

Medicare

Provider Reimbursement Manual

Part 2, Provider Cost Reporting Forms and Instructions, Chapter 34, Form CMS-265-94

Department of Health and
Human Services (DHHS)

Centers for Medicare and
Medicaid Services (CMS)

Transmittal 9

Date: December 2005

Transmittal 8, dated December 2005, is rescinded and replaced by Transmittal 9 to include the Excel forms file inadvertently omitted in Transmittal 8. In addition, material is being added to the first paragraph of §3412 on page 34-27 to cover cost reporting periods that straddle April 1, 2005. Finally, pages 34-511 (and 34-512) were added to include a NOTE on page 34-511 under the heading Multiple ESRD Payment Rates.

<u>HEADER SECTION NUMBERS</u>	<u>PAGES TO INSERT</u>	<u>PAGES TO DELETE</u>
3404.1 - 3404.1 (Cont.)	34-9 - 34-9.1 (2 pp.)	34-9 - 34-9.1 (2 pp.)
3411 - 3413 (Cont.)	34-23 - 34-28 (6 pp.)	34-23 - 34-28 (6 pp.)
3490 (Cont.) - 3490 (Cont.)	34-309 - 34-313 (5 pp.)	34-309 - 34-313 (5 pp.)
3495 - 3495 (Cont.)	34-503 - 34-504 (2 pp.)	34-503 - 34-504 (2 pp.)
	34-507 - 34-508 (2 pp.)	34-507 - 34-508 (2 pp.)
	34-511 - 34-514 (4 pp.)	34-511 - 34-514 (4 pp.)
	34-517 - 34-522 (6 pp.)	34-517 - 34-522 (6 pp.)
	34-525 - 34-528 (4 pp.)	34-525 - 34-528 (4 pp.)

REVISED COST REPORTING FORMS AND INSTRUCTIONS--EFFECTIVE DATE: ESRD changes effective for cost reporting periods ending on or after April 1, 2005.

This transmittal updates Chapter 34, Renal Dialysis Facility for Cost Reporting Form CMS-265-94 to reflect further clarifications to existing instructions and implement specific provisions of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA). The effective dates will vary due to various implementation dates.

The following revisions are implemented:

- 1) Section 623(d)(1) revises section 1881(b)(12)(A) of the Act, and adjusts composite payment rates for individual renal dialysis patient characteristics effective for services rendered on or after April 1, 2005. (Change Request 3720, Dated February 18, 2005)
- 2) Eliminated the A&G allocation to separately billable drugs effective for cost reporting periods beginning on or after January 1, 2005.

This transmittal also includes instructional revisions to insure consistency with the electronic reporting specifications.

The following is a list of the revised cost reporting forms:

Form CMS
265-94 Wkst:

Summary of Changes:

- | | |
|---|---|
| B | Shaded column 10, line 2. |
| C | Added columns 4.01 and 6.01 for cost reporting periods that straddle (overlap) April 1, 2005. |

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

CMS-Pub. 15-2-34

3404. WORKSHEET S - INDEPENDENT RENAL DIALYSIS FACILITY COST REPORT CERTIFICATION

The intermediary should indicate in the appropriate box whether this is the initial cost report (first cost report filed for the period), final report due to termination, or if this is a reopening. If it is a reopening, indicate the number of times the cost report has been reopened. The intermediary should also indicated in HCRIS on line 1, column 3 of worksheet S the following codes that correspond to the filing status of the cost report: 1=As submitted; 2=Settled; 3=Settled with Audit; 4=Reopened; and 5=Amended.

3404.1 Part I - General.--

Line 1.--Enter name of the facility.

Line 1.01--Enter the street address and P.O. Box (if applicable).

Line 1.02--Enter the city, state, and zip code.

Line 1.03--Enter the county where the facility is located.

Line 2.--Enter your provider number.

Line 3.--Enter the date the facility was certified.

Line 4.--Enter the name and phone number of the person to be contacted if any questions arise about the information in this report.

Line 5.--Enter the inclusive dates covered by this cost report. Generally, a cost reporting period consists of 12 consecutive calendar months or 13 four-week periods with an additional day (two in a leap year) added to the last week in the period to make it coincide with the end of the calendar year or month. See CMS Pub. 15-I, chapter 24, for situations where a short period cost report may be filed. A new facility may select an initial cost reporting period of at least one month, but not in excess of 13 months. (See CMS Pub. 15-I, §2414.1.)

A 30-day extension of the due date for a cost report may, for good cause, be granted by the program. To be granted this extension, you must submit a written request and obtain written approval from the servicing intermediary prior to your cost report due date.

Line 6

Column 1--Type of Control--Indicate the ownership or auspices of the facility by entering the number below that corresponds to the type of control of the facility.

Voluntary Non Profit
1=Corporation
2=Other (specify)

Proprietary
3=Individual
4=Corporation
5=Partnership
6=Other (specify)

Government
7=Federal
8=State
9=County
10=City
11=Other (specify)

Column 2--If item 2, 6, or 11 is selected, "Other (specify) category, specify the type of provider in column 2 of the worksheet.

Line 7.--Indicate whether the physicians providing outpatient maintenance dialysis and other physician services for ESRD patients are paid under the initial method or the MCP method. Indicate the date of election of the initial method if applicable.

Column 1--Type of Reimbursement--Enter the number 1 for the initial method and number 2 for the MCP method.

Column 2--If the initial method is selected, enter the date of election of the initial method.

Line 8.--Indicate whether you were previously certified as a hospital-based unit. In Column 1 enter "Y" for yes or "N" for no.

Line 9.--If you are part of a chain organization, enter a "Y" for yes in Column 1 and enter the name and address of the organization on the lines listed below. Otherwise enter "N" for no in column 1. See CMS Pub. 15-I, §2150 for a definition of a chain organization.

Line 9.01--Enter the name of the Home Office.

Line 9.02--Enter the street address and P. O. Box (if applicable) of the Home Office.

Line 9.03--Enter the city, state and zip code of the Home Office.

3404.2 Part II - Certification by Officer or Administrator of Facility.--Prepare and sign this certification after the cost report has been completed in its entirety.

Section 1128B(a) of the Act states that, "Whoever knowingly and willfully makes or causes to be made any false statement or representation of material fact in any application for any benefit or payment under this title--shall (i) in the case of such a statement, representation, concealment, failure or conversion by any person in connection with the furnishing (by that person) of items or service for which payment is or may be made under this title, be guilty of a felony and upon conviction thereof fined not more than \$25,000 or imprisoned for not more than 5 years or both, or (ii) in the case of such statement, representation, concealment, failure or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than \$10,000 or imprisoned for not more than 1 year or both."

