4100. GENERAL

The Paperwork Reduction Act of 1995 requires that the private sector be informed as to why information is collected and what the information is used for by the government. In accordance with §§1815(a) and 1861(v)(1)(A) of the Act, providers of service participating in the Medicare program are required to submit annual information to achieve settlement of costs for health care services rendered to Medicare beneficiaries. Also, 42 CFR 413.20 requires cost reports from providers on an annual basis. In accordance with these provisions, FORM CMS 2540-10 must be completed by all skilled nursing facilities (SNFs) and SNF health care complexes in determining program reimbursement. Besides determining program reimbursement, the data submitted on the cost report supports management of the Federal programs, e.g., data extraction in developing cost limits. In completing FORM CMS 2540-10, the information reported must conform to the requirements and principles set forth in the Provider Reimbursement Manual, Part I (CMS Pub. 15-1). The filing of the cost report is mandatory and failure to do so results in all payments to be deemed overpayment, and 100 percent of these payments are withheld until the cost report is received. See chapter 1 of CMS PRM 15-2. The instructions contained in this chapter are effective for cost reporting periods ending on or after XX, XX, 201X.

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

42 CFR §413.321 allows a SNF to use the "simplified" method of reimbursement. SNF's with less than 1500 Medicare days, who have no subproviders attached, and filed their previous year's cost report using the "simplified" method, will file their cost reports on FORM CMS 2540-10, completing ONLY the worksheets identified in §4101.2. Form CMS 2540S is an obsolete form, and no longer in use.

Effective for cost reporting periods ending on and after March 31, 2000, the electronic cost report (ECR) file is considered the official means of cost report submissions. The submission of the hard copy cost report is not required, except for providers that use the Centers for Medicare & Medicaid Services supplied free software. Those providers must continue to submit the manually completed hard copy cost report to their contractor (along with the corresponding ECR file) due to an inability of the free software to create a print image file. The free software generated ECR file will, however, be considered the official copy.

This form is not used by a SNF that is a distinct part of a hospital. Instead, they must use the Hospital Form CMS 2552.

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

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

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

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

Centers for Medicare and Medicaid Services
PRA Reports Clearance Officer
7500 Security Boulevard
Mail Stop C4-26-05
Baltimore, Md. 21244-1850

4100.1 Rounding Standards for Fractional Computations.--Throughout the Medicare cost report, required computations result in the use of fractions. The following rounding standards must be employed for such computation.

1. Round to 2 decimal places:
   a. Percentages (e.g., capital reduction, outpatient cost reduction)
   b. Averages, standard work week, payment rates, and cost limits
   c. Full time equivalent employees
   d. Per diem
   e. Hourly rates

2. Round to 3 decimal places:
   a. PCR Rates

3. Round to 5 decimal places:
   a. Sequestration (e.g., 2.092 percent is expressed as .02092)
   b. Payment reduction

4. Round to 6 decimal places:
   a. Ratios (e.g., unit cost multipliers, cost/charge ratios)

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

4100.2 Acronyms and Abbreviations.--Throughout the Medicare cost report and instructions, a number of acronyms and abbreviations are used. For your convenience, commonly used acronyms and abbreviations are summarized below.

