

3506. WORKSHEET S - SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

For intermediary use only.

The intermediary should indicate in the appropriate box whether this is the initial cost report, final report due to termination, or if this is a reopening. If it is a reopening, indicate the number of times the cost report has been reopened.

3506.1 Part I - Certification.--This certification is read, prepared, and signed after the cost report has been completed in its entirety.

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 intermediary and is archived accordingly. This file is your original submission and is not to be modified.

3506.2 Part II - 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:

Skilled Nursing Facility Component	Title V	From		Title XIX
		Title XVIII Part A	Title XVIII Part B	
Skilled Nursing Facility	Wkst. E, Part I, Line 36	Wkst. E, Part I, Line 36 or Wkst. E, Part III, Line 17	Wkst. E, Part II, Line 28 or Wkst. E, Part III, Line 37	Wkst. E, Part I, Line 36
Do not enter any data on line 2.				
Nursing Facility	Wkst. E, Part I, Line 36	N/A	N/A	Wkst. E, Part I, Line 36
ICF/MR	N/A	N/A	N/A	Wkst. E, Part I, Line 36
SNF-Based Home Health Agency Col. 2	Wkst. H-6, Part II, Col. 2 Line 22	Wkst. H-6, Part II, Col. 1 Line 22	Wkst. H-6, Part II, Col. 2 Line 22	Wkst. H-6, Part II, Line 22
SNF-Based Outpatient Rehabilitation Facility	Wkst. J-3, Part I, Col. 1, Line 17 or Wkst. J-3 Part III, Line 24	N/A	Wkst. J-3, Part I Col. 2, Line 17 or Wkst. J-3 Part III, Line 24	Wkst. J-3, Pt.I Col. 3, Ln. 17 or Wkst. J-3 Part III, Ln.24
SNF-Based RHC/FQHC	Wkst. I-3 N/A Line 26		Wkst. I-3 Line 26	Wkst I-3 Line 26

3508. WORKSHEET S-2 - 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 the county in column 1. Sub-script column 2. Enter in column 2 the MSA Code of this SNF. Enter in column 2.01, the Core Based Statistical Area (CBSA) code. Enter in column 3, a "U" or "R" designating urban or rural.

Line 3.1.--Enter the Facility Specific Rate, supplied by your intermediary. Enter the transition period of 1 = 25/75, (25 percent Federal Case Mix - 75 percent Facility Specific Rate), 2 = 50/50, 3 = 75/25, (75 percent Federal Case Mix - 25 percent Facility Specific Rate), or 100 for 100 percent Federal Case Mix Rate.

Line 3.2.-- Enter in column 1 the wage adjustment factor in effect before October 1, and in column 2 the adjustment in effect on or after October 1.

This information is needed to properly determine which RUG rates are applicable.

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. (Subscript column 2 for each line. Enter in column 2 the Provider Number, and enter in column 2.01 the NPI (National Provider Identifier) number for each provider) 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 which meets the requirements of §1819 of the Social Security Act. Skilled Nursing Facility cost reporting periods beginning on and after 07/01/98 and reimbursed under title XVIII will be using the Prospective Payment System.

Line 6.--This is a portion of a SNF which has been issued a separate identification number and which meets the requirements of §1919 of the Act.

Line 6.1.--This is a portion of a SNF which has been issued a separate identification number and which meets the requirements of §1905(d) of the Act.

Line 7.--This is a distinct part and separately certified component of a SNF which meets the requirements of §1886(d)(1)(B) of the Act.

Line 8.--This is a distinct part 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.

Line 9.--Do not enter any data on line 9.

Line 10.--This is a SNF-based outpatient rehabilitation facility that has been issued a separate identification number. Indicate the type of facility through subscripted line numbers, as follows. Use line 10.00 for a CORF, line 10.10 for a CMHC, line 10.20 for an OPT, line 10.30 for an OOT, and line 10.40 for an OSP.

Line 11.--This is a distinct part and separately certified component of an SNF which meets the requirements of §1861 (aa) of the Act.

Line 12.--This is a distinct part and separately certified component of an SNF which meets the requirements of §1861 (dd) of the 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 150 days 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 | 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 on line 19.

Lines 15 through 18.--These lines provide for furnishing certain information concerning the provider. All applicable items must be completed.

