Medicare

Provider Reimbursement Manual Part 2, Provider Cost Reporting Forms and Instructions, Chapter 1, General

Department of Health and Human Services (DHHS)

Centers for Medicare & Medicaid Services (CMS)

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NEW/REVISED MATERIAL--*EFFECTIVE DATE: Cost reporting periods ending on or* September 30, 2007.

This transmittal updates Chapter 1, General Cost Report, to reflect further clarification to existing instructions, and incorporates specific instructions regarding the electronic filing of some additional cost reports. 42 CFR §413.24(f) (4) outlines the requirements for electronic submission of cost reports, which are further defined in the policy of PRM-II, §130ff. On August 22, 2003, CMS published a final rule in the Federal Register (Vol. 68 No 163) to add the requirement that for cost reporting periods ending on or after December 31, 2004, Hospice, Organ Procurement Organization/ Histocompatibility Laboratory (OPO), Independent Rural Health Clinic (RHC), Federally Qualified Health Center (FQHC), Outpatient Rehabilitation for Community Mental Health Clinic (CMHC), and Independent End-Stage Renal Dialysis Facility (ESRD), providers must submit cost reports in a standardized electronic format.

Under the revised regulation, CMS postponed the requirement for electronic submission for the RHCs, FQHCs, and CMHCs until cost reporting periods ending on or after March 31, 2005. CMS also postponed the electronic submission of the OPOs until cost reporting periods ending on or after September 30, 2005.

The effective date for instructional changes will vary due to various implementation dates.

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

CHAPTER 1

COST REPORTING--GENERAL

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100. REQUIREMENT TO FILE COST REPORTS

Providers of service participating in the Medicare program are required to submit information to achieve settlement of costs relating to health care services rendered to Medicare beneficiaries [42 U.S.C. 1395g (section 1815(a) of the Social Security Act]. Regulations state that cost reports "will be required from providers on an annual basis..."[42 C.F.R. §413.20(b)]. When a provider fails to file a timely cost report, all interim payments since the beginning of the cost reporting period can be deemed overpayments. (See Part I, §2413.)

102. COST REPORTING PERIOD

For cost reporting purposes, Medicare requires submission of annual reports covering a 12-month period of operations based upon the provider's accounting year.

The provider may select any annual period for Medicare cost reporting purposes regardless of the reporting period it uses for other programs. Once a provider has made a selection and reported accordingly, it is required thereafter to report annually for periods ending as of the same date unless the contractor/contractor approves a change in the provider's reporting period.

A cost reporting period under the program consisting of one of the following will be considered in compliance with the reporting periods cited above:

A. Twelve (12) successive calendar months,

B. Thirteen (13) four-week periods with an additional day (two in leap year) added to the last week or period to make it coincide with the end of the calendar year or month,

C. A reporting period which will vary from 52 to 53 weeks because it must always end on the same day of the week (Monday, Tuesday, etc.) and always end on (1) whatever date this same day of the week last occurs in a calendar month, or (2) whatever date this same day of the week falls which is nearest to the last day of the calendar month, even though this same day falls in the first week of the following month. A new provider beginning operations on January 1, *2006*, and entering the program as of that date, could choose a reporting period beginning with that date and ending, for example, Wednesday, December *27*, *2006*. This provider's accounting period would end on the same day of the week (Wednesday) and on whatever date that day of the week last occurs in the final month of the year. Alternatively, the provider could elect to end its first reporting period on January 1, *2007*; this would be based on the election to end the period on the same day of the week which is nearest to the last day of the calendar year, even though the last day falls in the first week of the following month. The method selected must be consistently followed.

A provider may prepare a short period cost report for part of a year under the circumstances described in §§102.1 through 102.3.

Where a provider did not furnish any covered services to Medicare beneficiaries or where it had low utilization of such services in a reporting period, a full cost report need not be filed. See §110 for an explanation of this procedure.

Providers in a chain organization, or other group of providers, are required to file individual cost reports as explained in §112.

102.1 Initial Cost Reporting Period.--In order to conform its initial Medicare cost reporting period to the annual reporting period it wishes to use, a provider may be permitted or required under the circumstances outlined below, to file its first Medicare cost report covering less than or more than a year (as defined below) of provider operations. The ending date (or day) chosen by the provider for its initial reporting period is presumed to be the ending date (or day) the provider elects for its subsequent annual reporting periods.

