4901.30 WORKSHEET S-2 - IDENTICATION DATA

The information reported on this worksheet is needed to properly identify the provider, who controls it, as well as, to provide information on its operations.

Line 1.--Enter the SNF street address and, if applicable, the post office box number.

Line 2.--Enter the SNF city, state, ZIP code, and, if applicable, county, in columns 1 through 4, respectively.

Line 3 through 8.--For each applicable line, enter the component name, CCN, core-based statistical area (CBSA) code for the physical location of the SNF, the rural/urban designation (R for rural or U for urban), Medicare certification date (if applicable), and Medicaid certification date (if applicable), in columns 1 through 7. If reporting a component name on line 8, column 2, enter the component type in column 1.

Descriptions for lines 3 through 7.--

Line 3.--This is an institution that meets the requirements set forth in 42 CFR 483.1 that has been issued a CCN indicating that it meets the requirements of §1819 of the Act.

Line 4.--This is an institution or distinct part of an institution that meets the requirements set forth in 42 CFR 483.5 that has been issued a separate identification number indicating that it meets the requirements of §1919 of the Act.

Line 5.--This is an institution or distinct part of an institution that meets the requirements set forth in 42 CFR 440.150 that has been issued a separate identification number indicating that it meets the requirements of §1905 of the Act.

Line 6.--This is a SNF-based HHA that has been issued a CCN and meets the requirements of §§1861(o) and 1891 of the Act.

Line 7.--This is a SNF-based hospice that has been issued a CCN and meets the requirements of §1861(dd) of the Act.

Line 8.--Other (specify).--For any component type not identified on lines 3 through 7, enter the required information in the appropriate column. Subscript this line accordingly to accommodate multiple SNF-based CORFs (lines 8.00-8.09), OPTs (lines 8.10-8.19), OOTs (lines 8.20-8.29) and OSPs (lines 8.30-8.39).

Line 9.--Enter the cost reporting period beginning date and the cost reporting period ending date in columns 1 and 2, respectively. In accordance with the regulations at 42 CFR 413.24(f), providers must submit periodic reports of operations which generally cover a consecutive 12-month period of operations. See CMS Pub. 15-2, chapter 1, §§102.1 through 102.3, for situations when you may file a short period cost report.

Line 10--In column 1, enter the type-of-control code from the list below that indicates the type of ownership or auspices under which the SNF operates.

1 = Voluntary Nonprofit, Church	8 = Governmental, City-County
2 = Voluntary Nonprofit, Other *	9 = Governmental, County
3 = Proprietary, Individual	10 = Governmental, State
4 = Proprietary, Corporation	11 = Governmental, Hospital District
5 = Proprietary, Partnership	12 = Governmental, City
6 = Proprietary, Other *	13 = Governmental, Other *
7 = Governmental, Federal	

*Where an "other" item is selected (column 1 equals 2, 6, or 13), specify type-of-control in column 2.

SNF ORGANIZATION AND OPERATION

Line 11.--Is the SNF a distinct part SNF that meets the requirements in 42 CFR 483.5? Enter Y or N.

Line 12.--Is the SNF a composite distinct part SNF that meets the requirements set forth in 42 CFR 483.5? Enter Y or N. If Y, complete line 13 and subscripts as needed.

Line 13.--If the response to line 12 is Y, enter the component name, street address, post office box number, city, state and ZIP code for the non-contiguous component in columns 1 through 6, respectively. For multiple non-contiguous component locations, subscript line 13 as needed to report each location.

Line 14.--Did the SNF terminate participation in the Medicare program? Enter Y or N in column 1. If column 1 is Y, enter the termination date in column 2, and enter V, for voluntary termination, or I, for involuntary termination, in column 3.

Line 15.--Did the SNF change ownership immediately prior to the beginning of this cost reporting period? Enter Y or N in column 1. If column 1 is Y, enter the date the change of ownership occurred in column 2. Submit documentation of the name and address of the new owner and a copy of the sales agreement with the cost report.

Line 16.--Is the SNF part of a home office/chain organization (HO/CO) as defined in CMS Pub. 15-1, chapter 21, §2150? Enter Y or N in column 1. If column 1 is Y, enter the number of HO/COs allocating cost to the SNF in column 2. If column 1 is Y and column 2 is greater than or equal to 1, complete line 17, and Worksheet A-8-1.

Lines 17.--If line 16, column 1 is Y, enter the HO/CO name, street address, post office box number (if applicable), city, state, ZIP code, HO/CO CCN, and HO/CO contractor number, in columns 1 through 8, respectively. If line 16, column 2, is greater than 1, subscript this line as needed to report each HO/CO allocating costs to the SNF.

