CMS Manual System

Pub. 100-07 State Operations Provider Certification

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 96 | **Date: December 13, 2013**

SUBJECT: State Operations Manual (SOM) Chapter 4, Policy and Nomenclature revisions for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)

I. SUMMARY OF CHANGES: Revisions have been made throughout Chapter 4 to reflect the federally mandated ICF/IID nomenclature (the nomenclature is no longer ICF/MR).

NEW/REVISED MATERIAL - EFFECTIVE DATE: December 13, 2013
IMPLEMENTATION DATE: December 13, 2013

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

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED) – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	4/4004/SA Reporting of Possible Certification Fraud
R	4/4009/4009B Health Professional Qualifications
R	4/4009/4009C Education, Training, and Experience
R	4/4149/4149C Review of Certification Data
R	4/4157/4157C Scope of Survey
R	4/4544/LTC Facility Workload (SNF/NF)
R	4/4611/Line Item Justifications for SA Direct and Indirect Costs
R	4/4628/Preparation of Budget Request
R	4/4766/Preparation of State Survey Agency Quarterly Expenditure Report, Long-Term Care Facility Workload, Form CMS-435

III. FUNDING: No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

IV. ATTACHMENTS:

	Business Requirements
X	**Manual Instruction**
	Confidential Requirements

	One-Time Notification
	One-Time Notification -Confidential
	Recurring Update Notification

***Unless otherwise specified, the effective date is the date of service.**

4004 - SA Reporting of Possible Certification Fraud

(Rev. 96, Issued, 12-13-13, Effective: 12-13-13, Implementation: 12-13-13)

Section 1128.B of the Act and P.L. 104.191, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) contains specific penalties for fraud and abuse under Medicare and Medicaid. It provides criminal penalties for:

- Making false statements or representation for any benefit or payment under Medicare and Medicaid;
- Soliciting or receiving any kickback, bribe, or rebate;
- Making false statements or representations with respect to the conditions or operation of any institution, facility, or entity in order to qualify (either initial certification or recertification) for participation in Medicare or Medicaid;
- Charging for any services provided to a patient under Medicaid at a rate in excess of the established State rate, or charging, soliciting, accepting, or receiving in addition to any amounts otherwise required to be paid under Medicaid, any gift, money, donation, or other consideration as a precondition of admitting a patient to a hospital, NF, or ICF/*IID*, or a requirement for the patient's continued stay in such a facility;
- Charging for services not rendered; and
- Physicians and suppliers who agree to accept assignment and violate the terms of that agreement.

When the SA believes that there may be certification fraud, it should immediately notify the RO via memorandum. This memorandum should include the name and provider number of the facility, together with a statement of the relevant facts. In addition, the SA should make no further contacts with the offending individual or facility with respect to this matter unless requested to do so by the appropriate RO personnel. This is necessary because any unauthorized contacts may compromise the potential or pending investigation, including chances for successful prosecution of any criminal violation that has occurred.

4009B - Health Professional Qualifications

(Rev. 96, Issued, 12-13-13, Effective: 12-13-13, Implementation: 12-13-13)

To perform the surveyor functions requires an appropriate background in the health professions or health administration, in addition to basic investigative skills. Therefore, one element in the standard is that the surveyor be qualified in one of the following professions:

- Hospital administrator;

- Industrial hygienist;
- Laboratory or medical technologist, bacteriologist, microbiologist, or chemist;
- Medical record librarian;
- Nurse;
- Nursing home administrator;
- Nutritionist;
- Pharmacist;
- Physical Therapist;
- Physician;
- Qualified *Intellectual Disabilities* Professional;
- Sanitarian;
- Social worker; or
- Any other professional category used within State merit systems for health professional positions, provided the State has determined the position classification skill level to be commensurate with any of the above professions.

This does not mean that the surveyor must belong to a professional organization or have prior work experience in the profession. It means that he/she must satisfy necessary requirements to be employed in one of these specialties by the State.