In the case of a newly constructed provider that enters the Medicare program during its initial business year, and in the case of providers that re-enter the Medicare program after a change of ownership, provider operations are considered to commence for cost reporting purposes when the first patient is admitted as an inpatient or receives outpatient services (hospital or SNF), when the first visit is rendered (home health agency), or when the first physical therapy or speech pathology service is rendered (rehabilitation agency, clinic, public health agency). Therefore, a provider's initial cost reporting period may not start before the beginning of the month in which it first renders patient care services which could be covered under the program.

A. Established Providers.--A provider is considered to be an established provider upon its entry into the Medicare program if it was in operation at least one year prior to the effective date of its participation. An established provider may file its initial Medicare cost report covering a period of at least one month of provider operations under the program, but not to exceed 13 months of operations under the program. However, any request for a period in excess of 13 months must be approved by *CMS* central office (CO). All requests are mailed to *Centers for Medicare and Medicaid Services*, Division of Cost Reporting, *C5-03-03*, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

If an established provider wished to report on a calendar year basis and entered the program on July 1, *2007*, it could have filed its initial cost report for the period beginning January 1, *2007*, and ending December 31, *2007*, or alternatively, for the period beginning July 1, *2007*, and ending December 31, *2007*.

B. New Providers.--A provider (including a provider that changes ownership) is considered to be a new provider upon its entry into the program if it enters the program at the inception of or during its initial business year. A new provider may file its initial cost report covering a period of at least one month of provider operations under the program but not to exceed 13 months of operations under the program. However, any request for a period in excess of 13 months must be approved by CMS CO.

If the provider enters the program at the same time that it begins operations, the initial cost reporting period will begin with the effective date of participation. For example, a hospital that began operations and entered the program on September 15, *2006*, and wished to adopt a reporting period ending date of September 30, must have filed its initial cost reporting covering the period from September 15, *2006*, through September 30, *2007*. It could not have filed the report for the 15-day period ending September 30, *2006*.

If a new provider wished to report on a calendar year basis, began operations on February 1, *2007*, and entered the program on July 1, *2007*, it could have filed its initial cost report for the period beginning February 1, *2007*, and ending December 31, *2007*, or, alternatively, for the period beginning July 1, *2007*, and ending December 31, *2007*.

If the provider does not begin operations until after the effective date of its entry into the program, the initial reporting period will begin with the first day of the month in which patient care service begins. For example, a hospital which entered the program effective August 1, *2007* but did not begin delivering patient care services until September 15, *2007*, and wished to adopt a reporting period ending date of September 30, could have filed its initial cost report covering a period beginning September 1, *2007* and ending on either September 30, *2007* or September 30, *2008*.

102.2 Cessation of Participation in Program.--

A. General.--When a provider ceases to participate in the health insurance program, it must file a cost report covering a period under the program up to the effective date of cessation of participation in the program. Depending on the circumstances involved in the preparation of the provider's final cost report, the provider may file the cost report for a period of not less than 1 month or not more than 13 months. However, any request for a period in excess of 13 months must be approved by *CMS* CO.

B. Payment for Services After A Provider Ceases to Participate in the Program (Termination, Expiration, or Cancellation of the Provider Agreement).--

1. Hospital and SNF.--Effective October 30, 1972, a hospital or skilled nursing facility whose provider agreement either voluntarily or involuntarily ceases (not a change of provider ownership) may be reimbursed under the agreement for up to 30 days of covered Part A inpatient services furnished on or after the effective date of cessation of participation in the program to patients who are admitted before the cessation date. No payment will be made for such services to patients admitted on or after the cessation date.

No payment will be made for hospital services to outpatients or for outpatient physical therapy or speech pathology services furnished by a provider on or after the effective date of cessation. However, payment may be made under Part B to a nonparticipating provider for the medical and other health services which it furnishes in compliance with specified requirements explained in the Nonparticipating Domestic Hospital Supplement (HIM-30) of the Hospital Manual (HIM-10).

2. Home Health Agency.--Payment can continue to be made to home health agencies for covered Part A and Part B home health services furnished through the calendar year in which the cessation is effective where the plan of treatment was established prior to the date of cessation. No payment will be made for home health services furnished under a plan or treatment established on or after the cessation date.

3. Interim Rate.--Payment for allowable covered services after cessation of participation will be made at an interim rate not to exceed the interim rate developed on the basis of the latest cost report submitted by the provider. No adjustment should be made to this interim rate until the cost report ending with the date of cessation has been audited, unless the *contractor* obtains information that would justify a change in the interim rate. Settlement for such services will be on the basis of a per diem rate developed from Medicare data appearing in the provider's final settled cost report ending with the date of cessation. No cost report will be required for the services furnished following cessation.