3411. WORKSHEET B - COST ALLOCATION - GENERAL SERVICE COSTS AND
WORKSHEET B-1 - COST ALLOCATION - STATISTICAL BASIS

Worksheet B provides for cost finding by using a combined methodology of cost centers and apportioning the costs to those cost centers which receive the services. The cost centers that are serviced include all cost centers within your organization; that is, separately billable, reimbursable cost centers, and nonreimbursable cost centers. Obtain the total direct expenses from Worksheet A, column 8.

Worksheet B-1 provides for the statistics necessary to allocate the cost to the revenue producing and nonreimbursable cost centers on Worksheet B.

To facilitate the allocation process, the general format of Worksheets B and B-1 are identical. The column and line numbers for the general service cost centers are identical on the two worksheets. In addition, the line numbers for each reimbursable and nonreimbursable cost center are identical on the two worksheets.

The statistical bases shown at the top of each column on Worksheet B-1 are the recommended bases of allocation of the cost centers indicated. Use these statistical bases of allocation unless you have intermediary approval in writing to use different bases. (See CMS Pub. 15-1, §2313.)

Certain cost centers are combined on Worksheet B-1 for cost allocation purposes. These combinations are not optional; that is, facilities must combine and allocate these costs as shown on the worksheet. The total costs of each combined group of cost centers are allocated in one process to the revenue producing and nonreimbursable cost centers.

Column Descriptions

Columns 6, 7, and 8.--These columns refer to drugs, supplies, and laboratory services, i.e., routine and nonroutine furnished to both Medicare and non-Medicare patients, furnished by, billed by, and reimbursed to your facility. Do not include any of these items and services that were billed by any physicians since these costs are not part of your facility's costs. To determine the costs allocated to the various cost centers, use actual costs if separate expense accounts are maintained, or allocate these costs based on the supplier's charge as reported on the costed requisitions. The cost or costed requisitions used for allocation purposes must bear a consistent relationship to the costs of all items and services. (See CMS Pub. 15-I, §§2710 and 2711.)

Line Descriptions

Items and services that are covered under the composite rate are those commonly furnished as part of a typical dialysis service. These costs are reimbursed through your dialysis rate and may not be separately billed. The costs of items and services covered under the composite payment rate are allocated to the various modes of treatment on lines 7 through 16, Worksheet B. The costs of separately billable items and services are not allocated to various modes of treatment because they are not considered one of the dialysis service costs that are used in computing the composite payment rate.

Line 2.--Separately billable injectable drugs are drugs that are not reimbursed under the composite payment rate but may be medically necessary for a patient. (See CMS Pub. 15-I, §2711.2.)

Effective for cost reporting periods beginning on or after January 1, 2005, A&G costs will no longer be allocated to separately billable drugs resulting in worksheet B, column 10, line 2 being shaded. However, for cost reporting periods which begin prior to January 1, 2005, worksheet B, column 10, line 2 shall remain unshaded.

Line 3.--These include medical supplies that are not related to the dialysis treatment. Facilities are primarily engaged in treating the patient's ESRD condition, and therefore this line should have a negligible or zero amount.

Line 4.--These lab tests are other than those included and explained in §207.1 of the Renal Dialysis Facility Manual. You may not bill for separately billable lab tests. They must be billed by the laboratory performing the tests. If you do not bill for these tests, then enter zeroes on this line.

Use the following procedures in completing these worksheets.

NOTE: EPO furnished to an in-facility ESRD beneficiary in a dialysis facility is paid by an add-on amount which is paid in addition to the composite rate for each administration of EPO. In the case of a home patient receiving EPO in a dialysis facility, only the add-on amount is paid. This is the only way payment is made when EPO is administered in a dialysis facility. Since only the cost of the EPO is included in this amount, there is no overhead to be allocated to the epoetin cost center. There is no line for EPO on these worksheets to accommodate this process.

1. Enter on Worksheet B-1, columns 2 through 10, line 22, and Worksheet B, columns 2 through 10, line 1, the following costs to be allocated. Obtain these costs from Worksheet A as follows:

<u>FROM</u>	<u>TO</u>
Worksheet A, column 8	Worksheet B-1, line 22 and Worksheet B, line 1
<u>Lines</u>	<u>Column</u>
5 Capital-Related, Operation and Maintenance of Plant and Housekeeping	2
6 Machine Capital-Related or Rental and Maintenance	3
7 Salaries for Direct Patient Care	4
8 Employee Health and Welfare Benefits for Direct Patient Care	5
9 Drugs	6
10 Supplies	7
11 Laboratory	8
18 Administrative and General and Other Cost Centers	10

2. On Worksheet B, column 1, line 1, enter the total of columns 2 through 10, line 1.

3. On Worksheet B, column 1, lines 5, 6, and 17 through 20, enter the direct costs of the revenue producing and nonreimbursable cost centers which are obtained from Worksheet A, column 8, lines 20 through 22 and 24 through 26 respectively.

4. On Worksheet B, column 1, line 21, enter the total of column 1, lines 1 through 20. This total must equal the amount on Worksheet A, column 8, line 27.

5. On Worksheet B-1, columns 2 through 8, enter on lines 2 through 20 the portion of the total statistical base over which the expenses of the cost centers are to be allocated. The statistical base to be used in each column is cited in the column heading and reflects only those statistics applicable to the revenue producing and nonreimbursable cost centers. Enter in columns 2 through 8, line 21, the sum of lines 2 through 20.

6. On Worksheet B-1, columns 2 through 8, line 23, determine the unit cost multiplier by dividing the amount on line 22 by the total statistics on line 21. The unit cost multiplier is rounded to the nearest six decimal places (e.g., \$4,000 / 15,000 square feet = .2666666 = .266667).

7. On Worksheet B-1, multiply the appropriate unit cost multipliers computed in step 6 by the individual cost center statistics in columns 2 through 8. Enter the resulting amounts in the corresponding columns and lines of Worksheet B.

8. On Worksheet B, columns 2 through 8, enter on line 21 the sum of the amounts computed on lines 2 through 20. Do not include in these totals the amounts entered on line 1. For each column, the amount on line 21 must equal the amount on line 1.

9. On Worksheet B, column 9, lines 2 through 20, enter the sum of columns 1 through 8.

10. On Worksheet B, column 9, line 21, enter the total of lines 2 through 20. This total plus the amount in column 10, line 1, must equal the amount in column 1, line 21.

