Medicare
Provider Reimbursement Manual
Part 2, Provider Cost Reporting Forms and Instructions, Chapter 35, Form CMS-2540-96

Department of Health and Human Services (DHHS)
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NEW/REVISED MATERIAL--*EFFECTIVE DATE:*

This transmittal updates Chapter 35, Skilled Nursing Facility (SNF) Complex Cost Report, Form CMS 2540-96, to reflect further clarification to existing instructions. The effective date for instructional changes is October 1, 2009.

Significant Revisions:

Worksheet S-2 -- When a provider has experienced low Medicare utilization, or no Medicare utilization, but wishes to file, or is required to file a full Medicare cost report, the letter "F" must be entered on line 20.

Worksheet I-4 -- Effective for services on and after 10/01/2009, a SNF-based Rural Health Clinic/Federally Qualified Health Clinic (RHC/FQHC) must subscript column 2. One subscript will be to capture the administration of H1N1 and the second column will be to capture the combination of administering both the influenza and the H1N1 vaccines during the same visit. There is no cost associated with the H1N1 vaccine itself to providers

REVISED ELECTRONIC SPECIFICATIONS EFFECTIVE DATE: Changes to the electronic reporting specifications are effective for cost reporting periods beginning on and after October 1, 2009.

Lines 23 through 30.--These lines provide for furnishing certain information concerning depreciation. All applicable items must be completed. (See CMS Pub. 15-I, chapter 1, regarding depreciation.)

Lines 23, 24, and 25.--Indicate, on the appropriate lines, the amount of depreciation claimed under each method of depreciation used by the SNF during the cost reporting period.

Line 26.--The total depreciation shown on this line may not equal the amount shown on lines 1 and/or 2 on the Trial Balance of Expenses Worksheet, but represents the amount of depreciation included in costs on Worksheet A, column 7.

Lines 29 through 32.--Indicate a "Yes" or "No" answer to each question on these lines.

Lines 33 through 44.--Indicate a "Yes" or "No" answer, where applicable, to each component and type of service that qualifies for the exception.

If you are a provider (public or non public) that qualifies for an exemption from the application of the lower of cost or charges (as explained in 42 CFR 413.13(f)), indicate the component and the appropriate services that qualify for this exemption. Subscript lines 35 through 40 as required for additional component(s).

Line 43.--Indicate whether the provider is licensed in a State that certifies the provider as an SNF as described on line 4 above, regardless of the level of care given for Titles V and XIX patients.

Line 44.-This line is not used for cost reporting periods beginning on and after July 1, 1998. Indicate whether the provider participated in the NHCMQ demonstration during the cost reporting period. All NHCMQ demonstration participants must file Form CMS 2540-96, including facilities reporting less than 1,500 program days which would otherwise be allowed to utilize the Form CMS 2540S-97. Only facilities in Kansas, Maine, Mississippi, New York, South Dakota, and Texas are eligible to participate in the NHCMQ demonstration. This demonstration will not be applicable for cost reporting periods beginning on and after July 1, 1998. At that time all SNFs will be reimbursed under PPS.

Section 222 (a)(1) of P.L. 92-603 (42 U.S.C. Section 1395b-1, note) authorizes the Secretary of the Department of Health and Human Services to engage in experiments and demonstrations regarding alternative methods of making payment on a prospective basis to SNFs and other providers. Section 222 (a)(3) authorizes the Secretary to grant waivers of certain Title XVIII requirements insofar as such requirements relate to methods of payment for services provided. Additional forms have been added to the SNF cost report to accommodate the NHCMQ demonstration project. Worksheet D-1 must be completed by a provider participating in the demonstration.

A provider participating in the NHCMQ demonstration, which otherwise is reimbursed by other than the Prospective Payment System and which indicates either an “O” or “N” on line 4, must complete Worksheet E, Part V in place of Worksheet E, Part I or Worksheet E, Part II.

Line 45.--List the total amount of malpractice premiums paid, (column 1) the total amount of paid losses, (column 2), and the total amount of self insurance, (column 3) allocated in this fiscal year.

Line 46.--Indicate if malpractice premiums and paid losses are reported in other than the Administrative and General cost center. If yes, provide a supporting schedule and list the amounts applicable to each cost center.

Line 47.--Are you claiming ambulance costs? Enter in column 1, "Y" for yes or "N" for no. If this is your first year of providing and reporting ambulance services, you are not subject to the payment limit. Enter in column 2, Y if this is your first year of providing ambulance service, or N if it is not.

NOTE: Do not complete lines 48 and 48.01 for cost reporting periods beginning on and after 01/01/2006.

Line 48.— If line 47 column 1 is Y, and column 2 is N, enter on line 48 column 1 the payment limit provided from your fiscal intermediary, and for services on or after 04/01/2002, enter in column 2, the Fee Amount from the PS&R. Use Worksheet S-2, line 48 (and subscripts) columns 1 and 2 for the Limit and Fee amount respectively. If your fiscal year is OTHER than a year beginning on October 1st, enter in Line 48, column 1, the payment limit for the period prior to October 1, and enter in column 2 the Fee Amount. Subscript line 48 for the applicable time periods, and enter in column 1 the Limit; enter in column 2 the Fee Amount. The per-trip rate is updated October 1st of each year. Subscript this line as needed.

Report your ambulance trip limits chronologically, in accordance with your fiscal year. Applicable chronological dates are 01/01/2001, 07/01/2001, 01/01/2002, 04/01/2002 (effective date of the blend), 01/01/2003, 01/01/2004, 01/01/2005, and 01/01/2006.

Line 48.01- 48.03. — Use lines 48.01-48.03 if your fiscal year is OTHER than a year beginning on October 1[s] Ambulance services will be based on a blend until 100 percent fee schedule is transitioned on 01/01/2006. The blend is effective for services on 04/01/2002 through 12/31/2005

Line 49.--Did you operate an ICF/MR facility for the purposes of title XIX? Enter "Y" for yes and "N" for no.

Line 50.-- Did this facility report less than 1500 Medicare days in its previous year's cost report? Enter "Y" for yes or "N" for no. If a new provider is filing a first year cost report, and qualifies to file a "simplified" SNF cost report, do not enter "Y" or "N".

Line 51.--If line 50 is yes, did you file your previous year's cost report using the "simplified" step-down method of cost finding? (See §3500.) Enter "Y" for yes or "N" for no. If a new provider is filing a first year cost report, and qualifies to file a "simplified" SNF cost report, do not enter "Y" or "N".

Line 52.--Is this cost report being filed under 42 CFR 413.321, (the "simplified" cost report)? Enter "Y" for yes, or "N" for no.

