

This table contains the Worksheet Indicators that are to be used with SNF data submissions extracted from the HCFA 2540-96. A Worksheet Indicator is provided only for those worksheets from which data are to be extracted.

The Worksheet Indicator consists of seven digits. The first three digits (positions 2-4) indicate the worksheet. The fourth digit (position 5) represents the type of provider, as listed below. The fifth and sixth digits (positions 6-7) represent worksheets required by a Federal Program (18=Title XVIII, 19=Title XIX). The seventh digit (position 8) represents the worksheet part.

Provider Type - Fourth Digit of the Worksheet Identifier

Universal	0	(Zero)
SNF	A	
NF	B	
ICF/MR	I	
CMHC	C	
CORF	D	
OPT	E	
OOT	F	
OSP	G	
Physical Therapy	P*	
Speech Therapy	S*	
Occupational Therapy	O*	
Respiratory Therapy	R*	

* For use with Worksheet A-8-5.

Worksheet	Part	Worksheet Indicator
S	Part 0	S000000 (s)
S	Part II	S000002 (s)
S-2		S200000 (s)
S-3	Part I	S300001 (s)
	Part II	S300002 (s)
	Part III	S300003 (s)
S-4	Part I	S410001 (a)
	Part II	S410002 (a)
	Part III	S410003 (a)

Note: WS S-4, Part III is effective for services rendered on or after October 1, 2000.

S-5	S51R000 (c)	R = RHC
	S51Q000 (c)	Q = FQHC

Note: WS S-5 is effective for services rendered on or after January 1, 1998.

S-6	S61C000 (b)
	S61D000 (b)
	S61E000 (b)
	S61F000 (b)
	S61G000 (b)

Worksheet	Part	Worksheet Indicator				
S-7	Part I	S700001				
	Part II	S700002				
	Part III	S700003	(s)			
	Part IV	S700004	(s)			
<p>Note: WS S-7, Parts II & III are effective for cost reporting periods beginning on or after July 1, 1998. WS S-7 Part IV is effective for cost reporting periods ending on and after February 28, 2001.</p>						
S-8		S810000	(d)			
A		A000000	(s)			
A-7		A700000	(s)			
A-8		A800000	(s)			
A-8-1	Part A	A81000A	(s)			
	Part B	A81000B	(s)			
	Part C	A81000C	(s)			
A-8-2		A820000				
A-8-3	Part I	A830001				
	Part II	A830002				
	Part III	A830003				
	Part V	A830005				
	Part VI	A830006				
	Part VII	A830007				
A-8-4	Part I	A840001				
	Part II	A840002				
	Part III	A840003				
	Part IV	A840004				
	Part V	A840005				
A-8-5	Part I	A85P001	A85S001	A85O001	A85R001	(s)
	Part II	A85P002	A85S002	A85O002	A85R002	(s)
	Part III	A85P003	A85S003	A85O003	A85R003	(s)
	Part V	A85P005	A85S005	A85O005	A85R005	(s)
	Part VI	A85P006	A85S006	A85O006	A85R006	(s)
	Part VII	A85P007	A85S007	A85O007	A85R007	(s)

Note: For all therapy services provided by outside suppliers on or after April 10, 1998, Worksheet A-8-5 will be used to determine reasonable costs. The Worksheet Indicator will have a P, S, O, or R in the fourth position. A separate worksheet will be used for each therapy service.

Worksheet	Part	Worksheet Indicator		
B	Part I	B000001		
B	Part II	B000002		
B	Part III	B000003	(s)	
B-1		B100000		
B-1	Part II	B100002	(s)	
C		C000000	(s)	
D	Part I	D00A181	(s)	D00A191 (s) D00B191 (s) D00I191 (s)
D	Part II	D00A182	(s)	D00A192 (s)
D	Part III	D00A183		

Note: Worksheet D, Part III is effective for cost reporting periods beginning on or after July 1, 1998.

D-1		D10A180		D10A190 D10B190
D-1	Part I	D10A181		D10A191 D10B191 D10I191
D-1	Part II	D10A182		

Note: Worksheet D-1, Part II, and the part numbers are effective for cost reporting periods beginning on or after July 1, 1998.

D-2	Part I	D200001		
	Part II	D200002		
E	Part I	E00A181		E00A191 E00B191 E00I191
E	Part II	E00A182		
E	Part III	E00A183	(s)	E00A193 (s)
E	Part V	E00A185		

Worksheet	Part	Worksheet Indicator	
E-1		E10A180	(s)
G		G000000	(s)
G-2	Part I	G200001	(s)
	Part II	G200002	(s)
G-3		G300000	(s)
H		H010000	(a)
H-1		H110000	(a)
H-2		H210000	(a)
H-3		H310000	(a)
H-4	Part I	H410001	(a)
	Part II	H410002	(a)
H-5		H510100	(a)
<p>Note: For cost reporting periods beginning on or after October 1, 1997, HHA services are reimbursed on the basis of geographic location identified by MSA Code. It becomes necessary to repeat Lines 1-14 and Columns 4-6, 8, 9, 11 and 11.01 for each MSA Code. Also note that H-5 contains an indicator for multiple (up to 99) MSA Codes. The fourth and fifth positions are used for this indicator. One MSA will have a "1" in the fifth position. Double digit MSA Codes will utilize the fourth and fifth positions.</p>			
H-6	Part II	H610002	(a)
H-7		H710000	(a)
I-1		I11R000 *	(c)
		I11Q000 **	(c)
I-2		I21R000 *	(c)
		I21Q000 **	(c)
I-3		I31R180 *	(c)
		I31Q180 **	(c)
		I31R190 *	(c)
		I31Q190 **	(c)
I-4		I41R000 *	(c)
		I41Q000 **	(c)

Worksheet	Part	Worksheet Indicator
I-5		I51R180 * (c) I51Q180 ** (c)

* R=Rural Health Clinic (RHC)

** Q=Federally Qualified Health Clinic (FQHC)

Worksheet I series is effective for services beginning on or after January 1, 1998. If there is more than one RHC and /or FQHC, a separate worksheet is required for each facility.

J-1, Part I	J11C001 * (b)
	J11D001 * (b)
	J11E001 * (b)
	J11F001 * (b)
	J11G001 * (b)

J-2, Part I	J21C001 * (b)
	J21D001 * (b)
	J21E001 * (b)
	J21F001 * (b)
	J21G001 * (b)

J-2, Part II	J21C002 * (b)
	J21D002 * (b)
	J21E002 * (b)
	J21F002 * (b)
	J21G002 * (b)

J-2, Part III	J21C003 * (b)
	J21D003 * (b)
	J21E003 * (b)
	J21F003 * (b)
	J21G003 * (b)

Note: Worksheet J-2, Part III is effective for services rendered on or after January 1, 1998.

Note: Worksheet J-3 is effective for cost reporting periods ending prior to January 1, 1998. Worksheet J-3, Part I is used only for Title 19, for cost reporting periods ending after January 1, 1998. Worksheet J-3, Parts II and III are effective for Title 18 services rendered for cost reporting periods beginning on or after January 1, 1998, and cost reporting periods beginning prior to and ending after January 1, 1998.

J-3	Part I	J31C001 (b)
		J31D001 (b)
		J31E001 (b)
		J31F001 (b)
		J31G001 (b)

Worksheet	Part	Worksheet Indicator	
J-3	Part II	J31D182 *	(b)
		J31E182 *	(b)
		J31F182 *	(b)
		J31G182 *	(b)
J-3	Part III	J31D183 *	(b)
		J31E183 *	(b)
		J31F183 *	(b)
		J31G183 *	(b)
J-4		J41C000	(b)
		J41D000	(b)
		J41E000	(b)
		J41F000	(b)
		J41G000	(b)
K		K010000	(d)
K-1		K110000	(d)
K-2		K210000	(d)
K-3		K310000	(d)
K-4	Part I	K410001	(d)
	Part II	K410002	(d)
K-5	Part I	K510001	(d)
	Part II	K510002	(d)
	Part III	K510003	(d)
K6		K610000	(d)

Note: Effective for cost reporting periods beginning on and after April 1, 1999, cost reporting is required for provider-based hospices. Worksheet S-8 and the K series worksheets are utilized for the SNF-based hospice.

FOOTNOTES:

(a) For multiple SNF-based Home Health Agencies, the third digit of the Worksheet Indicator (position 4 of the record) is numeric from 1 to 5 to accommodate up to 5 SNF-based HHAs. If there is only one HHA, the default is 1. This affects Worksheet S-4, Parts I, II, III and the H series.

(b) For multiple SNF-based Outpatient Providers (CORF, CMHC, OPT, OOT, and OSP), the third digit of the Worksheet Indicator (position 4 of the record) is numeric from 1 to 9 to accommodate up to 9 SNF-based providers. If there is only one Outpatient Rehab, the default is 1. This affects Worksheet S-6 and the J series.

(c) For multiple SNF-based Rural Health Clinics (RHC) and Federally Qualified Health Clinics (FQHC), the third digit of the Worksheet Indicator (position 4 of the record) is numeric from 1 to 9 to accommodate up to 9 SNF-based providers. If there is only one clinic, the default is one. This affects Worksheet S-5 and the I series worksheets.

(d) For multiple SNF-based Hospices, the third digit of the Worksheet Indicator (position 4 of the record) is numeric from 1 to 5 to accommodate up to 5 SNF-based providers. If there is only one Hospice, the default is 1. This affects Worksheet S-8 and the K series worksheets.