Subscript line 15 in the following:

Lines 15.01 through 15.20--A notice published in the August 4, 2003, **Federal Register**, Vol. 68, No. 149 provided for an increase in RUG payments to Skilled Nursing Facilities (SNF) for payments on or after October 1, 2003, however, this data is required for cost reporting periods beginning on or after October 1, 2003. Congress expected this increase to be used for direct patient care and related expenses. Subscript line 15 into the following lines: 15.01 - Staffing, 15.02 - Recruitment, 15.03 - Retention of Employees, 15.04 - Training, and 15.05-15.20 - Other. Enter in column 1 the 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 2 whether the increased RUG payments received for cost reporting periods beginning on or after 10/01/2003 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 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.

Line 21.--Enter ONLY A, D, or E for the all-inclusive method, or leave it BLANK. Do not enter an "N". (See CMS Pub 15-I, §2208.2.)

Lines 23 through 30.--These lines provide for furnishing certain information concerning depreciation. All applicable items must be completed. (See CMS Pub. 15-I, chapter 1, regarding depreciation.)

Lines 23 through 30.--These lines provide for furnishing certain information concerning depreciation. All applicable items must be completed. (See CMS Pub. 15-I, chapter 1, regarding depreciation.)

Lines 23, 24, and 25.--Indicate, on the appropriate lines, the amount of depreciation claimed under each method of depreciation used by the SNF during the cost reporting period.

Line 26.--The total depreciation shown on this line may not equal the amount shown on lines 1 and/or 2 on the Trial Balance of Expenses Worksheet, but represents the amount of depreciation included in costs on Worksheet A, column 7.

Lines 29 through 32.--Indicate a "Yes" or "No" answer to each question on these lines.

Lines 33 through 44.--Indicate a "Yes" or "No" answer, where applicable, to each component and type of service that qualifies for the exception.

If you are a provider (public or non public) that qualifies for an exemption from the application of the lower of cost or charges (as explained in 42 CFR 413.13(f)), indicate the component and the appropriate services that qualify for this exemption. Subscript lines 35 through 40 as required for additional component(s).

Line 43.--Indicate whether the provider is licensed in a State that certifies the provider as an SNF as described on line 4 above, regardless of the level of care given for Titles V and XIX patients.

Line 44.--This line is not used for cost reporting periods beginning on and after July 1, 1998. Indicate whether the provider participated in the NHCMQ demonstration during the cost reporting period. All NHCMQ demonstration participants must file Form CMS 2540-96, including facilities reporting less than 1,500 program days which would otherwise be allowed to utilize the Form CMS 2540S-97. Only facilities in Kansas, Maine, Mississippi, New York, South Dakota, and Texas are eligible to participate in the NHCMQ demonstration. This demonstration will not be applicable for cost reporting periods beginning on and after July 1, 1998. At that time all SNFs will be reimbursed under PPS.

Section 222 (a)(1) of P.L. 92-603 (42 U.S.C. Section 1395b-1, note) authorizes the Secretary of the Department of Health and Human Services to engage in experiments and demonstrations regarding alternative methods of making payment on a prospective basis to SNFs and other providers. Section 222 (a)(3) authorizes the Secretary to grant waivers of certain Title XVIII requirements insofar as such requirements relate to methods of payment for services provided. Additional forms have been added to the SNF cost report to accommodate the NHCMQ demonstration project. Worksheet D-1 must be completed by a provider participating in the demonstration.

A provider participating in the NHCMQ demonstration, which otherwise is reimbursed by other than the Prospective Payment System and which indicates either an "O" or "N" on line 4, must complete Worksheet E, Part V in place of Worksheet E, Part I or Worksheet E, Part II.

Line 45.--List the total amount of malpractice premiums paid, (column 1) the total amount of paid losses, (column 2), and the total amount of self insurance, (column 3) allocated in this fiscal year.

Line 46.--Indicate if malpractice premiums and paid losses are reported in other than the Administrative and General cost center. If yes, provide a supporting schedule and list the amounts applicable to each cost center.

Line 47.--Are you claiming ambulance costs? Enter in column 1, "Y" for yes or "N" for no. If this is your first year of providing and reporting ambulance services, you are not subject to the payment limit. Enter in column 2, Y if this is your first year of providing ambulance service, or N if it is not.