A&G	-	Administrative and General
AHSEA	-	Adjusted Hourly Salary Equivalency Amount
ASC	-	Ambulatory Surgical Center
BBA	-	Balanced Budget Act of 1997 (PL105-33)
CAPD	-	Continuous Ambulatory Peritoneal Dialysis
CAP-REL	-	Capital-Related
CBSA	-	Core-Based Statistical Area
CCPD	-	Continuous Cycling Peritoneal Dialysis
CCU	-	Coronary Care Unit
CFR	-	Code of Federal Regulations
CMHC	-	Community Mental Health Center
CMS	-	Centers for Medicare and Medicaid Services (Formerly HCFA - Health Care Financing Administration)
COL	-	Column
CORF	-	Comprehensive Outpatient Rehabilitation Facility
CRNA	-	Certified Registered Nurse Anesthetist
CTC	-	Certified Transplant Center
DMERC	-	Durable Medical Equipment Regional Carrier
DRA	-	Deficit Reduction Act of 2005
DRG	-	Diagnostic Related Group
EKG	-	Electrocardiogram
ESRD	-	End Stage Renal Disease
FQHC	-	Federally Qualified Health Center
FR	-	Federal Register
GME	-	Graduate Medical Education
HCFA Pub.*	-	Health Care Financing Administration Publication
HIPPS	-	Health Insurance Prospective Payment System
HHA	-	Home Health Agency
HMO	-	Health Maintenance Organization
HSPC	-	Hospice
I&Rs	-	Interns and Residents
ICF/MR	-	Intermediate Care Facility for the Mentally Retarded
ICU	-	Intensive Care Unit
IME	-	Indirect Medical Education
INPT	-	Inpatient
LCC	-	Lesser of Reasonable Cost or Customary Charges
LUPA	-	Low Utilization Payment Adjustment
MDH	-	Medicare Dependent Hospitals
MED-ED	-	Medical Education
MSA	-	Metropolitan Statistical Area
NHCMQ	-	Nursing Home Case Mix and Quality Demonstration
NF	-	Nursing Facility
NPI	-	National Provider Identifier
OBRA	-	Omnibus Budget Reconciliation Act
OLTC	-	Other Long Term Care
OOT	-	Outpatient Occupational Therapy
OPO	-	Organ Procurement Organization
OPT	-	Outpatient Physical Therapy
OSP	-	Outpatient Speech Pathology

PBP	-	Provider-Based Physician
PEP	-	Partial Episode Payment
PPS	-	Prospective Payment System
PRM	-	Provider Reimbursement Manual
PRO	-	Professional Review Organization
PS&R	-	Provider Statistical and Reimbursement System
PT	-	Physical Therapy
RCE	-	Reasonable Compensation Equivalent
RHC	-	Rural Health Clinic
RPCH	-	Rural Primary Care Hospitals
ROE	-	Return on Equity Capital
RT	-	Respiratory Therapy
RUG	-	Resource Utilization Group
SCH	-	Sole Community Hospitals
SCIC	-	Significant Change in Condition
SNF	-	Skilled Nursing Facility
TEFRA	-	Tax Equity and Fiscal Responsibility Act of 1982
WKST	-	Worksheet

NOTE: In this chapter, TEFRA refers to §1886(b) of the Act and not to the entire Tax Equity and Fiscal Responsibility Act.

4101 RECOMMENDED SEQUENCE FOR COMPLETING A SNF COST REPORT

4101.1 Recommended Sequence for Completing an SNF or SNF Health Care Complex - Full Cost Report.--

Part I - Departmental Cost Adjustments and Cost Allocation

Step No.	Worksheet	
1	S-2	Read §4104. Complete entire worksheet.
2	S-3, Parts I, II AND III	Read §4105. Complete entire worksheet.
3	S-7	Read §4109. Complete entire worksheet
4	A	Read §4113. Complete columns 1 through 3, lines 1 through 100.
5	A-6	Read §4114. Complete, if applicable.
6	A	Read §4113. Complete columns 4 and 5, lines 1 through 100...
7	A-7	Read §4115. Complete line 1 only.
8	A-8-1	Read §4117. Complete entire worksheet
9		
10	A-8	Read §4116. Complete entire worksheet.
11	A	Read §4113. Complete columns 6 and 7, lines 2 through 100.
12	B (Parts I and II), B-1, and B-2	Read §§4120 and 4121. Complete all worksheets entirely.

Part II - Departmental Cost Distribution and Cost Apportionment

Step No.	Worksheet	
1	C	Read §4123. Complete entire worksheet.
2	D	Read §4124. Complete entire worksheet. A separate copy of this worksheet must be completed for each applicable health care program for each SNF and nursing facility (NF).
3	D-1	Read §4125. A separate worksheet must be completed for each applicable health care program for each SNF and NF.

