Provider Reimbursement Manual

Part 2, Provider Cost Reporting Forms and Instructions, Chapter 40, Form CMS-2552-10

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

Transmittal 25 **Date: February 27, 2026**

HEADER SECTION

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This transmittal updates Chapter 40, Hospital and Hospital Health Care Complex Cost Report (Form CMS-2552-10), by clarifying and revising the existing instructions and by revising existing edits. Effective dates vary.

Revisions include:

- Worksheet S:
  - Updated expiration date to 9/30/2028
  - Updated hours to complete the forms

- Worksheet S-12: Added OMB # 0938-1486, Supplemental to Form CMS-2552-10 to report the weighted median of the payer-specific negotiated charges the hospital has negotiated with each Medicare Advantage Organization (MAO) for each MS-DRG

- Worksheet D-4, Part IV: Removed shading from line 76, columns 1, 2 and 3

- Worksheet L-1, Part I: Corrected instructions for calculating the unit cost multiplier for line 204, columns 1 through 23

- Worksheet N-3: Corrected reference to line 4 instructions

- New Edits: 10510D, 10511D, 10512D, 10513D, 10514D, 10515D, 10516D, 10517D, 10155M

- Revised Edits: 10450S, 12410S

REVISED ELECTRONIC SPECIFICATIONS EFFECTIVE DATE: Changes to the electronic reporting specifications are effective for cost reporting periods ending on or after December 31, 2025.

DISCLAIMER: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged.

CHAPTER 40
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT FORM CMS-2552-10

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4000. GENERAL

The Paperwork Reduction Act of 1995 requires that you be informed why information is collected and what the information is used for by the government. In accordance with §§1815(a), 1833(e), and 1861(v)(1)(A) of the Social Security Act (the Act), providers of service participating in the Medicare program are required to submit annual information to achieve settlement of costs for health care services rendered to Medicare beneficiaries. In accordance with these provisions, all hospital and hospital health care complexes must complete Form CMS-2552-10 with a valid Office of Management and Budget (OMB) control number in order to determine program payment. In addition to determining program payment, the data submitted on the cost report support management of the federal programs, e.g., data extraction in developing cost limits, data extraction in developing and updating various prospective payment systems. The information reported on Form CMS-2552-10 must conform to the requirements and principles set forth in 42 CFR 412, 42 CFR 413, and in the Provider Reimbursement Manual, Part 1 (CMS Pub. 15-1). The filing of the cost report is mandatory, and failure to do so results in all payments for the cost reporting period being deemed overpayments and up to 100 percent withhold of subsequent payments until the cost report is received. (See Provider Reimbursement Manual, Part 2 (CMS Pub. 15-2), chapter 1, §100.) The Medicare cost report information is considered public record under the Freedom of Information Act, 45 CFR Part 5. The Form CMS-2552-10 is effective for hospitals and hospital health care complexes with cost reporting periods beginning on or after May 1, 2010.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The number for this information collection is OMB 0938-0050 (expires *09/30/2028*) *and the number for the Supplement to Form CMS 2552-10, Worksheet S-12, is OMB 0938-1486 (expires 01/31/2029)*. The time required to complete this information collection is estimated to average *685* hours per response, including the time to review instructions; search existing data resources; gather the data needed; and complete and review the information collection. Direct any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form to:

Center for Medicare and Medicaid Services
Attn: PRA Report Clearance Officer
7500 Security Boulevard
Mail Stop C4-26-05
Baltimore, MD 21244-1850

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

Worksheets are provided on an as needed basis dependent on the needs of the hospital. Not all worksheets are needed by all hospitals. The following are a few examples of conditions for which worksheets are needed:

- Reimbursement is claimed for hospital swing beds;
- Reimbursement is claimed for a hospital-based inpatient rehabilitation facility (IRF) or inpatient psychiatric facility (IPF);
- Reimbursement is claimed for a hospital-based community mental health center (CMHC);
- The hospital has physical therapy services furnished by outside suppliers (applicable for cost reimbursement and Tax Equity and Fiscal Responsibility Act of 1982 (PL97248) (TEFRA providers, not PPS); or
- The hospital is a certified transplant center (CTC).

