/2010b] |
| 1135S | The amount of hours reported on Worksheet S-3, Part III, column 4, lines 1-13 must be greater than or equal to zero. [12/01/2010b] |
| 1140S | The amount reported on Worksheet S-3, Part IV, line 24 must be greater than zero. [12/01/2010b] |
| 1160S | If Worksheet S-4 column 1, line 23 has data, then it must be a five character alpha numeric. [12/01/2010b] |
| 1200S | Worksheet S-5, Line 13: 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. [12/01/2010b] |
| 1210S | Worksheet S-7: Column 2, sum of lines 1 through 99 must agree with Worksheet S-3, Part I, column 4, line 1. [12/01/2010b] |
| 1000A | Worksheet A, columns 1 and 2, line 100 must be greater than zero. [12/01/2010b] |
| 1015A | On Worksheet A, line 81 column 2 and the corresponding reclassifications and adjustments must equal zero. On lines 80 and 82, respectively, the sum of columns 1 and 2 and the corresponding reclassifications and adjustments must equal zero. [12/01/2010b] |
| 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). [12/01/2010b] |
| 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 <i>and it must be an UPPER CASE Alpha Character</i> . 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. [12/01/2010b] |
| <i>1040A</i> | <i>For Worksheet A-8 adjustments on lines 1-7, 9-11, and 13-24, if column 2 has an entry, then columns 1, 2 and 4 must have entries and if any one of columns 0, 1, 2, or 4 for lines 25-99 and subscripts thereof has an entry, then all four columns for that line must have entries. [12/01/2010b]</i> |

ELECTRONIC COST REPORTING SPECIFICATIONS FOR FORM CMS-2540-10
TABLE 6 – EDITS

| <u>Reject Code</u> | <u>Condition</u> |
|--------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1041A | The total Utilization Review amount shown on Worksheet E, Part I, Line 10, may not be greater than the amount on Worksheet A-8, line 22.(Absolute value of line 22) [12/01/2010b] |
| 1045A | <i>If Worksheet A-8-1, Part I, either of columns 4 or 5, lines 1 through 9 does not equal zero, then column 1 of the corresponding line must be present and vice versa. [12/01/2010b]</i> |
| 1050A | On Worksheet A-8-2, column 3 must be equal to or greater than the sum of columns 4 and 5. If column 5 is greater than zero, column 6, and column 7 must be greater than zero. Transfer only the total on line 100, column 18 to Worksheet A-8, column 2 [12/01/10b] |
| 1000B | On Worksheet B-1, all statistical amounts must be greater than or equal to zero, except for reconciliation columns. [12/01/2010b] |
| 1005B | Worksheet B, Part I, column 18, line 100 must be greater than zero. [12/01/2010b] |
| 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 100), 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. [12/01/2010b] |
| 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. [12/01/2010b] |
| 1010C | On Worksheet C, all amounts in columns 1 and 2, respectively, line 100 must be greater than or equal to zero. [12/01/2010b] |
| 1000D | On Worksheet D, all amounts must be greater than or equal to zero. [12/01/2010b] |
| 1005D | The total inpatient charges on Worksheet C, column 2, line 49 must be greater than, or equal to the sum of all Worksheets D, Part I, line 49, plus Worksheet D, Part II, line 2. [12/01/2010b] |
| 1000H | Worksheet H-2 Part I: Column 0 line 21 must equal Worksheet A column 7 line 70. [12/01/2010b] |
| 1005H | Worksheet H-2 Part I: sum of columns 0-3, 4-15, line 21 must equal the corresponding columns on Worksheet B Part I, line 70 and its subscripted lines, respectively. [12/01/2010b] |
| 1010H | Worksheet H-2, Part II: sum of lines 1-21 for each of columns 1-3, and 4-15, must equal the corresponding columns on Worksheet B-1, line 70 and its subscripted lines, respectively. Include reconciliation and accumulated cost columns with negative one entries only. [12/01/2010b] |

ELECTRONIC COST REPORTING SPECIFICATIONS FOR FORM CMS-2540-10
TABLE 6 – EDITS

- 1015H Worksheet H-3, Part I, column 4, sum of lines 1 through 6, must equal total visits reported on Worksheet S-3, Part I, column 7, line 4. [12/01/2010b]
- 1020H The sum of *title XVIII visits*, columns 6 and 7 on Worksheet H-3, Part I, must equal, the corresponding amounts on Worksheet S-4, lines 24, 26, 28, 30, 32 and 34, respectively. [12/01/2010b]
- 1000I If Worksheet I-1 is present, then Worksheet S-5 must be present and vice versa. [12/01/2010b]
- 1010I If Worksheet S-5, line 12 equals "Y", Worksheet I-2, column 3, lines 1, 2, and 3 must each be greater than zero and at least one line must contain a value other than the standard amount. Conversely if Worksheet S-5, line 13 equals "N", Worksheet I-2, column 3, lines 1, 2, and 3 must contain the values 4200, 2100, and 2100. Apply this edit to both the RHC and FQHC components. [12/01/2010b]
- 1020I The sum of Worksheet I-1, column 7, lines 1-9, 11-13, 15-19, 23-26, and 29-30 must equal the amount on Worksheet A, column 7, RHC/FQHC as appropriate. [12/01/2010b]
- 1025I The sum of Worksheet I-3, line 15.02, columns 1 and 2, must be less than or equal to line 15.01. [12/01/2010b]*
- 1000J Worksheet J-1 Part I: sum of columns 0-3, and 4-15, line 22 must equal the corresponding columns on Worksheet B Part I, line 73 and its subscripted lines, respectively. [12/01/2010b]
- 1010J Worksheet J-1 Part II: sum of lines 1-21 for each of columns 1-3, and 4-15, must equal the corresponding columns on Worksheet B-I, line 73 and its subscripted lines, respectively. Include reconciliation and accumulated cost columns with negative one entries only. [12/01/2010b]
- 1000K Worksheet K, column 10, line 39, must equal Worksheet A column 7 line 83.
- 1010K Worksheet K-5 Part II: sum of lines 1-33 for each of columns 1-3, and 4-15, must equal the corresponding columns on Worksheet B-I, line 83 and its subscripted lines, respectively. Include reconciliation and accumulated cost columns with negative one entries only. [12/01/2010b]