Line 53.—*Are there any related organizations or home office costs as defined in CMS Pub 15-1, chapter 10? Enter "Y" for yes, or "N" for no, in column 1. If yes, and there are home office costs, enter the home office provider number. If this facility is part of a chain organization, enter the name and address of the home office on lines 54, 55 and 56.*

Line 54, columns 1, 2, and 3.— Enter the name of the home office in column 1, and enter the name of the fiscal intermediary or contractor of the home office in column 2. Enter the fiscal intermediary or contractor number in column 3.

Line 55, columns 1, and 2.—Enter the street address in column 1, or the post office box number in column 2.

Line 56, columns 1, 2 and 3.—Enter the city, State and zip code in columns 1, 2, and 3.

3512. WORKSHEET S-5 - SKILLED NURSING FACILITY-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA

In accordance with 42 CFR 413.20(a), 42 CFR 413.24(a), and 42 CFR 413.24(c), you are required to maintain statistical records for proper determination of costs payable under the Medicare program. The statistics reported on this worksheet pertain to provider-based rural health clinics (RHCs) and provider-based Federally Qualified Health Centers (FQHCs). If you have more than one of these clinics, complete a separate worksheet for each facility.

Lines 1 and 2.--Enter the full address of the RHC/FQHC.

Line 3.--For FQHCs only, enter your appropriate designation (U = urban or R =rural). See §505.2 of the RHC/FQHC Manual, CMS Pub. 27, for information regarding urban and rural designations. If you are uncertain of your designation, contact your intermediary. RHCs do not complete this line.

Lines 4 through 9.--In column 1, enter the applicable grant award number(s). In column 2, enter the date(s) awarded.

Line 10.--Subscript line 10 as needed to list all physicians furnishing services at the RHC/FQHC. Enter the physician's name in column 1, and the physician's Medicare billing number in column 2. *This line is not applicable for cost reporting periods ending on and after May 31, 2009*

Line 11.--Subscript line 11 as needed to list all supervisory physicians. Enter the physician's name in column 1, and the number of hours the physician spent in supervision in column 2. *This line is not applicable for cost reporting periods ending on and after May 31, 2009*

Line 12--If the facility operates as other than an RHC or FQHC, answer yes to this question and indicate the number of other operations in column 2. List other types of operations and hours on subscripts of line 13.

Line 13.--Enter the starting and ending hours for each applicable day(s) in the columns for the clinic services provided. If the facility provides other than RHC or FQHC services (e.g., laboratory or physician services), subscript line 13 and enter the type of operation on each of the subscripted lines. Enter in each column the starting and ending hours for the applicable day(s) that a facility is available to provide other than RHC/FQHC services.

NOTE: Line 13 must still be completed even if the facility answers NO to the question on line 12.

Line 15. --Is this a consolidated cost report? If yes, enter the provider names, addresses and provider numbers for all providers included in this cost report. (See CMS Pub.27 §508.D.)

Line 16. --Did you provide all or substantially all of the direct GME training costs for services on or after October 1, 1997? If yes, you must separately identify allowable and non-allowable costs on Worksheet I-1 and enter in column 2 the number of Medicare visits performed by Interns and Residents.

Enter the primary payer payment is not credited toward the beneficiary's deductible and coinsurance (situations 4 and 5). Primary payer payments that are credited toward the beneficiary's deductible and coinsurance are not entered on line 9.

Line 9.--Enter the Part A coinsurance billed to Medicare beneficiaries. Include any primary payer payments applied to Medicare beneficiaries' coinsurance in situations where the primary payer payments do not fully satisfy the obligation of the beneficiary to the provider. Do not include any primary payer payments applied to Medicare beneficiaries' coinsurance in situations where the primary payer payment fully satisfies the obligation of the beneficiary to the provider. DO NOT INCLUDE coinsurance billed to program patients for physicians' professional services.

Line 10.--Enter program reimbursable bad debts for deductibles and coinsurance (from your records), excluding deductibles and coinsurance for physicians' professional services. *Report any recovery of bad debts on line 10.04 below.*

Line 10.01—Multiply the amount (including negative amounts) on line 10 by 100 percent for cost reporting periods beginning before 10/01/2005.

Line 10.02—Enter the gross reimbursable bad debts for full-benefit dual eligible individuals. This amount must also be included in the amount on line 10.

Line 10.03—DRA 2005 SNF Bad Debt – For cost reporting periods beginning on or after October 1, 2005, calculate as follows: [(Line 10 – line 10.02) times .7], PLUS the amount on line 10.02. This is the adjusted SNF allowable bad debt in accordance with DRA 2005, section 5004. (10/01/2005)

Line 10.04—Recovery of reimbursable bad debts.

Line 11.--Enter the applicable program's share of the reasonable compensation paid to physicians for services in utilization review committees applicable to the SNF. Include this amount in the amount eliminated from total costs on Worksheet A-8, line 28.

Line 12.--Enter the program's share of any recovery of excess depreciation applicable to prior years resulting from provider termination or a decrease in program utilization. (See §§136-136.16.)

Line 13.--Enter the program's share of any net depreciation adjustment applicable to prior years resulting from the gain or loss on the disposition of depreciable assets. (See §§132 - 132.4.) Enter in parentheses ( ) the amount of any excess depreciation taken.

NOTE: Section 1861 (v) (1) (O) sets a limit on the valuation of a depreciable asset that may be recognized in establishing an appropriate allowance for depreciation, and for interest on capital indebtedness after a change of ownership that occurs on or after December 1, 1997.

Line 14.—For cost reporting periods beginning prior to October 1, 2005, enter the sum of lines 3, 7, 10 and 11, minus lines 12, 8 & 9, plus line 13. For cost reporting periods beginning on and after October 1, 2005 enter the sum of lines *(3, 7,and line 10.03), minus line 10.04* for title XVIII, plus lines 11and 13, minus lines 8, 9, and 12.

Line 15.--Using the methodology outlined in §120, enter the sequestration adjustment.

Line 16.--Enter interim payments from Worksheet E-1.

NOTE: Include amounts received from PPS (for inpatient routine services) as well as amounts received from ancillary services.

Line 16.01.--Your fiscal intermediary will enter the Part A tentative adjustments from Worksheet E-1, column 2.

Line 16.20.--Enter OTHER adjustments from Worksheet E-1, column 2.

Line 17.--Enter the amount on line 14 minus the sum of lines 15, 16, and 16.01. Enter a negative amount in parentheses ( ). Transfer this amount to Worksheet S, Part II, column 2, line 1 or line 2, as applicable.

Line 18.--Enter the program reimbursement effect of protested items. Estimate the reimbursement effect of the nonallowable items by applying reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See §115.2.) Attach a worksheet showing the details and computations for this line.