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

Line 48.— If line 47 column 1 is Y, and column 2 is N, enter on line 48 column 1 the payment limit provided from your fiscal intermediary, and for services on or after 04/01/2002, enter in column 2, the Fee Amount from the PS&R. Use Worksheet S-2, line 48 (and subscripts) columns 1 and 2 for the Limit and Fee amount respectively. If your fiscal year is OTHER than a year beginning on October 1st, enter in Line 48, column 1, the payment limit for the period prior to October 1, and enter in column 2 the Fee Amount. Subscript line 48 for the applicable time periods, and enter in column 1 the Limit; enter in column 2 the Fee Amount. The per-trip rate is updated October 1st of each year. Subscript this line as needed.

Report your ambulance trip limits chronologically, in accordance with your fiscal year. Applicable chronological dates are 01/01/2001, 07/01/2001, 01/01/2002, 04/01/2002 (effective date of the blend), 01/01/2003, 01/01/2004, 01/01/2005, and 01/01/2006.

Line 48.01- 48.03.— Use lines 48.01-48.03 if your fiscal year is OTHER than a year beginning on October 1^s Ambulance services will be based on a blend until 100 percent fee schedule is transitioned on 01/01/2006. The blend is effective for services on 04/01/2002 through 12/31/2005

Line 49.--Did you operate an ICF/MR facility for the purposes of title XIX? Enter "Y" for yes and "N" for no.

Line 50.-- Did this facility report less than 1500 Medicare days in its previous year's cost report? Enter "Y" for yes or "N" for no. If a new provider is filing a first year cost report, and qualifies to file a "simplified" SNF cost report, do not enter "Y" or "N".

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

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

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

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

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

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

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

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

Column Descriptions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Line 18.--Enter the salaries and wage related costs (as defined on line 19 below) paid to personnel who are affiliated with a home office, 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 exists or if you cannot accurately determine the hours associated with the home office 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. Amounts related to excluded units should be included on lines 19 and 20.

Line 19.--Enter the total core wage related costs as described in Exhibit 7 of Form HCFA-339. 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 20.--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 on Exhibit 7, Part II of Form HCFA-339. 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 I of Form HCFA-339,
- 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 II of Form HCFA-339. Form HCFA-339, Exhibit 7, Part III must be completed by all facilities reconciling wage related costs reported on lines 19 through 21 to the fringe benefits reported using Medicare principles.

Line 21.--Enter the total wage related costs applicable to the excluded areas reported on lines 8 through 14.

Line 22.--Enter the total adjusted wage related costs, line 19 plus line 20, minus line 21.

Line 23.--Enter the sum of lines 16 through 18 and 22.

Line 24.--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. Submit a reconciliation identifying the amount of salary relating to each reclassification.

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 18 and lines 23 and 24 the average hourly wage resulting from dividing column 3 by column 4. Enter on line 22 the wage related cost percentage computed by dividing column 3, line 22 by column 3, line 16. Round the result to 4 decimal places.

Column 6.--Enter in the appropriate lines the source used to determine the data entered in columns 1, 2, and 4, as applicable. If necessary, attach appropriate explanations. This column is used to provide information for future reference regarding the data sources and to assist intermediaries in verifying the data and method used to determine the data. In addition, this column is used when you can identify the wages but cannot identify the hours.

3509.2 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. Submit a reconciliation identifying the amount of the salary relating to each reclassification on the worksheet.

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.

3511. WORKSHEET S-4 - SNF-BASED HOME HEALTH AGENCY STATISTICAL DATA

In accordance with 42 CFR 413.413(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 an SNF-based home health agency. The data needed to be maintained, depending on the services provided by the agency, include number of program visits, total number of agency visits, number of program home health aide hours, total agency home health aide hours, program unduplicated census count and total unduplicated census count, program patient count, and total agency patient count. In addition, FTE data is required by employee staff, contracted staff, and total staff. Complete a separate Worksheet S-4 for each SNF-based home health agency.

All data required on this worksheet, as well as in the entire HHA cost report for a given fiscal year must only be associated with services rendered during episodes of care that conclude during that fiscal year. (See §3511.3 for a further discussion of episodes.)

Home Health Agency Visits.--Use lines 1 through 8 to identify the number of service visits and corresponding number of patients. The patient count in columns 2, 5, and 8 includes each individual who received each type of service. The sum of the patient count in columns 3 and 6 may not equal the amount in column 9 for each line. Also, the total of all of the lines does not equal line 9, unduplicated census count, since many patients receive more than one service.