Part III - Calculation of Reimbursement Settlement

Step No.	Worksheet	
1	E, Part I	Read §§4130. Complete through line 21 for Part A and lines 22 through 39 for Part B services.
2	E-1	Complete lines 1-4. See Section 4131. .
3	G through G-3	Read §4140. This step is completed by all providers maintaining fund type accounting records. Non-proprietary providers which do not maintain fund type records complete the General Fund column only.

Calculation of Reimbursement Settlement of Subproviders

III - Calculation of Reimbursement Settlement

1	S-4	Read §4106. Complete this worksheet when applicable.
2	H	Read §4141. Complete this worksheet where applicable.
3	H-1	Read §4142. Complete this worksheet where applicable.
4	H-2	Read §4143. Complete this worksheet where applicable.
5	H-3	Read §4144. Complete this worksheet where applicable.
6	H-4	Read §4145. Complete this worksheet when applicable.
7	H-5	Read §4146. Complete this worksheet when applicable.
8	S-5	Read §4107. Complete this worksheet when applicable.
9	I-1 through I-3	Read §§4148-4150. Complete these worksheets when applicable.
10	I-5	Read §4152. Complete this worksheet when applicable.
11	J-1 through J-4	Read §4153-4156. Complete these worksheets when applicable. A separate copy of this worksheet must be completed for each component.
12	S-8	Read §4110. Complete this worksheet when Applicable.
13	K-1	Read §4158. Complete this worksheet when applicable.
14	K-2	Read §4159. Complete this worksheet when applicable.

Step No	Worksheet	
15	K-3	Read §4160. Complete this worksheet when applicable.
16	K-4	Read §4161 Complete this worksheet when Applicable.
17	K-5	Read §4162. Complete this worksheet when Applicable.
18	K-6	Read §4163. Complete this worksheet when Applicable.

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4101.2 Recommended Sequence for Completing an SNF Cost Report Under the Simplified Method - Less Than 1500 Medicare Days.--

Step No.:	Worksheet	
1	S-2	Read §4104. Complete lines 1 through 6, 13, 14, 20, and 23 through 32, 43, and 45 through 48, 50, 51 and 52.Complete Part II.
2	S-3, Parts I and II	Read §4105 Complete lines as applicable.
3	S-3, Part III	Complete lines 1 through 11, 13 and 14.
4	S-7, Part IV	Read §4109 Complete entire worksheet.

Step No.:	Worksheet	
6	A	Read §4113. Complete columns 1, 2 and 3. Complete lines 1 through 9, 30, through 52, 82, 84, 91, 95 and 100.
7	A-6	Read §4114. Complete, if applicable.
8	A-7	Read §4115. Complete, if applicable.
9	A	Read §4113. Complete columns 4 and 5 (lines as listed above).
10	A-8-1	Read §4117. Complete worksheet if applicable
12	A-8	Read §4116. Complete entire worksheet.
13	A	Read §4113. Complete columns 6 and 7, (lines as listed above).
14	B, Part III	Read §4121. Complete entire worksheet.
15	B-1, Part II	Read §4122. Complete entire worksheet.
16	C	Read §4123. Complete lines 21 through 33, and line 75.
17	D, Part I	Read §4124. Complete lines 21 through 33, and line 75. A separate copy of this worksheet must be completed for each applicable health care program for each SNF and nursing facility (NF).
18	E-1	See Section 4131. Complete lines 1 - 4.
19	E,	Read §4130. Complete
20	G through G-3	Read §4140. This step is completed by all providers maintaining fund type accounting records. Non-proprietary providers which do not maintain fund type records complete the General

4102. SEQUENCE OF ASSEMBLY

The following examples of assembly of worksheets are provided so all providers are consistent in the order of submission of their annual cost report. All providers using FORM CMS 2540-10 must adhere to this sequence. If worksheets are not completed because they are not applicable, do not include blank worksheets in the assembly of the cost report.

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

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

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.