(s) For worksheets used by SNF under the "Simplified Method", if applicable. Effective for cost reporting periods beginning on or after April 1, 1999. SNFs that were eligible to use Form 2540S-97 will now use Form 2540-96, completing only the identified worksheets.

Specifications for the Form CMS 2540-96 10/1/2003
Table 3 - Cost Report Data Specifications - Transmittal 13

Worksheet S				
Description	Lines	Columns	Field Size	Usage
<u>Part O</u>				
Date Cost Report Received from the Provider MM/DD/YY	1	2	8	x
<u>Part II</u>				
Balance Due Provider or (Program) by Component and in Total:				
Title V	7	1	9	-9
Title XVIII Part A	1,4,7	2	9	-9
Title XVIII Part B	1,4,5,6,7	3	9	-9
Title XIX	7	4	9	-9
Worksheet S-2				
Description	Lines	Columns	Field Size	Usage
Skilled Nursing Facility (SNF) and Complex Address:				
Street	1	1	36	x
P O Box	1	3	9	x
City	2	1	36	x
State	2	2	2	x
Zip Code	2	3	10	x
County	3	1	36	x
MSA Code	3	2	4	x
<i>CBSA Code</i>	<i>3</i>	<i>2.01</i>	<i>5</i>	<i>x</i>
Urban/Rural - U/R	3	3	1	x
Facility Specific Rate	3.1	1	9	9(6).9(2)
Transition Period	3.1	2	3	9
Wage Index Factor:				
Prior to October 1	3.2	1	9	9(4).9(4)
After September 30	3.2	2	9	9(4).9(4)
For the Skilled Nursing Facility:				
Name	4	1	36	x
Provider Number (xxxxxx)	4	2	6	x
Certification Date MM/DD/YY	4	3	8	x
Payment System - Title XVIII	4	5	1	x
Payment System - Title XIX	4	6	1	x
For the Nursing Facility:				
Provider Number (xxxxxx)	6	2	6	x
Certification Date MM/DD/YY	6	3	8	x
Payment System - Title XIX	6	6	1	x
For the ICF/MR:				
Provider Number (xxxxxx)	6.1	2	6	x
Certification Date MM/DD/YY	6.1	3	8	x
Payment System - Title XIX	6.1	6	1	x
For the SNF-Based HHA:				
Provider Number (xxxxxx)	8	2	6	x
Certification Date MM/DD/YY	8	3	8	x
Payment System - Title XVIII	8	5	1	x
Payment System - Title XIX	8	6	1	x
For the SNF-Based Outpatient Rehab Facilities, each CORF, CMHC, OPT, OOT, OSP:				

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Provider Number (xxxxxx)	10	2	6	x
Certification Date MM/DD/YY	10	3	8	x
Payment System -Title XVIII	10	5	1	x
Payment System -Title XIX	10	6	1	x
For the SNF-Based RHC:				
Provider Number (xxxxxx)	11	2	6	x
Certification Date MM/DD/YY	11	3	8	x
Payment System - Title XVIII	11	5	1	x
Payment System - Title XIX	11	6	1	x
For the SNF-Based Hospice:				
Provider Number (xxxxxx)	12	2	6	x
Certification Date MM/DD/YY	12	3	8	x
Type of Control (see Table 3A)	14	1	2	9
Type of Free-Standing SNF (indicate with Y/N):				
Entirely Participating SNF	15	1	1	x
Staffing %	15.01	1	6	9(3).99
Recruitment %	15.02	1	6	9(3).99
Retention %	15.03	1	6	9(3).99
Training %	15.04	1	6	9(3).99
Staffing (Y/N)	15.01	2	1	x
Recruitment (Y/N)	15.02	2	1	x
Retention (Y/N)	15.03	2	1	x
Training (Y/N)	15.04	2	1	x
Other (Text as needed for blank line)	15.05-15.20	0	36	x
Other %	15.05-15.20	1	6	9(3).99
Other (Y/N)	15.05-15.20	2	1	x
Partially Participating SNF	16	1	1	x
SNF Unit of Domiciliary Institution	17	1	1	x
SNF of Rehab Center	18	1	1	x
Other (Specify)	19	1	36	x
If this is an All-Inclusive Provider Enter (A,B,E)	21	1	1	x
Is the difference between total interim payments and the net cost of covered services included in the balance sheet? Y/N				
	22	1	1	x
Depreciation Reported in this Cost Report:				
Straight Line	23	2	9	9
Declining Balance	24	2	9	9
Sum of Year's Digits	25	2	9	9
Total (Sum of Lines 23-25)	26	2	9	9
If Depreciation is Funded, Year-End Balance	27	2	9	9
Were Assets Disposed of During Period? Y/N	28	1	1	x
Was Accelerated Depreciation claimed on any Asset in the Current or Prior Reporting Period? Y/N	29	1	1	x
Was Accelerated Depreciation claimed on any Asset Acquired on or After August 1, 1970? Y/N	30	1	1	x
Did you cease to participate in the Medicare Program at the end of this period? Y/N	31	1	1	x
Was there substantial decrease in health insurance proportion of allowable costs from prior periods? Y/N	32	1	1	x

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If this facility contains a public or non-public provider that qualifies for exception of the lower of cost or charges, enter "Y" for each component and type of service that qualifies for the exemption: Enter "Y" in Col 1 for Part A, Col 2 for Part B:				
SNF - Part A	33	1	1	x
SNF - Part B	33	2	1	x
Nursing Facility Other	35	3	1	x
ICF/MR Other	35.1	3	1	x
SNF-Based OLTC Part A	36	1	1	x
SNF-Based OLTC Part B	36	2	1	x
SNF-Based HHA Part A	37	1	1	x
SNF-Based HHA Part B	37	2	1	x
SNF-Based OP Rehab Facility Part B	39	2	1	x
SNF-Based RHC Part A	40	1	1	x
SNF-Based RHC Part B	40	2	1	x
Is this SNF exempt from cost limits? Y/N	41	1	1	x
Is this NF exempt from cost limits? Y/N	42	1	1	x
Is this SNF located in a state that certifies the provider as a SNF regardless of level of care for Titles V & XIX patients? Y/N	43	1	1	x
Did provider participate in NHCQM Demo during the cost reporting period? If yes, enter Phase #	44	1	1	9
Malpractice Premiums and Paid Losses:				
Premiums	45	1	9	9
Paid Losses	45	2	9	9
Self Insurance	45	3	9	9
Are malpractice premiums and paid losses reported in other than A & G cost centers? Y/N (If yes, submit supporting schedules.)	46	1	1	x
Are you claiming Ambulance costs? Y/N	47	1	1	x
If Col 1 is yes, enter in Col 2 if this is the first year for providing ambulance services. Y/N	47	2	1	x
If Line 47, Col 1 is yes, enter in Column 1 the payment limit provided by your intermediary.	48	1	9	9(6).99
If your fiscal year is other than beginning on October 1st, enter in Col 1 the payment limit for the period prior to October 1st, and enter in Col 2 the payment limit for the period beginning October 1st.	48	2	9	9
Ambulance Payment Limit	48.01-48.03	1	9	9(6).99
Ambulance Fee Amount	48.01-48.03	2	9	9
Did you operate an ICF/MR under Title XIX? Y/N	49	1	1	x
Did this facility report less than 1500 Medicare days in previous year cost report? Y/N	50	1	1	x
If Line 50 is Yes, did you file previous year cost report using "Simplified Method" ? Y/N	51	1	1	x
Is this cost report filed using the "Simplified Method" of cost finding? Y/N	52	1	1	x
Worksheet S-3				
Description	Lines	Columns	Field Size	Usage
Part 1				

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Table 3 - Cost Report Data Specifications - Transmittal 13

For SNF, NF, OLTC, HHA, OP Rehab, and Hospice, in Total for each and in Total for Facility:				
Number of Beds	1,3,3.1,4,8,9	1	9	9
Bed Days Available	1,3,3.1,4,8,9	2	9	9
Title V Inpatient Days	1,3,8,9	3	9	9
Title XVIII Inpatient Days	1,8,9	4	9	9
Ambulance Trips	10-10.03	4	9	9
Title XIX Inpatient Days	1,3,3.1,8,9	5	9	9
Other Inpatient Days	1,3,3.1,4,8,9	6	9	9
Total Inpatient Days	1,3,3.1,4,8,9	7	9	9
Title V Discharges	1,3,8,9	8	9	9
Title XVIII Discharges	1,8,9	9	9	9
Title XIX Discharges	1,3,3.1,8,9	10	9	9
Other Discharges	1,3,3.1,4,8,9	11	9	9
Total Discharges	1,3,3.1,4,8,9	12	9	9
Title V Average Length of Stay	1,3,8,9	13	9	9(6).99
Title XVIII Average Length of Stay	1,8,9	14	9	9(6).99
Title XIX Average Length of Stay	1,3,3.1,8,9	15	9	9(6).99
Total Average Length of Stay	1,3,3.1,4,8,9	16	9	9(6).99
Title V Admissions	1,3,8,9	17	9	9
Title XVIII Admissions	1,8,9	18	9	9
Title XIX Admissions	1,3,3.1,8,9	19	9	9
Other Admissions	1,3,3.1,4,8,9	20	9	9
Total Admissions	1,3,3.1,4,8,9	21	9	9
Employees on Payroll - FTEs	1,3-5,7-9	22	9	9(6).99
Nonpaid Workers	1,3-5,7-9	23	9	9(6).99
Part II				
SNF Wage Index Information:				
Direct Salaries	1-8,10-24	1	9	9
Reclass of Salaries	2-6,8,10-15, 17-21,24	2	9	-9
Adjusted Salaries	1-8,10-24	3	9	9
Paid Hours Related to Salaries	1-8,10- 18,23,24	4	9	9(7).99
Average Hourly Wage	1-8,10- 18,23,24	5	9	9(6).9(2)
Wage Related Cost Percentage	22	5	9	9(4).9(4)
Part III				
Overhead Costs-Direct Salaries:				
Direct Overhead Salaries	1-14	1	9	9
Reclass of Salaries	1-14	2	9	-9
Adjusted Salaries	1-14	3	9	9
Paid Hours Related to Salaries	1-14	4	9	9(7).99
Average Hourly Wage	1-14	5	9	9(6).9(2)
Worksheet S-4				
Description	Lines	Columns	Field Size	Usage
Part I				
Number of HHA Visits, by Discipline, and by Total:				
Title XVIII	1-6,8	2	9	9
Total	1-8	8	9	9
Patient Count by Discipline:				

