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

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

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

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

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

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

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

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

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

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

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

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

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

	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 II, Line 33	Wkst. E, Part I, Line 15	Wkst. E, Part I, Line 29	Wkst. E, Part II, Line 33
Nursing Facility Line 2	Wkst. E, Part II Line 33	N/A	N/A	Wkst. E, Part II, Line 33
ICF/MR Line 3	N/A	N/A	N/A	Wkst. E, Part II, Line 33
SNF-Based Home Health Agency Line 4	Wkst. H-4, Part II, Sum of Cols. 1&2, Line 34	Wkst. H-4, Part II, Col. 1 Line 34	Wkst. H-4, Part II, Col. 2 Line 34	Wkst. H-4, Part II, Sum of Cols. 1&2, Line 34
SNF-Based RHC Line 5	Wkst. I-3, Line 28	N/A	Wkst. I-3, Line 28	Wkst. I-3, Line 28
SNF-Based FQHC Line 6	Wkst. I-3, Line 28	N/A	Wkst. I-3, Line 28	Wkst. I-3, Line 28
SNF-Based CMHC Line 7	Wkst. J-3, Col. 1, Line 20	N/A	Wkst. J-3, Col. 1, Line 20	Wkst J-3, Col. 1, Line 20

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

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

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

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

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

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

Line 5.--This is an institution or distinct part of an institution that meets the requirements set forth in 42 CFR 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 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 § 1861(ff) of the Social Security Act.

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

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

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

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

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

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

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

1 = Voluntary Nonprofit, Church
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 in column 2.

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

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

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

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

Lines 20, 21, and 22.--Indicate, on the appropriate lines, the amount of depreciation claimed under each method of depreciation used by the SNF during the cost reporting period.

Line 23.--The total depreciation shown on this line may not equal the amount shown on lines 1 and/or 2 on the Trial Balance of Expenses Worksheet, but represents the amount of depreciation included in costs on Worksheet A, column 7.

Lines 25 through 28.--Indicate a "Yes" or "No" answer to each question on these lines.

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

Line 37.--Indicate whether the provider is licensed in a State that certifies the provider as an SNF as described on line 4 above, regardless of the level of care given for Titles V and XIX patients.

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

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

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

Line 41.--List the total amount of malpractice premiums paid, (column 1) the total amount of paid losses, (column 2), and the total amount of self insurance, (column 3) allocated in this fiscal year.

Line 42.--Indicate if malpractice premiums and paid losses are reported in other than the Administrative and General cost center. If yes, provide a supporting schedule and list the amounts applicable to each cost center.

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

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

Line 44.--If *line 43 is* yes, enter the home office chain number *and* enter the name and address of the home office on lines 45, 46 and 47.

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

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

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

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

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

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

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

Line Descriptions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The minimum requirements are:

- Copies of input tables, calculations, or charts supporting data elements for PPS operating rate components and other PRICER information covering the cost reporting period.

- Internal records supporting program utilization statistics, charges, prevailing rates and payment information broken into each Medicare bill type in a consistent manner with the PS&R.

- Reconciliation of remittance totals to the provider's internal records.

- Include the name of the system used and indicate how the system was maintained (vendor or provider). If the provider maintained the system, include date of last software update.

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

EXHIBIT 1

LISTING OF MEDICARE BAD DEBTS AND APPROPRIATE SUPPORTING DATA

PROVIDER _____
NUMBER _____
FYE _____

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

(1) Patient Name	(2) HIC. NO.	(3) DATES OF SERVICE		(4) INDIGENCY & WEL. RECIP. (CK IF APPL)		(5) DATE FIRST BILL SENT TO BENEFICIARY	(6) DATE COLLECTION EFFORTS CEASED	(7) REMITTANCE 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 413.20(a), and 42 CFR 413.24(a), you are required to maintain statistical records for proper determination of costs payable under the Medicare program. The statistics reported on this worksheet pertain to SNF, NF, ICF/MR, HHA, CMHC, OLTC and hospice. The data to be maintained, depending on the services provided by the component, include the number of beds, the number of bed days available, the number of inpatient days/visits, the number of discharges, the average length of stay, the number of admissions, and full time equivalents (FTEs).

Column Descriptions

Column 1.--Enter on the appropriate line the beds available for use by patients at the end of the cost reporting period.

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

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

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

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

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

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

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

a. Column 13, lines 1, 2 & 7	Column 3 divided by column 8
b. Column 14, lines 1 & 7	Column 4 divided by column 9
c. Column 15, lines 1, 2, 3, & 7	Column 5 divided by column 10
d. Column 16, lines 1, 2, 3, 5 & 7	Column 7 divided by column 12
e. Column 16, line 8	Column 7 (line 8 minus line 4) 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 a SNF wage index, CMS has developed an SNF wage index form, as part of the cost report, to be completed by all SNFs.

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

Line 1.--Enter the wages and salaries paid to employees from Worksheet A, column 1, line 100.