11. Transfer the total on Worksheet B, column 9, line 21, to Worksheet B-1, column 10, line 21. *For cost reporting periods beginning on or after January 1, 2005, transfer the total on Worksheet B, column 9, line 21, less the amount on Worksheet B, column 9, line 2 to Worksheet B-1, column 10, line 21.*

12. On Worksheet B-1, column 10, line 23, determine the unit cost multiplier by dividing the amount on line 22 by the amount on line 21.

13. Multiply the unit cost multiplier computed in step 12 by the individual cost center amounts on Worksheet B, column 9. Enter the resulting amounts on Worksheet B, column 10, lines 1 through 20. Enter on line 21 of Worksheet B the total of the amounts thus computed. The amount on line 21 must equal the amount on line 1.

14. On Worksheet B, column 11, lines 2 through 16 and lines 17 through 20, enter the total of columns 9 and 10.

15. On Worksheet B, column 11, line 16.01, enter the subtotal of lines 2 through 16.

16. On Worksheet B, column 11, line 21, enter the total of lines 16.01 through 20. The amount on line 21 must equal the amount in column 1, line 21.

17. Transfer the expenses from Worksheet B as follows:

<u>From Worksheet B</u>	<u>To</u>
Column 11, line 7	Worksheet C, column 2, line 1
Column 11, line 8	Worksheet C, column 2, line 2
Column 11, line 9	Worksheet C, column 2, line 3
Column 11, line 10	Worksheet C, column 2, line 4
Column 11, line 11	Worksheet C, column 2, line 5
Column 11, line 12	Worksheet C, column 2, line 6
Column 11, line 13	Worksheet C, column 2, line 7
Column 11, line 14	Worksheet C, column 2, line 8
Column 11, line 15	Worksheet C, column 2, line 9
Column 11, line 16	Worksheet C, column 2, line 10

The totals in column 11, lines 2 through 6 and lines 17 through 20, are not transferred because only the figures for the reimbursable cost centers are transferred to Worksheet C.

3412. WORKSHEET C - COMPUTATION OF AVERAGE COST PER TREATMENT

This worksheet records the apportionment of total costs to the types of dialysis treatment furnished by you and shows the computation of expenses of dialysis items and services that you furnished to Medicare dialysis patients. This information is used for overall program evaluation, determining the appropriateness of program reimbursement rates, and meeting statutory requirements of determining the cost of ESRD care. *For cost reporting periods that straddle April 1, 2005 where multiple payment rates are applicable for the portion of the cost reporting period prior to April 1, 2005, complete a separate Worksheet C for each rate period prior to April 1, 2005; and, subscript columns 4 and 6 on the penultimate Worksheet C to report the average composite rate for each modality in column 6.01 for services rendered on or after April 1, 2005. For cost reporting periods beginning on or after April 1, 2005, complete only one Worksheet C as only one average composite rate will apply to each modality.*

Column 1.--Enter the total number of treatments/patient weeks by type for all renal dialysis patients from your records. These statistics include all treatments furnished to all patients, both Medicare and non-Medicare.

Column 2.--Enter the total cost transferred from Worksheet B, column 11, lines 7 through 16.

Column 3.--The amounts entered are determined by dividing the cost entered on each line in column 2 by the number of treatments/patient weeks entered on each line in column 1.

Columns 4 through 7.--Refer only to treatments furnished to Medicare beneficiaries that were billed to and reimbursed by the program directly.

Column 4.--Enter the number of treatments billed to the Medicare program directly. Enter on lines 9 and 10 the patient weeks. Obtain this information from your records. *For cost reporting periods which straddle April 1, 2005, subscript this column by adding column 4.01 to identify total treatments rendered on or after April 1, 2005. Enter in column 4 the total number of treatments rendered prior to April 1, 2005. For cost reporting periods beginning on or after April 1, 2005, eliminate column 4.01 and enter all treatments in column 4.*

Column 5.--The amounts entered are determined by multiplying the number of treatments or patient weeks by the average cost per treatment entered on each corresponding line in column 3. Transfer the total from column 5, line 11, to Worksheet D, line 1. *For cost reporting periods which straddle April 1, 2005, enter the result of column 3 times the sum of columns 4 and 4.01.*

Column 6.--Enter your Medicare program payment rates by type of treatment for the cost reporting period. If your cost reporting period covers a time when you had more than one rate for a particular treatment type (e.g., the composite rate may have been updated or an exception amount approved during the period), complete a separate Worksheet C to calculate the total payment for each composite rate. When you complete a separate Worksheet C because more than one payment rate was in effect during the cost reporting period, also complete a summary Worksheet C showing the totals of the separate Worksheet Cs. Do not complete column 6 on the summary Worksheet C. However, complete columns 4, 5, and 7, which consist of the sum of the respective amounts computed on the separate Worksheet C for each payment rate. *For cost reporting periods which straddle April 1, 2005, subscript this column by adding column 6.01 and enter the average composite rate by type of treatment for services rendered on or after April 1, 2005. Enter in column 6 the standard payment rate for services rendered prior to April 1, 2005. For cost reporting periods beginning on or after April 1, 2005, eliminate column 6.01 and enter all average composite rates in column 6.*

The ESRD composite payment rate is an average payment calculated based on the total Medicare payments (by type of treatment) divided by the total corresponding ESRD treatments. For example, the total Medicare payment for Hemo Dialysis is divided by the total ESRD Hemo Dialysis treatments. For cost reporting periods which straddle April 1, 2005, columns 4 and 6 must be

subscribed. (See CR 3720 dated February 18, 2005.)

When the facility reports only one payment rate, enter the rate in column 6.

Column 7.--The amounts entered are determined by multiplying the number of treatments or patient weeks entered on each line in column 4 by the payment rate entered on each corresponding line in column 6. *For cost reporting periods which straddle April 1, 2005, add results of column 4 times column 6 and column 4.01 times column 6.01.*

Lines 9 and 10.--Report CAPD and CCPD in terms of weeks. Patient weeks are computed by totaling the number of weeks each patient dialyzed at home by CCPD and/or CAPD. Obtain this information from your records.

3413. WORKSHEET D - CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII, PART B

Under the composite rate system, the intermediary pays the facility its allowable ESRD bad debts, up to the facility's reasonable costs as determined under Medicare principles. Allowable bad debts must relate to specific Medicare deductibles and coinsurance amounts. If you have completed more than one Worksheet C, make a consolidated bad debt computation.