Section 4007(b) of the Omnibus Budget Reconciliation Act (OBRA 1987) states that effective with cost reporting periods beginning on or after October 1, 1989, you are required to submit your cost report electronically unless you receive an exemption from CMS. The legislation allows CMS to delay or waiver implementation if the electronic submission results in financial hardship (in particular for providers with only a small percentage of Medicare volume). Exemptions are granted on a case-by-case basis (see 42 CFR 413.24(h)).

In addition to Medicare reimbursement, these forms also provide for the computation of reimbursement applicable to titles V and XIX to the extent required by individual State programs. Generally, the worksheets and portions of worksheets applicable to titles V and XIX are completed only to the extent these forms are required by the State program. However, Worksheets S-3 and D-1 must always be completed with title XIX data.

Each electronic system provides for the step-down method of cost finding. This method provides for allocating the cost of services rendered by each general service cost center to other cost centers, which utilize the services. Once the costs of a general service cost center have been allocated, that cost center is considered closed. Once closed, it does not receive any of the costs subsequently allocated from the remaining general service cost centers. After all costs of the general service cost centers have been allocated to the remaining cost centers, the total costs of these remaining cost centers are further distributed to the departmental classification to which they pertain, e.g., hospital general inpatient routine, subprovider.

This cost report is designed to accommodate a hospital health care complex with multiple entities. If a hospital health care complex has more than one entity reporting (except skilled nursing facilities and nursing facilities which cannot exceed more than one hospital-based facility), add additional lines for each entity by subscripting the appropriate line designation.

In completing the worksheets, show reductions in expenses in parentheses ( ) unless otherwise indicated.

4000.1 Rounding Standards for Fractional Computations.--Throughout the Medicare cost report, required computations result in fractions. The following rounding standards must be employed for such computations. When performing multiple calculations, round after each calculation.

1. Round to 2 decimal places:
   a. Percentages
   b. Averages, standard work week, payment rates, and cost limits
   c. Full time equivalent (FTE) employees
   d. Per diems, hourly rates

2. Round to 3 decimal places:
   a. Payment to cost ratio

3. Round to 4 decimal places:
   a. Wage adjustment factor
   b. Medicare SSI ratio
   c. Disproportionate patient percentage
   d. EHR Medicare Share

4. Round to 5 decimal places:
   a. Payment reduction (e.g., capital reduction, outpatient cost reduction)

5. Round to 6 decimal places:
   a. Ratios (e.g., unit cost multipliers, cost/charge ratios, days to days)

6. Round to 9 decimal places:
   a. Uncompensated care factor 3

Where a difference exists within a column as a result of computing costs using a fraction or decimal, and the sum of the parts do not equal the whole, the highest amount in that column must either be increased or decreased by the difference. If there are two high numbers equaling the same amount, adjust the first high number from the top of the worksheet for which it applies.

4000.2 Acronyms and Abbreviations.--Throughout the Medicare cost report and instructions, a number of acronyms and abbreviations are used. For your convenience, commonly used acronyms and abbreviations are summarized below.