For contractor use only.

The contractor should indicate in the appropriate box this cost report status, As Submitted, Amended, Settled, or Reopened. If it is a reopening, indicate the number of times the cost report has been reopened. If this is a "Settled" or "Reopened" cost report, indicate if desk reviewed or audited.

4103.1 Part II - Certification.--This certification is read, prepared, and signed after the cost report has been completed in its entirety.

4103.2 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:

	From			
Skilled Nursing Facility Component	Title V	Title XVIII Part A	Title XVIII Part B	Title XIX
Skilled Nursing Facility Line 1	Wkst. E, Part I, Line 21	Wkst. E, Part I, Line 21	Wkst. E, Part I, Line 40	Wkst. E, Part I, Line 21
Nursing Facility Line 2	Wkst. E, Part II Line 34	N/A	N/A	Wkst. E, Part II, Line 34
ICF/MR Line 3	N/A	N/A	N/A	Wkst. E, Part II, Line 34
SNF-Based Home Health Agency Line 4	Wkst. H-4, Part II, Col. 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, Col. 2 Line 34
SNF-Based RHC Line 5	Wkst. I-3 Line 29	N/A	Wkst. I-3 Line 29	Wkst I-3 Line 29
SNF-Based FQHC Line 6	Wkst. I-3 Line 29	N/A	Wkst. I-3 Line 29	Wkst I-3 Line 29
SNF-Based CMHC Line 7	Wkst. J-3 Column 1 Line 18	N/A	Wkst. J-3 Column 2 Line 18	Wkst J-3 Column 3 Line 18

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

Line 13.--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 14.--Enter a number from the list below which indicates the type of ownership or auspices under which the SNF is conducted.

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 *

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

Lines 15 through 17.--These lines provide for furnishing certain information concerning the provider. All applicable items must be completed.

Line 18.--If this is a low or no Medicare utilization cost report, indicate with an "F" for full cost report, "L", for Low Medicare Utilization, or "N" for No Medicare Utilization.

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

Lines 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 35.--Indicate for each component the type of service that qualifies for the exception.

Line 36.--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 37 –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 38-- 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 39-- 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 40.--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 41.--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 42.-- Did this facility report less than 1500 Medicare days in its previous year's cost report? Enter "Y" for yes or "N" for no. If a new provider is filing a first year cost report, and qualifies to file a "simplified" SNF cost report, do not enter "Y" or "N".

Line 43.--If line 42 is yes, did you file your previous year's cost report using the "simplified" step-down method of cost finding? (See §4100.) Enter "Y" for yes or "N" for no. If a new provider is filing a first year cost report, and qualifies to file a "simplified" SNF cost report, do not enter "Y" or "N".

Line 44.--Is this cost report being filed under 42 CFR 413.321, (the "simplified" cost report)? Enter"Y" for yes, or "N" for no.

Line 45.—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 46.—If yes, and there are home office costs, enter the home office provider number. If this facility is part of a chain organization, enter the name and address of the home office on lines 47, 48 and 49.

Line 47, 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 48, columns 1, and 2.—Enter the street address in column 1, or the post office box number in column 2.

Line 49, columns 1, 2 and 3.—Enter the city, State and zip code in columns 1, 2, and 3.

4004.2 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 cost reports. It is designed to answer pertinent questions about key reimbursement concepts displayed in the cost reports 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.

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.

Filing Requirements of Provider Cost Report Reimbursement Questionnaire.--Providers receiving payments and filing a cost report are required to maintain sufficient financial records and statistical data for the contractor to use for the proper determination of costs payable under the Medicare program. The PRM Part I, and the applicable regulations issued by CMS (42 CFR 413.20) set forth the criteria for fulfilling these requirements. The questionnaire is designed to facilitate this process and must be completed and submitted with each full cost report. Submit the questionnaire as required by §§1815(a) and 1833(e) of the Act to assure proper payments by Medicare. Failure to submit this questionnaire and the supporting documents will result in suspension of payments to you and may result in a determination that all interim payments made since the beginning of the cost reporting period are overpayments.