Columns 1, 2, and 3.--Enter data pertaining to title XVIII patients only. Enter in column 2 the title XVIII visits for each discipline for services rendered through September 30, 2000 for reporting periods which overlap October 1, 2000. For reporting periods which begin on or after October 1, 2000 enter in column 2 all visits rendered during entire cost reporting period. Enter in column 3 the patient count applicable to the title XVIII visits in column 2 for each line description. See Home Health Agency Manual (CMS Pub. 11), §322 for patient count determination. Enter the sum of lines 1 through 6 in column 2 on line 8 (total visits). The sum of lines 1 through 6 in column 3 does not equal the unduplicated census count on line 9 because a beneficiary could be receiving more than one type of service.

Columns 4, 5, and 6.--Enter data pertaining to all other patients. Enter in column 5 the count of all the agency visits except title XVIII visits for each discipline. Enter in column 6 the total agency patient count, except title XVIII, applicable to the agency visits entered in column 5. Enter the sum of lines 1 through 7 in column 5 on line 8 (total visits). The sum of lines 1 through 7 in column 6 does not equal the unduplicated census count on line 9 because a patient could be receiving more than one type of service.

Columns 7, 8, and 9.--The amounts entered in column 8 are the sum of columns 2 and 5 for each discipline for cost reporting periods ending on or before September 30, 2000. For cost reporting periods which overlap October 1, 2000, enter in column 8 the total visits rendered during the entire reporting period. For cost reporting periods which overlap October 1, 2000 the amounts entered in column 8 may not equal the sums of columns 2 and 5 for each discipline. For cost reporting periods beginning on or after October 1, 2000, column 8 will again equal the sum of columns 2 and 5. The amounts entered in column 9 may not be the sum of columns 3 and 6 for each discipline. The unduplicated census count on line 9, column 9, does not necessarily equal the sum of title XVIII unduplicated census count (line 9, column 3) plus the "Other" unduplicated census count (line 9, column 6). For example, if a patient receives both covered services and non-covered services, he or she is counted once as title XVIII (for covered services), once as other (for non-covered services), and only once as total. (See Mr. Washington example below.)

3511.1 Part I - Home Health Agency Visits.--

Lines 1 through 6.--These lines identify the type of home health services which are reimbursable by title XVIII. These lines reflect the number of visits furnished and the number of patients receiving a particular type of service.

EXAMPLE: Mr. Washington become a patient of First Home Health Agency on March 21, 1996. While he is a patient, he received skilled nursing and physical therapy services which are covered under title XVIII and home delivered meals service which are not covered under title XVIII. Mr. Washington is discharged June 22, 1996. Mr. Washington is readmitted to the First Home Health Agency on October 25, 1996, and received only skilled nursing services covered under title XVIII. The First Home Health Agency is a calendar year provider. Count Mr. Washington twice as a patient for skilled nursing services in column 3, line 1, once as a physical therapy patient in column 3, line 2, and once on the "All Other Services" line in column 6, line 7, for the home delivered meals service. In addition, count Mr. Washington once on the unduplicated census count for title XVIII (column 3, line 9), once on the unduplicated census count for "Other" (column 6, line 9), and once on the unduplicated census count for "Total" (column 9, line 9).

Line 6.--Enter the number of hours applicable to home health aide services in columns 1, 4, and 7.

Line 7.--Enter in columns 5 and 8 the total of all other visits. Enter in columns 6 and 9 the patient count applicable to visits furnished by the agency but which are not reimbursable by title XVIII.

Line 8.--Enter in column 2, line 8 the sum of lines 1 through 6. Enter in column 5, line 8 the sum of lines 1 through 7. Enter in column 8, line 8 the sum of columns 2 and 5.