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

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

Line 4.--If you are a member of a chain or other related organization, as defined in CMS Pub. 15-1, §2150, enter the allowable wages and salaries and wage related costs for home office personnel from your records that are included in line 1.

Line 5.--Enter the sum of lines 2 through 4.

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

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

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

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

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

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

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

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

Line 14.--Enter the amount paid (include only those costs attributable to services rendered in the SNF and/or NF), rounded to the nearest dollar, for contracted direct patient care services, i.e., nursing, therapeutic, rehabilitative, or diagnostic services furnished under contract rather than by employees and management contract services as defined below. For example, you have a contract with a nursing service to supply nurses for the general routine service area on weekends. Report only those personnel costs associated with these contracts. Eliminate all supplies and other miscellaneous items. Do not apply the guidelines for contracted therapy services under §1861(v) (5) of the Act and 42 CFR 413.106. Contracted labor for purposes of this worksheet does **NOT** include the following services: consultant contracts, billing services, legal and accounting services, Part A CRNA services, clinical psychologists and clinical social worker services, housekeeping services, planning contracts, independent financial audits, or any other service not directly related to patient care.

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

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

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

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

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

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

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

Line 18.--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 19.--Enter the total (core and other) wage-related costs applicable to the excluded areas reported on line 12.

Line 20. -- Enter the total wage-related costs applicable to Part A Physicians. Do not include wage-related costs for excluded areas reported on line 19.

Line 21. -- Enter the total wage-related costs applicable to Part B Physicians. Do not include wage-related costs for excluded areas reported on line 19.

Line 22.--Enter the total adjusted wage related costs, line 17 plus line 18, minus lines 19 through 21.

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.

Column 5.--Enter on line 1 through line 16 the average hourly wage resulting from dividing column 3 by column 4.

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 on lines 1 through 13, from Worksheet A, column 1, 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.

4105.3 Part IV--Wage Related Costs.--The SNF must provide the contractor with a complete list of all core wage related costs included in Part II (section 4105.1), lines 17 and 19 through 21. This worksheet provides for the identification of such costs.

The provider must determine whether each wage related cost "other than core", reported on line 25, exceeds one (1) percent of the total adjusted salaries net of excludable salaries and meets all of the following criteria:

- The costs are not listed on lines 1 through 23, "Wage Related Costs Core"
- If any of the additional wage related cost applies to the excluded areas of the SNF, the cost associated with the excluded areas has been removed prior to making the 1 percent threshold test.
- The wage related cost has been reported to the IRS, as a fringe benefit if so required by the IRS.
- The individual wage related cost is not included in salaries reported on Worksheet S-3, Part II, column 3, line 17.
- The wage related cost is not being furnished for the convenience of the employer.

For wage related costs not covered by Medicare reasonable cost principles, a SNF shall use GAAP in reporting wage related costs. In addition, some costs such as payroll taxes, which are reported as a wage related cost(s) on Worksheet S-3, Part IV, are not considered fringe benefits for Medicare cost finding.

Enter on each line as applicable the corresponding amount from you accounting books and/or records.

4105.4 Part V - Direct Care Expenditures--Section 6104(1) of Public Law 111-148 amended section 1888(f) of the Social Security Act ("Reporting of Direct Care Expenditures"), to require Skilled Nursing Facilities (SNF) to separately report expenditures for wages and benefits for direct care staff (breaking out (at a minimum) registered nurses, licensed professional nurses, certified nurse assistants, and other medical and therapy staff).

Effective for cost reporting periods beginning on or after January 1, 2012, this part provides for the collection of SNF and/or Nursing Facilities (NF) direct care expenditures. Complete this form for employees who are full-time and part-time, directly hired, and acquired under contract. Do not include employees in areas excluded from SNF PPS via Worksheet S-3, Part II, Lines 8 through 14. This exclusion applies to directly-hired and contract employees who provide either direct or indirect patient care services in SNF PPS excluded areas. Also, do not include employees whose services are excluded from the SNF PPS, such as physician Part B, and interns and residents. This form is completed by all SNFs and/or NFs.

Column 1--Enter the total of paid wages and salaries for the specified category of SNF/NF employees including overtime, vacation, holiday, sick, lunch, and other paid-time-off, severance, and bonuses on lines 1 through 3 and 5 through 13. Do not include fringe benefits or wage-related costs as defined in Provider Reimbursement Manual, Part II, Section 4105.1.

Enter the amount paid (include only those costs attributable to services rendered in the SNF/NF), rounded to the nearest dollar, for contracted direct patient care services on lines 14 through 16 and 18 through 26.

Column 2--Enter the appropriate portion of fringe benefits corresponding to paid wages and salaries reported in column 1, lines 1 through 3and 5 through 13.

Column 3--Enter the result of column 1 plus 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.

Line 4--Enter the sum of the amounts of lines 1 through 3.

Line 17--Enter the sum of the amounts of lines 14 through 16.