102.3 Changing of Cost Reporting Periods.—*Per (42 CFR §413.24 (f)(3))and (PRM Part I § 2414.3) a provider may change the cost reporting period if a change in ownership is experienced, or if the following occurs: Provider request the change in writing from the contractor; the provider's written request must be received by the contractor 120 days or more before the close of the reporting period which the change proposes to establish; contractor determines that good cause for the change exist.* The *contractor must* notify *CMS* of the authorized change 30 days or more before the close of the reporting period which the change proposes to establish to allow the administration sufficient time to adjust its records. For example, where a provider wishes to change the ending date of its cost reporting period from December 31, *2007* to July 31, *2007* the provider's request for a change must be received by the *contractor* 120 days or more before the July 31, *2007* date on which the change is to take effect.

Such a change may be made only after the contractor has established that the reason is consistent with the purposes and intent of the program. Under the foregoing circumstances, the provider may file a cost report for a period of not less than one month or not more than 13 months. A change made primarily to maximize reimbursement in any one period is not acceptable. **Any request for a period in excess of 13 months must be approved by *CMS* CO.**

Providers owned and/or operated by governmental entities using fiscal year ending dates established by local law may require changes in the reporting year ending dates as a result of legislative action. In such situations, a provider with the approval of its *contractor* may revise its cost reporting period to conform to the new fiscal year established by the applicable lawmaking body. A transitional period report covering the period initially affected by the change should be filed, provided it covers a period of not less than one month or more than 13 months.

104. COST REPORT DUE DATES

Cost reports are required to be filed following the close of a provider's reporting period. (See §102.) The due dates for cost reports are as follows:

A. Provider Continues to Participate in Program.--

1. Cost reports are due on or before the last day of the fifth month following the close of the cost reporting period. *For cost reports ending on a day other than the last day of the month, cost reports are due 150 days after the last day of the cost reporting period.*

2. No extensions will be granted except when provider's operations are significantly adversely affected due to extraordinary circumstances over which the provider has no control. An example would be a flood or fire that forces a provider to cease operations and to transfer its patients temporarily to other providers outside of the impacted area. The *contractor* would still be required to obtain *CMS* approval (see §413.24(f) (2) (ii))

3. The provider must receive the Provider Statistical and Reimbursement Report (PS&R) on or before the 120th day. If the *contractor* is late mailing the PS&R, the provider will have 30 days from the date of receipt of the PS&R to file its cost report, even if it extends beyond the 5 month due date. No interest will be assessed against the provider for filing the cost report beyond the 5 month period if the cost report is late due to late receipt of the PS&R.

4. A cost report is considered to be timely filed if the cost report is postmarked by the due date. This requirement applies regardless of whether the provider furnishes a hard copy or a diskette version. If a cost report is due on a Saturday, Sunday, or Federal holiday, the cost report is considered timely filed if postmarked by the following working day.

B. Provider Agreement to Participate in Program Terminates (Voluntarily or Involuntarily) or Provider Experiences Change in Ownership.--

1. Cost reports are due no later than 5 months following the effective date of the termination of the provider agreement or the change of ownership.

2. Items 2 through 4 in subsection A will apply.

106. COST REPORTING FORMS

Medicare issues standard forms for the preparation of provider cost reports:

FORM	USED BY
CMS-2552-96	Hospitals and Hospital Health Care Complex. (See Chapter 36.)
CMS-2540-96	Skilled Nursing Facility and Skilled Nursing Facility Health Care Complex. (See Chapter 35.)
CMS-1728-94	Home Health Agencies. (See Chapter 32.)
CMS-2088-92	Outpatient Rehabilitation Providers. (See Chapter 18.)
CMS-222-92	Independent Rural Health Clinics/Freestanding Federally Qualified Health Centers. (See Chapter 29.)
CMS-216-94	Organ Procurement Organization/Histocompatibility Laboratory Providers. (See Chapter 33.)

CMS-265-94 Independent Renal Dialysis Facility. (See Chapter 34.)

CMS-1984-99 Hospice Cost and Data Report. (See Chapter 38.)

CMS-287-92 Home Office Cost Statement. (See Chapter 31.)

CMS-287-05 Home Office Cost Statement (See Chapter 39)

CMS-276 Health Maintenance Organization. (See Chapter 23.)

Cost reporting forms for all inclusive rate and no-charge structure providers are listed in *Chapter 22, PRM I.*

108. USE OF SUBSTITUTE COST REPORTING FORMS

Substitute cost reporting forms may be accepted for use in lieu of the official CMS forms. However, substitute cost reporting forms may not be used until they have been reviewed and accepted by *CMS* CO.