Line 9.--Enter on line 9 in the appropriate column the unduplicated count of all patients receiving home visits or the care provided by employees of the agency or under contracted services for the entire reporting period. Enter on line 9.01 in the appropriate column the unduplicated count of all patients receiving home visits or other care provided prior to October 1, 2000, by employees of the agency or under contracted services during the reporting period. Enter on line 9.02 in the appropriate column the unduplicated count of all patients receiving home visits or other care provided on or after October 1, 2000, by employees of the agency or under contracted services during the reporting period. (Beneficiaries who receive services before and after October 1, 2000, must be included in both unduplicated census counts before and after October 1, 2000. The sum of lines 9.01 and 9.02 may not necessarily equal line 9.) For cost reporting periods beginning on or after October 1, 2000, do not subscript line 9 as all unduplicated census count data is entered online 9. Count each individual only once. However, because a patient may be covered under more than one health insurance program, the total census count may not be equal the sum of the Title XVIII and all other census counts. For the purpose of calculating the unduplicated census count, if a beneficiary has received health care in more than one Metropolitan Statistical Area (MSA), you must prorate the unduplicated census count based on the ratio of visits provided in an MSA to the total visits furnished to the beneficiary so as to not exceed a total of (1). For example, if an HHA furnishes 100 visits to an individual beneficiary in one MSA during the cost reporting period, and the same individual received a total of 400 visits (the other 300 visits were furnished in other MSAs during the cost reporting period), the reporting HHA would count the beneficiary as a .25 (100 divided by 400) in the unduplicated census count for Medicare patients for the cost reporting period. Round the result to two decimal places, e.g., .2543 is rounded to .25. **A provider is also to query the beneficiary to determine if he or she has received health care from another provider during the year, e.g., Maryland versus Florida for beneficiaries with seasonal residence.**

3511.2 Part II - Employment Data.--

Lines 1 through 15 --Lines 1 through 15 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 1 through 15. Enter any additional categories needed on lines 13 to 15.

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

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 issued.

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

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

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

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

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

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

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

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

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

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

Less than a full Episode of Care--

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

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

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

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

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

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

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

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

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

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

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

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

3512. 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 42 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 Centers (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 FQHCs only, enter your appropriate designation (U = urban or R =rural). See §505.2 of the RHC/FQHC Manual, CMS Pub. 27, for information regarding urban and rural designations. If you are uncertain of your designation, contact your intermediary. 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.--Subscript line 10 as needed to list all physicians furnishing services at the RHC/FQHC. Enter the physician's name in column 1, and the physician's Medicare billing number in column 2. *This line is not applicable for cost reporting periods ending on and after May 31, 2009*

Line 11.--Subscript line 11 as needed to list all supervisory physicians. Enter the physician's name in column 1, and the number of hours the physician spent in supervision in column 2. *This line is not applicable for cost reporting periods ending on and after May 31, 2009*

Line 12.--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 13.

Line 13.--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 13 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 a facility is available to provide other than RHC/FQHC services.

NOTE: Line 13 must still be completed even if the facility answers NO to the question on line 12.

Line 15. --Is this a consolidated cost report? If yes, enter the provider names, addresses and provider numbers for all providers included in this cost report. (See CMS Pub.27 §508.D.)

Line 16. --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.

3513. WORKSHEET S-6 - SKILLED NURSING FACILITY-BASED OUTPATIENT REHABILITATION STATISTICAL DATA

NOTE: If this component is paid 100% under established fee schedules, you are not required to complete lines 1 through 19, or the related J series worksheets for cost reporting periods beginning on or after 04/01/2001.

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 outpatient rehabilitation provider. Complete a separate schedule for each box checked at the top of this form. The data needed to be maintained, depending on the services provided by the outpatient rehabilitation facility, include number of program treatments, total number of treatments, number of program patients, and total number of patients. In addition, FTE data is required by employee staff, contracted staff, and total.

Lines 1 through 19.--These lines provide statistical data related to the human resources of the outpatient rehabilitation provider checked. 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.

Report in column 1 the FTE employees on the outpatient rehabilitation provider'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 outpatient rehabilitation provider.

Staff FTEs are computed for column 1 as follows: sum of all hours for which employees were paid divided by 2080 hours, rounded 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, rounded to two decimal places.

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

3514. WORKSHEET S-7 - NHCMQ DEMONSTRATION AND PPS STATISTICAL DATA

NOTE: 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. Therefore, SNFs will not be reimbursed under demonstration procedures for cost reporting periods beginning on and after that date. An expansion to Worksheet S-7 was needed to accommodate cost reporting periods which begin on and after July 1, 1998. This expansion is designated as Part II. Part I will continue as the original form as published in June 1996, and updated with Transmittal # 3, and will be in effect for providers with cost reporting periods which begin PRIOR to July 1, 1998. Part II will be used for ALL SNFs with cost reporting periods beginning on and after July 1, 1998.