Line 1.--Enter the amount from Worksheet C, column 5, line 11. If you have completed more than one Worksheet C, enter the sum of the total from each Worksheet C, column 5, line 11.

Line 2.--Enter the amount from Worksheet C, column 7, line 11, minus any applicable Part B deductibles. This represents the total reimbursement due to you which includes program payment plus the beneficiaries' liabilities for deductible and coinsurance amounts. It is equal to the sum of the number of Medicare treatments furnished, by mode of treatment, times the respective rate by mode. If you have completed more than one Worksheet C, enter the sum of the total from each Worksheet C, column 7, line 11.

Line 3.--Enter 80 percent of the amount on line 2.

Line 4.--Enter the amount on line 1 minus the amount on line 3.

Line 5.--Enter the amount shown in your records for deductibles and coinsurance billed to Medicare (Part B) patients. The deductibles and coinsurance only include the amounts relative to the expenses and payments listed on lines 1 and 2 that apply to Medicare beneficiaries under the composite payment rate. These amounts, at a minimum, should be 20 percent of the payment due on line 2.

Line 6.--To determine the amount to be entered on this line, you must determine what amount of the figure entered on line 5 is uncollectible. After determining the uncollectible amount, reduce any amount recovered during the cost reporting period covered by this report that had been uncollectible in a cost reporting period prior to the period covered by this report. The resulting amount is then entered on line 6.

Line 7.--Subtract the amount on line 6 from the amount on line 5 and enter the result.

Line 8.--Subtract the amount on line 7 from the amount on line 4 and enter the difference. If the amount on line 7 exceeds the amount on line 4, do not complete line 9.

Line 9.--Enter the lesser of the amount on line 6 or the amount on line 8.

Line 9.01--Enter the gross reimbursable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. This amount must also be included in the amount on line 9, i.e., line 9.01 is a subset of line 9. (1/1/2005b)

**ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-265-94
TABLE 1 - RECORD SPECIFICATIONS**

Table 1 specifies the standard record format to be used for electronic cost reporting. Each electronic cost report submission (file) has three types of records. The first group (type one records) contains information for identifying, processing, and resolving problems. The text used throughout the cost report for variable line labels (e.g., Worksheet A) and variable column headers (Worksheet B-1) is included in the type two records. Refer to Table 5 for cost center coding. The data detailed in Table 3 are identified as type three records. The encryption coding at the end of the file, records 1, 1.01, and 1.02, are type 4 records.

The medium for transferring cost reports submitted electronically to fiscal intermediaries is 3½" diskette. These disks must be in IBM format. The character set must be ASCII. You must seek approval from your fiscal intermediary regarding alternate methods of submission to ensure that the method of transmission is acceptable.

The following are requirements for all records:

1. All alpha characters must be in upper case.
2. For micro systems, the end of record indicator must be a carriage return and line feed, in that sequence.
3. No record may exceed 60 characters.

Below is an example of a set of type 1 records with a narrative description of their meaning.

1	2	3	4	5	6
12345678901	2345678901	2345678901	2345678901	2345678901	234567890
1	1	2500002004001	20043666A99P001	20050312004366	

Record #1: This is a cost report file submitted by Provider 279999 for the period from January 1, 2004 (2004001) through December 31, 2004 (2004366). It is filed on FORM CMS-265-94. It is prepared with vendor number A99's PC based system, version number 1. Position 38 changes with each new test case and/or approval and is alpha. Positions 39 and 40 remain constant for approvals issued after the first test case. This file is prepared by the independent renal dialysis facility on January 31, 2005 (2005031). The electronic cost report specification dated December 31, 2004 (2004366) is used to prepare this file.

FILE NAMING CONVENTION

Name each cost report file in the following manner:

RDNNNNNN.YYL, where

1. RD (Independent Renal Dialysis Facility Electronic Cost Report) is constant;
2. NNNNNN is the 6 digit Medicare independent renal dialysis facility provider number;
3. YY is the year in which the provider's cost reporting period ends; and
4. L is a character variable (A-Z) to enable separate identification of files from independent renal dialysis facility with two or more cost reporting periods ending in the same calendar year.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-265-94
TABLE 1 - RECORD SPECIFICATIONS

RECORD NAME: Type 1 Records - Record Number 1

	<u>Size</u>	<u>Usage</u>	<u>Loc.</u>	<u>Remarks</u>
1. Record Type	1	X	1	Constant "1"
2. NPI	10	9	2-11	Numeric only
3. Spaces	1	X	12	
4. Record Number	1	X	13	Constant "1"
5. Spaces	3	X	14-16	
6. ESRD Provider Number	6	9	17-22	Field must have 6 numeric characters.
7. Fiscal Year Beginning Date	7	9	23-29	YYYYDDD - Julian date; first day covered by this cost report
8. Fiscal Year Ending Date	7	9	30-36	YYYYDDD - Julian date; last day covered by this cost report
9. MCR Version	1	X	37	Constant "6" (for FORM CMS-265-94)
10. Vendor Code	3	X	38-40	To be supplied upon approval. Refer to page 32-503.
11. Vendor Equipment	1	X	41	P = PC; M = Main Frame
12. Version Number	3	X	42-44	Version of extract software, e.g., 001=1st, 002=2nd, etc. or 101=1st, 102=2nd. The version number must be incremented by 1 with each recompile and release to client(s).
13. Creation Date	7	9	45-51	YYYYDDD - Julian date; date on which the file was created (extracted from the cost report)
14. ECR Spec. Date	7	9	52-58	YYYYDDD - Julian date; date of electronic cost report specifications used in producing each file. Valid for cost reporting periods ending on or after <i>2005091 (4/1/2005). Prior approval(s) 2004366.</i>

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 265-94
TABLE 1 - RECORD SPECIFICATIONS

Type 2 records for Worksheet B-1, columns 2-8, for lines 1-6 are listed below. The numbers running vertical to line 1 descriptions are the general service cost center line designations.

LINE						
1	2	3	4	5	6	
2	CAP REL OP	OF MAINT	& HOUSE	SQUARE	FEET	1
3	MACH CAP	REL OR REN	& MAINT	PERCENT OF	TIME SPENT	3
4	<i>SALARIES</i>	FOR DIRECT	<i>PAT</i> CARE	HRS OF	SERVICE	
5	<i>EMP</i> H&W	BENEFITS	DIR PAT CR	GROSS	SALARIES	
6	DRUGS			CHARGES		
7	SUPPLIES			CHARGES		
8	LABORATORY			CHARGES		

Examples of type 2 records are below. Either zeros or spaces may be used in the line, subline, column, and subcolumn number fields (positions 11-20). However, spaces are preferred. Refer to Table 5 and 6 for additional cost center code requirements.