If a provider chooses to submit a substitute cost reporting form on an electronically prepared vendor system, that vendor system must be approved by CMS CO before that substitute form can be used.

110. CONDITIONS UNDER WHICH LESS THAN FULL COST REPORT MAY BE FILED

A. No Medicare Utilization.--A provider that has not furnished any covered services to Medicare beneficiaries during the entire cost reporting period need not file a full cost report to comply with program cost reporting requirements. The provider must submit to its contractor/contractor a statement, signed by an authorized provider official, which identifies the reporting period to which the statement applies and states that (1) no covered services were furnished during the reporting period and (2) no claims for Medicare reimbursement will be filed for this reporting period. This statement must be accompanied by a completed certification page of the applicable cost report forms. The proper form and signed statement must be submitted within *150* days following the close of the reporting period.

B. Low Medicare Utilization.--The contractor/contractor may authorize less than a full cost report where a provider has had low utilization of covered services by Medicare beneficiaries in a reporting period and received correspondingly low interim reimbursement payments which, in the aggregate, appear to justify making a final settlement for that period based on less than a normally required full cost report. Based on the contractor/contractor's knowledge of the provider's Medicare utilization and interim payments as set forth in the Provider Statistical and Reimbursement Report and the contractor/contractor's conclusion that it can determine the reasonable cost of covered services furnished beneficiaries, the *contractor* will advise the provider that less than a full cost report may be filed. Under this situation, the *contractor* will require that the provider furnish all of the following information using program forms: (1) page one of the applicable cost report form, (2) the officer certification sheet, (3) the balance sheet, (4) the statement of income and expense, and (5) other financial and statistical data the *contractor* may deem appropriate depending upon the circumstances in the individual case. However, regardless of low Medicare utilization or the amount of aggregate interim reimbursement, the *contractor* may require full cost reporting and auditing if that is necessary to serve the best interest of the program. Providers must submit the forms and data under this alternate procedure within the same time period required for full cost reports. *Low Medicare utilization providers may submit to the contractor on a CMS approved vendor's system the required worksheets in hard copy, ECR submission is not required and the edits are not enforceable. For example on the hospital cost report the worksheets must contain the term "In Lieu Of 2552-96" on each worksheet submitted. In addition on Worksheet S the check off box for manually submitted must be properly checked. Other provider types may also submit low utilization cost reports.*

C. Low Medicare Utilization-Complex Provider.--The *contractor* may authorize less than a full cost report when a complex provider, including all of the provider based components, e.g., SNF, HHA, had low utilization of covered services by Medicare beneficiaries in a reporting period and received correspondingly low payments which, in the aggregate, appear to justify making a final settlement for that period based on less than a normally required full cost report. If the main provider or any of the provider based components do not qualify for low utilization treatment, a full cost report is required. (See paragraph B above for the required filing under the low utilization procedure.)

D. Implementation.--The procedures described in this section are effective only where, prior to the end of the reporting period or filing period for the cost report, the *contractor* advises the provider that it may file less than a full cost report and the provider gives assurance that it will timely file such data. These procedures are not applicable to cost reporting periods where both the reporting period and the related filing period have expired, even though a cost report has not yet been filed for such period. If the provider is required to file a full cost report for other Federal programs, e.g., titles XIX and/or V, the provider may be required by the contractor/contractor to also file a full cost report with the Medicare program.

112. FILING OF COST REPORTS BY PROVIDERS OF CHAIN ORGANIZATION OR OTHER GROUP OF PROVIDERS

Each provider in a chain organization or other group of providers, except as noted below, must file a separate, individual cost report. (See 42 CFR 413.20(b).) Such organizations are not permitted to file a combined or consolidated cost report under the Medicare program. The only exception under this rule applies to State health department home health agencies with subunits or branches, and related Rural Health Clinics (RHCs) that are permitted to file a combined cost report under the 7800 series of provider numbers. "Other group of providers" refers to an informal assembly of providers (hospitals, SNFs, and HHAs) not owned or controlled by a central group or related interest, but who join together to obtain the benefits of centralized cooperative buying, exchange of medical information, etc.