3514.1 Part I - NHCMQ Demonstration Statistical Data.-- Complete this part for cost reporting periods beginning prior to July 1, 1998.

The statistics reported on this worksheet pertain to SNF facilities participating in the NHCMQ demonstration. 42 CFR 413.30 provides waivers to enable the use of the Resource Utilization Group (RUG-III) case mix adjusted prospective payment rate setting methodology for routine costs and Part A ancillary rehabilitation services in place of the routine systems of cost finding/payment determination and/or prospective payment option for low utilization providers.

Only facilities in Kansas, Maine, Mississippi, New York, South Dakota, and Texas are eligible to participate in the NHCMQ demonstration. The data to be maintained for title XVIII demonstration days include, by group, the M3PI revenue code, the rate, the number of inpatient days, and the dollar amount for Medicare residents during this cost reporting period.

Column Descriptions

Column 1.--The case mix group designations are already entered in this column.

Column 2.--The M3PI revenue code designations are already entered in this column.

NOTE: Worksheet S-7 was designed to accommodate one RUG group rate applicable for the entire year. However, since this rate could change each calendar year, this worksheet needs to be modified to accommodate TWO rates. This form has been revised to reflect heading changes published in Transmittal #3. Column headings are as follows:

Services Prior To January 1st		Services On Or After January 1st	
Rate	Days	Rate	Days
3	3.01	4	4.01

Columns 3 and 4.--Enter the rate assigned to the provider for each applicable group. This rate is effective as of January 1 and may be changed each January 1. Providers with fiscal years other than the calendar year could have two rates to report. The second rate is entered in column 4. If your fiscal year begins January 1 and ends December 31, enter your rate in column 4, and do not use column 3.

Column 3.01.--Enter the number of demonstration inpatient days applicable to each group, associated with the rate in place at the beginning of your fiscal year. This column is not used for calendar year providers. Enter the total on line 46.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Column 10.--Multiply the facility specific amount times the reciprocal percentage applied to the Federal rate, i.e. 75 percent, 50 percent, 25 percent, or 0 percent. Enter the result on the appropriate line for each RUG. Enter the sum of lines 1 through 45 on line 75. Add the amount in column 9, line 75, plus the amount in column 10, line 75, together, and transfer this total to Worksheet E, Part III, line 7.

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

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

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

Subscript columns 3 and 4 of this worksheet to columns 3.01 and 4.01 respectively. Identify column 3.01 as "Federal Rate – High Cost Add-On", (for services between April 1, 2000 and September 30, 2000). Identify column 4.01 as "Add-On Days" (for services between April 1, 2000 and September 30, 2000). Enter in column 3.01 for each of the 15 lines identified above, 20 percent of the amount on the corresponding line in column 3. Enter in column 4.01 the days applicable to services, for the 15 lines listed above, from April 1, 2000 through September 30, 2000 or the end of the fiscal year. Where the fiscal year ends between April 2, 2000 and September 30, 2000 the provider should report in column 6.01 only the days applicable for April 1 through the end of the fiscal year. The days from the beginning of the next fiscal year through September 30, 2000 will be reported in column 4.01 of the subsequent cost report.

Section 101 of the BBRA also provides for an additional 4 percent increase in payment for ALL services furnished during fiscal years (FYs) 2001 and 2002. Therefore, for services furnished after September 30, 2000, and before October 1, 2002, columns 5 and 6 of this worksheet should be subscripted to columns 5.01 and 6.01, respectively. Identify column 5.01 as "Federal Rate – High Cost Add-On" (for services after September 30), and identify column 6.01 as "Add-On Days" (for services after September 30). Enter in column 5.01 for each line identified above, 20 percent of the Federal Case Mix Rate. Enter in column 6.01 the days applicable to services associated with the high cost RUGs (as listed above), from October 1, 2000 to the end of the provider's fiscal year.

All of the RUG rates will be increased by 4 percent. Enter in column 5, the Federal Case Mix Rate times 104 percent.

3514.4 Part IV - PPS Statistical Data for Electronic Filing.--Use Part IV for cost reporting periods ending on and after February 28, 2001. Use this part to report the Medicare days of the provider by RUG.

NOTE: Effective for services on and after January 1, 2006, nine new RUGs are introduced into the reimbursement calculation on this worksheet. These new RUGs are: "RUX", "RUL", "RVX", "RVL", "RHX", "RHL", "RMX", "RML", and "RLX".