Line 18.--Did the total number of available beds permanently maintained for lodging inpatients change from the prior cost reporting period? These beds must be available for use and be housed in patient rooms or wards (i.e., do not include beds in corridors or temporary beds). (See 42 CFR §412.105(b) and CMS Pub. 15-1, §2200.2.C.) Enter Y or N in column 1. If column 1 is Y, and the change resulted in an increase or decrease in the number of Medicare certified beds, submit with the cost report a copy of the approval from the Regional Office for a change in Medicare bed size required under CMS Pub. 15-1, §2337.2.

Line 19.--Did the SNF operate a ventilator care unit? Enter Y or N.

SNF OWNED SERVICES

Line 20.--Did the SNF and/or SNF-based HHA operate a Medicare approved laboratory with its own Clinical Laboratory Improvement Act (CLIA) number or CLIA certificate of waiver that meets the requirements in 42 CFR 493? Enter Y or N in column 1. If column 1 is Y, enter the CLIA number in column 2.

Line 21.--Did the SNF operate a radiological department that meets the standards required of a hospital furnishing such services under the program at 42 CFR 482.26 or the standards to provide portable x-ray services . Enter Y or N.

Line 22.--Did the SNF operate an institutional-based ambulance service. Enter Y or N in column 1. If column 1 is Y, enter the ambulance provider number in column 2.

Line 23.--Is the SNF involved in business transactions, including management contracts, with individuals or entities (e.g., drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships. Enter Y or N. If Y, submit with the cost report a list of the individuals, the organizations involved, and a description of the transactions.

Lines 24 through 28--Reserved for future use.

PROFESSIONAL SERVICES PURCHASED BY THE SNF

Line 29.--Did the SNF or its sub-providers (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter a Y or N. If column 1 is Y, were the majority of the expenses (i.e., greater than 50 percent of the total professional services expenses) for services purchased from an unrelated organization located outside of the SNF's local area labor market (CBSA)? In column 2, enter Y or N.

SNF-BASED HHA THERAPY COSTS

Line 31.--Did the SNF-based HHA contract with outside suppliers for physical therapy (PT) services (see CMS Pub. 15-1, chapter 14)? Enter Y or N.

Line 32.--Did the SNF-based HHA contract with outside suppliers for occupational therapy (OT) services (see CMS Pub. 15-1, chapter 14)? Enter Y or N.

Line 33.--Did the SNF-based HHA contract with outside suppliers for speech language pathology (SLP) services (see CMS Pub. 15-1, chapter 14)? Enter Y or N.

MEDICAL MALPRACTICE

Line 34.--Is the SNF legally required to carry malpractice coverage? Enter Y or N. Malpractice insurance premiums are money paid to a commercial insurer to protect against potential negligence claims made by patients/clients.

Line 35.--If line 34 is Y, is the malpractice insurance coverage a claims-made or an occurrence policy? Enter a 1 for a claims-made insurance policy that covered claims first made (reported or filed) during the year the policy was in force for any incidents that occurred that year or during any previous period that the insured was covered under contract. Enter a 2 for an occurrence insurance policy that covered an incident occurring while the policy was in force regardless of when the claim arising out of that incident was filed.

Line 36.--If line 34 is Y, enter the total amount of malpractice premiums paid in column 1, the total amount of paid losses in column 2, (paid losses is money paid to compensate a patient/client for professional negligence), and the total amount of self-insurance paid in column 3, (self-insurance is money paid by a SNF or SNF healthcare complex whom acts as its own insurance company; see §2162 of CMS Pub. PRM 15-1).

Line 37.--Are malpractice premiums and paid losses reported in other than the Administrative & General (A&G) cost center? Enter a Y or N. If Y, submit with the cost report a supporting schedule listing cost centers and amounts.

Lines 38 and 39.--Reserved for future use.

LOWER OF COST OR CHARGE EXEMPTION

Line 40.--Did the SNF qualify for exemption from the application of the lesser of cost or charge (see 42 CFR 413.13)? Enter Y in column 1 if the exemption applies for Medicare Part A and in column 2 if the exemption applies for Medicare Part B; otherwise, enter N.

Line 41.--If the complex includes a SNF-based HHA, did the SNF-based HHA qualify for exemption from the application of the lesser of cost or charge (see 42 CFR 413.13)? Enter a Y or N in column 1 if the exemption applies for Medicare Part A and in column 2 if the exemption applies for Medicare Part B. No response required if no SNF-based HHA.

Lines 42 through 49.--Reserved for future use.