Multiple-facility complex providers (hospital, hospital-based SNFs, hospital-based HHAs, CORFs, etc.) use the cost report designated for this type of facility which provides adequate cost data. Institutions which have multiple facilities but only one provider number, or one provider number with subprovider numbers for its related cost entities, are required to submit one cost report under that principle provider number together with the subprovider numbers, if any. Hospitals which have subproviders and hospital-based SNFs must also maintain uniform charges across all payer categories, as well as like charges for like services across each provider setting, in order to properly apportion costs. If like charges for like services are not maintained across provider settings, the cost report must not combine charges when calculating cost-to-charge ratios but must report separately, by department, costs and charges for the hospital, subprovider, and skilled nursing facility. An exception to this requirement is if the provider has the ability to gross-up charges as described in Provider Reimbursement Manual, Part I, §2314.B.

The filing of a combined or a consolidated cost report for a chain organization or other group of providers is not acceptable practice under the Medicare program. If the *contractor* unknowingly accepts a consolidated report from a chain, the *contractor* may reopen the report within the 3-year period following the date of the notice of program reimbursement issued by the *contractor*.

114. DISTINCT PART COST REPORTS MUST NOT BE FILED BY FULLY CERTIFIED SNFs

A fully certified SNF provider may not file a cost report claiming Medicare reimbursement as a distinct part provider. (Section 1861(j) of the Medicare law includes in the definition of the term "skilled nursing facility" a distinct part or a separately operating subunit of an institution.) The determination of program reimbursement due a SNF provider for covered skilled nursing services furnished program beneficiaries during the provider's cost reporting period is dependent on whether the entire institution or only a portion of it is the certified provider.

The determination of whether the entire institution or only a portion of it is the certified provider is made by the Office of the Regional Administrator servicing the facility and can be changed only by that office in accordance with the appropriate regulations and implementing procedures applicable to the certification process. This status is not subject to change or interpretation by the contractor/contractor. (See CMS Pub. 15-I, §2415.)

115. COST REPORTS FILED UNDER PROTEST

You are permitted to dispute regulatory and policy interpretations through the appeals process established by the Social Security Act. Include the nonallowable item in the cost report in order to establish an appeal issue, and the disputed item must pertain to the cost reporting period for which the cost report is filed. Retroactive application of any decision from adjudicated issues are governed by §2931.1 of CMS Pub. 15-I.

115.1 Provider Disclosure of Protest.--When you file a cost report under protest, the disputed item and amount for each issue must be specifically identified in footnotes to the settlement worksheet and the fact that the cost report is filed under protest must be disclosed.

115.2 Method for Establishing Protested Amounts.--The effect of each nonallowable cost report item is estimated by applying reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. In addition, you must submit, with the cost report, copies of the working papers used to develop the estimated adjustments in order for the contractor/contractor to evaluate the reasonableness of the methodology for purposes of establishing whether the cost report is acceptable. The cumulative effect on reimbursement for all disputed issues is shown as an adjustment to balance due to the program (provider) in the reimbursement settlement computation. The actual effect on reimbursable cost(s) is determined after final adjudication of the issue(s).

115.3 Noncompliance With Requirements for Filing Cost Reports Under Protest.--If you deliberately include cost, without disclosing the fact, in the provider cost report that is nonreimbursable under the regulations you are subject to those provisions concerning suspected fraud or abuse. Where you fail to comply with the requirements for filing cost reports under protest as set forth above, such cases are referred to the CMS regional office.

130. ELECTRONIC SUBMISSION OF COST REPORTS

130.1 General.--Section 1886(f)(1) of the Act required the Secretary to place into effect a standardized electronic cost reporting (ECR) format for hospitals under the Medicare program for cost reporting periods beginning on or after October 1, 1989. The Secretary may delay or waive the implementation of such format in particular instances where such implementation results in financial hardship (in particular with respect to hospitals with a small percentage of inpatients entitled to Medicare benefits).

Sections 1815(a) and 1833(e) of the Act provide that no payments are made to a provider unless it has furnished the information requested by the Secretary, needed to determine the amount of payments due to the provider. For cost reporting periods ending on or after March 31, 2000, skilled nursing facilities (SNF) and home health agencies (HHA) must submit cost reports currently required under the Medicare regulations in a standardized electronic cost reporting (ECR) format. (See 42 CFR Part 413.24 (f)(4).)

130.2 Submission of Cost Reports.--Submit the Hospital and Hospital Health Care Complex Cost Report (Form *CMS*-2552), Skilled Nursing Facilities Cost Report (Form *CMS*-2540), and the Home Health Agency Cost Report (Form *CMS*-1728) in American Standard Code for Information Interchange (ASCII) format to the *contractor* in accordance with the electronic reporting specification (ERS) contained in §3695 of the hospital cost reporting instructions, §3295 of the home health agency cost report instructions, and §3595 of the skilled nursing facility cost report. The electronic programs must be a system approved by *CMS* CO and must be programmed to pass all level I edits contained in the ERS before an electronic cost reporting file can be created. The fiscal intermediaries have been instructed to reject all electronic cost report files which fail level 1 edits.