Examples:

Worksheet A line labels with embedded cost center codes:

2A000000	1	0100CAP REL COSTS-BLDG & FIXT
2A000000	2	0200CAP REL COSTS-MVBLE EQUIP
2A000000	9	0900DRUGS
2A000000	15	1500MEDICAL RECORDS
2A000000	19	1900PHY ROUT PRO SERVICES-MCP METHOD
2A000000	23	2300EPOETIN

Examples of column headings for Worksheets B-1 and B; statistical bases used in cost allocation on Worksheet B-1; and statistical codes used for Worksheet B-1 (line 6) are displayed below.

2B10000*	1	2	CAP REL OP
2B10000*	2	2	OF MAINT
2B10000*	3	2	& HOUSE
2B10000*	4	2	SQUARE
2B10000*	5	2	FEET
2B10000*	6	2	1
2B10000*	1	3	MACH CAP
2B10000*	2	3	REL OR REN
2B10000*	3	3	& MAINT
2B10000*	4	3	PERCENT OF
2B10000*	5	3	TIME SPENT
2B10000*	6	3	3

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 265-94
TABLE 1 - RECORD SPECIFICATIONS

RECORD NAME: Type 3 Records for Nonlabel Data

	<u>Size</u>	<u>Usage</u>	<u>Loc.</u>	<u>Remarks</u>
1. Record Type	1	9	1	Constant "3"
2. Wkst. Indicator	7	X	2-8	Alphanumeric. Refer to Table 2.
3. Spaces	2	X	9-10	
4. Line Number	3	9	11-13	Numeric
5. Subline Number	2	9	14-15	Numeric
6. Column Number	3	X	16-18	Alphanumeric
7. Subcolumn Number	2	9	19-20	Numeric
8. Field Data				
a. Alpha Data	36	X	21-56	Left justified. (Y or N for yes/no answers; dates must use MM/DD/YYYY format - slashes, no hyphens.) Refer to Table 6 for additional requirements for alpha data.
	4	X	57-60	Spaces (optional).
b. Numeric Data	16	9	21-36	Right justified. May contain embedded decimal point. Leading zeros are suppressed; trailing zeros to the right of the decimal point are not. Positive values are presumed; no A+@ signs are allowed. Use leading minus to specify negative values. Express percentages as decimal equivalents, i.e., 8.75% is expressed as .087500. All records with zero values are dropped. Refer to Table 6 for additional requirements regarding numeric data.

A sample of type 3 records are below.

3A000000	12	1	36000
3A000000	15	2	12064
3A000000	19	1	144000

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-265-94
TABLE 2 - WORKSHEET INDICATORS

FOOTNOTES:

(a) Multiple Worksheets for Reclassifications and Adjustments Before Stepdown

The fifth and sixth digits of the worksheet indicator (positions 6 and 7 of the record) are numeric from 01-99 to accommodate reports with more lines on Worksheets A-1. For reports that do not need additional worksheets, the default is 01. For reports that do need additional worksheets, the first page is numbered 01. The number for each additional page of the worksheet is incremented by 1.

b) Multiple ESRD Payment Rates

The sixth digit of the worksheet indicator (position 7 of the record) is numeric from 1 to 9 to accommodate two or more payment rates in effect during one cost reporting period. If there is only a single payment rate, the default is 1. This applies only to Worksheet C. *NOTE: For cost reporting periods beginning on or after April 1, 2005, the sixth digit of the worksheet indicator (position 7 of the record) will always default to 1, as Worksheet C is no longer subscriptable.*

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-265-94
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN
DESIGNATIONS

This table identifies those data elements necessary to calculate a independent renal dialysis cost report. It also identifies some figures from a completed cost report. These calculated fields (e.g., Worksheet B, column 8) are needed to verify the mathematical accuracy of the raw data elements and to isolate differences between the file submitted by the independent renal dialysis facility and the report produced by the fiscal intermediary. Where an adjustment is made, that record must be present in the electronic data file. For explanations of the adjustments required, refer to the cost report instructions.

Table 3 "Usage" column is used to specify the format of each data item as follows:

9	Numeric, greater than or equal to zero.
-9	Numeric, may be either greater than, less than, or equal to zero.
9(x).9(y)	Numeric, greater than zero, with x or fewer significant digits to the left of the decimal point, a decimal point, and exactly y digits to the right of the decimal point.
X	Character.

Consistency in line numbering (and column numbering for general service cost centers) for each cost center is essential. The sequence of some cost centers does change among worksheets.

Table 3 refers to the data elements needed from a standard cost report. When a standard line is subscripted, the subscripted lines must be numbered sequentially with the first subline number displayed as "01" or " 1" (with a space preceding the 1) in field locations 14-15. It is unacceptable to format in a series of 10, 20, or skip subline numbers (i.e., 01, 03), except for skipping subline numbers for prior year cost center(s) deleted in the current period or initially created cost center(s) no longer in existence after cost finding. Exceptions are specified in this manual. For Other (specify) lines, i.e., Worksheet settlement series, all subscripted lines should be in sequence and consecutively numbered beginning with subscripted line number 01. Automated systems should reorder these numbers where providers skip or delete a line in the series.

Drop all records with zero values from the file. Any record absent from a file is treated as if it were zero.

All numeric values are presumed positive. Leading minus signs may only appear in data with values less than zero that are specified in Table 3 with a usage of "-9". Amounts that are within preprinted parentheses on the worksheets, indicating the reduction of another number, are reported as positive values.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 265-94
 TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

<u>DESCRIPTION</u>	<u>LINE(S)</u>	<u>COLUMN(S)</u>	<u>FIELD SIZE</u>	<u>USAGE</u>
WORKSHEET S				
Name	1	1	36	X
Street	1.01	1	36	X
P.O. Box	1.01	2	9	X
City	1.02	1	36	X
State	1.02	2	2	X
Zip Code	1.02	3	10	X
County	1.03	1	36	X
Facility Number (xxxxxxx)	2	1	6	X
Date Certified (MM/DD/YYYY)	3	1	10	X
Name	4	1	36	X
Phone number (xxx-xxx-xxxx)	4	2	12	X
Cost reporting period beginning date (MM/DD/YYYY)	5	1	10	X
Cost reporting period ending date (MM/DD/YYYY)	5	2	10	X
Type of control: (See Table 3B)	6	1	2	9
Other(Specify)	6	2	36	X
Type of physicians' reimbursement: (See Table 3B)	7	1	1	9
Date of election of initial method (MM/DD/YYYY)	7	2	10	X
Was this facility previously certified as a Hospital-based unit/ (y/n)	8	1	1	X
If you are part of a chain organization check "yes", otherwise check "no". (y/n)	9	1	1	X
If you checked "yes", enter the				
Name	9.01	1	36	X
Street	9.02	1	36	X
P.O. Box	9.02	2	9	X
City	9.03	1	36	X
State	9.03	2	2	X
Zip code of the organization	9.03	3	10	X