ACA	-	Affordable Care Act
A&G	-	Administrative and General
AHSEA	-	Adjusted Hourly Salary Equivalency Amount
AKI	-	Acute Kidney Injury
ARRA	-	American Recovery and Reinvestment Act of 2009
ASC	-	Ambulatory Surgical Center
BBA	-	Balanced Budget Act
BBRA	-	Balanced Budget Reform Act
BIPA	-	Benefits Improvement and Protection Act
CAH	-	Critical Access Hospitals
CAPD	-	Continuous Ambulatory Peritoneal Dialysis
CAP-REL	-	Capital-Related
CBSA	-	Core Based Statistical Areas
CCN	-	CMS Certification Number
CCPD	-	Continuous Cycling Peritoneal Dialysis
CCU	-	Coronary Care Unit
CFR	-	Code of Federal Regulations
CHIP	-	Children's Health Insurance Program
CMHC	-	Community Mental Health Center
CMS	-	Centers for Medicare & Medicaid Services
CNA	-	Certified Nursing Assistant
COL	-	Column
CORF	-	Comprehensive Outpatient Rehabilitation Facility
CRNA	-	Certified Registered Nurse Anesthetist
CT	-	Computer Tomography
CTC	-	Certified Transplant Center
DEFRA	-	Deficit Reduction Act of 1984
DRA	-	Deficit Reduction Act of 2005
DRG	-	Diagnostic Related Group
DSH	-	Disproportionate Share
EACH	-	Essential Access Community Hospital
ECR	-	Electronic Cost Report
EHR	-	Electronic Health Records
ESRD	-	End Stage Renal Disease
FFY	-	Federal Fiscal Year (October 1 through September 30)
FQHC	-	Federally Qualified Health Center

FR - Federal Register
FTE - Full Time Equivalent
GME - Graduate Medical Education
HCERA - Health Care and Education Reconciliation Act of 2010
HCHC - Hospice Continuous Home Care
HCPCS - Healthcare Common Procedure Coding System
HCRIS - Healthcare Cost Report Information System
HFS - Health Financial Systems
HGIP - Hospice General Inpatient Care
HIRC - Hospice Inpatient Respite Care
HRHC - Hospice Routine Home Care
HRSA - Health Resources and Services Administration
HHA - Home Health Agency
HIT - Health Information Technology
HMO - Health Maintenance Organization
HSR - Hospital Specific Rate
I&Rs - Interns and Residents
ICF/IID - Intermediate Care Facility for Individuals with Intellectual Disabilities
ICU - Intensive Care Unit
IME - Indirect Medical Education
INPT - Inpatient
IOM - Internet Only Manual
IOP - Intensive Outpatient Program
IPF - Inpatient Psychiatric Facility
IPPS - Inpatient Prospective Payment System
IRF - Inpatient Rehabilitation Facility
KPMG - Klynveld, Peat, Marwick, & Goerdeler
LCC - Lesser of Reasonable Cost or Customary Charges
LDP - Labor, Delivery and Postpartum
LIP - Low Income Patient
LOC - Level of Care
LOS - Length of Stay
LPN - Licensed Practical Nurse
LTCH - Long Term Care Hospital
LVN - Licensed Vocational Nurse
MA - Medicare Advantage (previously known as M+C)
M+C - Medicare + Choice (also known as Medicare Part C, Medicare Advantage and Medicare HMO)
MCP - Monthly Capitation Payment
MDH - Medicare Dependent, Small Rural Hospital
MED-ED - Medical Education
MFT - Marriage and Family Therapist
MHC - Mental Health Counselor
MIPPA - Medicare Improvements for Patients and Providers Act of 2008
MMA - Medicare Prescription Drug Improvement and Modernization Act of 2003
MMEA - Medicare and Medicaid Extenders Act of 2010
MRI - Magnetic Resonance Imaging
MS-DRG - Medicare Severity Diagnosis-Related Group
MSP - Medicare Secondary Payer
NAH - Nursing and Allied Health
NF - Nursing Facility
NPI - National Provider Identifier
NPR - Notice of Program Reimbursement
OBRA - Omnibus Budget Reconciliation Act
OLTC - Other Long Term Care
OOT - Outpatient Occupational Therapy
OPD - Outpatient Department
OPO - Organ Procurement Organization
OPPS - Outpatient Prospective Payment System