4009C - Education, Training, and Experience

(Rev. 96, Issued, 12-13-13, Effective: 12-13-13, Implementation: 12-13-13)

To assure that individuals have the necessary knowledge, skills, and abilities to carry out survey functions, the following prerequisites apply:

- The amount of academic education required is that which is necessary to qualify in a profession listed in §4009B;
- Newly hired surveyors must successfully complete an orientation program approved by CMS that includes the core elements of the CMS-developed orientation program. (See Exhibit 42.) The CMS provides this program for Federal surveyors and the States provide it for theirs;

- The CMS and States assure that the health facility surveyors, laboratory surveyors, and Life Safety Code (LSC) surveyors have successfully completed, within the first 12 months of employment, the basic surveyor training course developed under CMS auspices, including all course prerequisites. LSC surveyors are required to complete a LSC basic course (there is self-paced training on a CD-ROM as a prerequisite). No individual may serve on a survey team until he or she fulfills this requirement, except as a trainee who is accompanied onsite by a surveyor, who has successfully completed the required training and testing program;

- In States implementing the Quality Indicator Survey (QIS) process to determine if Medicare and Medicaid certified nursing homes meet the Federal participation requirements, additional training in QIS as described below at §4009F must be completed.

- Before any State or Federal surveyor may serve on a survey team (except as a trainee) for an ICF/*IID*, ESRD facility, HHA, or Hospice survey, he/she must have successfully completed the relevant provider-specific Basic course and any course prerequisites;

- Some State position classifications may require additional education, training, and experience as State minimums, as requirements for promotion, or entry at a higher scale of position classification; and

- SAs must have a mechanism to identify and respond to the in-service training needs of the surveyors.

4149C - Review of Certification Data

(Rev. 96, Issued, 12-13-13, Effective: 12-13-13, Implementation: 12-13-13)

It is crucial that the SA and RO review all certification documents for completeness and accuracy prior to data entry to maintain the integrity of the OSCAR database. To avoid processing delays, make sure the appropriate forms, as listed below, are at hand. The ODIE and ACO systems are programmed to accept data from complete certification kits that contain all required forms. Some documents are common to all initial and recertification kits including the "Medicare/Medicaid Certification and Transmittal" (Form CMS-1539), the appropriate Request for Certification form, the "Statement of Deficiencies and Plan of Correction" (Form CMS-2567), and the Crucial Data Extract (CDE). The SA and RO may enter the data from the "Post-Certification Revisit Report" (Form CMS-2567B) detailing the status of the deficiencies on the revisit either at the time of initial data entry or, if the facility record is already in OSCAR, at a later time. The CDE must be present in every kit. The CDE for each type of institution corresponds to the respective Survey Report and abstracts certain compliance and deficiency information for data collection purposes.

The following list includes all the basic certification documents (including their provider number series that follows the 2-digit State code) required for ODIE or ASPEN Central Office input in all routine initial and recertification packages:
(See also §2779.)

1. **Nonaccredited Acute Hospital** (0001 to 0879)
    - "Medicare/Medicaid Certification and Transmittal," Form CMS-1539
    - "Request to Establish Eligibility," Form CMS-1514
    - "Statement of Deficiencies and Plan of Correction," Form CMS-2567
    - Crucial Data Extract for Form CMS-2786
    - "Survey Team Composition and Workload Report," Form CMS-670
2. **Nonaccredited Psychiatric Hospital** (4000 to 4499)
    - "Medicare/Medicaid Certification and Transmittal," Form CMS-1539
    - "Request to Establish Eligibility," Form CMS-1514
    - "Statement of Deficiencies and Plan of Correction," Form CMS-2567
    - Crucial Data Extracts for Form CMS-2786
    - "Survey Team Composition and Workload Report," Form CMS-670
3. **Accredited Acute Hospital** (0001 to 0879)
    - "Medicare/Medicaid Certification and Transmittal," Form CMS-1539
    - "Request to Establish Eligibility," Form CMS-1514
4. **Accredited Psychiatric Hospital** (4000 to 4499)
    - "Medicare/Medicaid Certification and Transmittal," Form CMS-1539
    - "Request to Establish Eligibility," Form CMS-1514
    - "Statement of Deficiencies and Plan of Correction," Form CMS-2567
    - "Survey Team Composition and Workload Report," Form CMS-670

5. **Home Health Agency** (7000 to 8499 and 9000 to 9499)

    - "Medicare/Medicaid Certification and Transmittal," Form CMS-1539
    - "Home Health Agency Survey and Deficiencies Report," Form CMS-1572(A)
    - "Statement of Deficiencies and Plan of Correction," Form CMS-2567
    - "Survey Team Composition and Workload Report," Form CMS-670