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 265-94
 TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN
 DESIGNATIONS

<u>DESCRIPTION</u>	<u>LINE(S)</u>	<u>COLUMN(S)</u>	<u>FIELD SIZE</u>	<u>USAGE</u>
WORKSHEET S-1				
Renal Dialysis Statistics				
Number of treatments not billed to Medicare and furnished directly	1	1-4	11	9
Number of treatments not billed to Medicare and furnished under arrangement	2	1-4	11	9
Number of patients currently in dialysis program	3	1-4	11	9
Average time per week patient receives dialysis	4	1-4	5	9(2).99
Number of days in average week for patient dialysis treatments	5	1-4	4	9.99
Average time of patient dialysis treatment including set up time	6	1-4	5	9(2).99
Number of machines regularly available for use	7	1-4	11	9
Number of standby machines	8	1-4	11	9
Number of shifts in typical week during regular reporting period	9	1-4	11	9
Hours per shift in typical week during regular reporting period:				
First shift	10.01	1-4	9	9
Second shift	10.02	1-4	9	9
Third shift	10.03	1-4	9	9
Number of treatments provided:				
One (1) time per week	11.01	1-4	11	9
Two (2) times per week	11.02	1-4	11	9
Three (3) times per week	11.03	1-4	11	9
More than three (3) times per week	11.04	1-4	11	9
Total Treatments	11.05	1-4	11	9
Type of dialyzers used: (See Table 3C)	12	1	1	9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 265-94
 TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

<u>DESCRIPTION</u>	<u>LINE(S)</u>	<u>COLUMN(S)</u>	<u>FIELD SIZE</u>	<u>USAGE</u>
WORKSHEET A-1				
For each expense reclassification:				
Explanation	1-35	0	36	X
Reclassification identification code	1-35	1	2	X
Increases:				
Worksheet A line number	1-35	3	6	9(3).99
Reclassification amount	1-35	4	9	9
Decreases:				
Worksheet A line number	1-35	6	6	9(3).99
Reclassification amount	1-35	7	9	9
WORKSHEET A-2				
Description of adjustment	17-20	0	36	X
Basis (A or B)	1,3-6,8-20	1	1	X
Amount	1-6,8-20,	2	9	-9
Worksheet A line number	1,3-6, 8-9,11,12, 17-20	4	6	9(3).99
WORKSHEET A-3				
<u>Part A</u> - Are there any related organization costs included on Worksheet A? (Y/N)	1	1	1	X
<u>Part B</u> - For costs incurred and adjustments required as a result of transactions with related organization(s):				
Worksheet A line number	1-4	1	6	9(3).99
Expense item(s)	1-4	3	36	X
Amount included in Worksheet A	1-4	4	9	-9
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ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 265-94
 TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN
 DESIGNATIONS

<u>DESCRIPTION</u>	<u>LINE(S)</u>	<u>COLUMN(S)</u>	<u>FIELD SIZE</u>	<u>USAGE</u>
WORKSHEET A-3 (Continued)				
Amount allowable in reimbursable cost	1-4	5	9	-9
<u>Part C</u> - For each related organization:				
Type of interrelationship (A through G)	1-4	1	1	X
If type is G, specify description of relationship	1-4	0	36	X
Name of related individual or organization	1-4	2	36	X
Percentage of ownership	1-4	3	6	9(3).99
Name of related individual or organization	1-4	4	36	X
Percentage of ownership of provider	1-4	5	6	9(3).99
Type of business	1-4	6	36	X
WORKSHEET A-4				
Owners Compensation-Part I				
Title	1-10	1	36	X
Function	1-10	2	36	X
Sole proprietorship				
Percentage of work week devoted to business	1-10	3	6	9(3).99
Partners				
Percent share of operating profit (loss)	1-10	4A	6	9(3).99
Percentage of week devoted to business	1-10	4B	6	9(3).99

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-265-94
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

<u>DESCRIPTION</u>	<u>LINE(S)</u>	<u>COLUMN(S)</u>	<u>FIELD SIZE</u>	<u>USAGE</u>
WORKSHEET A-4 (Continued)				
Corporation				
Percent of provider's stock owned	1-10	5A	6	9(3).99
Percentage of work week devoted to business	1-10	5B	6	9(3).99
Total compensation included in allowable cost	1-10	6	11	9
Part II				
Title	1-10	1	36	X
Percentage of work week devoted to business	1-10	2	6	9(3).99
Total compensation	1-10	3	11	9
WORKSHEETS B and B-1				
Column heading (cost center name)	1-3 +	2-9	10	X
Statistical basis	4, 5 +	2-9	10	X
+ Refer to Table 1 for specifications and Table 2 for the worksheet identifier for column headings. There may be up to five type 2 records (3 for cost center name and 2 for the statistical basis) for each column. However, for any column that has less than five type 2 record entries, blank records or the word blank is not required to maximize each column record count.				
WORKSHEET B				
Costs after cost finding by department	2-20 (excluding line 16.01)	11	9	-9
Total costs after cost finding	21	11	9	9
WORKSHEET B-1				
All cost allocation statistics	2-20	2-8	9	9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-265-94
 TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

<u>DESCRIPTION</u>	<u>LINE(S)</u>	<u>COLUMN(S)</u>	<u>FIELD SIZE</u>	<u>USAGE</u>
WORKSHEET C				
Total number of treatments	1-8,11	1	11	9
Total CAPD patient weeks	9	1	11	9
Total CCPD patient weeks	10	1	11	9
Number of treatments-Medicare	1-8,11	4 & 4.01	11	9
CAPD patient weeks-Medicare	9	4 & 4.01	11	9
CCPD patient weeks-Medicare	10	4 & 4.01	11	9
Payment Rates	1-10	6 & 6.01	6	9(3).99
WORKSHEET D				
Total expenses related to care of Medicare beneficiaries	1	1	11	9
<i>Total Payment Due</i>	<i>2</i>	<i>1</i>	<i>11</i>	<i>9</i>
Part B deductibles & coinsurance billed	5	1	11	9
Reimbursable bad debts	6	1	11	9
<i>Reimbursable bad debts for dual eligible beneficiaries</i>	<i>9.01</i>	<i>1</i>	<i>11</i>	<i>9</i>