OPT - Outpatient Physical Therapy
OSP - Outpatient Speech Pathology
ORF - Outpatient Rehabilitation Facility
PCR - Payment to Cost Ratio
PCRE - Primary Care Residency Expansion Program
PBP - Provider-Based Physician
PHE - Public Health Emergency
PPS - Prospective Payment System
PRF - Provider Relief Fund
PRM - Provider Reimbursement Manual
PRA - Per Resident Amount
PS&R - Provider Statistical and Reimbursement Report (or System)
PT - Physical Therapy
PTO - Paid Time Off
RCE - Reasonable Compensation Equivalent
REH - Rural Emergency Hospital
RHC - Rural Health Clinic
RN - Registered Nurse
RPCH - Rural Primary Care Hospitals
RT - Respiratory Therapy
RUG - Resource Utilization Group
SCH - Sole Community Hospitals
SNF - Skilled Nursing Facility
SSI - Supplemental Security Income
TEFRA - Tax Equity and Fiscal Responsibility Act of 1982
THC - Teaching Health Center
TOPPS - Transitional Corridor Payment for Outpatient Prospective Payment System
TPA - Third Party Administrator
UPIN - Unique Physician Identification Number
WKST - Worksheet

NOTE: In this chapter, TEFRA refers to §1886(b) of the Act and not to the entire Tax Equity and Fiscal Responsibility Act.

4000.3 Instructional, Regulatory and Statutory Effective Dates.--Throughout the Medicare cost report instructions, various effective dates implementing instructions, regulations and/or statutes are utilized.

Where applicable, at the end of select paragraphs and/or sentences the effective date(s) is indicated in parentheses ( ) for cost reporting periods ending on or after that date, e.g., 12/31/2010. Dates followed by a "b" are effective for cost reporting periods beginning on or after the specified date, e.g., 9/30/2010b. Dates followed by an "s" are effective for services rendered on or after the specified date, e.g. 4/1/2010s. Instructions not followed by an effective date are effective retroactive back to cost reporting periods beginning on or after 5/1/2010 (transmittal 1).

4001. RECOMMENDED SEQUENCE FOR COMPLETING FORM CMS-2552-10

Part I - Statistics, Departmental Cost Adjustments and Cost Allocations

Step	Worksheet	Instructions
1	S-2, Parts I and II	Read §§4004.1 and 4004.2. Complete entire worksheet.
2	S-3, Parts I, II, III, IV, and V	Read §§4005 through 4005.5. Complete entire worksheets.
3	S-4	Read §4006. Complete entire worksheet, if applicable.
4	S-5	Read §4007. Complete entire worksheet, if applicable.
5	S-6	Read §4008. Complete entire worksheet, if applicable.
6	S-7	Read §4009. Complete entire worksheet, if applicable.
7	S-8	Read §4010. Complete entire worksheet, if applicable.
8	S-9	Read §4011. Complete portions of worksheet, as applicable.
9	S-11, Parts I, II, and III	Read §§4010.1 through 4010.4. Complete entire worksheet, if applicable.
10	A	Read §4013. Complete columns 1 through 3, lines 1 through 200.
11	A-6	Read §4014. Complete, if applicable.
12	A	Read §4013. Complete columns 4 and 5, lines 1 through 200.
13	A-7, Parts I, II, and III	Read §4015. Complete entire worksheet.
14	A-8-1	Read §4017. Complete Parts A and B.
15	A-8-2	Read §4018. Complete, if applicable.
16	A-8-3, Parts I, II, III, IV, V, and VI	Read §§4019 through 4019.6. Complete, if applicable.

Part I - Statistics, Departmental Cost Adjustments and Cost Allocations (Cont.)

Step	Worksheet	Instructions
17	A-8	Read §4016. Complete entire worksheet.
18	A	Read §4013. Complete columns 6 and 7, lines 1 through 200.
19	B, Part I and B-1	Read §4020. Complete all columns through column 26.
20	B, Part II	Read §4021. Complete entire worksheet.
21	B-2	Read §4022. Complete, if applicable.
22	L-1, Part I	Read §§4065 and 4065.1. Complete, if applicable.