ELECTRONIC COST REPORTING SPECIFICATIONS FOR FORM CMS-2540-10
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 contractor. Failure to clear these errors in a timely fashion, as determined by your contractor, may be grounds for withholding payments.

| <u>Edit</u> | <u>Condition</u> |
|-------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 2000 | All type 3 records with numeric fields and a positive usage must have values equal to or greater than zero (supporting documentation may be required for negative amounts). [12/01/2010b] |
| 2005 | Only elements set forth in Table 3, with subscripts as appropriate, are required in the file. [12/01/2010b] |
| 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. [12/01/2010b] |
| 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. [12/01/2010b] |
| 2025 | All nonstandard cost center codes may be used on any standard subscripted cost center line within the cost center category, i.e. only nonstandard cost center codes of the general service cost center may be placed on standard subscripted cost center lines of general service cost center. [12/01/2010b] |
| 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. [12/01/2010b] |

| <u>Cost Center</u> | <u>Line</u> | <u>Code</u> |
|----------------------------------------------|-------------|-------------|
| CAP REL COSTS - BLDGS & FIXTURES | 1 | 0100-0199 |
| CAP REL COSTS - MOVEABLE EQUIPMENT | 2 | 0200-0299 |
| EMPLOYEE BENEFITS | 3 | 0300-0399 |
| SKILLED NURSING FACILITY | 30 | 3000 |
| NURSING FACILITY | 31 | 3100 |
| INTERMEDIATE CARE FACILITY/MENTALLY RETARDED | 32 | 3200 |
| OTHER LONG TERM CARE | 33 | 3300 |
| AMBULANCE | 71 | 7100 |
| MALPRACTICE PREMIUMS & PAID LOSSES | 80 | 8000 |
| INTEREST EXPENSE | 81 | 8100 |
| UTILIZATION REVIEW - SNF | 82 | 8200 |
| HOSPICE | 83 | 8300-8304 |
| GIFT, FLOWER, COFFEE SHOPS & CANTEEN | 90 | 9000-9099 |
| BARBER & BEAUTY SHOP | 91 | 9100-9199 |
| PHYSICIANS-PRIVATE OFFICES | 92 | 9200-9299 |
| NONPAID WORKERS | 93 | 9300-9349 |
| PATIENTS-LAUNDRY | 94 | 9400-9499 |

ELECTRONIC COST REPORTING SPECIFICATIONS FOR FORM CMS-2540-10
TABLE 6 – EDITS

| <u>Edit</u> | <u>Condition</u> |
|--------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 2040 | All calendar format dates must be edited for 10 character format, e.g., 06/22/2011 (MM/DD/YYYY).] [12/01/2010b] |
| 2045 | Administrative and general cost center code 0400-0499 may appear only on line 4 and subscripts of line 4. [12/01/2010b] |
| 2050 | All dates must be possible, e.g., no "00", no "30" or "31" of February. [12/01/2010b] |
| 2000S | The SNF certification date (Worksheet S-2, Part I, column 3, line 4) should be on or before the cost report beginning date (Worksheet S-2, Part I, column 1, line 14). [12/01/2010b] |
| 2005S | The length of the cost reporting period should be greater than 27 days and less than 459 days. [12/01/2010b] |
| 2010S | Worksheet S-2, Part I, line 15 (type of control) must have a value of 1 through 13. [12/01/2010b] |
| 2015S | The sum of column 1, lines 1-4, 7-11, 14-16, and 17-21 (Worksheet S-3, Part II) must be greater than zero. [12/01/2010b] |
| 2025S | The sum of column 4, lines 1-4, 7-11, and 14-16 (Worksheet S-3, Part II) must be greater than zero. [12/01/2010b] |
| <i>2120S</i> | <i>If Worksheet S-2, part I, line 19 is Y for yes, then line 19.01 must be Y for yes. [12/01/2010b]</i> |
| 2150S | If Worksheet S-3, Part II (column 4, sum of lines 7 through 11 divided by the sum of line 1 minus the sum of lines 3 and 4) 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. [12/01/2010b] |
| 2155S | If Worksheet S-3, Part II (column 4, sum of lines 7 through 11 divided by the sum of line 1 minus the sum of lines 3 and 4) 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. [12/01/2010b] |
| 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. [12/01/2010b] |
| 2000A | Worksheet A-6, column 1 (reclassification code) must be alpha characters. [12/01/2010b] |
| 2041A | For Worksheet A-7, line 7, the sum of columns 1 through 3, minus column 5 must be greater than zero. [12/01/2010b] |
| 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. [12/01/2010b] |
| 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. [12/01/2010b] |

ELECTRONIC COST REPORTING SPECIFICATIONS FOR FORM CMS-2540-10
TABLE 6 – EDITS

- 2000G Total assets on Worksheet G (line 34, sum of columns 1-4) must equal total liabilities and fund balances (line 60, sum of columns 1-4). [12/01/2010b]
- 2010G Net income or loss (Worksheet G-3, column 1, line 31) should not equal zero. [12/01/2010b]

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.