6. **Portable X-Ray** (X0000001 to X9999999)

    - "Medicare/Medicaid Certification and Transmittal," Form CMS-1539
    - "Request to Establish Eligibility," Form CMS-1880
    - "Portable X-Ray Survey Report," Form CMS-1882
    - "Statement of Deficiencies and Plan of Correction," Form CMS-2567
    - "Survey Team Composition and Workload Report," Form CMS-670

7. **Rehabilitation Agency (OPT/SP)** (6500 to 6989)

    - "Medicare/Medicaid Certification and Transmittal," Form CMS-1539
    - "Request to Establish Eligibility," Form CMS-1856
    - Crucial Data Extract for Form CMS-1893
    - "Statement of Deficiencies and Plan of Correction," Form CMS-2567
    - "Survey Team Composition and Workload Report," Form CMS-670

8. **Rural Health Clinic** (3400 to 3499, 3800 to 3999 and 8500 to 8999)

    - "Medicare/Medicaid Certification and Transmittal," Form CMS-1539
    - "Request to Establish Eligibility," Form CMS-29
    - "Statement of Deficiencies and Plan of Correction," Form CMS-2567
    - Crucial Data Extract for Form CMS-30(E)
    - "Survey Team Composition and Workload Report," Form CMS-670

9. **ESRD** (2300 to 2999 and 3500 to 3799)

- "Medicare/Medicaid Certification and Transmittal," Form CMS-1539
- "Statement of Deficiencies and Plan of Correction," Form CMS-2567
- Crucial Data Extract for Form CMS-3427
- "Survey Team Composition and Workload Report," Form CMS-670

10. **SNF and SNF/NF** - Titles XVIII and XVIII/XIX (5000 to 6399)

- "Medicare/Medicaid Certification and Transmittal," Form CMS-1539
- "Long Term Care Facility Application for Medicare/Medicaid," Form CMS-671
- "Resident Census and Conditions of Residents," Form CMS-672
- "Statement of Deficiencies and Plan of Correction," Form CMS- 2567
- "Fire Safety Survey Report Crucial Data Extract," Form CMS-2786
- "Survey Team Composition and Workload Report," Form CMS-670

11. **NF** (A001 to A999, 00-B001 to B999, E001 to E999, and F001 to F999)

- "Medicare/Medicaid Certification and Transmittal," Form CMS-1539
- "Long Term Care Facility Application for Medicare/Medicaid," Form CMS-671
- "Resident Census and Conditions of Residents," Form CMS-672
- "Statement of Deficiencies and Plan of Correction," Form CMS-2567
- "Fire Safety Survey Report Crucial Data Extract," Form CMS-2786
- "Survey Team Composition and Workload Report," Form CMS-670

12. **Intermediate Care Facilities for** ***Individuals with Intellectual Disabilities*** (GOO1 to G999, H001 to H999)

- "Medicare/Medicaid Certification and Transmittal," Form CMS-1539

- "Intermediate Care Facility for *Individuals with Intellectual Disabilities* Survey Report," Form CMS-3070G

- "Statement of Deficiencies and Plan of Correction," Form CMS-2567

- "Fire Safety Survey Report Crucial Data Extract," Form CMS-2786

- "Survey Team Composition and Workload Report," Form CMS-670

13. Ambulatory Surgical Centers (C0000001 to C9999999)

- "Medicare/Medicaid Certification and Transmittal," Form CMS-1539

- "Ambulatory Surgical Center Request for Certification in the Medicare Program," Form CMS-377

- "Statement of Deficiencies and Plan of Correction," Form CMS-2567

- "Ambulatory Surgical Center Survey Report," Form CMS-378 and "Ambulatory Surgical Center Report -- Crucial Data Extract," Form CMS-378E