The responses to all lines are Yes or No unless otherwise indicated.

Line Descriptions

Lines 1 through 15 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 PRM-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 a reconciliation with the cost report.

Line 11-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 PRM-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 subprovider.

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 PRM-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 PRM-I, §§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 PRM-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 12--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 13--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 14--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 PRM I, section 2337. NOTE: An institution or institutional complex may only change the bed size of its SNF and/or its NF 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 section 2337.

Note: For purposes of line 14, 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 PRM-1, §2200.2.C.)

Line 15--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 16--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 17--If you entered "Y" on either line 15 or 16, 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 18--If you entered "Y" on either line 15 or 16, 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 19--If you entered "Y" on either line 15 or 16, 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 20--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 ADVICE DATES	(8)* DEDUCT	(9)* CO-INS	(10) TOTAL
		FROM	TO	YES	MEDICAID NUMBER						

* 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 413.60(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, nursing facility, ICF/MR, HHA, CMHC, and hospice. The data to be maintained, depending on the services provided by the component, include the number of beds available, the number of admissions, the number of discharges, the average length of stay, the number of inpatient days, the bed days available, and full time equivalents (FTEs).

Column Descriptions

Column 1.--Enter on the appropriate line the beds available for use by patients at the end of the cost reporting period (SNF on line 1, nursing facility on line 2, ICF/MR on line 3, or hospice on line 6).

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 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 rporting year in order to effect *one* of the combinations set forth in section 2337

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

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

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

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

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

a.	Column 13, lines 1 & 2	Column 3 divided by column 8
b.	Column 14, line 1	Column 4 divided by column 9
c.	Column 15, lines 1 2 & 3	Column 5 divided by column 10
d.	Column 16, lines 1, 2, 3, & 7	Column 7 divided by column 12

EXCEPTION: Where the skilled nursing facility is located in a State that certifies the provider as an SNF regardless of the level of care given for Titles V and XIX patients, combine the statistics on lines 1 and 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 an SNF wage index, CMS has developed an SNF wage index form, as part of the cost report, to be completed by all SNFs.

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

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

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

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

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

Line 8.--Enter the total of Worksheet A, column 1, line 33. This amount represents other long term care.

Line 9.- Enter the amount from Worksheet A, column 1, line 72.

Line 10.-- 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 11.-- Enter the amount from Worksheet A, column 1, line 73

Line 12.-- Enter the amount from Worksheet A, column 1, line 83.

Line 13.--Enter the amount from Worksheet A, column 1, lines 90 through 95.

Line 14.--Enter the sum of lines 8 through 13.

Line 15.--Subtract line 14 from line 7 and enter the result.

Line 16.--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 17.--Enter the salaries and wage related costs (as defined on line 19 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 5. 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: Do not include any Part A physician service cost included in the home office allocation and/or related organization. These amounts are reported on line 23. Amounts related to excluded units should be included on lines 18 and 19.

Line 18.--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.

Line 19.--Enter the total of all wage related costs that are considered an exception to the core list. A detailed list of each additional wage related core must be shown in Part IV. In order for a wage related cost to be considered an exception, it must meet the following tests:

a. The costs are not listed on Part IV,

b. The cost is reasonable and prudent,

c. The individual wage related cost exceeds 1 percent of total salaries after the direct excluded salaries are removed,

d. The wage related cost is a fringe benefit and has not been furnished for the convenience of the provider, and

e. The wage related costs that are fringe benefits, where required, have been reported as wages to Internal Revenue Service, (e.g., the unrecovered cost of employee meals, education costs, auto allowances).

Wage related cost exceptions are not to include those wage related costs that are required to be reported to the Internal Revenue Service, since they are considered as salary or wages, i.e., loan forgiveness, sick pay accruals. Include these costs in total salaries reported on line 1 of this worksheet. The total wage related costs listed on this line must agree with the total of all other wage related costs listed in Part IV.