Part B Line Descriptions.-

Use this part to calculate reimbursement settlement for Part B services for SNFs under title XVIII.

Line Descriptions

Line 19.--Enter the amount of Part B ancillary services furnished to Medicare patients. Obtain this amount from Worksheet D, Part I column 9, line 75.

Line 21.--Enter the intern and resident cost from Worksheet D-2, column 8, lines 16 or 20 for title XVIII

Line 23.--Report the charges applicable to the ancillary services from Worksheet D, Part I, column 3, line 75, plus Part II, line 2.

Line 24.--Enter the intern and resident charges from the provider's records.

Line 26.--Enter the amounts paid or payable by workmen's compensation and other primary payers when program liability is secondary to that of the primary payer. There are six situations under which Medicare payment is secondary to a primary payer:

1. Workmen's compensation,
2. No fault coverage,
3. General liability coverage,
4. Working aged provisions,
5. Disability provisions, and
6. Working ESRD beneficiary provisions.

Generally, when payment by the primary payer satisfies the liability of the program beneficiary, for cost reporting purposes, the services are considered non-program services. (The primary payment satisfies the beneficiary's liability when you accept that payment as payment in full. Note this on no-pay bills submitted in these situations.) The patient days and charges are included in total patient days and charges but are not included in program patient days and charges. In this situation, no primary payer payment is entered on line 26.

However, if the payment by the primary payer does not satisfy the beneficiary's obligation, the program pays (in situations 1, 2, and 3) the amount it otherwise pays (absent primary payer payment) less the primary payer payment and any applicable deductible and coinsurance. In situations 1, 2, and 3, primary payer payment is not credited toward the beneficiary's deductibles and coinsurance. In situations 4 and 5, the program pays the lesser of (a) the amount it otherwise pays (without regard to the primary payer payment or deductibles and coinsurance) less the primary payer payment; or (b) the amount it otherwise pays (without regard to primary payer payment or deductibles and coinsurance) less applicable deductible and coinsurance. In situations 4 and 5, primary payer payment is credited toward the beneficiary's deductible and coinsurance obligation.

3560. WORKSHEET I-3 - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

This worksheet provides for the reimbursement calculation of Rural Health Clinics and Federal Qualified Health Clinics. Use this worksheet to determine the interim all inclusive rate of payment and the total Medicare payment due you for the reporting period.

3560.1 Part I - Determination of Rate For RHC/FQHC Services.--Part I calculates the cost per visit for RHC/FQHC services and applies the screening guideline established by CMS on your health care staff productivity.

Line Descriptions

Line 1.--Enter the total allowable cost from Worksheet I-2, Part II, line 20.

Line 2.--Enter the amount from Worksheet I-4. Line 15, on this line.

Line 3.--Subtract the amount on line 2 from the amount on line 1 and enter the result.

Line 4.--Enter the greater of the minimum or actual visits by the health care staff from Worksheet I-2, Part I, column 5, line 8.

Line 5.--Enter the visits made by physicians under agreement from Worksheet I-2, Part I, column 5, line 9.

Line 6.--Enter the total adjusted visits (sum of lines 4 and 5).

Line 7.--Enter the adjusted cost per visit. This is determined by dividing the amount on line 3 by the visits on line 6. *For services rendered from January 1, 2010, through December 31, 2013, the maximum rate per visit entered on line 8 and the outpatient mental health treatment service limitation applied on line 14 both correspond to the same time period (partial calendar year). Consequently, both are entered in the same column and no further subscripting of the columns is necessary.*

Lines 8 and 9.—The limits are updated every January 1, (except calendar year 2003 updates that occurred January 1 and March 1 (See PM A-03-21)). Complete columns 1, 2 and 3 of lines 8 and 9, if applicable (add a column 3 for lines 8-14 if the cost reporting overlaps 3 limit update periods) to identify costs and visits affected by different payment limits during a cost reporting period. If only one payment limit is applicable during the cost reporting period, complete column 2 only.

Line 8.--Enter the maximum rate per visit that can be received by you. Obtain this amount from CMS Pub. 27, §505 or from your intermediary.

Line 9.--Enter the lesser of the amount on line 7 or line 8. For periods with cost reporting periods beginning on or after January 1, complete column 2 only. For cost reporting periods beginning prior to January 1, amounts will be entered in columns 1 and 2.

3560.2 Part II - Calculation of Settlement.--Use Part II to determine the total payment based on specific title due you for covered RHC/FQHC services furnished to program beneficiaries during the reporting period.

Complete columns 1 and/or 2 of lines 10 through 14 to identify costs and visits affected by different payment limits during a cost reporting period. If the provider's cost reporting period begins on or after January 1, then only column 2 is completed. For all other cost reporting periods beginning prior to January 1, both columns 1 and 2 must be completed.

Line Descriptions

Line 10.--Enter the number of program covered visits, excluding visits subject to the outpatient mental health services limitation from your intermediary records.

Line 11.--Enter the subtotal of program cost. This cost is determined by multiplying the rate per visit on line 9 by the number of visits on line 10 (the total number of covered Medicare beneficiary visits for RHC/FQHC services during the reporting period).

Line 12.--Enter the number of program covered visits subject to the outpatient mental health services limitation from your intermediary records.

Line 13.--Enter the program covered cost for outpatient mental health services by multiplying the rate per visit on line 9 by the number of visits on line 12.

Line 14.--Enter the limit adjustment. *In accordance with MIPPA 2008, section 102, the outpatient mental health treatment service limitation applies as follows: for services rendered through December 31, 2009, the limitation is 62.50 percent; for services from January 1, 2010, through December 31, 2011, the limitation is 68.75 percent; for services from January 1 2012, through December 31, 2012, the limitation is 75 percent; for services from January 1, 2013, through December 31, 2013, the limitation is 81.25 percent; and for services on and after January 1, 2014, the limitation is 100 percent.* This is computed by multiplying the amount on line 13 by the *corresponding* outpatient mental health service limit percentage. This limit applies only to therapeutic services, not initial diagnostic services.

Line 15. --Enter the total allowable GME pass-through costs. To determine the direct GME cost, divide the program visits performed by Interns and Residents from Worksheet S-5, line 16, column 2, by the total visits from Worksheet I-3, line 6. Multiply the result by the total allowable GME costs from Worksheet I-1, column 7, line 20. Add the applicable overhead costs associated with GME, from Worksheet I-2, line 15. Add the provider facility overhead applicable to GME, from Worksheet B, Part I, column 14, line 35. Enter the result on this line. (If there are no allowable GME pass-through costs, this line is zero.)