Subscript the lines on Worksheet S-7, Part IV to accommodate the following. Line 3.01 for "RUX", Line 3.02 for "RUL", Line 6.01 for "RVX", Line 6.02 for "RVL", Line 9.01 for "RHX", Line 9.02 for "RHL", Line 12.01 for "RMX", Line 12.02 for "RML", and Line 14.01 for "RLX". All payment data is reported as a total amount paid under the RUG PPS payment system on Worksheet E, Part III, line 7, and is generated from the PS&R or your records. The total on line 46 must agree with the amount on Worksheet S-3, column 4, line 1. DO NOT COMPLETE columns 3, 4, 4.01, 4.05 or 5.

Instructions from this point to the end of the section are not applicable after January 1, 2006.

All SNF's which have elected the 100 percent Federal rate, or those that are on the 100 percent rate via the fourth transition year (or forward), should enter all days in column 3.01 with no calculations indicated. The amount previously indicated on line 46, column 5 is now to be entered on Worksheet E, Part III, line 7 as an input. However, this may not apply to SNF's in MSA's # 1123, 3810, and 7520, for cost reporting periods that overlap 12/01/01. Complete column 3.01.

For cost reporting periods beginning on and after July 1, 2001, the only data required to be reported are the days associated with each RUG. These days can be reported in column 3.01, and do not have to be split between "before and after" October 1. The calculation of the total payment for each RUG is no longer required. All payment data is reported as a total amount paid under the RUG PPS payment system on Worksheet E, Part III, line 7, and is generated from the PS&R or your records. The total *days* on line 46 must agree with the amount on Worksheet S-3, column 4, line 1. DO NOT COMPLETE columns 3, 4, 4.01, 4.05 or 5.

Column Descriptions

Column 1--The case mix group designations are already entered in this column.

Column 2--The M3PI revenue code designations are already entered in this column.

Columns 3 and 4--Enter the rate assigned to the provider for each applicable RUG, and period. This rate is updated annually effective October 1. Providers with fiscal years other than October 1 to September 30 may have two rates to report. Enter the rate prior to October 1 in column 3 and the rate on or after October 1 in column 4. Providers with a fiscal year October 1st to September 30th use column 4 only. This Federal rate is adjusted for the labor portion by the update factor specific to the provider's MSA. This update factor is reported on Worksheet S-2, line 3.2 columns 1 and 2.

Columns 3.01 and 4.01--Enter in column 3.01 the days, for each RUG, of the period before October 1 and in column 4.01 for the days on and after October 1. Enter the total on line 46.

Column 4.05--For cost reporting periods that end prior to April 1, 2000, do not complete this column. For services rendered on and after April 1, 2000, through September 30, 2000, enter the days associated with the high cost RUGs at an increase of 20 percent.

Column 5--Multiply columns 3 and 4 times columns 3.01 and 4.01 (column 4 times column 4.01 for cost reporting periods beginning October 1) respectively, rounded to zero and add the two results. This becomes the Federal amount. Multiply the Federal amount by the appropriate transition period percentage, i.e. 25 percent, 50 percent, 75 percent, or 100 percent identified on Worksheet S-2 line 3.1, column 2. Add to the Federal amount the result of the calculation of (total days from columns 3.01 and 4.01 multiplied by the facility specific rate (that result rounded to zero) identified on worksheet S-2, line 3.1, column 1) times the reciprocal percentage applied to the Federal rate, i.e., 75 percent, 50 percent, 25 percent, or 0 percent. Enter the result on the appropriate line for each RUG. Enter the sum of lines 1 through 45 on line 46, and transfer this total to Worksheet E, Part III, line 7.

3515. WORKSHEET S-8 - HOSPICE IDENTIFICATION DATA

In accordance with 42 CFR 418.310, hospice providers of service participating in the Medicare program are required to submit information for health care services rendered to Medicare beneficiaries. 42 CFR 413.20 requires cost reports from providers on an annual basis. The data submitted on the cost reports supports management of Federal programs. The statistics required on this worksheet pertain to a SNF-based hospice. Complete a separate Worksheet S-8 for each SNF-based hospice.