- "Fire Safety Survey Report," Form CMS-2786H

- "Survey Team Composition and Workload Report," Form CMS-670

14. Comprehensive Outpatient Rehabilitation Facilities (4500 to 4599, 3200 to 3299, 4500 to 4599 and 4800 to 4899)

- "Medicare/Medicaid Certification and Transmittal," Form CMS-1539

- "Request to Establish Eligibility," Form CMS-359

- "Statement of Deficiencies and Plan of Correction," Form CMS-2567

- "Survey Team Composition and Workload Report," Form CMS-670

15. Hospice (1500 to 1799)

- "Medicare/Medicaid Certification and Transmittal," Form CMS-1539

- "Request to Establish Eligibility," Form CMS-417

- "Statement of Deficiencies and Plan of Correction," Form CMS-2567

- Crucial Data Extract for Form CMS-643
- "Survey Team Composition and Workload Report," Form CMS-670

16. Community Mental Health Centers (4600 to 4999 and 1400 to 1499)

- "Medicare/Medicaid Certification and Transmittal," Form CMS-1539
- "Community Mental Health Center Crucial Data Extract (No CMS number.)

17. Federally Qualified Health Centers (1800 to 1989)

- "Medicare/Medicaid Certification and Transmittal," Form CMS-1539
- Federally Qualified Health Center Crucial Data Extract

18. CLIA Laboratories (D0000001 to D9999999)

- "Medicare/Medicaid Certification and Transmittal Form CMS-1539
- "Survey Report Form (CLIA)," Form CMS-1557
- "Statement of Deficiencies and Plan of Correction," Form-2567
- "Survey Team Composition and Workload Report," Form CMS-670

4157C - Scope of Survey

(Rev. 96, Issued, 12-13-13, Effective: 12-13-13, Implementation: 12-13-13)

1. Full Survey

A survey of all applicable CoPs and standards for all types of Medicare/Medicaid providers and/or suppliers except SNFs, NFs and ICFs/*IID*. SNFs, NFs are described separately in 3 below, and ICFs/*IID* are described separately in 4 below.

2. Partial Survey

A survey of selected Conditions and/or standards for any type of Medicare/Medicaid provider and/or supplier, except SNFs and/or NFs and ICFs/*IID*. SNFs and/or NFs are described separately in 3 below, and ICFs/*IID* are described separately in 4 below.

3. SNF and/or NF Surveys

a. **Standard Survey** - A standard survey is composed of Tasks 1-7, and is a resident-centered, outcome-oriented inspection which relies on a case-mix stratified sample of residents to gather information about the facility's compliance

with participation requirements. Based on the specific procedures detailed in Appendix P, a standard survey assesses:

- Compliance with residents' rights and quality of life requirements;
- The accuracy of residents' comprehensive assessments and the adequacy of care plans based on these assessments;
- The quality of services furnished, as measured by indicators of medical, nursing, rehabilitative care and drug therapy, dietary and nutrition services, activities and social participation, sanitation and infection control; and
- The effectiveness of the physical environment to empower residents, accommodate resident needs, and maintain resident safety.

If in conducting the information gathering tasks of the standard survey the RO identifies a possible noncompliant situation related to any requirement, it investigates the situation to determine whether the facility is in compliance with the requirements.

b. **Extended Survey** - The extended survey is conducted after substandard quality of care is found during a standard survey. When, based on performing the resident-centered tasks of the standard survey the RO makes a determination that the facility has provided substandard quality of care in 42 CFR 483.13, Resident Behavior and Facility Practices; 42 CFR 483.15, Quality of Life; and/or 42 CFR 483.25, Quality of Care, then an extended survey must be conducted within 14 days after completion of a standard survey. (See Appendix P, Part I, Section III, the extended and partial extended survey.)

c. Partial Extended Survey - A partial extended survey is always conducted after substandard quality of care is found during an abbreviated standard survey. When, based on performing the abbreviated standard survey, the RO makes a determination that the facility has provided substandard quality of care in 42 CFR 483.13, Resident Behavior and Facility Practices; 42 CFR 483.15, Quality of Life; and/or 42 CFR 483.25, Quality of Care, it must conduct a partial extended survey. (See Appendix P, Part I, Section III, the extended and partial extended survey.)