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Title XVIII	1-6	3	9	9
Other	1-7	6	9	9
Total	1-7	9	9	9
Home Health Aide Hours:				
Title XVIII	6	1	9	9
Total	6	7	9	9
Unduplicated Census Count:				
Full Cost Reporting Period	9	3,6,9	9	9(8).99
Pre October 1, 2000	9.01	3,6,9	9	9(8).99
Post September 30, 2000	9.02	3,6,9	9	9(8).99
Part II				
Number of Hours in Normal Work Week	1	0	9	9(3).99
Number of FTEs:				
Staff	1-15	1	9	9(3).99
Contract	1-15	2	9	9(3).99
Total	1-15	3	9	9(3).99
Employment Category-Specify	13,14	0	36	x
How many MSAs were serviced for the report period?	16	1	9	9
List MSA Codes serviced for the Period	17	1	4	x
Note: Line 17 is for the 1st code. Subscript Line 17 as 17.01, 17.02, etc for more than 1 code.				
Part III				
PPS Activity Data (Applicable for services rendered on and after October 1, 2000):				
Visits	1,3,5,7,9,11	1-6	9	9
Charges	2,4,6,8,10,12, 14,18	1-6	9	9
Episodes	16	1,3-6	9	9
Outlier Episodes	17	2,4-6	9	9
Worksheet S-5				
Description	Lines	Columns	Field Size	Usage
For cost reporting periods beginning on or after 10/01/97:				
For SNF-Based RHC and/or FQHC:				
Street	1	1	36	x
County	1	2	36	x
City	2	1	36	x
State	2	2	36	x
Zip Code	2	3	10	x
FQHC only - Rural=R, Urban, = U	3	1	1	x
Grant Award-Community Health Center	4	1	9	9
Date of Award-Comm Health Ctr MM/DD/YY	4	2	8	x
Grant Award-Migrant Health Center	5	1	9	9
Date of Award-Migrant Health Ctr MM/DD/YY	5	2	8	x
Grant Award-Health Services for Homeless	6	1	9	9
Date of Award-Services for Homeless MM/DD/YY	6	2	8	x
Grant Award-Appalachin Regional Commission	7	1	9	9
Date of Award-Appalachin Reg Comm MM/DD/YY	7	2	8	x
Grant Award-Look Alikes	8	1	9	9
Date of Award-Look Alikes MM/DD/YY	8	2	8	x
Grant Awards-Other	9	1	9	9

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Table 3 - Cost Report Data Specifications - Transmittal 13

Date of Awards-Other MM/DD/YY	9	2	8	x
* Physician(s) furnishing services at clinic or under agreement - Name of Physician(s)	10-10.10	1	36	x
* Physician(s) Billing Number	10-10.10	2	10	x
* Supervising Physician(s) - Name	11-11.10	1	36	x
Hours of Supervision	11-11.10	2	9	9(3).99
Note: *Lines 10 and 11 can be subscripted as 10.01, 10.02, 10.03, 11.01, 11.02, etc.				
Does facility operate other than RHC/FQHC? Y/N	12	1	1	x
If Yes, enter number of other operations in Column 2	12	2	9	9
Hours of Operation:				
Clinic	13	1-14	4	x
Other-Type of Operation	13.01	0	36	x
Other-Hours of Operation	13.01	1-14	4	x
Note: For more than one "Other" type of operation, continue Line 13.01 as 13.02, 13.03, etc.				
Have you received approval for exception to the productivity standard? Y/N	14	1	1	x
Is this a consolidated report in accordance with HCFA Pub 27, Sec 508D? Y/N	15	1	1	x
If Line 15, Column 1 is Y, enter in Column 2 the number of providers in this report.	15	2	2	9
If Line 15, Column 2 is completed, list provider name	15.01	1	36	x
If Line 15, Column 2 is completed, list provider number	15.01	2	6	x
Note: If more than one provider is indicated in Line 15, Col 2, Line 15.01 is to be further subscripted as 15.02, 15.03, etc.				
Have you provided all GME costs? Y/N	16	1	1	x
If Line 16, Column 1 is Y, enter in Column 2 the number of Medicare visits performed by I & Rs	16	2	9	9
Worksheet S-6				
Description	Lines	Columns	Field Size	Usage
Number of Hours in Normal Work Week	1	0	9	9(3).99
Number of Full-Time Equivalent Employees:				
Staff	1-19	1	9	9(3).99
Contract	1-19	2	9	9(3).99
Worksheet S-7				
Description	Lines	Columns	Field Size	Usage
<u>Part I</u>				
NHCMQ Demonstration Statistical Data for SNFs in the States of Kansas, Maine, Mississippi, New York, South Dakota and Texas that are participating in the demo:				
Rate	1-45	3,4	9	9(6).9(2)
Days	1-46	3.01,4.01	9	9
Amount	1-46	5	9	9
<u>Part II</u>				
For cost reporting periods beginning on or after July 1, 1998, PPS Statistical Data:				
Medicare Days	1-46	3	9	9
<u>Part III</u>				
For Transition Periods beginning on or after July 1,1998:				
Transition Period Years 1-4	0	1-4	1	x
Facility Specific Rate	1-45	2,8	9	9(6).9(2)

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Federal Case Mix Rates	1-45	3,5,7	9	9(6).9(2)
Days	1-45,75	4,6	9	9
PPS Reimbursement	1-45	9,10	9	9(6).9(2)
For Periods Beginning on or After 04/01/00:				
Federal Case Mix Rates	7,10,11,15-26	3.01,5,01	9	9(6).9(2)
Days	7,10,11,15-26	4.01,6.01	9	9
Part IV				
Rate	1-3 ,3.01, 3.02, 4-6, 6.01, 6.02, 7-9, 9.01, 9.02, 10-12, 12.01, 12.02, 13-14, 14.01, 15-45	3, 4, 4.02	9	9(6).9(2)
Days	1-3 ,3.01, 3.02, 4-6, 6.01, 6.02, 7-9, 9.01, 9.02, 10-12, 12.01, 12.02, 13-14, 14.01, 15-46	3.01, 4.01, 4.03, 5	9	9
High Cost RUGs-Days	7,10,11,15- 26,46	4.05	9	9
Worksheet S-8				
Description	Lines	Columns	Field Size	Usage
Number of Unduplicated Days, by Enrollment and Total:				
Unduplicated Medicare Days	1-5	1	9	9
Unduplicated Medicaid Days	1-5	2	9	9
Unduplicated SNF Days-Title 18	1-5	3	9	9
Unduplicated NF Days-Title 19	1-5	4	9	9
Other Unduplicated Days	1-5	5	9	9
Total Unduplicated Days	1-5	6	9	9
Number of Patients-Hospice-by Title				
Total Number of Unduplicated Continuous Care Hours Billable to Medicare	7	1,3	9	9(8).99
Average Length of Stay	8	1-6	9	9(6).99
Unduplicated Census Count	9	1-6	9	9
Worksheet A				
Description	Lines	Columns	Field Size	Usage
Line Labels and Cost Center Codes-Table 4, are for use with Type 2 Records only.	1-14,16,18, 18.1,19, 21- 32,34,35, 37- 47, 47.1-50,52- 55, 58-62	0	36	x
Direct Salaries by Department	3-16,18,18.1, 19,21-47,47.1- 52,54-63	1	9	-9
Total Direct Salaries	75	1	9	-9