Line 20.--Enter the total wage related costs applicable to the excluded areas reported on lines 8 through 13

Line 21.--Enter the total adjusted wage related costs, line 18 plus line 19, minus line 20.

Line 22.--Enter the sum of lines 15 through 17 and 21.

Line 23.--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.

Column 2.--Enter on each line, as appropriate, the **salary** portion of any reclassification made on Worksheet A-6.
Column 3.--Enter the result of column 1 plus or minus column 2.

Column 4.--Enter on each line the number of **paid** hours corresponding to the amount reported in column 3.

NOTE: The hours must reflect any change reported in column 2. On call hours are not included in the total paid hours. Overtime hours are calculated as one hour when an employee is paid time and a half. The intern and resident hours associated with the salaries reported on line 4 must be based on 2080 hours per full time intern and resident employee.

Column 5.--Enter on line 1 through line 17 and lines 22 and 23 the average hourly wage resulting from dividing column 3 by column 4. Enter on line 21 the wage related cost percentage computed by dividing column 3, line 21 by column 3, line 15. Round the result to 4 decimal places.

4105.2 Part III - Overhead Cost - Direct Salaries.--This part provides for the collection of SNF and/or NF wage data for overhead costs to properly allocate the salary portion of the overhead costs to the appropriate service areas for excluded units. This form is completed by all SNFs and/or NFs.

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

Column 1--Enter the direct wages and salaries paid from Worksheet A, column 1 for the appropriate cost center identified on lines 1 through 13, respectively.

Column 2--Enter on the line, as appropriate, the salary portion of any reclassification made on Worksheet A-6.

Column 3--Enter the result of column 1 plus or minus column 2.

Column 4--Enter on each line the number of paid hours corresponding to the amount reported in column 3.

Column 5--Enter on each line the average hourly wage resulting from dividing column 3 by column 4.

4106 WORKSHEET S-4 - SNF-BASED HOME HEALTH AGENCY 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 titles V, XVIII, and XIX. The statistics required on this worksheet pertain to a SNF-based home health agency. The data maintained is dependent upon the services provided by the agency, number of program home health aide hours, total agency home health aide hours, program unduplicated census count, and total unduplicated census count. In addition, FTE data are required by employee staff, contracted staff, and total. Complete a separate Worksheet S-4 for each SNF-based home health agency.

Line 1--Enter the county of residence.

Line 2--Enter the number of hours applicable to home health aide services.

Line 3--Enter the unduplicated count of all individual patients and title XVIII patients receiving home visits or other care provided by employees of the agency or under contracted services during the reporting period. Count each individual only once. However, because a patient may be covered under more than one health insurance program, the total census count (column 5, line 3) may not equal the sum of columns 1 through 4, line 3. For purposes of calculating the unduplicated census, if a beneficiary has received healthcare in more than one CBSA, you must prorate the count of that beneficiary so as not to exceed a total of (1). A provider is to also query the beneficiary to determine if he or she has received healthcare from another provider during the year, e.g., Maine versus Florida for beneficiaries with seasonal residence.

Lines 4 through 20--Lines 4 through 20 provide statistical data related to the human resources of the HHA. The human resources statistics are required for each of the job categories specified in lines 5
through line 20.

Line 4--Enter the number of hours in your normal work week.

Report in column 1 the full time equivalent (FTE) employees on the HHA's payroll. These are staff for which an IRS Form W-2 is used.

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

Compute staff FTEs for column 1 as follows. Add all hours for which employees were paid and divide by 2080 hours. Round to two decimal places, e.g., .4452 is rounded to .45. Compute contract FTEs for column 2 as follows. Add all hours for which contracted and consultant staff worked and divide by 2080 hours.

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

Line 22--Enter the number of CBSAs that you serviced during this cost reporting period.

Line 23--Identify each CBSA where the reported HHA visits are performed by entering the 5 digit CBSA code and Non-CBSA (rural) code as applicable. Subscript the lines to accommodate the number of CBSAs in which you provide services. Rural CBSA codes are assembled by placing the digits "999" in front of the two digit State code, e.g., for the state of Maryland the rural CBSA code is 99921.