Nursing personnel working in the following cost centers as used for Medicare cost reporting purposes must be included in the appropriate nursing subcategory. These cost centers reflect where the majority of nursing employees are assigned in SNFs and are selected to ensure consistent reporting among SNFs. The wages and hours for nursing personnel working in other areas of the SNF or nurses who are performing solely administrative functions, should not be included.

COST CENTER DESCRIPTIONS

Lines for 2540-10	**Cost Centers**
09	Nursing Administration
30	Skilled Nursing Facility
31	Nursing Facility
47	Electrocardiology

NOTE: Subscripted cost centers that would normally fall into one of these cost centers should be included.

Definitions

Paid Salaries, Paid Hours and Wage Related Costs:

- **Paid Salaries** – Include the total of paid wages and salaries for the specified category of SNF employees including overtime, vacation, holiday, sick, lunch, and other paid-time-off, severance, and bonuses.

- **Paid Hours** – Include the total paid hours for the specified category of SNF employees. Paid hours include regular hours, overtime hours, paid holiday, vacation, sick, and other paid-time-off hours, and hours associated with severance pay. Do not include non-paid lunch periods and on-call hours in the total paid hours. Overtime hours must be calculated as one hour when an employee is paid time and a half. No hours are required for bonus pay. The hours reported for salaried employees who are paid a fixed rate must be recorded based on 40 hours per week or the number of hours in the hospital's standard workweek.

- **Wage Related Costs** –Include wage related costs applicable to the specific category of SNF employees as reported in Part II, (section 4105.1), lines 18 and 20 through 22.

Nursing Occupations

- **Registered Nurses (RNs) -** Assess patient health problems and needs, develop and implement nursing care plans, and maintain medical records. Administer nursing care to ill, injured, convalescent, or disabled patients. May advise patients on health maintenance and disease prevention or provide case management. Licensing or registration required.

- **Licensed Practical Nurses (LPNs) -** Care for ill, injured, convalescent, or disabled persons in SNF. Most LPNs provide basic bedside care, such as vital signs including temperature, blood pressure, pulse, and respiration. LPNs may work under the supervision of a registered nurse. Some more experienced LPNs supervise nursing assistants and aides. Licensing is required after the completion of a State-approved practical nursing program.

- **Nursing Assistants/Aides -** Provide basic patient care under direction of nursing staff. Perform duties, such as feed, bathe, dress, groom, move patients, or change linens. **Examples: Certified Nursing Assistant; Hospital Aide; Infirmary Attendant.**

Other Medical Staff

Non-nursing employees (directly hired and under contract) that provide direct patient care. Do not include employees in excluded areas or that function solely in administrative or leadership roles that do not provide any direct patient care themselves. This category must not include occupations such as physician Part B services and the services of Advance Practice Nurses (APNs) such as nurse practitioners, clinical nurse specialists, certified nurse midwives, and certified registered nurse anesthetists that are billable under a Part B fee schedule.

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 employed 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 21--Enter the number of CBSAs that you serviced during this cost reporting period.

Line 22--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 that 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 CMS Pub. 15-2, Chapter 32, §3205, 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 23 through 34 to identify the number of visits and the corresponding visit charges for each discipline for each episode payment category. Lines 35 and 37 identify the total number of visits and the total corresponding charges, respectively, for each episode payment category. Line 35 identifies the total number of episodes completed for each episode payment category. Line 39 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 40 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 must equal the sum of 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 23 through 34, 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 35--Enter in columns 1 through 4 for each episode of care payment category, respectively, the sum of total visits from lines 23, 25, 27, 29, 31 and 33.

Line 36--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 37--Enter in columns 1 through 4 for each episode of care payment category, respectively, the sum of total visit charges from lines 24, 26, 28, 30, 32, 34 and 36.

Line 38--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 39--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 38 and 39 are mutually exclusive.

Line 40--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 23 through 40, 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 IOM 100-04, Chapter 9, §20.6.2, 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 12.--Have you received an approval for an exception to the productivity standards? Enter a "Y" for yes or an "N" for no.

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's name and CCN number filing the consolidated cost report. (See IOM 100-04, Chapter 9, §30.8)

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

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

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

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

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

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

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

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

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

4109. WORKSHEET S-7 PROSPECTIVE PAYMENT FOR SKILLED NURSING FACILITIES STATISTICAL DATA

In accordance with 42 CFR 413.60(a), 42 CFR 413.24(a), and 42 CFR 413.40(c), you are required to maintain statistical records for proper determination of costs payable under the Medicare program. Public Law 105-33 (Balanced Budget Act of 1997) requires that all SNFs be reimbursed under PPS for cost reporting periods beginning on and after July 1, 1998. Use this form to report the Medicare days of the provider by Resource Utilization Group (RUG).

Column Descriptions

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

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

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

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

4110 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.

4110.1 Part I - Enrollment Days Based on Level of Care.

Lines 1 through 4.--Enter on lines 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 4, 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.

4110.2 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 (Insurance) Days (87 & 27)	114 Days
Other Payments (D & E)	2
Average LOS (Other)	57 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 IOM CMS Pub. 100-02, Chapter 9, §10). 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.