Effective for cost reporting periods ending on or after September 30, 1993, all approved vendor systems must be compiled to maintain program integrity and minimize provider error.

The vendor programs approved by *CMS* must be in accordance with the electronic reporting specifications as set forth in the cost report instructions. The approval process conducted by CMS does not ensure that the vendor programs are error free. Although CMS does extensive testing of the vendor systems prior to approval, there may be some cases of undetected programming errors which may not be discovered until live operation of the software. Vendors are expected to follow the ERS in its entirety and make their systems error free. Any programming errors detected either during testing or live operations are grounds for denial of approval and/or revocation of approval until resolution of those errors are attained.

The medium for transfer of cost reports submitted electronically to *contractors* is either a 3 1/2" diskette, *a compact diskette (CD), or a flash drive*. Contact your *contractor* to determine the appropriate medium of transmission. These forms of transmission must be in IBM compatible format and the character set must be in ASCII. You must seek advanced approval from your *contractor* to use other media such as magnetic tape, telephone transfer (i.e., modem), *electronic mail (e-mail), or a secured website.*

130.3 Requests for Delay or Waiver.--If you believe that implementation of these requirements causes a financial hardship, submit a written request for a delay or waiver from these requirements with supporting documentation to your *contractor.* Send your request at least 120 days prior to the end of your cost reporting period. Within 30 days of receipt, the *contractor* reviews the request and forwards it to CMS CO with its recommendation. *CMS* CO either approves or denies the request and notifies the *contractor* of this decision within 30 days of receipt. An implementation delay or waiver is granted on a year to year basis.

A permanent waiver of the electronic cost reporting requirements has been granted to all-inclusive rate providers using Methods B and E for Medicare cost apportionment. However, if the provider elects to file the Medicare cost report electronically, the electronic cost report must be submitted on a CMS approved vendor system. (See §108 concerning substitute cost reporting forms.)

130.4 Grace Period for Early Cost Report Filers.--Effective for cost reporting periods ending on or after June 30, 1997, providers submitting their cost reports prior to the due date (5 months after the end of the cost reporting period) and whose cost report has been subsequently rejected have the benefit of a grace period equal to the number of days the cost report was filed and the end of the required due date of the cost report. This **one time** grace period is based on the date the *contractor* receives the cost report and not the postmark date. These days could be used to resolve the reason for rejection and resubmit the cost report before withholding of interim payments, or the assessment of interest or penalties, by the contractor. For example, if the provider's cost report is rejected and the provider had 15 day grace period for filing early, its late penalty does not commence until the 16th day after written notification of the cost report rejection. If the resubmitted cost report is subsequently rejected, no additional grace period is afforded the provider and the contractor institutes the withholding of interim payments and/or assessment of interest and penalties.

131. ELECTRONIC SUBMISSION OF HOSPITAL COST REPORTS

Effective for cost reporting periods ending on or after March 31, 1993, submit the electronic cost report (utilizing an approved vendor system) to your *contractor*. The electronic cost report file is considered the official cost report by the *contractor*. A hard copy of the cost report is no longer required to be submitted to the *contractor*. Effective for cost reporting periods ending on or after September 30, 1994, all electronically submitted files must be accompanied by Worksheet S (computer generated), which must electronically print the date and time the electronic file was encrypted and replicate the encryption coding in the ECR file parallel and to the left of the officer or administrator of provider(s) signature block. The purpose of the encryption coding is to give further assurance to the integrity of the ECR file beyond the date and time stamp requirement. This Worksheet S must also contain the penalty and certification statements attesting to the validity of the data submitted to the contractor (Part I) and the data required in the settlement summary (Part II). The signature block of the officer or administrator must contain an original signature. A facsimile or stamped copy of the signature is unacceptable. (See 42 CFR §413.24(f)(4)(iv).)

For cost reporting periods ending on or after September 30, 1994, hospitals and health care complexes that use a CMS approved vendor program must submit a print image file (an electronic picture image of the entire cost report) with their electronic cost report (ECR) file. The print image file must be in ASCII format. For those providers who create print image files which are too large to be placed on a diskette with the ECR file, a compression program must be employed. Your software vendor either provides this program or instructs you on obtaining the necessary software, where applicable. The compressed file must be self extracting. For cost reporting periods ending on or after December 31, 1994, all print image files must contain the encryption coding both in the print image file and on Worksheet S just below the ECR encryption code. The order of processing these files should be ECR creation, print image creation, and Worksheet S.