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Other Direct Costs by Department	1-16,18,18.1, 19,21-47,47.1- 63	2	9	-9
Total Other Direct Costs	75	2	9	-9
Reclassifications by Department	1-16,18,18.1, 19,21-47,47.1- 63	4	9	-9
Total Reclassifications	75	4	9	-9
Adjustments to Expenses by Department	1-16,18,18.1, 19,21-47,47.1- 63	6	9	-9
Total Adjustments	75	6	9	-9
Worksheet A-7				
Description	Lines	Columns	Field Size	Usage
For Land, Land Improvements, Buildings and Fixtures, Building Improvements, Fixed Equipment, Moveable Equipment and in Total:				
Beginning Balances	1-7	1	9	9
Purchases	1-7	2	9	9
Donations	1-7	3	9	9
Disposals and Retirements	1-7	5	9	9
Worksheet A-8				
Description	Lines	Columns	Field Size	Usage
Adjustments to Expenses:				
Amount of Adjustment	1,8,9,11,12, 14,15,21, 28- 30	2	9	-9
Total	32	2	9	-9
Worksheet A-8-1				
Description	Lines	Columns	Field Size	Usage
<u>Part A</u>				
Any related organization costs included on Wksht A? Y/N	1	1	1	x
<u>Part B</u>				
Costs incurred and adjustments required as a result of transactions w/related organizations:				
Worksheet A Line Number	1-29	1	4	9
Expense Items	1-29	3	36	x
Expense Amount	1-29	4	9	-9
Amount Allowable in Costs	1-29	5	9	-9
Adjustments	1-29	6	9	-9
Totals	30	4-6	9	-9
<u>Part C</u>				
For each related organization:				
Type of Interrelationship (A-G)	1-30	1	1	x
Specify if Type G	31	0	36	x
Name of Individual or Organization	1-30	2	36	x
Percentage of Ownership of Provider	1-30	3	6	9(3).99
Name of Related Organization	1-30	4	36	x

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Percent Ownership of Related Organization	1-30	5	6	9(3).99
Type of Business	1-30	6	36	x
Worksheet A-8-2				
Description	Lines	Columns	Field Size	Usage
For each facility, total physician remuneration, fringe benefits, unadjusted and adjusted RCE limits, and total provider-based physician disallowance	75	3-5,7,8, 12-17	9	9
Worksheet A-8-3				
Description	Lines	Columns	Field Size	Usage
Reasonable cost determination for Physical Therapy, Speech Pathology and Occupational Therapy services provided prior to April 1, 1998:				
<u>Part I</u>				
Total number of weeks worked	1	1	9	9
Line 1 times 15 hours per week	2	1	9	9
Number of unduplicated days supervisor or therapist was on provider site	3	1	9	9
Number of unduplicated days therapy assistant was on provider site without supervisor or therapist	4	1	9	9
Number of unduplicated HHA visits-supervisor therapist	5	1	9	9
Number of unduplicated HHA visits-therapy assistant	6	1	9	9
Total hours worked by supervisors, therapists, assistants and aides	9	1-4	9	9
Adjusted hourly salary equivalency amount	10	1-4	9	9(6).9(2)
Number of travel hours	12	1-3	9	9
Number of miles driven	13	1-3	9	9
<u>Part II</u>				
Total Allowance Amount	19	1	9	9
Weighted Average Rate	20	1	9	9(6).9(2)
Weighted Allowance	21	1	9	9
Total Salary Equivalency	22	1	9	9
<u>Part III</u>				
Standard Travel Allowance For:				
Therapists	23	1	9	9
Assistants	24	1	9	9
Standard Travel Expense	26	1	9	9
Total Standard Travel Allowance and Travel Expense at Provider Site	27	1	9	9
<u>Part V</u>				
Overtime Hours Worked	39	1-3	9	9
Standard Work Year for One Employee	43	1-3	9	9(6).9(2)
Overtime Allowance	48	1-3	9	9
<u>Part VI</u>				
Travel Allowance and Expense	51	1	9	9
Equipment Cost	53	1	9	9
Supplies	54	1	9	9
Total Cost of Outside Supplier Service	56	1	9	9
Excess Cost Over Limitations	57	1	9	9
<u>Part VII</u>				

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Cost of Outside Suppliers - SNF	58	1	9	9
Cost of Outside Suppliers - HHA	59	1	9	9
Excess Cost Over Limitations - SNF	63	1	9	9
Excess Cost Over Limitations - HHA	64	1	9	9
Worksheet A-8-4				
Description	Lines	Columns	Field Size	Usage
<u>Part I</u>				
Total Number of Weeks Worked	1	1	9	9
Line 1 Times 15 Hours Per Week	2	1	9	9
Registered Therapists	3	1	9	9
Certified Therapist	4	1	9	9
Non-registered, Non-certified Therapist	5	1	9	9
Standard Travel Expense Rate	6	1	9	9(6).9(2)
Total Hours Worked by Supervisors, Therapists, Aides, and Trainees	7	1-8	9	9
Average Hourly Standard Expense Allowance	8	1-8	9	9(6).9(2)
<u>Part II</u>				
Supervisory Registered Therapist	10	1	9	9
Total Allowance Amount	19	1	9	9
Weighted Average Rate	20	1	9	9(6).9(2)
Weighted Allowance	21	1	9	9
Total Salary Equivalency	22	1	9	9
<u>Part III</u>				
Standard Travel Allowance-Registered Therapists	23	1	9	9
Standard Travel Allowance-Certified Therapists	24	1	9	9
Standard Travel Allowance Non-Registered, Non-certified Therapists	25	1	9	9
Standard Travel Expense	27	1	9	9
Total Standard Travel Allowance and Standard Travel Expense	28	1	9	9
<u>Part IV</u>				
Overtime Hours Worked	29	1-5	9	9
Standard Work Year for One Full-Time Employee	33	1-5	9	9(6).9(2)
Overtime Allowance	38	1-5	9	9
<u>Part V</u>				
Travel Allowance and Expense	40	1	9	9
Equipment Cost	42	1	9	9
Supplies	43	1	9	9
Total Cost of Outside Supplier Services	45	1	9	9
Excess Cost Over Limitations	46	1	9	9
Worksheet A-8-5				
Description	Lines	Columns	Field Size	Usage
Reasonable Cost Determination for all Therapy Services furnished by Outside Suppliers on or After April 10, 1998:				
<u>Part I</u>				
Total Number of Weeks Worked	1	1	9	9
Line 1 Times 15 Hours Per Week	2	1	9	9

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Number of Unduplicated Days Supervisor or Therapist was on Provider Site	3	1	9	9
Number of Unduplicated Days Therapy Assistant was on Provider Site without Supervisor or Therapist	4	1	9	9
Number of Unduplicated HHA Visits- Supervisor Therapist	5	1	9	9
Number of Unduplicated HHA Visits- Therapy Asstnt	6	1	9	9
Total Hours Worked by Supervisors, Therapists, Assistants, Aides and Trainees	9	1-5	11	9(8).99
Adjusted Hourly Salary Equivalency Amount	10	1-5	9	9(6).9(2)
Number of Travel Hours-Provider Onsite	12	1-3	9	9
Number of Travel Hours-Provider Offsite	12.01	1-3	9	9
Number of Miles Driven-Provider Onsite	13	1-3	9	9
Number of Miles Driven-Provider Offsite	13.01	1-3	9	9
Part II				
Total Allowance Amount	20	1	9	9
Weighted Average Rate	21	1	9	9(6).9(2)
Weighted Allowance	22	1	9	9
Total Salary Equivalency	23	1	9	9
Part III				
Standard Travel Allowance For:				
Therapists	24	1	9	9
Assistants	25	1	9	9
Standard Travel Expense	27	1	9	9
Total Standard Travel Allowance and Travel Expense at Provider Site	28	1	9	9
Part V				
Overtime Hours Worked	47	1-4	11	9(8).99
Standard Work Year for One Employee	51	1-4	7	9(4).9(2)
Overtime Allowance	56	1-4	9	9
Part VI				
Travel Allowance and Expense	59	1	9	9
Equipment Cost	61	1	9	9
Supplies	62	1	9	9
Total Cost of Outside Supplier Service	64	1	9	9
Excess Cost Over Limitations	65	1	9	9
Part VII				
Cost of Outside Suppliers - SNF	66	1	9	9
Cost of Outside Suppliers - CORF	67	1	9	9
Cost of Outside Suppliers - CMHC	68	1	9	9
Cost of Outside Suppliers - OPT	69	1	9	9
Cost of Outside Suppliers - HHA	70	1	9	9
Excess Cost Over Limitations - SNF	77	1	9	9
Excess Cost Over Limitations - CORF	78	1	9	9
Excess Cost Over Limitations - CMHC	79	1	9	9
Excess Cost Over Limitations - OPT	80	1	9	9
Excess Cost Over Limitations - HHA	81	1	9	9
Total Excess Cost Over Limitation	82	1	9	9
Worksheet B Part I				
Description	Lines	Columns	Field Size	Usage

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Allocation of General Service Costs, Cost Finding by Department	1-16,18,18.1, 19,21-47,47.1-51,55-63	0-3,3A,4-18	9	-9
Cross Foot Adjustments	64	0-3,3A, 4-10,14-18	9	-9
Negative Cost Centers	65	0-3,3A,4-18	9	-9
Total Costs after Step Down	75	0-3,3A,4-18	9	9
Worksheet B Part II				
Description	Lines	Columns	Field Size	Usage
Directly Assigned Capital Related Costs by Department	1-16,18,18.1, 19,21-47,47.1-51,55-63	0	9	-9
Total Directly Assigned Capital-Related Costs	75	0	9	9
Allocation of Capital-Related Costs by Department	1-16,18,18.1, 19,21-47,47.1-51,55-63	2a-18	9	-9
Cross Foot Adjustment	64	14-18	9	-9
Negative Cost Center	65	2a-18	9	-9
Total Capital Costs after Step Down	75	2a-18	9	9
*Worksheet B Part III				
Description	Lines	Columns	Field Size	Usage
Allocation of General Service Costs	15.1	0-4	9	9
Cost Finding by Department	16,18,18.1-33, 56,59,63	0-5	9	-9
Total Costs After Step Down	75	0-5	9	9
Worksheet B-1				
Description	Lines	Columns	Field Size	Usage
Type 2 Record with the code for allocation basis-See Table 4 "Column Codes for Worksheet B-1"	0	1-15	36	x
Allocation Statistics for the General Service Cost Centers to Skilled Nursing Facility	16	1-3,4-15	9	9
*Worksheet B-1 Part II				
Description	Lines	Columns	Field Size	Usage
Allocation of Statistics for the General Service Cost Centers to Skilled Nursing Facility	16,18,18.1-33, 56,59,63	1-4	9	9
Total General Service Costs	70	1-4	9	9
Total Statistics	71	1-4	9	9
Unit Cost Multiplier	72	1-4	9	9(6).9(6)
Note: *To be completed only by SNFs using "Simplified Method".				
Worksheet C				
Description	Lines	Columns	Field Size	Usage
Departmental Costs From Worksheet B Part I	21-36,48	1	9	9
Total Departmental Costs	75	1	9	9
Departmental Charges	21-36,48	2	9	9
Total Departmental Charges	75	2	9	9