Line 16.--Enter the total program cost. This is equal to the sum of the amounts on lines 11 and 14, columns 1 and 2, (and column 3 if applicable), plus the GME pass through costs on line 15.

Line 17.--Enter the amount credited to the RHC program patients to satisfy their deductible liabilities on the visits on lines 10 and 12 as recorded by the intermediary from clinic bills processed during the reporting period. RHCs determine this amount from the interim payment lists provided by the intermediaries. FQHCs enter zero on this line as deductibles do not apply.

Line 18.--Enter the net program cost, excluding vaccines. This is equal to the result of subtracting the amount on line 17 from the amount on line 16.

Line 19.--Enter 80 percent of the amount on line 18.

Line 20.--Enter zero on this line. Worksheet I-4 has been eliminated.

Line 21--Enter the total reimbursable program cost. This is equal to the sum of the amounts on line 19 and 20.

Line 22--Enter the total reimbursable bad debts, net of recoveries, from your records.

Line 23.-Enter any other adjustment. For example, if you change the recording of vacation pay from the cash basis to the accrual basis (See CMS Pub 15-1,§ 2146.4), enter the adjustment. Specify the adjustment in the space provided.

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Line 24.--This is the sum of lines 21 and 22 plus or minus line 23.

Line 25--Enter the total interim payments made to you for covered services furnished to program beneficiaries during the reporting period (from intermediary records). Transfer amount from Worksheet I-5, line 4.

Line 25.01—Your Fiscal Intermediary will enter the tentative adjustment from Worksheet I-5, line 5.99.

Line 26--Enter the total amount due to/from the program (line 24 minus line 25). Transfer this amount to Worksheet S, Part II, columns 1, 3, or 4 as applicable, line 6.

Line 27--Enter the program reimbursement effect of protested items. The reimbursement effect of nonallowable items is estimated by applying reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See PRM-15-1 §115.2).

3562. WORKSHEET I-4 - COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

The cost and administration of pneumococcal and influenza vaccine to Medicare beneficiaries are 100 percent reimbursable by Medicare. This worksheet provides for the computation of the cost of these vaccines for services rendered on and after August 1, 2000. Prior to that date all vaccines were reimbursed through the parent provider and could not be claimed by the RHC and FQHC. Additionally, use this worksheet only for vaccines rendered to patients who at the time of receiving the vaccine(s) were not inpatients or outpatients of the parent provider. If a patient simultaneously received vaccine(s) with any Medicare covered services as an inpatient or outpatient, those vaccine costs are reimbursed through the parent provider and cannot be claimed by the RHC and FQHC.

Effective for services rendered on and after September 1, 2009, in accordance with CR 6633, dated August 27, 2009, the administration of influenza A (H1N1) vaccines furnished by RHC's and FQHC's is cost reimbursed. However, no cost will be incurred for the H1N1 vaccine as this is provided free of charge to providers/suppliers

This worksheet must be completed for services furnished on and after October 1, 2009. The administrative cost of influenza vaccines to Medicare beneficiaries is 100 percent reimbursable by Medicare This worksheet provides for the computation of these services rendered on and after October 1, 2009.

To account for the cost of administering seasonal influenza A vaccines, influenza A (H1N1) vaccines, and/or both vaccines administered during the same patient visit, column 2 is subscripted adding column 2.01 (administration of only H1N1 vaccines) and 2.02 (administration of both seasonal influenza and H1N1 vaccines during the same patient visit). The data entered in all columns (1 ,2 and applicable subscripts) for lines 4, 11, and 13 are mutually exclusive. That is, the vaccine costs, the total number of vaccines administered, and the total number of Medicare covered vaccines shall only be represented one time in the appropriate column. Columns 2.01 and 2.02 will not reflect the

cost of H1N1 vaccines as it is furnished at no cost to the provider. However, the cost of seasonal influenza vaccines is required in columns 2 and 2.02, line 4.

Line 1.--Enter the health care staff cost from Worksheet I-1, column 7, line 10.

Line 2.--Enter the ratio of the estimated percentage of time involved in administering pneumococcal and influenza vaccine injections to the total health care staff time. Do not include physician service under agreement time in this calculation.

Line 3.--Multiply the amount on line 1 by the amount on line 2 and enter the result.

Line 4.--Enter the cost of pneumococcal and influenza vaccine medical supplies from your records.

Line 5.--Enter the sum of lines 3 and 4.

Line 6.--Enter the amount on Worksheet I-1, column 7, line 21. This is your total direct cost of the facility.

Line 7.--Enter the amount from Worksheet I-2, *line 14, plus the amount on line 17.*

Line 8.--Divide the amount on line 5 by the amount on line 6 and enter the result.

Line 9.--Multiply the amount on line 7 by the amount on line 8 and enter the result.

Line 10.--Enter the sum of the amounts on lines 5 and 9.

Line 11.--Enter the total number of pneumococcal and influenza vaccine injections from your records.

Line 12.--Enter the cost per pneumococcal and influenza vaccine injection by dividing the amount on line 10 by the number on line 11 and entering the result.

Line 13.--Enter the number of pneumococcal and influenza vaccine injections from your records.

Line 14.--Enter the Medicare cost for vaccine injections by multiplying the amount on line 12 by the amount on line 13.

Line 15.--Enter the total cost of pneumococcal and influenza vaccine and its (their administration) and the administration of H1N1 vaccines by entering the sum of the amount in column 1, line 10 and the amount in column 2, *and applicable subscripts*, line 10. Transfer this amount to Worksheet I-3, Part I, line 2.

Line 16.--Enter the Medicare cost of pneumococcal and influenza vaccine and its (their administration) and the administration of H1N1 vaccines. This is equal to the sum of the amount in column 1, line 14 and column 2, *and applicable subscripts,* line 14. Transfer the result to Worksheet I-3, Part II, line 20.

3563. WORKSHEET I-5 - ANALYSIS OF PAYMENTS TO SNF-BASED RURAL HEALTH CLINIC AND FEDERALLY QUALIFIED HEALTH CENTERS

Complete this worksheet for Medicare interim payments only. Complete a separate worksheet for each rural health clinic and federally qualified health center.

Complete the identifying information on lines 1 through 4. The remainder of the worksheet is completed by your intermediary.

NOTE: DO NOT reduce any interim payments by recoveries as result of medical review adjustments where recoveries were based on a sample percentage applied to the universe of claims reviewed and the PS&R was not also adjusted

Line Descriptions

Line 1.--Enter the total program interim payments paid to the component. The amount entered reflects the sum of all interim payments paid on individual bills (net of adjustment bills) for services rendered in this cost reporting period. The amount entered include amounts withheld from the component's interim payments due to an offset against overpayments to the component applicable to prior cost reporting periods. It does not include any retroactive lump sum adjustment amounts based on a subsequent revision of the interim rate or tentative or net settlement amounts. Nor does it include interim payments payable.