4. ICF/IID Surveys

a. **Fundamental Survey** - Conducted to determine the quality of services and supports received by individuals, as measured by outcomes for individuals and essential components of a system which must be present for the outcomes of active treatment to occur. Certain requirements are designated as fundamental and are reviewed first. The remaining requirements (that are not designated as fundamental) are supporting structures or processes that the facility must implement. A decision that a provider is in compliance with the fundamental

requirements indicates an outcome-reviewed compliance with the non-fundamental requirements and associated Conditions of Participation. (Reference Transmittal No. 278 for specific tag numbers included primarily under 42 CFR 483.420, Client Protections, 42 CFR 483.440, Active Treatment Services, 42 CFR 483.450, Client Behavior and Facility Practices, 42 CFR 483.460, Health Care Services).

b. **Extended Survey** - Conducted when standard-level deficiencies are found during the fundamental survey and the survey team has determined or suspects that one or more CoP examined during the fundamental survey are "not met." The team needs to gather additional information in order to identify the structural and process requirements that are "not met" and to support their condition-level compliance decision. The team reviews all of the requirements within the CoP(s) for which compliance is in doubt.

c. **Full Survey** - A survey of all applicable CoPs and standards. A full survey is conducted by the State Agency at an initial survey and at the discretion of the RO, based on the RO's identification of concerns related to the provider's capacity to furnish adequate services.

4544 - LTC Facility Workload (SNF/NF)

(Rev. 96, Issued, 12-13-13, Effective: 12-13-13, Implementation: 12-13-13)

The certification requirements for SNFs and NFs in the Medicare and Medicaid programs are virtually identical. The same staff must perform the survey activity relating to SNF/NFs. This ensures that interpretation of the regulations to the provider remains consistent regardless of program participation. In addition to surveying SNFs, the same staff may survey ICFs/*IID* for the Medicaid program in order to consolidate survey activities being performed for both programs.

The Federal share of the costs of the survey and certification activities and follow-up visits related to surveys of nursing homes participating in both titles XVIII and XIX are to be divided equally by the two programs. FFP in the costs for each program are to be in accordance with regulations pertaining to the respective program. Costs of survey and certification activities and follow-up visits related to surveys of ICFs/*IID* are to be chargeable entirely to title XIX in accordance with Federal regulations.

The costs of activities performed by this survey staff for purposes of the State licensure program or any other State program must be borne entirely by the State. The SA maintains records to reflect the costs of these activities. Time records having prior approval by the RO are used to support the actual charges made to either the Medicaid or Medicare program.

Since a portion of the survey and certification costs for Medicaid continues to be borne by the State, it is necessary that the budget and activity plan be submitted to the SMA for review and approval. This procedure will also assure proper coordination and scheduling

of survey and certification activities by the SA with the medical review and UR responsibilities of the title XIX agency.

4611 - Line Item Justifications for SA Direct and Indirect Costs

(Rev. 96, Issued, 12-13-13, Effective: 12-13-13, Implementation: 12-13-13)

In making the entries for items under non-personal services (Other Direct Costs, lines 5 through 14, of Form CMS-435), the SA is required to justify the amounts approved by providing the rationale developed for each line item separately, using base period data and format as described in §4605. Specific guides and criteria are listed below.

A. Retirement Contributions and Fringe Benefits

The SA enters the estimated total of the employer's share of social security taxes, State retirement system(s) contributions and other fringe benefits. Also, the SA indicates the percentage used to determine the level of funding for Retirement and Fringe Benefits.

B. Travel

The SA includes the estimated travel costs of its personnel, including, where appropriate, per diem or subsistence in lieu of per diem, applicable to the State survey program. The SA derives estimated costs based on provisions of State law, regulation and administrative procedures applicable to travel of State employees. The SA indicates in the budget estimate expected number, type and extent of trips, and purpose. For out-of-state travel, the SA indicates the number of trips, the purpose, and basis for charges to the State survey program. The SA includes the basis for charges for all out-of-State travel other than to meetings called by CMS.

C. Communications

In the budget estimate, the SA breaks out e-mail, telephone, telegraph, postage, and other communications separately.

D. Supplies

In the budget estimate, the SA breaks out all major items of supplies, i.e., any supplies comprising 20 percent or more of the total cost of supplies.

E. Office Space

1 - Agency In Identifiable Space

Analysis of base period expenditures and the budget estimate must contain these elements for each location: total rental costs, number of square feet of space, cost per square foot, and services included in rental. The SA identifies office space that is State-owned.

2 - Office Space - Agency In Shared Space

SA analysis of base period expenditures and the budget estimate must contain these elements:

- Total cost of space to the agency;
- Basis of proration;
- Office locations of SA staff; and
- Estimate of square feet allocated to the State survey program. The SA identifies State-owned space.