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Departmental Cost/Charge Ratio	21-36,48	3	9	9.9(6)
Worksheet D				
Description	Lines	Columns	Field Size	Usage
<u>Part I</u>				
Apportionment of Inpatient Ancillary Service Charges by Department for:				
Part A	21-36,48-48.03	2	9	9
Part B	21-36,48-48.03	3	9	9
Total Part A and Part B Charges	75	2,3	9	9
Apportionment of Inpatient Ancillary Service Costs by Department for:				
Part A	21-36,48-48.03	4	9	9
Part B	21-36,48-48.03	5	9	9
Total Part A and Part B Costs	75	4,5	9	9
For services rendered on and after January 1, 1998:				
Title 18 Outpatient Therapy Charges	25-27	6	9	9
Total Outpatient Therapy Charges	75	6	9	9
Title 18 Outpatient Therapy Costs	25-27	7	9	9
Total Outpatient Therapy Costs	75	7	9	9
10% Reduction of Therapy Costs	25-27	8	9	9
Total Reduction of Therapy Costs	75	8	9	9
Net Allowable Part B Costs	21-36,48-48.03	9	9	9
Total Costs	75	9	9	9
<u>Part II</u>				
Drugs Charged to Patients-Ratio Cost/Charges	1	1	9	9.9(6)
Program Vaccine Charges	2	1	9	9
Program Costs	3	1	9	9
<u>Part III</u>				
For cost reporting periods beginning on or after July 1, 1998, I & R Ancillary Pass Through Costs-PPS SNF:				
Title 18 I & R Pass Thru Costs	21-30,32,33	5	9	9
Total Pass Through Costs	75	5	9	9
Worksheet D-1				
Description	Lines	Columns	Field Size	Usage
<u>Part I</u>				
For the SNF and Nursing Facility:				
Inpatient Days	1-5	1	9	9
Private Room Differential Adjust	6,8,10,14,15	1	9	9
	7	1	9	9.9(6)
	9,11-13	1	9	9(6).9(2)
	17-20,22-25,27,28	1	9	9
Program Inpatient Routine Service Costs	16,21,26	1	9	9(6).9(2)
<u>Part II</u>				
For cost reporting periods beginning on or after July 1, 1998, Inpatient I & R costs for pass-through:				
Title 18 I & R Pass Through Costs	5	1	9	9

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Worksheet D-2				
Description	Lines	Columns	Field Size	Usage
Part I				
Percent of Time I & Rs not in Approved Program	2,4-6,8-12	1	9	9(3).99
Total Cost of Services Rendered	1	2	9	9
Title XVIII Part B Inpatient Days	2	6	9	9
Title XVIII Part B Inpatient Costs	2	9	9	9
Title XIX Inpatient Costs	2,4,4.1,11	10	9	9
Subtotals	12	9,10	9	9
Part II				
Title XVIII Part B Inpatient Days, Approved Program	17	4	9	9
Title XVIII Part B Inpatient Costs, Approved Program	17	5	9	9
Total Program Part B Inpatient Costs	20	5	9	9
Worksheet E Part I				
Description	Lines	Columns	Field Size	Usage
Part A, Inpatient Settlement for SNF, NF, ICF/MR	1-18,20-37	1	9	-9
	19	1	9	9.9(6)
Worksheet E Part II				
Description	Lines	Columns	Field Size	Usage
Part B, Title XVIII Inpatient Settlement for SNF Only	1-13,15-29	1	9	-9
	14	1	9	9.9(6)
Worksheet E Part III				
Description	Lines	Columns	Field Size	Usage
Part A Inpatient Service Reimbursement for SNF Only under Title XVIII PPS and Title XIX	1-10, 10.01,10.02, 11-16,16.01-18	1	9	-9
Part B Ancillary Service Reimbursement for SNF Only under Title XVIII	19-36,36.01-38	1	9	-9
Worksheet E Part V				
Description	Lines	Columns	Field Size	Usage
NHCMQ Demo Reimbursement Settlement:				
Part A Inpatient Services	1-6,9	1	9	-9
Capital Related Costs Allocated to I/P Routine	7	1	9	-9
Per Diem Capital-Related Costs	8	1	9	9(6).9(2)
Ancillary Services-Indirect Costs	10-18,22-25	1	9	-9
Charge/Charge Ratio	19-21	1	9	9.9(6)
Worksheet E-1				
Description	Lines	Columns	Field Size	Usage
For the SNF, Title XVIII Only:				
Total Interim Payments Paid to Provider	1	2,4	9	9
Interim Payments Payable to Provider	2	2,4	9	9
Retroactive Adjustments:				
Program to Provider - Date MM/DD/YY	3.01-3.49	1,3	8	x
Program to Provider - Amount	3.01-3.49	2,4	9	9

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Provider to Program - Date MM/DD/YY	3.50-3.98	1,3	8	x
Provider to Program - Amount	3.50-3.98	2,4	9	9
Net Retroactive Lump-Sum Adjust Amount	3.99	2,4	9	-9
Total Interim Payments	4.00	2,4	9	9
Tentative Settlement Payments:				
Program to Provider - Date MM/DD/YY	5.01-5.49	1,3	8	x
Program to Provider - Amount	5.01-5.49	2,4	9	9
Provider to Program - Date MM/DD/YY	5.50-5.98	1,3	8	x
Provider to Program - Amount	5.50-5.98	2,4	9	9
Net Tentative Settlement Amounts	5.99	2,4	9	-9
Net Settlement:				
Date (MM/DD/YY) of Each Settlement-Prgm to Provider	6.01	1,3	8	x
Amount of Each Settlement-Prgm to Provider	6.01	2,4	9	9
Date (MM/DD/YY) of Each Settlement-Provider to Prgm	6.50	1,3	8	x
Amount of Each Settlement-Provider to Prgm	6.50	2,4	9	9
Total Medicare Program Liability	7	2,4	9	9
Worksheet G				
Description	Lines	Columns	Field Size	Usage
For all SNFs or SNF Complexes:				
General and Fund Accounts	1-47,49-51,58,59	1	9	-9
For SNFs or SNF Complexes Using Fund Accounting:				
Specific Fund	1-38,40-47,49,50,52,58,59	2	9	-9
Endowment Fund	1-38,40-47,49,50,53-55,58,59	3	9	-9
Plant Fund	1-38,40-47,49,50,56-59	4	9	-9
Worksheet G-2				
Description	Lines	Columns	Field Size	Usage
<u>Part I</u>				
Revenue for General Inpatient Routine Care Services	1,3,4	1	9	9
Total General Inpatient Care Services	5	1	9	9
Revenues for All Other Care Services	6,7,10-13	1	9	9
Total Inpatient Revenues	14	1	9	9
Outpatient Revenues	6-8,10-13	2	9	9
Total Outpatient Revenues	14	2	9	9
Total Revenues-Inpatient and Outpatient	14	3	9	9
<u>Part II</u>				
Total Operating Expenses-From WS A	1	2	9	9
Increases to Operating Expenses	8	2	9	9
Decreases to Operating Expenses	14	2	9	9
Total Operating Expenses	15	2	9	9
Worksheet G-3				
Description	Lines	Columns	Field Size	Usage

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Net Patient Revenues	3	1	9	9
Net Income from Services to Patients	5	1	9	-9
Contributions, Donations, Bequests	7	1	9	9
Income from Investments	8	1	9	9
Governmental Appropriations	24	1	9	9
Total Other Income	26	1	9	9
Total Other Expenses	31	1	9	9
Net Income (Loss)	32	1	9	-9
Worksheet H				
Description	Lines	Columns	Field Size	Usage
For SNF-Based HHA-Analysis of HHA Costs:				
Salaries, Employee Benefits, Transportation and Contracted/Purchased Services	3-23,23.5-25	1-4	9	9
Other Costs and Total HHA Costs	1-23,23.5-25	5,6	9	9
Worksheet H-1				
Description	Lines	Columns	Field Size	Usage
Analysis of Salaries and Wages for:				
Administrators, Directors, Supervisors, Nurses, Therapists and Aides	3-11,15-23,23.5-25	1,2,4-7	9	9
All Other salaries and Wages	3-23,23.5-25	8	9	9
Worksheet H-2				
Description	Lines	Columns	Field Size	Usage
Analysis of Employee Benefits for:				
Administrators, Directors, Supervisors, Nurses, Therapists and Aides	3-11,15-23,23.5-25	1,2,4-7	9	9
All Other Employee Benefits	3-23,23.5-25	8	9	9
Worksheet H-3				
Description	Lines	Columns	Field Size	Usage
Analysis of Contracted/Purchased Services for:				
Administrators, Directors, Supervisors, Nurses, Therapists and Aides	3-11,15-23,23.5-25	1-7	9	9
All Other Contracted/Purchased Services	3-23,23.5-25	8	9	9
Worksheet H-4				
Description	Lines	Columns	Field Size	Usage
<u>Part I</u>				
Allocation of HHA Admin and General Costs:				
Shared Ancillary Costs	3-5,10,11,13,13.1,14	2	9	9
Allocation of HHA A & G Costs	1-13,13.1	4	9	9
Total HHA Costs	2-13,13.1	5	9	9
<u>Part II</u>				
Total HHA Charges for Shared Ancillary Services	1-8	1	9	9
Total HHA Costs for Shared Ancillary Services	1-8	3	9	9