PPS Activity Data--Applicable for Medicare Services.

In accordance with 42 CFR §484.200(a) and §1895 of the Social Security Act, home health agencies transitioned from a cost based reimbursement system to a prospective payment system (PPS) effective for home health services rendered on or after October 1, 2000.

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

HHA Visits--See PRM-2, chapter 32, §3205, page 32-13 for the definition of an HHA visit.

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

Less than a full Episode of Care--When 4 or fewer visits are provided by the HHA in a 60 day episode period, the result is a low utilization payment adjustment (LUPA). In this instance the HHA will be reimbursed based on a standardized per visit payment.

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

Use lines 24 through 35 to identify the number of visits and the corresponding visit charges for each discipline for each episode payment category. Lines 36 and 38 identify the total number of visits and the total corresponding charges, respectively, for each episode payment category. Line 36 identifies the total number of episodes completed for each episode payment category. Line 40 identifies the total number of outlier episodes completed for each episode payment category. Outlier episodes do not apply to 1) Full Episodes without Outliers and 2) LUPA Episodes. Line 41 identifies the total medical supply charges incurred for each episode payment category. Column 5 displays the sum total of data for columns 1 through 4. The statistics and data required on this worksheet are obtained from the provider statistical and reimbursement (PS&R) report.

When an episode of care is initiated in one fiscal year and concludes in the subsequent fiscal year, all statistical data (i.e., cost, charges, counts, etc…) associated with that episode of care will appear on the PS&R of the fiscal year in which the episode of care is concluded. Similarly, all data required in the cost report for a given fiscal year must only be associated with services rendered during episodes of care that conclude during the fiscal year. Title XVIII visits reported on this worksheet will not agree with the title XVIII visits reported on Worksheet H-3, sum of columns 6 and 7 line 7.

Columns 1 through 4--Enter data pertaining to title XVIII patients only. Enter, as applicable, in the appropriate columns 1 through 4, lines 24 through 35, the number of aggregate program visits furnished in each episode of care payment category for each covered discipline and the corresponding aggregate program visit charges imposed for each covered discipline for each episode of care payment category. The visit counts and corresponding charge data are mutually exclusive for all episodes of care payment categories. For example, visit counts and the corresponding charges that appear in column 4 (PEP only Episodes) will not include any visit counts and corresponding charges that appear in column 5

Line 36--Enter in columns 1 through 4 for each episode of care payment category, respectively, the sum total of visits from lines 24, 26, 28, 30, 32 and 34.

Line 37--Enter in columns 1 through 4 for each episode of care payment category, respectively, the charges for services paid under PPS and not identified on any previous lines.

Line 38--Enter in columns 1 through 4 for each episode of care payment category, respectively, the sum total of visit charges from lines 25, 27, 29, 31, 33, and 35.

Line 39--Enter in columns 1 through 4 for each episode of care payment category, respectively, the total number of episodes (standard/non-outlier) of care rendered and concluded in the provider's fiscal year.

Line 40--Enter in columns 2 and 4 for each episode of care payment category identified, respectively, the total number of outlier episodes of care rendered and concluded in the provider's fiscal year. Outlier episodes do not apply to columns 1 and 3 (Full Episodes without Outliers and LUPA Episodes, respectively).

NOTE: Lines 39 and 40 are mutually exclusive.

Line 41--Enter in columns 1 through 4 for each episode of care payment category, respectively, the total non-routine medical supply charges for services rendered and concluded in the provider's fiscal year.

Column 5--Enter on lines 24 through 41, respectively, the sum total of amounts from columns 1 through 4.

4107 WORKSHEET S-5 – SKILLED NURSING FACILITY-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA

In accordance with 42 CFR 413.20(a), 42 CFR 413.24(a) and 41 CFR 413.24 (c), you are required to maintain statistical records for proper determination of costs payable under the Medicare program. The statistics reported on this worksheet pertain to provider-based rural health clinics (RHCs) and provider-based Federally Qualified Health Clinics (FQHCs). If you have more than one of these clinics, complete a separate worksheet for each facility.