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-265-94
TABLE 3A - WORKSHEETS REQUIRING NO INPUT

Worksheet B

TABLE 3B-TABLES TO WORKSHEET S

Type of Control

- 1 = Voluntary Non Profit, Corporation
- 2 = Voluntary Non Profit, Other
- 3 = Proprietary, Individual
- 4 = Proprietary, Corporation
- 5 = Proprietary, Partnership
- 6 = Proprietary, Other
- 7 = Government, Federal
- 8 = Government, State
- 9 = Government, County
- 10 = Government, City
- 11 = Government, Other

Type of Reimbursement

- 1 = Initial Method
- 2 = MCP Method

TABLE 3C-TABLES TO WORKSHEET S-1

Type of Dialyzers Used

- 1 = Hollow Fiber
- 2 = Parallel Plate
- 3 = Coil
- 4 = Other

TABLE 3D- LINES THAT CANNOT BE SUBSCRIBED
(BEYOND THOSE PREPRINTED)

<u>Worksheet</u>	<u>Lines</u>
S	1-9
S-1	<i>1-11, 13-18, 20-28</i>
A	5,18,27
A-1	1-36
A-2	1-16,21
A-3-Part A	All
A-3, Part B	1-3,5
A-3, Part C	1-3
A-4, Part I	1-9
A-4, Part II	1-9
B	1-19, 21
B-1	1-19,21-23
C	ALL
D	<i>1-8</i>

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 265-94
TABLE 5 - COST CENTER CODING

INSTRUCTIONS FOR PROGRAMMERS

Cost center coding is required because there are thousands of unique cost center names in use by providers. Many of these names are peculiar to the reporting provider and give no hint as to the actual function being reported. Using codes to standardize meanings makes practical data analysis possible. The method to accomplish this must be rigidly controlled to assure accuracy.

For any added cost center names (the preprinted cost center labels must be precoded), preparers must be presented with the allowable choices for that line or range of lines from the lists of standard and nonstandard descriptions. They then select a description that best matches their added label. The code associated with the matching description, including increments due to choosing the same description more than once, will then be appended to the user's label by the software.

Additional guidelines are:

- Do not allow any pre-existing codes for the line to be carried over.
- Do not precode all Other lines.
- For cost centers, the order of choice must be standard first, then specific nonstandard, and finally the nonstandard "Other . . ."
- For the nonstandard "Other . . .", prompt the preparers with, "Is this the most appropriate choice?," and then offer the chance to answer yes or to select another description.
- Allow the preparers to invoke the cost center coding process again to make corrections.
- For the preparers' review, provide a separate printed list showing their added cost center names on the left with the chosen standard or nonstandard descriptions and codes on the right.
- On the screen next to the description, display the number of times the description can be selected on a given report, decreasing this number with each usage to show how many remain. The numbers are shown on the cost center tables.
- Do not change standard cost center lines, descriptions and codes. The acceptable formats for these items are listed on page 34-524 of the Standard Cost Center Descriptions and Codes. The proper line number is the first two digits of the cost center code.

INSTRUCTIONS FOR PREPARERS

Coding of Cost Center Labels

Cost center coding standardized the meaning of cost center labels used by health care providers on the Medicare cost reporting forms. The use of this coding methodology allows providers to continue to use their labels for cost centers that have meaning within the individual institution.

The four digit codes that are required to be associated with each label provide standardized meaning for data analysis. Normally, it is necessary to code only added labels because the preprinted standard labels are automatically coded by CMS approved cost report software.

Additional cost center descriptions have been identified. These additional descriptions are hereafter referred to as the nonstandard labels. Included with the nonstandard descriptions is an "Other . . ." designation to provide for situations where no match in meaning can be found. Refer to Worksheet A, line 17 or 26.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-265-94
TABLE 6 - EDITS

Medicare cost reports submitted electronically must be subjected to various edits, which are divided into two categories: Level I and level II edits. These include mathematical accuracy edits, certain minimum file requirements, and other data edits. Any vendor software that produces an electronic cost report file for Medicare ESRD must automate all of these edits. Failure to properly implement these edits may result in the suspension of a vendor's system certification until corrective action is taken. The vendor's software should provide meaningful error messages to notify the home health agency of the cause of every exception. The edit message generated by the vendor systems must contain the related 4 digit and 1 alpha character, where indicated, reject/edit code specified below. Any file containing a level I edit will be rejected by your fiscal intermediary without exception.

Level I edits (1000 series reject codes) test that the file conforms to processing specifications, identifying error conditions that would result in a cost report rejection. These edits also test for the presence of some critical data elements specified in Table 3. Level II edits (2000 series edit codes) identify potential inconsistencies and/or missing data items that may have exceptions and should not automatically cause a cost report rejection. Resolve these items and submit appropriate worksheets and/or data supporting the exceptions with the cost report. Failure to submit the appropriate data with your cost report may result in payments being withheld pending resolution of the issue(s).

The vendor requirements (above) and the edits (below) reduce both intermediary processing time and unnecessary rejections. Vendors should develop their programs to prevent their client home health agencies from generating either a hard copy substitute cost report or electronic cost report file where level I edits exist. Ample warnings should be given to the provider where level II edit conditions are violated.