3515.1 Part I - Enrollment Days Based on Level of Care.

Lines 1--4--Enter on line 1 through 4 the enrollment days applicable to each type of care. Enrollment days are unduplicated days of care received by a hospice patient. A day is recorded for each day a hospice patient receives one of four types of care. Where a patient moves from one type of care to another, count only one day of care for that patient for the last type of care rendered. For line 5, an inpatient care day may be reported only where the hospice provides or arranges to provide the inpatient care.

For the purposes of the Medicare and Medicaid hospice programs, a patient electing hospice can receive only one of the following four types of care per day:

Line 1--**Continuous Home Care Day** - A continuous home care day is a day on which the hospice patient is not in an inpatient facility. A day consists of a minimum of 8 hours and a maximum of 24 hours of predominantly nursing care. Convert continuous home care hours into days so that a true accountability can be made of days provided by the hospice.

Line 2.--**Routine Home Care Day** - A routine home care day is a day on which the hospice patient is at home and not receiving continuous home care.

Line 3.--**Inpatient Respite Care Day** - An inpatient respite care day is a day on which the hospice patient receives care in an inpatient facility for respite care.

Line 4.--**General Inpatient Care Day** - A general inpatient care day is a day on which the hospice patient receives care in an inpatient facility for pain control or acute or chronic symptom management which cannot be managed in other settings.

Column 1.--Enter only the unduplicated Medicare days applicable to the four types of care. Enter on line 5 the total unduplicated Medicare days.

Column 2.--Enter only the unduplicated Medicaid days applicable to the four types of care. Enter on line 5 the total unduplicated Medicaid days.

Column 3.--Enter only the unduplicated days applicable to the four types of care for all Medicare hospice patients residing in a skilled nursing facility. Enter on line 5 the total unduplicated days.

Column 4.--Enter only the unduplicated days applicable to the four types of care for all Medicaid hospice patients residing in a nursing facility. Enter on line 5 the total unduplicated days.

Column 5.--Enter in column 5 only the days applicable to the four types of care for all other non Medicare or non Medicaid hospice patients. Enter on line 5 the total unduplicated days.

Column 6.--Enter the total days for each type of care, (i.e., sum of columns 1, 2, and 5). The amount entered in column 6 line 5 represents the total days provided by the hospice.

NOTE: Convert continuous home care hours into days so that column 6 line 5 reflects the actual total number of days provided by the hospice.

3515.2 Part II --Census Data

Line 6.--Enter on line 6 the total number of patients receiving hospice care within the cost reporting period for the appropriate payer source.

The total under this line equals the actual number of patients served during the cost reporting period for each program. Thus, if a patient's total stay overlapped two reporting periods, the stay is counted once in each reporting period. The patient who initially elects the hospice benefit, is discharged or revokes the benefit, and then elects the benefit again within a reporting period is considered to be a new admission with a new election and is counted twice.

A patient transferring from another hospice is considered to be a new admission and is included in the count. If a patient entered a hospice under a payer source other than Medicare and then subsequently elects Medicare hospice benefit, count the patient once for each pay source.

The difference between line 6 and line 9 is that line 6 equals the actual number of patients served during the reporting period for each program, whereas under line 9, patients are counted once, even if their stay overlaps more than one reporting period.

Line 7.--Enter the total Title XVIII unduplicated continuous care hours billable to Medicare. When computing the unduplicated continuous care hours, count only one hour regardless of the number of services or therapies provided simultaneously within that hour.

Line 8.--Enter the average length of stay for the reporting period. Include only the days for which a hospice election was in effect. The average length of stay for patients with a payer source other than Medicare and Medicaid is not limited to the number of days under a hospice election.

The statistics for a patient who had periods of stay with the hospice under more than one program is included in the respective columns. For example, patient A enters the hospice under Medicare hospice benefit, stays 90 days, revokes the election for 70 days (and thus goes back into regular Medicare coverage), then reelects the Medicare hospice benefits for an additional 45 days, under a new benefit period and dies (patient B). Medicare patient C was in the program on the first day of the year and died on January 29 for a total length of stay of 29 days. Patient D was admitted with private insurance for 27 days, then their private insurance ended and Medicaid covered an additional 92 days. Patient E, with private insurance, received hospice care for 87 days. The average length of stay (LOS) (assuming these are the only patients the hospice served during the cost reporting period) is computed as follows:

Medicare Days (90 & 45 & 29) Patient (A, B & C)		164 days
Medicare Patients		/3

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

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

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

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