Effective for cost reporting periods ending on or after September 30, 1994, until further notice, CMS no longer supplies free software for electronic filing of the Form CMS-2552 cost report.
Providers who previously used the free software will be given a waiver for cost reporting periods ending on or after September 30, 1994, and prior to October 1, 1997, if required. If waiver is required after this period, providers may apply under §130.3.

132. ELECTRONIC SUBMISSION OF SNF AND HHA COST REPORTS

Effective for cost reporting periods ending on or after March 31, 2000, for SNFs and HHAs, submit a diskette of the electronic cost report (utilizing an approved vendor system) to your *contractor*. The electronic cost report is considered the official cost report by the *contractor.* A hard copy of the cost report is no longer required to be submitted to your *contractor.* However, providers that do not use a CMS approved vendor system and use the CMS provided free software, must submit a completed hard copy of the cost report to the contractor. The contractor has been instructed to reject all electronic cost reports that fail level 1 edits. (See §130.2.)

If you do not use CMS approved cost reporting vendors systems for the SNFs and HHAs, CMS provides you with free software which produces a standardized output file (consisting of input data and various check figures) for electronic submission to any contractor. This software does not, however, produce a completed cost report. Contact your contractor to obtain the software.

All electronically submitted files must be accompanied by Worksheet S (computer generated), which must electronically print the date and time the electronic file was encrypted and replicate the encryption coding in the ECR file parallel and to the left of the officer or administrator of provider(s) signature block. The purpose of the encryption coding is to give further assurance to the integrity of the ECR file beyond the date and time stamp requirement. This Worksheet S must also contain the penalty and certification statements attesting to the validity of the data submitted to the contractor (Part 1) and the data required in the settlement summary (Part II). The signature block of the officer or administrator must contain an original signature. A facsimile or stamped copy of the signature is unacceptable. (See 42 CFR 413.24 (f) (4) (iv) and §131.)

133. ELECTRONIC SUBMISSION OF HOSPICE, OPO, RHC, FQHC, CMHC, AND ESRD

42 CFR §413.24(f)(4) outlines the requirements of electronic submission of cost reports, which are further defined in the policy of PRM-II, §130ff. On August 22, 2003, CMS published a final rule in the Federal Register (Vol. 68 No 163) to add the requirement that for cost reporting periods ending on or after December 31, 2004, Hospice, Organ Procurement Organization/ Histocompatibility Laboratory (OPO), Independent Rural Health Clinic (RHC), Federally Qualified Health Center (FQHC), Outpatient Rehabilitation for Community Mental Health Clinic (CMHC), and Independent End-Stage Renal Dialysis Facility (ESRD) providers must submit cost reports currently required under the Medicare regulations in a standardized electronic format.

Under the revised regulation, CMS postponed the requirement for electronic submission for the ***RHCs, FQHCs, and CMHCs*** *until cost reporting periods ending* ***on or after March 31, 2005.*** *CMS also postponed the electronic submission of the* ***OPOs*** *until cost reporting periods ending* ***on or after September 30, 2005.***

If you do not use CMS approved cost reporting vendors systems for the hospice, OPO, RHC, FQHC, CMHC, and ESRD, and can demonstrate financial hardship, CMS provides you with free software which produces a standardized output file (consisting of input data and various check figures) for electronic submission to any contractor. Financial hardship is defined as Gross Medicare reimbursement equal to or less than $200,000 per cost reporting period for ESRDs, hospices, RHCs, FQHCs, and CMHCs. There are high costs for services rendered by OPOs, therefore CMS raised the threshold. As such, financial hardship is redefined as Gross Medicare reimbursement equal to or less than $900,000 per cost reporting period for OPOs. This software does not, however, produce a completed cost report. Contact your contractor to obtain the software.

134. ELECTRONIC SUBMISSION OF ALL COST REPORTS

Electronic submission of the cost report requires providers using a CMS approved vendor program to submit a print image file (an electronic picture image of the entire cost report) with their electronic cost report (ECR) file. The print image file must be in ASCII format. For those providers who create print image files which are too large to be placed on a diskette with the ECR file, a compression program must be employed. Your software vendor either provides this program or instructs you on obtaining the necessary software, where applicable. The compressed file must be self extracting. All print image files must contain the encryption coding at the end of the print image file and on Worksheet S just below the ECR encryption code. The order of processing these files should be ECR creation, print image creation, and Worksheet S.