Line 2.--Enter the total program interim payments payable on individual bills. Since the cost in the cost report is on an accrual basis, this line represents the amount of services rendered in the cost reporting period, but not paid as of the end of the cost reporting period, and does not include payments reported on line 1.

Line 3.--Enter the amount of each retroactive lump sum adjustment and the applicable date.

Line 4.--Transfer the total interim payments to the title XVIII Worksheet I-3, Part II, line 25.

DO NOT COMPLETE THE REMAINDER OF WORKSHEET I-5. LINES 5 THROUGH 7 ARE FOR INTERMEDIARY USE ONLY.

Line 5.--List separately each tentative settlement payment after desk review together with the date of payment. If the cost report is reopened after the Notice of Program Reimbursement (NPR) has been issued, report all settlement payments prior to the current reopening settlement.

Line 6.--Enter the net settlement amount (balance due to the provider or balance due to the program) for the NPR, or, if this settlement is after a reopening of the NPR, for this reopening.

NOTE: On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment, even though total repayment is not accomplished until a later date.

Line 7.--Enter the sum of the amounts on lines 4, 5.99, and 6 in column 2. The amount in column 2 must equal the amount on Worksheet I-3, line 24.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 2540-96

TABLE 1 - RECORD SPECIFICATIONS

Table 1 specifies the standard record format to be used for electronic cost reporting. Each electronic cost report submission (file) has four types of records. The first group (type 1 records) contains information for identifying, processing, and resolving problems. The text used throughout the cost report for variable line labels (e.g., Worksheet A) and variable column headers (Worksheet B-1) is included in the type 2 records. Refer to Table 5 for cost center coding. The data detailed in Table 3 are identified as type three records. The encryption coding at the end of the file, records 1, 1.01, and 1.02, are type 4 records.

The medium for transferring cost reports submitted electronically to fiscal intermediaries is 3 diskette. These disks must be in IBM format. The character set must be ASCII. Seek approval from your fiscal intermediary regarding alternate methods of submission to ensure that the method of transmission is acceptable.

The following are requirements for all records:

1. All alpha characters must be in upper case.

2. For micro systems, the end of record indicator must be a carriage return and line feed, in that sequence.

3. No record may exceed 60 characters.

Below is an example of a Type 1 record with a narrative description of its meaning.

```
          1         2         3         4         5
12345678901234567890123456789012345678901234567890123456789012345678
1             1    0101231999274200030 53C99P00520000202000305
1             7          17:15
```

Record #1: This is a cost report file submitted by Provider 010123 for the period from October 1, 1999 (1999274) through October 31, 2000, (2000305). It is filed on Form CMS-2540-96. It is prepared with vendor number C99's PC based system, version number 1. Position 38 changes with each new test case and/or approval and is alpha. Positions 39 and 40 will remain constant for approvals issued after the first test case. This file is prepared by the skilled nursing facility on January 20, 2000, (2000020). The electronic cost report specification, dated October 31, 2000, (2000305), is used to prepare this file.

FILE NAMING CONVENTION

Name each cost report file in the following manner:

SNNNNNNN.YYL, where

1. SN (SNF electronic cost report) is constant;
2. NNNNNN is the 6 digit Medicare skilled nursing facility provider number;
3. YY is the year in which the provider's cost reporting period ends; and
4. L is a character variable (A-Z) to enable separate identification of files from skilled nursing facilities with two or more cost reporting periods ending in the same calendar year.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 2540-96

TABLE 1 - RECORD SPECIFICATIONS

RECORD NAME: Type 1 Records - Record Number 1

		Size	Usage	Loc.	Remarks
1.	Record Type	1	X	1	Constant "1"
2.	NPI	10	9	2-11	Numeric only
3.	Spaces	1	X	12	
4.	Record Number	1	X	13	Constant "1"
5.	Spaces	3	X	14-16	
6.	SNF Provider Number	6	9	17-22	Field must have 6 numeric characters
7.	Fiscal Year Beginning Date	7	9	23-29	YYYYDDD - Julian date; first day covered by this cost report
8.	Fiscal Year Ending Date	7	9	30-36	YYYYDDD - Julian date; last day covered by this cost report
9.	MCR Version	1	9	37	Constant "3" (for Form CMS 2540-96)
10.	Vendor Code	3	X	38-40	To be supplied upon approval. Refer to page 35-503.
11.	Vendor Equipment	1	X	41	P = PC; M = Main Frame
12.	Version Number	3	X	42-44	Version of extract software, e.g., 001=1st, 002=2nd, etc. or 101=1st, 102=2nd. The version number must be incremented by 1 with each recompile and release to client(s).
13.	Creation Date	7	9	45-51	YYYYDDD - Julian date; date on which the file was created (extracted from the cost report)
14.	ECR Spec. Date	7	9	52-58	YYYYDDD - Julian date; date of electronic cost report specifications used in producing each file. Valid for cost reporting periods beginning on and after *2009275 (October 1, 2009).* Prior approval(s) are for cost reporting periods ending on or after *2008274* 2005304 (October 31, 2005). 2002365 (12/31/02), 2001059, 2000274, 1999334, 1998273, 1997273, and 1996274.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 2540-96
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

WORKSHEET S-2 (Continued)

Is the skilled nursing facility located in a State that certifies the provider as an SNF regardless of the level of care given for titles V and XIX patients? (Y/N)	43	1	1	X
Did the provider participate in the NHCMQ Demonstration during the cost reporting period? (Y/N)	44	1	1	X
If yes, enter phase number.	44	0	2	9
List malpractice premium and paid losses				
Premium:	45	1	11	9
Paid Losses:	45	2	11	9
Self Insurance:	45	3	11	9
Are malpractice premiums and paid losses reported in other than the Administrative and General cost Center? If yes, check box, and submit supporting schedules listing cost centers and amounts contained therein.	46	1	1	X
Are you claiming ambulance costs? Enter Y or N in column 1. If column 1 is Y, and this is your first year of operation for rendering ambulance services, enter Y in column 2. If it is not enter N.	47	1 & 2	1	X
If line 47 column 1 is Y, and column 2 is N, enter on line 48 column 1 the payment limit provided from your fiscal intermediary, and for services on or after 04/01/2002	48	1	9	9(8).99
Enter in column 2, the Fee Amount from the PS&R. Use Worksheet S-2, line 48 (and subscripts) columns 1 and 2 for the Limit and Fee amount respectively. If your fiscal year is OTHER than a year beginning on October 1st, enter in Line 48, column 1, the payment limit for the period prior to October 1, and enter in column 2 the Fee Amount.	48	2	9	9
Subscript line 48 for the applicable time periods, and enter in column 1 the Limit; enter in column 2 the Fee Amount. The per-trip rate is updated October 1st of each year. Subscript this line as needed.	48.01 48.01	1 2	9 9	9(8).99 9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 2540-96
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