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Worksheet H-5 Description	Lines	Columns	Field Size	Usage
Cost Per Visit Computation by Discipline:				
Total Costs	1-7	2	9	9
Total Visits	1-7	3	9	9
Average Cost Per Visit	1-6	4	9	9(3).9(2)
Computation of Aggregate Medicare Costs and Aggregate Medicare Cost Limitation:				
MSA Code	0	0	4	x
Average Cost Per Visit	1.01-6.01	4	9	9(3).9(2)
Program Visits - Part A (Pre 10/1/2000)	1-6	5	9	9
Program Visits - Part A (Post 9/30/2000)	1.01-6.01	5	9	9
Total Part A Visits	7	5	9	9
Program Visits - Part B (Pre 10/1/2000)	1-6	6	9	9
Program Visits - Part B (Post 9/30/2000)	1.01-6.01	6	9	9
Total Part B Visits	7	6	9	9
Cost of Services - Part A (Pre 10/1/2000)	1-6	8	9	9
Cost of Services - Part B (Post 9/30/2000)	1-.01-6.01	8	9	9
Total Cost of Part A Services	7	8	9	9
Cost of Services Part B (Pre 10/1/2000)	1-6	9	9	9
Cost of Services Part B (Post 9/30/2000)	1.01-1.06	9	9	9
Total Cost of Part B Services	7	9	9	9
Total Program Costs (Pre 10/1/2000)	1-7	11	9	9
Total Program Costs (Post 9/30/2000)	1.01-6.01,7	11.01	9	9
Program Cost Limits - Per Visit	8-13	4	9	9(3).9(2)
Cost of Services Limitation - Part A	8-14	8	9	9
Cost of Services Limitation - Part B Not Subject to Coins and Deductibles	8-14	9	9	9
Total Program Cost Limitation	8-14	11	9	9
Note: A separate Worksheet H-5, Lines 1-14, Columns 4-6,8,9,11 and 11.01 is to be completed for each MSA Code reported on Line 0, Col 0.				
Supplies and Drug Cost Computation:				
Total Cost of Med Supplies & Drugs (Pre 10/1/2000)	15,16	2	9	9
Total Cost of Med Supplies & Drugs (Post 9/30/2000)	15.01,16.01	2	9	9
Total Cost of Med Supplies & Drugs	17	2	9	9
Total Charges-Med Supplies & Drugs (Pre 10/1/2000)	15,16	3	9	9
Total Charges-Med Supplies & Drugs (Post 9/30/2000)	15.01,16.01	3	9	9
Total Charges-Med Supplies & Drugs	17	3	9	9
Part A Covered Charges (Pre 10/1/2000)	15	5	9	9
Part A Covered Charges (Post 9/30/2000)	15.01	5	9	9
Total Part A Covered Charges	17	5	9	9
Part B Covered Charges Not Subject to Coin (Pre 10/1/2000)	15,16	6	9	9
Part B Covered Charges Not Subject to Coin (Post 9/30/2000)	15.01,16.01	6	9	9
Total Part B Covered Charges Not Subject to Coin	17	6	9	9
Part B Covered Charges Subject to Coin (Pre 10/1/2000)	15,16	7	9	9
Part B Covered Charges Subject to Coin (Post 9/30/2000)	15.01,16.01	7	9	9
Total Part B Covered Charges Subject to Coin	17	7	9	9

Specifications for the Form CMS 2540-96 10/1/2003
Table 3 - Cost Report Data Specifications - Transmittal 13

Part A Cost of Medical Supplies (Pre 10/1/2000)	15	8	9	9
Part A Cost of Medical Supplies (Post 9/30/2000)	15.01	8	9	9
Total Part A Cost of Medical Supplies	17	8	9	9
Part B Cost of Medical Supplies and Drugs not subject to Coins & Ded (Pre 10/1/2000)	15,16	9	9	9
Part B Cost of Medical Supplies and Drugs not subject to Coins & Ded (Post 9/30/2000)	15.01,16.01	9	9	9
Total Part B Cost of Medical Supplies and Drugs not subject to Coins & Ded	17	9	9	9
Part B Cost of Medical Supplies and Drugs subject to Coins & Ded (Pre 10/1/2000)	15,16	10	9	9
Part B Cost of Medical Supplies and Drugs subject to Coins & Ded (Post 9/30/2000)	15.01,16.01	10	9	9
Total Part B Cost of Medical Supplies and Drugs subject to Coins & Ded	17	10	9	9
Comparison of Lesser of Aggregate Medicare Costs and Aggregate Medicare Cost Per Visit Limitation:				
Total Cost of Medicare Services- A and B	18	3,4,6	9	9
Cost of Medicare Supplies	19	3,4,6	9	9
Total Costs	20	3,4,6	9	9
Total Cost Per Visit Limitation	21	3,4,6	9	9
Cost of Medical Supplies	22	3,4,6	9	9
Total (Sum of 20 and 22)	23	3,4,6	9	9
MSA Code	24	0	4	x
Per Beneficiary Cost Limit-Per MSA Code	24	1,2,6	9	9
MSA Code	24.01-24.99	0	4	x
Per Beneficiary Cost Limit-Per MSA Code	24.01-24.99	1,2,6	9	9(3).9(2)
Aggregate per Beneficiary Cost Limitation	25	1,3,4,6	9	9(3).9(2)
Outpatient Therapy Reduction Computation:				
Physical Therapy	26	3-8	9	9
Occupational Therapy	27	3-8	9	9
Speech Pathology	28	3-8	9	9
Total	29	3,4,8	9	9
Program Visits from 01/01/1999 through 9/30/2000 to Non-Homebound Beneficiaries	26-28	5.01	9	9
Program Visits after 9/30/2000 to Non-Homebound Beneficiaries	26-28	5.02	9	9
Worksheet H-6				
Description	Lines	Columns	Field Size	Usage
Part II				
Computation of HHA Reimbursement Settlement:				
Part A - Title XVIII	8,8.01-8.14,10,12-23	1	9	-9
Part B - Title XVIII	8,8.01-8.14, 9-23	2	9	-9
Other Adjustments	18.01	1	9	9
Note: Lines 8.01 through Lines 8.14 have been added for PPS Reimbursement.				
Worksheet H-7				
Description	Lines	Columns	Field Size	Usage

Specifications for the Form CMS 2540-96 10/1/2003
Table 3 - Cost Report Data Specifications - Transmittal 13

Analysis of Payments to SNF-Based HHAs:				
Total Interim Payments Paid to Providers	1	2,4	9	9
Interim Payments Payable	2	2,4	9	9
Retroactive Adjustments:				
Program to Provider-Date MM/DD/YY	3.01-3.49	1,3	8	x
Program to Provider-Amount	3.01-3.49	2,4	9	9
Provider to Program-Date MM/DD/YY	3.50-3.98	1,3	8	x
Provider to Program-Amount	3.50-3.98	2,4	9	9
Net Retroactive Lump Sum Payment Amt	3.99	2,4	9	-9
Total Interim Payments	4.00	2,4	9	9
Tentative Settlement Payments:				
Program to Provider-Date MM/DD/YY	5.01-5.49	1,3	8	x
Program to Provider-Amount	5.01-5.49	2,4	9	9
Provider to Program-Date MM/DD/YY	5.50-5.98	1,3	8	x
Provider to Program-Amount	5.50-5.98	2,4	9	9
Tentative Settlement	5.99	2,4	9	-9
Net Settlement:				
Program to Provider-Date MM/DD/YY	6.01	1,3	8	x
Program to Provider-Amount	6.01	2,4	9	9
Provider to Program-Date MM/DD/YY	6.50	1,3	8	x
Provider to Program-Amount	6.50	2,4	9	9
Total Medicare Program Liability	7	2,4	9	9
Note: The Worksheet I series is effective for cost reporting periods beginning on or after January 1, 1998.				
Worksheet I-1				
Description	Lines	Columns	Field Size	Usage
For each SNF-Based RHC or FQHC, the analysis of RHC/QHC costs:				
Salaries by Department	1-31	1	9	-9
Total Salaries	32	1	9	-9
Other Direct Costs by Department	1-31	2	9	-9
Total Other Direct Costs	32	2	9	-9
Reclassifications by Department	1-31	4	9	-9
Total Reclassifications	32	4	9	-9
Adjustments to Expenses by Department	1-31	6	9	-9
Total Adjustments	32	6	9	-9
Net Costs for Allocation by Department	1-31	7	9	-9
Total Facility Costs	32	7	9	-9
Worksheet I-2				
Description	Lines	Columns	Field Size	Usage
Allocation of Overhead to RHC/FQHC Services:				
Number of FTEs	1-8	1	9	9(6).99
Total Visits	1-9	2	9	9
Productivity Standard	1-3	3	4	9
Minimum Visits	1-4	4	9	9
Net Visits	4	5	9	9
Allowable Costs Applicable to RHC/FQHC Services	10-12,14-18	1	9	9
Ratio of RHC/FQHC Services	13	1	9	9.9(6)