3 - Office Maintenance

In the budget estimate, the SA breaks out the major items of expense, e.g., light, heat, janitorial service, office equipment repair. If office maintenance, in whole or in part, is included in the SA rental contract, the SA notes this fact and the amount need not be separated.

F. Equipment

The SA enters costs of equipment to support specific personnel positions such as desks, chairs, typewriters, computers and computer-related equipment, file cabinets, tables, and other machines (fax machines, photocopiers, etc.) that are necessary for program operational, administrative and management needs. In addition to line item justification, the SA documents the budget estimate through use of Form CMS-1466 (Exhibit 54) for both LTC and non-LTC requirements. (See §4614.)

G. Training

The budget estimate should provide for the cost of training SA personnel. The SA includes the cost of travel and per diem associated with training sessions.

H. Consultants

The SA provides the estimated cost of consultants who are not State employees, but who are used on a part-time, temporary, or fee-for-service basis.

I. Subcontracts

The SA provides the estimated cost of subcontracts when part of its responsibilities are assigned to another State or local public agency. Subcontract costs attributable to State survey activities (e.g., State Fire Marshal) are allowable and payable at the FFP rate established for surveyors, i.e., 100 percent Federal payment for Medicare and 75 percent/25 percent FFP for Medicaid, with the exception of ICF/*IID*. The Federal

matching rate for ICF/*IID* is 75 percent of FFP for salary, fringe benefits, travel and training. All other costs are matched at 50 percent FFP.

J. Miscellaneous

The SA provides the estimated cost of other items, which have not been reported in any of the preceding classifications. Also, the SA enters as a separate line item anticipated cost associated with the NAR and NATCEP, line 14A. (See §4543.)

K.. Total Direct Costs

Calculated sum total cost of all line items outlined here and in §4612.

L. Indirect Costs

The SA provides the rate negotiated and approved by the Director, Division of Cost Allocation and Liaison, DHHS, for use during the budget FY together with the line item base, against which it is applied.

Expenditures included in this category must not be duplicated under direct costs.

M. Total Budget Request

Calculated total of all direct and indirect costs.

4628 - Preparation of Budget Request

(Rev. 96, Issued, 12-13-13, Effective: 12-13-13, Implementation: 12-13-13)

A. List of Materials and Order of Assembly

The SA assembles the budget documents in descending order, as follows:

1. Form CMS-435 and Form CMS-434;
2. State Agency Budget List of Positions, three Forms CMS-1465A;
3. State Agency Schedule for Equipment Purchases, three Forms CMS-1466;
4. The justification arranged in line item order;
5. Any bulky exhibit referred to in the line item justification; and
6. Supplemental documentation as requested in the annual budget call letter.

B. Routing

The SA certified documents are made available to RO and CO in accordance with the due date provided by CO. This will ensure that CMS can complete the budget approval process in time to prevent interruption to cash flow when one FY ends and the

succeeding FY begins. The request supporting title XIX SNF/NF, NFs, and ICF/*IID* workload (forms and narrative justification) should have the concurrence of the SMA. All additional documentation that was requested in the annual budget call letter should be sent the CO/RO.

4766 - Preparation of State Survey Agency Quarterly Expenditure Report, Long-Term Care Facility Workload, Form CMS-435

(Rev. 96, Issued, 12-13-13, Effective: 12-13-13, Implementation: 12-13-13)

The purpose of Form CMS-435 (Exhibit 45) is to report in a categorical listing the expenditures for each quarter and to separate the costs according to funding source. Because Form CMS-435 is designed to capture the costs of both non-LTC and LTC expenditures by funding source, only one form needs to be prepared quarterly.

A. Heading

The SA checks the boxes entitled title XVIII State Quarterly Expenditure and title XIX State Quarterly Expenditures Reports. The SA selects the State agency and the automated system inserts the official name for the agency, and the appropriate Region and State Code. The SA through a drop box selects the quarter and enters the year for budget period covered by the expenditure report.

B. Rounding to Next Higher Dollar

In preparing the Form CMS-435, the automated system rounds amounts of expenses incurred for each line item to the closest dollar.