FINANCIAL STATEMENTS

Line 50.--Were the financial statements prepared by a certified public accountant (CPA)? Enter Y or N in column 1. If the response is Y in column 1, enter "A" for audited, "C" for compiled, or "R" for reviewed in column 2. Submit with the cost report a complete copy of the financial statements (i.e., the independent public accountant's opinion, the statements themselves, and the footnotes) with the cost report. If the financial statements are not available for submission with the cost report, enter the date they will be available in column 3.

If column 1 is N, submit a copy of the SNF-prepared financial statements and written statements of significant accounting policy and procedure changes affecting Medicare reimbursement that occurred during the cost reporting period (or submit the changed accounting or administrative procedures manual in lieu of written statements of significant accounting policy and procedure changes).

Line 51.--Do the total expenses and total revenues reported on the cost report differ from those on the filed financial statements? Enter Y or N. If Y, submit a reconciliation with the cost report.

BAD DEBTS

Line 52.--Is the SNF seeking reimbursement for bad debts resulting from Medicare deductible and coinsurance amounts that are uncollectible from Medicare beneficiaries? (See 42 CFR 413.89, for the criteria for an allowable bad debt.) If Y, submit a completed Medicare Bad Debts Listing (see Exhibit 1 on page 49-22) to support the bad debts claimed. If the SNF complex includes a SNF-based HHA or SNF-based hospice, complete a separate Medicare Bad Debts Listing for the claimed bad debts of each.

Line 53.--If line 52 is yes, did the SNF bad debt collection policy change during this cost reporting period? Enter Y or N. If the response is Y, submit with the cost report a copy of the changed policy.

Line 54.--If line 52 is yes, did the SNF waive beneficiary deductibles and/or coinsurance? If Y, ensure that waived deductibles and/or coinsurance are not included on the Medicare Bad Debts Listing.

PS&R REPORT DATA

Line 55.--Is this cost report prepared using only the Provider Statistical & Reimbursement Report (PS&R) for Medicare Part A and Part B? For Part A, enter Y or N in column 1; and, if column 1 is Y, enter the paid-through date of the PS&R used to prepare the cost report in column 2. For Part B, enter Y or N in column 3; and, if column 3 is Y, enter the paid-through date of the PS&R used to prepare the cost report in column 4. Also, submit with the cost report a crosswalk of revenue codes and charges on the PS&R to the cost center groupings on the cost report.

Line 56.--Is this cost report prepared using the PS&R for totals and provider records for allocation for Medicare Part A and Part B? For Part A, enter Y or N in column 1; and, if column 1 is Y, enter the paid-through date of the PS&R used to prepare the cost report in column 2. For Part B, enter Y or N in column 3, and, if 3 is Y, enter the paid through date of the PS&R used to prepare the cost report in column 4. Also, submit with the cost report a crosswalk of revenue codes, departments and charges on the PS&R to the cost center groupings on the cost report. The crosswalk must include which revenue codes were allocated to each cost center. Supporting work papers must accompany this crosswalk to provide sufficient documentation as to the accuracy of provider records.

Line 57.--If you entered Y on either line 55 or 56, columns 1 and/or 3, were adjustments made to the PS&R data for additional claims that have been billed, but not included on the PS&R, used to file this cost report? Enter Y or N in columns 1 and 3. If either column 1 or 3 is Y, include a schedule that supports the adjustments made to the PS&R. This schedule must include totals consistent with the breakdowns on the PS&R and must include claims unprocessed or unpaid as of the paid-through date of the PS&R used to prepare the cost report.

Line 58.--If you entered Y on either line 55 or 56, columns 1 and/or 3, were adjustments made to the PS&R data for corrections of other PS&R information? Enter Y or N in columns 1 and 3. If either column 1 or 3 is Y, submit a detailed explanation and documentation that provides an audit trail from the PS&R to the cost report.

Line 59.--If you entered Y on either line 55 or 56, columns 1 and/or 3, indicate whether other adjustments were made to the PS&R data. Enter Y or N in columns 1 and 3. If either column 1 or 3 is Y, include a description of the other adjustments and documentation that provides an audit trail from the PS&R to the cost report.

Line 60.--If the cost report was prepared using only provider records for Part A, enter Y in column 1; otherwise, enter N. If the cost report was prepared using only provider records for Part B, enter Y in column 3; otherwise, enter N. If column 1 or column 3 is Y, submit with the cost report detailed documentation of the system used to support the data reported on the cost report. If detailed documentation was previously supplied, submit updated documentation only (if any).