Specifications for the Form CMS 2540-96 10/1/2003
Table 3 - Cost Report Data Specifications - Transmittal 13

Overhead Applicable to RHC/FQHC Services	19	1	9	9
Total Allowable Costs of RHC/FQHC Services	20	1	9	9
Worksheet I-3				
Description	Lines	Columns	Field Size	Usage
Calculation of Reimbursement Settlement for RHC/QHC Services:				
Determination of RHC/FQHC Rates	1,3-6	1	9	9
Adjusted Cost Per Visit	7	1	9	9(6).9(2)
Rate Per Visit Limit	8	1, 2, 3	9	9(6).9(2)
Rate for Medicare Visits	9	1, 2, 3	9	9(6).9(2)
Calculation of Settlement-Prior to Jan 1	10-14	1	9	-9
Calculation of Settlement-After Jan 1	10-19,21-27	2	9	-9
Calculation of Settlement - 3rd Overlap Period if needed	10,12	3	9	9
Worksheet I-4				
Description	Lines	Columns	Field Size	Usage
Pneumococcal and Influenza Vaccine Costs	1,3-7,9-11,13,14	1,2	9	9
Ratios for Vaccine Costs to Total Costs	2,8	1,2	9	9.9(6)
Cost per Injection	12	1,2	9	9(3).9(2)
Total Cost of Vaccines	15	2	9	9
Total Medicare Cost of Vaccines	16	2	9	9
Worksheet I-5				
Description	Lines	Columns	Field Size	Usage
Analysis of Payments to SNF-Based RHC or FQHC:				
Total Payments to Provider	1	2	9	9
Interim Payments Payable	2	2	9	9
Retroactive Adjustments:				
Program to Provider-Date MM/DD/YY	3.01-3.49	1	8	x
Program to Provider-Amount	3.01-3.49	2	9	9
Provider to Program-Date MM/DD/YY	3.50-3.98	1	8	x
Provider to Program-Amount	3.50-3.98	2	9	9
Net Retroactive Lump Sum Amount	3.99	2	9	9
Total Interim Payments	4.00	2	9	9
Tentative Settlement Payments:				
Program to Provider-Date MM/DD/YY	5.01-5.49	1	8	x
Program to Provider-Amount	5.01-5.49	2	9	9
Provider to Program-Date MM/DD/YY	5.50-5.98	1	8	x
Provider to Program-Amount	5.50-5.98	2	9	9
Tentative Settlement	5.99	2	9	-9
Net Settlement:				
Program to Provider-Date MM/DD/YY	6.01	1	8	x
Program to Provider-Amount	6.01	2	9	9
Provider to Program-Date MM/DD/YY	6.50	1	8	x
Provider to Program-Amount	6.50	2	9	9
Total Medicare Program Liability	7	2	9	9

Specifications for the Form CMS 2540-96 10/1/2003
Table 3 - Cost Report Data Specifications - Transmittal 13

Worksheet J-1				
Description	Lines	Columns	Field Size	Usage
<u>Part I</u>				
Allocation of General Service Costs to Component Cost Centers for each CORF, CMHC, OPT, OOT, OSP:				
Outpatient Rehab Provider Cost Centers	1-22	0-3,4-16,18	9	9
Total Costs	2-22	20	9	-9
Worksheet J-2				
Description	Lines	Columns	Field Size	Usage
<u>Part I</u>				
Apportionment of OP Rehab Costs for Each CORF, CMHC, OPT, OOF, OSP:				
Outpatient Charges-In Total, Title XVIII, and Title XIX	2-22	2,6,8	9	9
Outpatient Costs-Title XVIII, and Title XIX	2-22	7,9	9	9
For Cost Reporting Periods Which Overlap August 1, 2000, Subscript Cols 8 & 9 to report CMHC charges and costs that occurred on or after 8/1/2000:				
Title XVIII Outpatient Charges	2-22	8.01	9	9
Title XVIII Outpatient Costs	2-22	9.01	9	9
Reasonable Cost Reduction Amount for Outpatient Rehab Costs for Cost Reporting periods on or after January 1, 1998.	3,4,5	10-13	9	9
<u>Part II</u>				
Apportionment of OP Rehab Shared Costs for each CORF, CMHC, OPT, OOT, OSP:				
Charges-Titles XVIII and XIX	23-30	6,8	9	9
Costs-Titles XVIII and XIX	23-30	7,9	9	9
Reasonable Cost Reduction Amount for Outpatient Rehab Shared Costs for Cost Reporting periods on or after January 1, 1998.	24,25,26	10-13	9	9
Total Costs Net of Reasonable Cost Reduction	30	13	9	9
<u>Part III</u>				
Total Rehab Costs	31	7,9,11,13	9	9
Worksheet J-3				
Description	Lines	Columns	Field Size	Usage
<u>Part I</u>				
Titles XVIII and XIX Settlement Data for Each CORF, CMHC, OPT, OOT, OSP - Prior to January 1, 1998:				
OP Rehab Settlement Data for Title XVIII	1-18	2	9	-9
OP Rehab Settlement Data for Title XIX	1-3,5,7-18	3	9	-9
For CMHC Title XVIII only, cost of Health Services rendered on or after August 1, 2000:				
Cost of Health Service	1.01	2, 2.01	9	-9
PPS Payment Received	1.02	2, 2.01	9	-9
1996 SNF Payment to Cost Ratio	1.03	2, 2.01	9	9.9(3)
Line 1.01 Times Line 1.03	1.04	2, 2.01	9	-9
Line 1.02 Divided by Line 1.04	1.05	2, 2.01	6	999.99
Transitional Corridor Payment	1.06	2, 2.01	9	-9
<u>Part II</u>				

Specifications for the Form CMS 2540-96 10/1/2003
Table 3 - Cost Report Data Specifications - Transmittal 13

Titles XVIII and XIX Settlement Data for Each CORF, CMHC, OPT, OOT, OSP - On or after January 1, 1998:				
Computation of Customary Charges	1,1.1,1.2,2-6,8,8.1,8.2	1	9	9
Ratio of Line 5 to Line 6	7	1	9	9.9(6)
Excess of Customary Charges Over Reasonable Costs	8.3	1	9	9
Excess of Reasonable Costs Over Customary Charges	8.4	1	9	9
Part III				
Computation of Reimbursement Settlement	9-11,11.1,11.2,12-26	1	9	-9
Worksheet J-4				
Description	Lines	Columns	Field Size	Usage
Analysis of Payments to Each CORF, CMHC, OPT, OOT, OSP:				
Total Interim Payments to Provider	1	2	9	9
Interim Payments Payable	2	2	9	9
Retroactive Adjustments:				
Program to Provider-Date MM/DD/YY	3.01-3.49	1	8	x
Program to Provider-Amount	3.01-3.49	2	9	9
Provider to Program-Date MM/DD/YY	3.50-3.98	1	8	x
Provider to Program-Amount	3.50-3.98	2	9	9
Net Retroactive Lump Sum Adjustments	3.99	2	9	-9
Total Interim Payments	4.00	2	9	9
Tentative Settlement Payments:				
Program to Provider-Date MM/DD/YY	5.01-5.49	1	8	x
Program to Provider-Amount	5.01-5.49	2	9	9
Provider to Program-Date MM/DD/YY	5.50-5.98	1	8	x
Provider to Program-Amount	5.50-5.98	2	9	9
Subtotal Tentative Settlement	5.99	2	9	-9
Net settlement:				
Program to Provider-Date MM/DD/YY	6.01	1	8	x
Program to Provider-Amount	6.01	2	9	9
Provider to Program-Date MM/DD/YY	6.50	1	8	x
Provider to Program-Amount	6.50	2	9	9
Total Medicare Liability	7	2	9	9
Worksheet K				
Description	Lines	Columns	Field Size	Usage
For SNF-based Hospice Reclassification and Adjustment of Trial Balance Expenses:				
Salaries, Employee Benefits, Transportation, Contracted Services and Other	3-34	1,2,4	9	9
	1-34	3,5,9	9	9
Reclassification	1-34	7	9	-9
Worksheet K-1				
Description	Lines	Columns	Field Size	Usage
Analysis of Salaries and Wages For:				
Administrator, Director, Social Services, Supervisors, Nurses, Therapists, Aides and All Other Salaries	3-34	1-8	9	9

Specifications for the Form CMS 2540-96 10/1/2003
Table 3 - Cost Report Data Specifications - Transmittal 13