The naming convention for the Electronic Cost Report (ECR) file will be as follow: Hospital(EC), SNF (SN), HHA (HH), Hospice (HS), Independent Rural Health Clinic/ Federally Qualified Health Clinics (RF), Independent Renal Dialysis Facility (RD), Community Mental Heal Clinics CM and Organ Procurement Facilities (OP). The first two letters will vary depending on the type of cost report, followded by the 6 digit provider number. The extension of the file will be the fiscal year of the cost report followed by an alpha character to signify which reiteration of the cost report the ECR file comprises e.g. A first submision, B for the second submission. The version of the submission is defined as to when providers refile their cost report because of an amendment or audit.

The naming convension for the Print Image (PI) file is consistent among all of the cost reports: PI followed by the provider's number with an extension of the Fiscal year followed by an alpha character to signify which reiteration of the cost report e.g. A first submission, B for the second. Except for the first two letters the PI name is identical to the ECR.

140. ACCEPTANCE/REJECTION OF COST REPORTS

The contractor/contractor has 30 days from the date of receipt of the provider's cost report to make a determination of acceptability. In order for a cost report to be acceptable, a provider must complete and submit the required cost reporting forms, including all required signatures to the contractor/contractor.

An acceptable cost report from providers filing electronic cost reports (ECRs) means that all the following items have been included in the submission:

1. A diskette, *compact diskette (CD) or a flash drive* of the ECR utilizing a CMS-approved vendor with the current specification date submitted.

2. An ECR that passes all level 1 edits.

3. A submitted print image file of the cost report except when using CMS free software.

4. The certification page (Worksheet S) of the ECR file with the actual signature of an officer (administrator or chief financial officer).

5. An exact match of the encryption code, date and time for the ECR displayed on the certification page to that of the ECR file encryption code, date and time. *The date and time printed on the signed certification page must match the date and time in the ECR file's type 1 record.*

6. An exact match of the encrytion code, date and time for the print image displayed on the certification page to that of the print image file encryption code, date and time except when using CMS free software. *The date and time printed on the signed certification page must match the date and time within the print image file.*

7. For teaching hospitals, a complete Intern and Resident Information System (IRIS) diskette that will pass all IRIS system edits.

8. The settlement summary on the electronic certification page agrees with the settlement summary *or applicable worksheet* on the Medicare cost report produced from the electronic file.

9. A completed, signed and submitted Form CMS-339 (Formally CMS-339).

An acceptable cost report from providers that do not file ECRs means that all the following items have been included in the submission:

1. A completed and legible cost report on the proper forms.

2. A general information and certification page which includes the original signature of an officer (administrator or chief financial officer).

3. A completed , signed, and submitted Form CMS-339 with an original signature

If the cost report does not contain the information/documentation described in Items 1-9 or 1-3 above, the contractor/contractor will reject the cost report immediately. However, if the cost report diskette is bad or damaged, the contractor/contractor will not reject the cost report immediately but will return it with instructions that a good diskette must be resubmitted within 15 days from the date of the letter. The contractor/contractor will mail this letter shortly after receipt of the cost report because the cost report must still be accepted or rejected within 30 days from the date of the original cost report submission (i.e., the 15-days to resubmit a bad or damaged diskette does not extend the acceptability period to 45 days). If a good diskette is not received within 15 days from the date of the request letter, the *contractor* will reject the cost report.

If the submitted cost report is considered unacceptable for reasons other than a bad or damaged cost report diskette, or because a good cost report diskette is not resubmitted by the provider within 15 days of the request letter, the contractor/contractor returns the cost report to the provider with a letter explaining the reasons for rejection. If the due date for the cost report has expired, the contractor/contractor will institute withholding of the interim payments and/or assessment of interest and penalties and issue a demand letter as soon as possible but no later than 30 days after the due date of the cost report.

Additionally, the *contractor* is to verify that, where appropriate, the provider has also submitted the following items with its cost report:

1. Correctly updated graduate medical education (GME) per resident amounts.
2. All applicable documentation required per Form CMS-2552-96.
3. All required documentation per Form CMS-339.
4. Documentation supporting exceptions to level 2 ECR and hospital cost report information system(HCRIS) edits.
5. A copy of the working trial balance.
6. A copy of the audited financial statements where applicable.
7. The supporting documentation for reclassifications, adjustments, related organizations, contracted therapists, and protested items, where applicable.

If any of those items are not submitted with the cost report, the *contractor* will request that the provider submit significant missing documentation/information within a certain time-frame. The *contractor* will adjust the tentative settlement amount to disallow the reimbursement affected if the provider does not submit the requested documentation/information.