NOTE: Dates in brackets [] at the end of an edit indicate the effective date of that edit for cost reporting periods ending on or after that date. Dates followed by a "b" are for cost reporting periods beginning on or after the specified date. Dates followed by an "s" are for services rendered on or after the specified date unless otherwise noted. [10/31/2000]

I. Level I Edits (Minimum File Requirements)

<u>Reject Code</u>	<u>Condition</u>
1000	The first digit of every record must be either 1, 2, 3, or 4 (encryption code only). [12/31/2004]
1005	No record may exceed 60 characters. [12/31/2004]
1010	All alpha characters must be in upper case. This is exclusive of the encryption code, type 4 record, record numbers 1, 1.01, and 1.02. [12/31/2004]
1015	For micro systems, the end of record indicator must be a carriage return and line feed, in that sequence. [12/31/2004]
1020	The independent renal dialysis facility provider number (record #1, positions 17-22) must be valid and numeric. [12/31/2004]
1025	All dates (record #1, positions 23-29, 30-36, 45-51, and 52-58) must be in Julian format and legitimate. [12/31/2004]
1030	The fiscal year beginning date (record #1, positions 23-29) must be less than the fiscal year ending date (record #1, positions 30-36). [12/31/2004]

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-265-94

TABLE 6 - EDITS

<u>Reject Code</u>	<u>Condition</u>
1035	The vendor code (record #1, positions 38-40) must be a valid code. [12/31/2004]
1050	The type 1 record #1 must be correct and the first record in the file. [12/31/2004]
1055	All record identifiers (positions 1-20) must be unique. [12/31/2004]
1060	Only a Y or N is valid for fields which require a Yes/No response. [12/31/2004]
1075	Cost center integrity must be maintained throughout the cost report. For subscripted lines, the relative position must be consistent throughout the cost report. [12/31/2004]
1080	For every line used on Worksheets A, there must be a corresponding type 2 record. [12/31/2004]
1090	Fields requiring numeric data (charges, treatments, costs, FTEs, etc.) may not contain any alpha character. [12/31/2004]
1100	In all cases where the file includes both a total and the parts that comprise that total, each total must equal the sum of its parts. [12/31/2004]
1005S	The cost report ending date (Worksheet S, column 2, line 4) must be on or after December 31, 2004. [12/31/2004]
1015S	The cost report period beginning date (Worksheet S, column 1, line 5) must precede the cost report ending date (Worksheet S, column 2, line 5). [12/31/2004]
1020S	The independent renal dialysis facility name, address, provider number, and certification date (Worksheet S, line 1, column 1; line 1.01, column 1; line 1.02, columns 1, 2, & 3; and line 1.03, column 1) must be present and valid. [12/31/2004]
<i>1021S</i>	<i>The type of control (Worksheet S, line 6, column 1) must be present and a valid code of 1 thru 11. [4/1/2005]</i>
1025S	The independent renal dialysis total number of hours per work week must be greater than zero (0) (Worksheet S-1, line 20, column 0). [12/31/2004]
1030S	The total number FTEs for Social Workers must be greater than zero (0) (Worksheet S-1, line 25, sum of columns 1 and 2). [12/31/2004]
1000A	All amounts reported on Worksheet A, columns 1-3, line 27, must be greater than or equal to zero. [3/31/1997]
1020A	For reclassifications reported on Worksheet A-1 the sum of all increases (column 4) must equal the sum of all decreases (column 7). [12/31/2004]
1025A	For each line on Worksheet A-1, if there is an entry in columns 3, 4, 6, or 7, there must be an entry in column 1. There must be an entry on each line of column 4 for each entry in column 3 (and vice versa), and there must be an entry on each line of column 7 for each entry in column 6 (and vice versa). [12/31/2004]
1040A	For Worksheet A-2 adjustments on lines <i>1,3-6,8,9,11</i> , and <i>12</i> , and if either columns 2 or 4 has an entry, then both columns 2 and 4 must have entries, and if any one of columns 0, 1, 2, or 4 for lines 17-20 and subscripts thereof has an entry, then all columns 0, 1, 2, and 4 must have entries. Only valid line numbers may be used in column 4. [12/31/2004]

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-265-94
TABLE 6 - EDITS

<u>Reject Code</u>	<u>Condition</u>
1045A	If there are any transactions with related organizations or home offices as defined in CMS Pub. 15-I, chapter 10 (Worksheet A-3, Part A, column 1, line 1 is "Y"), Worksheet A-3, Part B, columns 4 or 5, sum of lines 1-4 must be greater than zero; and Part C, column 1, any one of lines 1-4 must contain any one of alpha characters A through G. Conversely, if Worksheet A-3, Part A, column 1, line 1 is "N", Worksheet A-3, Parts B and C must not be completed. [12/31/2004]
1000B	On Worksheet B-1, all statistical amounts must be greater than or equal to zero. [4/1/2005]
<i>1010B</i>	<i>Edit 1010B - For each overhead cost center with a net expense for cost allocation greater than zero (Worksheet A, column 8, lines 1-4 & 6-11, respectively), the corresponding total cost allocation statistics (Worksheet B-1, columns 2-8, respectively, sum of lines 2-20) must also be greater than zero. Exclude from this edit any column that uses accumulated cost as its basis for allocation and any reconciliation column. [4/1/2005]</i>
1005B	Worksheet B, column 11, line 21 must be greater than zero. [12/31/2004]

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-265-94
TABLE 6 – EDITS

II. Level II Edits (Potential Rejection Errors)

These conditions are usually, but not always, incorrect. These edit errors should be cleared when possible through the cost report. When corrections on the cost report are not feasible, provide additional information in schedules, note form, or any other manner as may be required by your fiscal intermediary (FI). Failure to clear these errors in a timely fashion, as determined by your FI, may be grounds for withholding payments.

<u>Edit</u>	<u>Condition</u>
2000	All type 3 records with numeric fields and a positive usage must have values equal to or greater than zero (supporting documentation may be required for negative amounts). [12/31/2004]
2005	Only elements set forth in Table 3, with subscripts as appropriate, are required in the file. [12/31/2004]
2010	The cost center codes (positions 21-24) (type 2 records) must be a code from Table 5, and each cost center code must be unique. [12/31/2004]
2015	Standard cost center lines, descriptions, and codes should not be changed. (See Table 5.) This edit applies to the standard line only and not subscripts of that code. [12/31/2004]
2020	All standard cost center codes must be entered on the designated standard cost center line and subscripts thereof as indicated in Table 5. [12/31/2004]
2025	Only nonstandard cost center codes within a cost center category may be placed on standard cost center lines of that cost center category. [12/31/2004]
2030	The standard cost centers listed below must be reported on the lines as indicated and the corresponding cost center codes may only appear on the lines as indicated. No other cost center codes may be placed on these lines or subscripts of these lines, unless indicated herein. [12/31/2004]

<u>Cost Center</u>	<u>Line</u>	<u>Code</u>
Cap Rel-Bldg & Fixt	1	0100
Cap Rel-Mvble Equip	2	0200
Operation and Maintenance of Plant	3	0300
Housekeeping	4	0400
Machine Cap-Rel or Rental and Maintenance	6	0600
Salaries for Direct Patient Care	7	0700
Emp. Health and wel Bene for Direct Pat Care	8	0800
Drugs	9	0900
Supplies	10	1000
Laboratory	11	1100
Administrative and General	12	1200