Worksheet K-2				
Description	Lines	Columns	Field Size	Usage
Analysis of Employee Benefits For:				
Administrator, Director, Social Services, Supervisors, Nurses, Therapists, Aides and All Other Employee Benefits	3-34	1-8	9	9
Worksheet K-3				
Description	Lines	Columns	Field Size	Usage
Analysis of Contracted Services For:				
Administrator, Director, Social Services, Supervisors, Nurses, Therapists, Aides and All Other Contracted Services	3-34	1-8	9	9
Worksheet K-4				
Description	Lines	Columns	Field Size	Usage
<u>Part I</u>				
Allocation of Service Cost Centers to Component Cost Centers	1-34	0-7	9	-9
<u>Part II</u>				
Cost Allocation-Hospice Statistical Basis:				
Cost to be Allocated	34	1-6	9	9
Unit Cost Multiplier	35	1-6	9	9(6).9(6)
Worksheet K-5				
Description	Lines	Columns	Field Size	Usage
<u>Part I</u>				
Allocation of General Service Costs to Hospice Cost Centers:				
Net Expense for Allocation	2-29	0	9	-9
Allocation of General Service Costs	1-29	1-16	9	-9
Total Costs after Allocation	2-29	18	9	-9
<u>Part II</u>				
Cost Allocation-Statistical Basis:				
Costs to be Allocated	29	1-15	9	9
Unit Cost Multiplier	30	1-15	9	9(6).9(6)
<u>Part III</u>				
Apportionment of Hospice Shared Costs	1-8	5,6	9	9
Worksheet K-6				
Description	Lines	Columns	Field Size	Usage
Calculation of Per Diem Cost:				
Title XVIII Days	4,8	1	9	9
Title XVIII -Average Cost	5,9	1	9	9
Title XIX Days	6,10	2	9	9
Title XIX-Average Cost	7,11	2	9	9
Other Days	12	3	9	9
Other-Average Cost	13	3	9	9
Total Days-Unduplicated	2	4	9	9

Specifications for the Form CMS 2540-96 - 10/1/2003
Table 4 - Label Coding - Transmittal 13

The 4-digit coding scheme used with the Form HCFA 2540-96 extracts will continue to be used in the manner previously established.

Vendor programmers should be aware that where precoding of additional lines is done as a convenience for the FI operator, only valid codes or their increments can be used.

COST CENTER CODING RULES

1. Every four-digit code in a file must be unique. If there are two or more cost centers with the same meaning, the code for the additional cost center(s) must be incremented by one.
2. Only those codes included in the Standard and Non-Standard lists (with increments referred to above) are to be used. These lists (Pages 37-40) include the range of codes permissible for each cost
3. A cost center code from one category (General Services, e.g.) cannot be used to identify a cost center in another category (Ancillary Service, e.g.).
4. Cost center codes will not be used for Balance Sheet items on Worksheet G. The lines are fixed and no sublining is allowed. Multiple "Other" items should be aggregated.
- 5.

Column codes for Worksheet B-1 are to identify the statistical basis for each cost center. The standard column code is used for the statistical base preprinted on the cost report. If a base other than the preprinted label was used, then the "Other" column

0100 Capital Related - Bldgs & Fix, Bldg #1 Square Feet
0101 Capital Related - Bldgs & Fix, Bldg #2 Square Feet
0102 Capital Related - Bldgs & Fix, Bldg #3 Square Feet

If the statistical base was Dollar Value for buildings #2 and #3, the column codes would appear as follows:

0100 Capital Related - Bldgs & Fix, Bldg #1 Square Feet
0150 Capital Related - Bldgs & Fix, Bldg #2 Dollar Value
0151 Capital Related - Bldgs & Fix, Bldg #3 Dollar Value

Column codes will not be obtained from Worksheet B-1, Part II for the "Simplified Method" SNF.

STANDARD COST CENTER CODES

GENERAL SERVICE COST CENTERS

<u>CODE</u>	<u>USE</u>	
0100	(100)	Capital Related Costs Buildings and Fixtures
0200	(100)	Capital Related Costs Movable Equipment
0300	(100)	Employee Benefits
0400	(100)	Administrative and General
0500	(100)	Plant Operation, Maintenance and Repairs
0600	(100)	Laundry and Linen Service
0700	(100)	Housekeeping
0800	(100)	Dietary
0900	(100)	Nursing Administration
1000	(100)	Central Services and Supply
1100	(100)	Pharmacy
1200	(100)	Medical Records and Library
1300	(50)	Social Service
1400	(100)	Interns and Residents (Approved Teaching Program)

INPATIENT ROUTINE SERVICE COST CENTERS

1600	(01)	Skilled Nursing Facility - High Intensity
1800	(01)	Nursing Facility
1810	(01)	ICF/MR
1900	(01)	Other Long Term Care

ANCILLARY SERVICE COST CENTERS

2100	(100)	Radiology
2200	(100)	Laboratory
2300	(100)	Intravenous Therapy
2400	(100)	Oxygen (Inhalation) Therapy
2500	(100)	Physical Therapy
2600	(100)	Occupational Therapy
2700	(100)	Speech Pathology
2800	(100)	Electrocardiology
2900	(100)	Medical Supplies Charged to Patients
3000	(50)	Drugs Charged to Patients
3100	(100)	Dental Care - Title XIX Only
3200	(100)	Support Surfaces

OUTPATIENT SERVICE COST CENTERS

3400	(50)	Clinic
3500	(09)	Rural Health Clinic (RHC)
3550	(09)	Federally Qualified Health Center (FQHC)

STANDARD COST CENTER CODES

OTHER REIMBURSABLE COST CENTERS

<u>CODE</u>	<u>USE</u>	
3700	(05)	Administrative and General - HHA
3800	(05)	Skilled Nursing Care - HHA
3900	(05)	Physical Therapy - HHA
4000	(05)	Occupational Therapy - HHA
4100	(05)	Speech Pathology - HHA
4200	(05)	Medical Social Services - HHA
4300	(05)	Home Health Aide - HHA
4400	(05)	Durable Medical Equipment Rented - HHA
4500	(05)	Durable Medical Equipment Sold - HHA
4600	(05)	Home Delivered Meals - HHA
4700	(05)	Other Home Health Services - HHA
4710	(05)	Telemedicine-HHA
4800	(05)	Ambulance
4900	(01)	Interns and Residents (Not in Approved Teaching Program)
5000	(09)	CORF
5010	(09)	Community Mental Health Center (CMHC)
5020	(09)	Outpatient Physical Therapy Facility (OPT)
5030	(09)	Outpatient Occupational Therapy Facility (OOT)
5040	(09)	Outpatient Speech Pathology Facility (OSP)

SPECIAL PURPOSE COST CENTERS

5200	(01)	Malpractice Premiums and Paid Losses
5300	(01)	Interest Expense
5400	(01)	Utilization Review - SNF
5500	(05)	Hospice

NONREIMBURSABLE COST CENTERS

5800	(100)	Gift, Flower, Coffee and Canteen
5900	(100)	Barber and Beauty Shop
6000	(100)	Physicians' Private Offices
6100	(50)	Nonpaid Workers
6200	(100)	Patients Laundry

NONSTANDARD COST CENTER CODES

GENERAL SERVICE COST CENTERS

<u>CODE</u>	<u>USE</u>	
1350	(50)	Other General Service Cost Centers

ANCILLARY SERVICE COST CENTERS

3050	(50)	Other Ancillary Service Cost Centers
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OUPATIENT SERVICE COST CENTERS

3450	(50)	Other Outpatient Service Cost Centers
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OTHER REIMBURSABLE COST CENTERS

4750	(50)	Other Reimbursable Cost Centers
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SPECIAL PURPOSE COST CENTERS

5350	(50)	Other Special Purpose Cost Centers
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NONREIMBURSABLE COST CENTERS

6150	(50)	Other Nonreimbursable Cost Centers
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Specifications for the Form CMS 2540-96 - 10/1/2003
Table 4 - Label Coding - Transmittal 13

COLUMN CODES FOR WORKSHEET B-1

<u>CODE</u>	<u>USE</u>	
0100	(50)	Capital Related - Buildings and Fixtures - Square Feet
0150	(50)	Capital Related - Buildings and Fixtures - Other
0200	(50)	Capital Related - Movable Equipment - Dollar Value/Square Feet
0250	(50)	Capital Related - Movable Equipment - Other
0300	(50)	Employee Benefits - Gross Salaries
0350	(50)	Employee Benefits - Other
0400	(50)	Administrative and General - Accumulated Cost
0450	(50)	Administrative and General - Other
0500	(50)	Plant Operation, Maintenance and Repair - Square Feet
0550	(50)	Plant Operation, Maintenance and Repair - Other
0600	(50)	Laundry and Linen Service - Pounds of Laundry
0650	(50)	Laundry and Linen Service - Other
0700	(50)	Housekeeping - Hours of Service
0750	(50)	Housekeeping - Other
0800	(50)	Dietary - Meals Served
0850	(50)	Dietary - Other
0900	(50)	Nursing Administration - Direct Nursing Hours of Service
0950	(50)	Nursing Administration - Other
1000	(50)	Central Service and Supply - Costed Requisitions
1050	(50)	Central Service and Supply - Other
1100	(50)	Pharmacy - Costed Requisitions
1150	(50)	Pharmacy - Other
1200	(50)	Medical Records and Library - Time Spent
1250	(50)	Medical Records and Library - Other
1300	(30)	Social Service - Time Spent
1330	(20)	Social Service - Other
1400	(50)	Interns and Residents - Assigned time
1450	(50)	Interns and Residents - Other
1350	(50)	Other General Service Cost Centers - Other