WORKSHEET S-2 (Continued)

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Enter in column 1 the subsequent ambulance payment limit as required. Subscript if more than 2 limits apply.	48.02 48.03	1	9	9(8).99
Enter in column 2, the fee schedule amounts for the initial or subsequent period as applicable.	48.02 48.03	2	9	9
Did you operate an Intermediate Care Facility for the Mentally Retarded (ICF/MR) under title XIX?	49	1	1	X
Did this facility report less than 1500 Medicare days in its previous year's cost report?	50	1	1	X
If line 50 is yes, did you file your previous year's cost report using the "simplified" step-down method of cost finding?	51	1	1	X
Is this cost report being filed under 42CFR 413.321, the simplified cost report?	52	1	1	X
Are there any related organizations or home office costs as defined in CMS Pub. 15-1, chapter 10?	53	1	1	X
If yes, and there are home office costs, enter the home office provider number. If this facility is part of a chain organization, enter the name and address of the home office on lines 54, 55 and 56.	*53*	*2*	*6*	*X*
Name	*54*	*1*	*36*	*X*
FI or Contractor name	*54*	*2*	*36*	*X*
FI or Contractor number	*54*	*3*	*6*	*X*
Street	*55*	*1*	*36*	*X*
P.O. Box	*55*	*2*	*9*	*X*
City	*56*	*1*	*36*	*X*
State	*56*	*2*	*2*	*X*
Zip Code	*56*	*3*	*10*	*X*

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 2540-96
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
WORKSHEET S-5				
RHC/FQHC Identification:				
Street	1	1	36	X
County	1	2	36	X
City	2	1	36	X
State	2	2	2	X
Zip Code	2	3	10	X
Designation for FQHC's only "R" for rural or "U" for urban	3	1	1	X
Source of Federal funds:				
Amount of Federal Funds:	4-9	1	11	9
Award Date (MM/DD/YYYY)	4-9	2	10	X
Other (specify)	9	0	36	X
Physician(s) furnishing services at the clinic or under agreement				
Physician Name	10	1	36	X
Billing Number	10	2	36	X
Supervision				
Supervisory physician name	11	1	36	X
Number of hours of supervision during period	11	2	11	9(8).99
Does this facility operate as other than an RHC or FQHC?	12	1	1	X
Indicate number of operation(s)	12	2	2	9
Facility hours of operations *				
Clinic - Hours: from/to	13	1-14	4	9

* List hours of operations based on a 24 hour clock. For example 8:00 is 0800, 6:30pm is 1830, and midnight is 2400.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 2540-96
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

WORKSHEET S-5 (Continued)

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Other operations	13.01-13.10	0	36	X
Other operations - Hours: from/to	13.01-13.10	1-14	4	9
Have you received an approval for an exception to the productivity standard?	14	1	1	X
Is this a consolidated cost report in accordance with CMS Pub. 27, section 508D	15	1	1	X
Enter the number of providers included in this report	15	2	2	9
Provider Name	15.01-15.10	1	36	X
Provider Number	15.01-15.10	2	6	X
Have you provided all or substantially all GME cost?	16	1	1	X
Enter the number of Medicare visits performed by Interns and Residents	16	2	5	9

WORKSHEET S-6

Number of hours in a normal work week	0	0	6	9(3).99
Text as needed for blank lines	18-19	0	36	X
Number of full time equivalent employees on staff	1-19	1	6	9(3).99
Number of full time equivalent contract personnel	1-19	2	6	9(3).99
Is this component paid 100% under the established fee schedules	20	1	1	X

WORKSHEET S-7, PART I

Title XVIII NHCMQ Demonstration Statistical Data				
Rates (see instructions)	1-45	3, 4	6	9(3).99
Days (see instructions)	1-45	3.01, 4.01	6	9

WORKSHEET S-7, PART II

Rates (See instructions)	1-45	3,5	6	9(3).99
Medicare Days	1-45	4,6	6	9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 2540-96

TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

WORKSHEET E, PART II

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Primary payer amount	6	1	9	9
Inpatient ancillary service charges	8	1	9	9
Intern and resident charges	10	1	9	9
Aggregate amount collected	12	1	9	9
Amount collectible	13	1	9	9
Deductibles and coinsurance	17	1	9	9
Reimbursable bad debt	19	1	9	9
Recovery of excess depreciation	21	1	9	9
Other adjustments (specify)	22	0	36	X
Other adjustments (see instructions)	22	1	9	-9
Amounts applicable to prior periods resulting from disposition of depreciable assets	23	1	9	-9
Sequestration adjustment (see instructions)	25	1	9	9
Protested amounts	29	1	9	-9

WORKSHEET E, PART III

Part A - Inpatient service PPS provider computation of reimbursement of lesser of cost or charges				
Intern and resident charges	5	1	9	9
Inpatient routine PPS amount (see instructions)	7	1	9	9
Primary payer amounts	8	1	9	9
Coinsurance	9	1	9	9

TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

WORKSHEET E, PART III (Continued)

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Reimbursable bad debts	10	1	9	-9
Reimbursable bad debts	10.01	1	9	-9
Reimbursable bad debts	10.02	1	9	-9
Recovery of reimbursable bad debts	*10.04*	*1*	*9*	*9*
Utilization review	11	1	9	9
Recovery of excess depreciation	12	1	9	9
Amounts applicable to prior periods resulting from disposition of depreciable assets	13	1	9	-9
Sequestration adjustment (see instructions)	15	1	9	9
Other Adjustments (Specify)	16.20 - 16.99	0	36	X
Other Adjustments	16.20 - 16.99	1	11	-9
Protested amounts	18	1	9	-9
Part B - Ancillary service computation of reimbursement of lesser of cost or charges (title XVIII only)				
Intern and resident charges	24	1	9	9
Primary payer amounts	26	1	9	9
Coinsurance and deductibles	27	1	9	9
Reimbursable bad debts	28	1	9	9
Recovery of excess depreciation	31	1	9	9
Other adjustments (specify)	32	0	36	X
Other adjustments	32	1	9	-9
Amounts applicable to prior periods resulting from disposition of depreciable assets	33	1	9	-9
Sequestration adjustment	35	1	9	9
Other Adjustments (Specify	36.20 – 36.99	0	36	X
Other Adjustments	36.20 – 36.99	1	11	-9
Protested amounts	38	1	9	-9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 2540-96

TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
WORKSHEET I-3				
Medicare covered visits for mental health services (from your intermediary)	12	1, 2, & 3	11	9
Beneficiary deductible (from your intermediary)	17	2	11	9
Reimbursable bad debt	22	2	11	9
Interim payments	25	2	11	9
Protested amounts	27	2	11	9
WORKSHEET I-4				
Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	2	1,2, *2.01&2.02*	8	9.9(6)
Medical supplies cost - pneumococcal and influenza vaccine	4	1, *2,&2.02*	11	9
Total number of pneumococcal and influenza vaccine injections	11	1, *2,* *2.01&2.02*	11	9
Number of pneumococcal and influenza vaccine injections administered to Medicare beneficiaries	13	1,2, *2.01&202*	11	9
WORKSHEET I-5				
Total interim payments paid to provider	1	2	11	9
Interim payments payable	2	2	11	9
Date of each retroactive lump sum adjustment (MM/DD/YYYY)	3.01-3.98	1	10	X
Adjustment of each retroactive lump sum adjustment:				
Program to provider	3.01-3.49	2	11	9
Provider to program	3.50-3.98	2	11	9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 2540-96

TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

WORKSHEET J-1, PART I

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Net expenses for cost allocation	1-21	0	9	9
Post step down adjustments (including total)	1-22	17	9	-9
Totals (sum of lines 1-21)	22	0-3, 4-15, 17	9	9

WORKSHEET J-1, PART III

Reconciliation	1-21	1A-15A	9	-9
Cost allocation statistics	1-21	1-15 *	9	9

* See note to Worksheet B-1 for treatment of administrative and general accumulated cost column.

WORKSHEET J-2

Part I: Facility charges				
In total	2-21	2	9	9
Title V	2-21	4	9	9
Title XVIII	2-21	8 & 10	9	9
Title XIX	2-21	6	9	9
Part II: Charges for rehabilitation services furnished by shared departments				
Title V	23-29	4	9	9
Title XVIII	23-29	8 & 10	9	9
Title XIX	23-29	6	9	9

ELECTRONIC COST REPORTING SPECIFICATIONS FOR FORM CMS 2540-96

TABLE 6 - EDITS

Reject Code	Condition
1055S	*Worksheet S-2: If the response on line 53 column 1 = Y, and column 2 contains a number, then there must be a response on line 54, columns 1, 2, and 3, line 55 column 1 or column 2; line 56 columns 1, 2, and 3. If the response on line 53 column 2 is blank, then lines 54-56 should also be blank. [4/30/2008].*
1075S	All amounts reported on Worksheet S-3, Part I must not be less than zero. [03/31/1997]
1080S	For Worksheet S-3, Part I, the sum of the inpatient days in columns 3-6 for each of lines 1, 3, and 4 must be equal to or less than the total inpatient days in column 7 for each line. [03/31/1997]
1100S	The amount of hours reported in column 4, lines 1-13 (Worksheet S-3, Part III) must be greater than or equal to zero. [03/31/1997]
1105S	For Worksheet S-3, Part I, the sum of the discharges in columns 8-11 for each of lines 1, 3, and 4 must be equal to or less than the total discharges in column 12 for each line indicated. [03/31/1997]
1110S	Worksheet S-3, Part II, columns 1 and 4, line 23 must be greater than zero. [03/31/1997]
1115S	The amount on Worksheet S-3, Part II, Column 3, line 22 (total wage related costs), must be greater than 7.65 percent and less than 50.0 percent of the amount in column 3, line 16 (total salaries). [12/31/2002]
1120S	For Worksheet S-3, Part II, all values for column 5 lines 1-18, and 23 must equal or exceed $5.15. When there are no salaries reported in column *three,* then it is okay to have zero amounts in columns 3 and 5. [12/31/2002]
1125S	The amount of total salaries reported in column 1, line 1 (Worksheet S-3, Part II) must equal Worksheet A, Column 1, line 75 [12/31/2002]
1130S	If Worksheet S-4, Part II, column 1, line 17 has data, then it must be a four character alpha numeric; or if column 1.01, line 17 has data, then it must be a five character alpha numeric.[04/30/08]

The following Wage Index edits are to be applied against PPS SNFs only, edit number 1200S, 1205S, and 1220S.

1200S	For Worksheet S-3, Part II, sum of columns 1 and 2 each of lines 2-5, 8-14, 17-21, and subscripts as applicable must be equal to or greater than zero. [01/31/2001]
1205S	The amount of salaries reported for Interns & Residents in approved programs Worksheet S-3, Part II column 1, line 4 must be equal to or greater than the amount on Worksheet A, column 1 line 14 (including subscripts). [09/30/1998]
1220S	Worksheet S-3, Part II, sum of columns 1 & 2, line 19 must be greater than zero. [09/30/1998]

ELECTRONIC COST REPORTING SPECIFICATIONS FOR FORM CMS 2540-96

TABLE 6 – EDITS

Reject Code	Condition
1225S	Worksheet S-5, Line 15: If the response in column 1 = "Y", then column 2 must be greater than zero. If the response in column 1 = "N", then column 2 must = zero. [04/30/2008]
1230S	Worksheet S-7 Part 4: Column 3.01 sum of lines 1 through 45 must agree with Worksheet S-3, Part I, column 4, line 1. [04/30/2008]
1000A	Worksheet A, columns 1 and 2, line 75 must be greater than zero. [03/31/97]
1015A	On Worksheet A, lines 52 and 53, the sum of column 2 and the corresponding reclassifications and adjustments must equal zero. On line 54, the sum of columns 1 and 2 and the corresponding reclassifications and adjustments must equal zero. [03/31/1997]
1020A	For reclassifications reported on Worksheet A-6, the sum of all increases (columns 4 and 5) must equal the sum of all decreases (columns 8 and 9). [03/31/1997]
1025A	For each line on Worksheet A-6, if there is an entry in column 3, 4, 5, 7, 8, or 9, there must be an entry in column 1. There must be an entry on each line of columns 4 and/or 5 for each entry in column 3 (and vice versa), and there must be an entry on each line of columns 8 and/or 9 for each entry in column 7 (and vice versa). All entries must be valid, for example, no salary adjustments in columns 3 and/or 7, for capital lines 1 & 2 of Worksheet A. [09/30/1998]
1040A	For Worksheet A-8 adjustments on lines 1-7, 9-11, and 13-21, if either columns 2 or 4 has an entry, then columns 1, 2, and 4 must have entries, and if any one of columns 0, 1, 2, or 4 for line 31 (and subscripts of line 31) has an entry, then all columns 0, 1, 2, and 4 must have entries. [03/31/1997] If lines 28-30 have an entry in column 2, then column 1 of that line must have an entry. [03/31/1997]
1041A	The total Utilization Review amount shown on Worksheet E, Part III, Line 11, may not be greater than the amount on Worksheet A-8, line 28.(Absolute value of line 28) [04/30/2008]
1045A	This edit was changed to a level two edit April 2003. See edit # 2045A
1050A	On Worksheet A-8-2, column 3 must be equal to or greater than the sum of columns 4 and 5. If column 5 is greater than zero, column 6, and column 7 must be greater than zero. [06/13/02]
1055A	Worksheet A-8-3, column 1, line 56 must equal the sum of column 1, lines 58 and 59. [03/31/1997]
1060A	If Worksheet A-8-5, column 5, line 47 is equal to zero, column 5, line 51 must also be equal to zero. Conversely, if Worksheet A-8-5, columns 1-4, line 47 is greater than zero, column 5, line 51 must be greater than column 5, line 47 and equal to or less than 2080 hours for a 12 month cost report, (2240 hours for a 13 month cost report, 2400 hours for a 14 month cost report, or 2560 hours for a 15 month cost report). [10/31/1998]