Detailed documentation must include, at a minimum, the following:

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

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

- Reconciliation of remittance totals to provider records.
- The name of the system used and indicate how the system was maintained (vendor or provider). If the provider maintained the system, include date of last software update.

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

Lines 61 through 69.--Reserved for future use.

COST REPORT PREPARER INFORMATION

Line 70.--Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.

Line 71.--Enter the employer/company name of the cost report preparer.

Line 72.--Enter the cost report preparer's contact information. Enter the telephone number in column 1 and email address in column 2.

EXHIBIT 1
LISTING OF MEDICARE BAD DEBTS AND APPROPRIATE SUPPORTING DATA
INSTRUCTIONS AND FORM

Exhibit 1 requires the following information: Enter the provider name, CCN, sub-provider CCN (if applicable), cost reporting period (CRP) beginning and ending dates, whether the listing represents Medicare bad debts for inpatient or outpatient services, the name of the preparer, the date prepared, the total of Medicare allowable bad debts (sum of column 15), and the total of dual-eligible Medicare bad debts (sum of amounts entered in column 15 where column 6 has an entry).

Columns 1, 2, 3, 4, and 5.--From the Medicare beneficiary's bill, enter the beneficiary's name, dates of service, and MBI or HICN, that correlate to the claimed bad debt. (See 42 CFR 413.89(f).)

Column 6.--Enter the Medicare beneficiary's Medicaid number if the beneficiary was dually eligible (eligible for Medicare and some category of Medicaid benefits). If there is an entry in this column, there must be an entry in column 9.

Column 7.--Enter "Y" if the Medicare beneficiary was not eligible for Medicaid but the provider deemed them to be indigent; otherwise, enter N for no. (See 42 CFR 413.89(e)(2)(ii).)

Column 8.--Enter the Medicare remittance advice date for the Medicare beneficiary information in columns 1 through 5.

Column 9.--Enter the Medicaid remittance advice date or, when the provider does not receive a Medicaid remittance advice, enter "AD" for alternate documentation used to determine state liability (42 CFR 413.89(e)(2)(iii)(B)), that corresponds to the Medicare beneficiary information in columns 1 through 6.

Column 10.--Enter the date that the first bill was sent to the Medicare beneficiary. If the beneficiary is a QMB, enter "QMB."

Column 11.--Enter the date all collection efforts ceased, both internal and external, including efforts to collect from Medicaid and/or from a state for its cost sharing liability.

Column 12.--Enter the Medicare deductible from the Medicare remittance advice (before any payments received from any party). Report deductible amounts only when the provider billed the patient with the expectation of payment. See 42 CFR 413.89(e)(2) for possible exception.

Column 13.--Enter the Medicare coinsurance amount from the Medicare remittance advice (before any payments received from any party). Report coinsurance amounts only when the provider billed the patient with the expectation of payment. See 42 CFR 413.89(e)(2) for possible exception.

Column 14.--Enter the date the uncollected deductible and coinsurance amounts were written off as a Medicare bad debt. In order to be considered written off for Medicare purposes, the amount must be written off as a bad debt in the provider's own accounting system, all collection effort against the patient or other third parties (internal and external) must have ceased, and a valid Medicaid RA must have been received from the State for Medicaid beneficiaries.

Column 15.--Enter the allowable Medicare bad debt amount. This amount must be less than or equal to the sum of the amounts in columns 11 and 12 less any payments received from the beneficiary.

Column 16.--This column is for informational purposes. Enter any comments or additional information as needed.

EXHIBIT 1

TITLE	MEDICARE BAD DEBTS LISTING
PROVIDER NAME	
CCN	
SUBPROVIDER CCN	
CRP BEGINNING DATE	
CRP ENDING DATE	
INPATIENT / OUTPATIENT	
PREPARED BY	
DATE PREPARED	
TOTAL COLUMN 15	
TOTAL DUAL ELIGIBLE	

PATIENT LAST NAME	PATIENT FIRST NAME	DATE OF SERVICE FROM	DATE OF SERVICE TO	MBI OR HICN	MEDICAID NUMBER	PROVIDER DEEMED INDIGENT	MEDICARE REMITTANCE ADVICE DATE
1	2	3	4	5	6	7	8

MEDICAID REMITTANCE ADVICE DATE	DATE FIRST BILL SENT TO BENEFICIARY	DATE COLLECTION EFFORT CEASED	MEDICARE DEDUCTIBLE AMOUNT	MEDICARE COINSURANCE AMOUNT	MEDICARE WRITE-OFF DATE	ALLOWABLE BAD DEBT AMOUNT	COMMENTS
9	10	11	12	13	14	15	16