C. Report Columns

Columns are provided for reporting staff-years and line item expenditures by funding source, i.e., Medicare, Medicaid, State matching, and totals by quarter. The SA reports all costs associated with the Medicaid program in the appropriate column, and in the State matching column, those matching costs associated with the Medicaid program. The SA does enters the State licensure costs in the State column.

D. FFP (Medicaid Only)

The Federal matching share of costs for the Medicaid nursing home survey and certification program is 75 percent.

The Federal matching rate for ICF/*IID* survey activity is 75 percent FFP for salaries, fringe benefits, travel, and training. All other costs are matched at 50 percent.

E. Line Entries

1. Line 1a Surveyor, 1b Non-Survey Professional

The SA enters the staff-years and total Federally supported salary costs of professional employees who worked on the LTC program during the reporting quarter. (See §4760 for instructions on determining staff-years.) For Title XVIII program, the SA enters in Columns (C) and (D) the staff-years and costs related to workload, and for Title XIX program the SA enters in Columns (E) and (F) the staff-years and costs related to workload. The State share is captured in column (G). The total costs for LTC survey activity is total by the automated system in Column (H). Survey activity relating to ICF/*IID* is to be entered in Columns (E), (F), and (G).

2. Line 2, Clerical

The SA follows the same instructions as for professionals and includes clerical supervisors, clerks, typists, stenographers, etc., working during the reporting quarter.

3. Line 3, Totals, Staff-Years, and Salaries (LTC)

Calculated sums of Lines 1 and 2.

4. Line 4, Fringe Benefit Rate

The SA enters the percentage used by the State to determine the level of funding for Retirement and Fringe Benefits.

5. Lines 5, Retirement/Fringe Benefits

The SA enters the total of the employer's share of social security taxes, State retirement system(s) contributions, and other fringe benefits.

6. Line 6, Travel

The SA enters the cost of travel, including per diem or subsistence in lieu of per diem and charges all travel for the LTC program in accordance with provisions of State law, regulations, and administrative procedures applicable to travel of State employees. The SA does not include in this section travel cost incurred for training purposes.

7. Line 7, 8, and 9, Communications, Supplies, and Office Space

The entries should cover total expenditures in each of these categories for the quarter covered by the report.

8. Line 10, Equipment

This is the amount expended for equipment during the reporting quarter. All equipment purchases must be supported by an accompanying "State Agency Schedule for Equipment Purchases," Form CMS-1466. (See instructions in §4614 for completing Form CMS-1466.) The SA does not include obligations for equipment.

9. Lines 11, Training

The SA enters the cost of training SA personnel. Training expenditures should include travel costs related to training.

10. Line 12 and 13, Consultants and Subcontracts

The SA enters total expenditures in each of these categories for the quarter covered by the report.

11. Line 14, Miscellaneous

The SA enters expenditures which have not been reported in any of the preceding classifications under Miscellaneous and enters all costs incurred for maintenance of the NAR and the NATCEP in line 14A under Miscellaneous. This should include salaries, fringe benefits, indirect costs and any other expenses incurred to maintain the NAR and NATCEP. The automated system sums of all miscellaneous expenditures itemized in rows (A) through (G) on line 14. If additional space is needed, the SA submits as supplemental data the attachment explaining these items.

12. Lines 15, Total Other Direct Costs

Calculated sum of lines 5 through 14.

13. Lines 16, Total Direct Costs

Calculated total of lines 3 and l5.

14. Lines 17, Indirect Costs for LTC Workload

This figure is derived by multiplying the approved Indirect Costs rate by the negotiated money base it is applied against. (See Line 18.)

15. Line 18, Indirect Costs Rate for LTC Workload

The SA indicates the rate negotiated and approved by the Director, Division of Cost Allocation and Liaison, DHHS, for use during the FY and the money base it is applied against. This official will also negotiate the money base at the same time the rate is established.

16. Line 19, Total Expenditures for LTC Workload

Calculated total of lines 16 and 17, Column (D). The complete quarterly expenditure report for the title XVIII Medicare program will be the total of Line 19, column (B) and (D).

17. Line 20, Total Un-liquidated Obligations

The SA enters the total obligations remaining unpaid at the end of the reporting period and itemizes all un-liquidated obligations by category (i.e., travel, office space, equipment) and submits as supplemental data.

18. Certification: Signature, Title, and Date

For the Form CMS-435s, the automated system enters the date and the SA certifying official types their name and title.