ELECTRONIC COST REPORTING SPECIFICATIONS FOR FORM CMS 2540-96

TABLE 6 – EDITS

Reject Code	Condition
1000B	On Worksheet B-1, all statistical amounts must be greater than or equal to zero, except for reconciliation columns. [03/31/1997] (A): On Worksheet B-1, Part II, all statistical amounts must be greater than or equal to zero, except for reconciliation columns. [02/01/2001] (B)
1005B	Worksheet B, Part I, column 18, line 75 must be greater than zero. [03/31/1997]
1010B	For each general service cost center with a net expense for cost allocation greater than zero (Worksheet B-1, columns 1 through 15, line *66*), the corresponding total cost allocation statistics (Worksheet B-1, column 1, line 1; column 2, line 2; etc.) must also be greater than zero. Exclude from this edit any column, including any reconciliation column, that uses accumulated cost as its basis for allocation. [03/31/1997]
1015B	For any column which uses accumulated cost as its basis of allocation (Worksheet B-1), there may not simultaneously exist on any line an amount both in the reconciliation column and the accumulated cost column, including a negative one. [03/31/1997]
1010C	On Worksheet C, all amounts in column 1 line 75 and column 2 must be greater than or equal to zero. [03/31/1997]
1000D	On Worksheet D, all amounts must be greater than or equal to zero. [03/31/1997]
1005D	The total inpatient charges on Worksheet C, Part I, Line 30 must be greater than or equal to the sum of Worksheet D, Part I, Line 30 plus Worksheet D, Part II, Line 2. [04-30--2008]
1000E	On Worksheet E, Part III, line 10.02, bad debt for dual eligible beneficiaries, new amounts cannot exceed total bad debts on line 10, (e.g., for Worksheet E, Part III, line 10.02, must be less than or equal to line 10, total bad debts). Do not apply this edit if the total bad debt line is negative. [04/30/2008]
1020H	For the home health agency, [FYs ending through 9/30/2000], the total Medicare program (Title XVIII) visits reported as the sum of all Worksheets H-5, Part II (sum of columns 5 and 6, lines 1-6, plus Worksheet H-5, Part V, columns 3, 5, and 5.01, lines 26-28) must equal the sum of the visits reported on Worksheet S-4 (column 2, sum of lines 1-6). Do not apply this edit for cost reports beginning on or after 10/01/2000. (A)
1021H	For the home health agency, [FYs which over lap 10/1/2000], the total Medicare program (Title XVIII) visits reported as the sum of all Worksheets H-5, Part II (sum of columns 5 and 6, lines 1-6 which are pre 10/1/2000 visits excluding subscripts, plus Worksheet H-5, Part V, columns 5.01 pre 10/1/2000 visits, lines 26-28) must equal the sum of the visits reported on Worksheet S-4, column 2, sum of lines 1-6. (A)

ELECTRONIC COST REPORTING SPECIFICATIONS FOR FORM CMS 2540-96

TABLE 6 – EDITS

1022H For the home health agency, [FYs beginning on or after 10/1/ 2000], the total Medicare program (Title XVIII) visits reported as the sum of all Worksheets H-5, Part II (sum of columns 5 and 6, lines 1-6, must equal the sum of the visits reported on Worksheet S-4, Part III, column 7, sum of lines 1, 3, 5, 7, 9 and 11. (A)

1023H For the home health agency, [FYs ending through 9/30/2000], the total Medicare (Title XVIII) unduplicated census count (Worksheet S-4, Part I, column 3, line 9) must be equal to or greater than the sum of the unduplicated census count for all MSAs (Worksheet H-5, Part IV, column 1, line 25). Do not apply this edit for cost reports beginning on or after 10/01/2000. (A)

1024H For the home health agency, [FYs which over lap 10/1/2000], the total Medicare (Title XVIII) unduplicated census count (Worksheet S-4, Part I, column 3, line 9.01) must be equal to or greater than the sum of the unduplicated census count for all MSAs (Worksheet H-5, Part IV, column 1, line 25). (A)

1030H For the home health agency, [FYs ending through 9/30/2000], if Medicare visits on Worksheet S-4, column 2, lines 1-6, respectively, are greater than zero, then the corresponding cost on Worksheet H-4, Part I, Column 3, lines 2 through 7, must also be greater than zero. Do not apply this edit for cost reports beginning on or after 10/01/2000. (A)

1035H Worksheet H-6 Part II: If line 2*0*, columns 1 and 2 respectively, are greater than zero (0), then Worksheet H-7 Line 1 columns 2 and 4, respectively, must be greater than zero (0) [04/30/2008]

1000J Worksheet J-1, Part I, sum of columns 0-3, 4-15, and 17, line 22, must equal the corresponding Worksheet B, column 18, line 50 or appropriate subscript as identifies this provider type. [03/31/1997]

II. Level II Edits (Potential Rejection Errors)

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

Edit	Condition
2000	All type 3 records with numeric fields and a positive usage must have values equal to or greater than zero (supporting documentation may be required for negative amounts).
2005	Only elements set forth in Table 3, with subscripts as appropriate, are required in the file.
2010	The cost center code (positions 21-24) (type 2 records) must be a code from Table 5, and each cost center code must be unique.
2015	Standard cost center lines, descriptions, and codes should not be changed. (See Table 5.) This edit applies to the standard line only and not subscripts of that code.
2020	All standard cost center codes must be entered on the designated standard cost center line and subscripts thereof as indicated in Table 5.