Lines 1 and 2. –Enter the full address of the RHC/FQHC.

Line 3.—For FQHC only, enter your appropriate designation (U=urban or R=rural). See SS505.2 of the RHC/FQHC Manual, CMS Pub 27, for information regarding urban and rural designations. If you are uncertain of your designation, contact your contractor. RHCs do not complete this line.

Lines 4 through 9. –In column 1, enter the applicable grant award number(s). In column 2, enter the date(s) awarded.

Line 10.—If the facility operates as other than an RHC or FQHC, answer yes to this question and indicate the number of other operations in column 2. List other types of operations and hours on subscripts of line 11.

Line 11.—Enter the starting and ending hours for each applicable day(s) in the columns for the clinic services provided. If the facility provides other than RHC or FQHC services (e.g. laboratory or physician services), subscript line 11 and enter the type of operation on each of the subscripted lines. Enter in each column the starting and ending hours for the applicable day(s) that the facility is available to provide other than RHC/FQHC services.

NOTE: Line 11 must still be completed even if the facility answers NO to the question on line 10.

Line 13.—Is this a consolidated cost report? Enter in column 1 “yes” or “no” for consolidated report. If column 1 = yes, then enter in column 2 the number of reports

Line 14 – If line 13 is yes, enter the provider names, addresses and provider numbers for all providers included in this cost report. (See CMS Pub. 27 SS508D.)

Line 15.—Did you provide all or substantially all of the direct GME training costs for services on or after October 1, 1997? If yes, you must separately identify allowable and non-allowable costs on Worksheet I-1 and enter in column 2 the number of Medicare visits performed by Interns and Residents.

4107 WORKSHEET S-5 – SKILLED NURSING FACILITY-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA

In accordance with 42 CFR 413.20(a), 42 CFR 413.24(a) and 41 CFR 413.24 (c), you are required to maintain statistical records for proper determination of costs payable under the Medicare program. The statistics reported on this worksheet pertain to provider-based rural health clinics (RHCs) and provider-based Federally Qualified Health Clinics (FQHCs). If you have more than one of these clinics, complete a separate worksheet for each facility.

Lines 1 and 2. –Enter the full address of the RHC/FQHC.

Line 3.—For FQHC only, enter your appropriate designation (U=urban or R=rural). See SS505.2 of the RHC/FQHC Manual, CMS Pub 27, for information regarding urban and rural designations. If you are uncertain of your designation, contact your contractor. RHCs do not complete this line.

Lines 4 through 9. –In column 1, enter the applicable grant award number(s). In column 2, enter the date(s) awarded.

Line 10.—If the facility operates as other than an RHC or FQHC, answer yes to this question and indicate the number of other operations in column 2. List other types of operations and hours on subscripts of line 11.

Line 11.—Enter the starting and ending hours for each applicable day(s) in the columns for the clinic services provided. If the facility provides other than RHC or FQHC services (e.g. laboratory or physician services), subscript line 11 and enter the type of operation on each of the subscripted lines. Enter in each column the starting and ending hours for the applicable day(s) that the facility is available to provide other than RHC/FQHC services.

NOTE: Line 11 must still be completed even if the facility answers NO to the question on line 10.

Line 13.—Is this a consolidated cost report? Enter in column 1 “yes” or “no” for consolidated report. If column 1 = yes, then enter in column 2 the number of reports

Line 14 – If line 13 is yes, enter the provider names, addresses and provider numbers for all providers included in this cost report. (See CMS Pub. 27 SS508D.)

Line 15.—Did you provide all or substantially all of the direct GME training costs for services on or after October 1, 1997? If yes, you must separately identify allowable and non-allowable costs on Worksheet I-1 and enter in column 2 the number of Medicare visits performed by Interns and Residents.

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