Part II - Departmental Cost Distribution and Cost Apportionment

Step	Worksheet	Instructions
1	C	Read §§4023 and 4023.1. Complete entire worksheet, except for line 92.
2	D, Part I	Read §§4024 and 4024.1. Complete entire worksheet.
3	D, Part III	Read §§4024 and 4024.3. Complete entire worksheet.
4	L-1, Part II	Read §4065.2. Complete, if applicable.
5	D-1, Parts I and IV	Read §§4025, 4025.1 and 4025.4. Complete both parts.
6	C	Read §4023.1. Complete line 92.
7	D, Part II	Read §§4024 and 4024.2. Complete entire worksheet. A separate worksheet must be completed for each applicable healthcare program for each hospital and subprovider subject to PPS or TEFRA provisions.
8	D, Part IV	Read §§4024 and 4024.4. Complete entire worksheet. A separate worksheet must be completed for each applicable health care program for each hospital and subprovider subject to PPS or TEFRA provisions.
9	L-1, Part III	Read §4065.3. Complete, if applicable.
10	D, Part V	Read §§4024 and 4024.5. Complete entire worksheet. A separate worksheet must be completed for each applicable health care program for each applicable provider component.
11	D-3	Read §4027. Complete entire worksheet. A separate copy of this worksheet must be completed for each applicable health care program for each applicable provider component.
12	D-1, Parts I and II	Read §§4025 through 4025.2. All providers must complete Part I. The hospital and subprovider(s) must complete Part II, lines 38 through 49, and lines 64 through 69.

Part II - Departmental Cost Distribution and Cost Apportionment (Cont.)

Step	Worksheet	Instructions
12	D-1, Parts III and IV	Read §§4025, 4025.3 and 4025.4. Only the hospital-based SNF and hospital-based NF must complete Part III, lines 70 through 86. All providers must complete Part IV.
13	D-2, Parts I through III	Read §§4026 through 4026.3. Complete only those parts that are applicable. Do not complete Part III unless both Parts I and II are completed.
14	L, Parts I through III	Read §4064. Complete applicable parts.
15	D-5, Parts I and II, or Parts III and IV	Read §§4029 through 4029.4. Complete applicable parts.
16	D-4, Parts I through IV	Read §§4028 through 4028.4. Complete only if hospital is a transplant hospital with a Medicare-certified transplant program.
17	D-6	Read §4029.5 through 4029.8. Complete entire worksheet, if applicable.
18	E-4	Read §4034. Complete entire worksheet, if applicable.
19	E-95	Read §4039. Complete entire worksheet, if applicable.

Part III - Calculation and Apportionment of Hospital-Based Facilities

A. Title XVIII - For SNF Only Reimbursed Under PPS.--

Step	Worksheet	Instructions
1	E-3, Part VI	Read §4033.6. If applicable, complete lines 1 through 15 for title XVIII SNF PPS services.
2	E-1, Part I	Read §4031.1. Complete this worksheet for title XVIII services corresponding to Worksheet E-3, Part VI.
3	E-3, Part VI	Complete the remainder of this worksheet, lines 16 through 19.

B. Titles V and XIX - For Hospital, Subprovider(s), NF and ICF/IIDs.--

Step	Worksheet	Instructions
4	E-3, Part VII	Read §4033.7. If applicable, complete entire worksheet for titles V and XIX services. Use a separate worksheet for each title.

C. Title XVIII - For Swing-Bed SNF and Titles V and XIX - For Swing-Bed NF.--

Step	Worksheet	Instructions
5	E-2	Read §4032. Complete a separate copy of this worksheet (lines 1 through 19) for each applicable health care program for each applicable provider component. Only entries applicable to title XVIII are made in column 2. Complete lines 9, 13, and 17 of column 1 for titles V and XIX, and columns 1 and 2 for title XVIII.
6	E-1, Part I	Read §4031.1. Complete this worksheet for title XVIII services corresponding to Worksheet E-2 title XVIII swing-bed SNF only.
7	E-2	Complete the remainder of this worksheet, lines 20 through 23.

Part III - Calculation and Apportionment of Hospital-Based Facilities (Cont.)

D. Title XVIII Only - For Home Health Agency (HHA).--

Step	Worksheet	Instructions
8	H	Read §4041. Complete entire worksheet, if applicable.
9	H-1, Parts I and II	Read §4042. Complete entire worksheet, if applicable.
10	H-2, Parts I and II	Read §§4043 through 4043.2. Complete entire worksheet, if applicable.
11	H-3, Parts I and II	Read §§4044 through 4044.2. Complete entire worksheet, if applicable.
12	H-4, Parts I and II	Read §§4045 through 4045.2. Complete entire worksheet, if applicable.
13	H-5	Read §4046. Complete entire worksheet, if applicable.

E. Title XVIII- For ESRD.--

Step	Worksheet	Instructions
14	I-1	Read §§4047 through 4048. Complete a separate worksheet for renal dialysis department(s) and a separate worksheet for home program dialysis department(s), if applicable.
15	I-2	Read §4049. Complete a separate worksheet for renal dialysis department(s) and a separate worksheet for home program dialysis department(s), if applicable.
16	I-3	Read §4050. Complete a separate worksheet for renal dialysis department(s) and a separate worksheet for home program dialysis department(s), if applicable.
17	I-4	Read §§4051. Complete a separate worksheet for renal dialysis department(s) and a separate worksheet for home program dialysis department(s), if applicable.
18	I-5	Read §4052. Complete only one worksheet combining all renal dialysis departments and home program dialysis departments, if applicable.

Part III - Calculation and Apportionment of Hospital-Based Facilities (Cont.)

F. Title XVIII - For CMHC.--

Step	Worksheet	Instructions
19	J-1, Parts I and II	Read §§4053 through 4053.2. Complete entire worksheet, if applicable.
20	J-2, Part I	Read §§4054 and 4054.1. Complete entire worksheet, if applicable.
21	J-2, Part II	Read §4054.2. Complete entire worksheet, if applicable.
22	J-3	Read §4055. Complete entire worksheet, if applicable.
23	J-4	Read §4056. Complete lines 1 through 4 for title XVIII only.

G. Titles XVIII and XIX - For Provider Based-Hospice.--

Step	Worksheet	Instructions
24	K-1	Read §4058. Complete entire worksheet, if applicable.
25	K-2	Read §4059. Complete entire worksheet, if applicable.
26	K-3	Read §4060. Complete entire worksheet, if applicable.
27	K	Read §4057. Complete entire worksheet, if applicable.
28	K-4, Parts I and II	Read §4061. Complete both worksheets, if applicable.
29	K-5, Parts I, II, and III	Read §§4062 through 4062.3. Complete all worksheets, if applicable.
30	K-6	Read §4063. Complete entire worksheet, if applicable.

Part III - Calculation and Apportionment of Hospital-Based Facilities (Cont.)

H. Titles V, XVIII, and XIX - For Hospital-Based RHC/FQHC.--

Step	Worksheet	Instructions
31	M-1	Read §4066. Complete entire worksheet, if applicable.
32	M-2	Read §4067. Complete entire worksheet, if applicable.
33	M-3	Read §4068. Complete entire worksheet, if applicable.
34	M-4	Read §4069. Complete entire worksheet, if applicable.
35	M-5	Read §4070. Complete entire worksheet, if applicable, for title XVIII only.

I. Titles V, XVIII, and XIX - For Hospital-Based FQHC.--

Step	Worksheet	Instructions
36	N-1	Read §4071. Complete entire worksheet, if applicable.
37	N-2	Read §4071.1. Complete entire worksheet, if applicable.
38	N-3	Read §4071.2. Complete entire worksheet, if applicable.
39	N-4	Read §4071.3. Complete entire worksheet, if applicable.
40	N-5	Read §4071.4. Complete entire worksheet, if applicable, for title XVIII only.

J. Titles V, XVIII, and XIX - For Hospital-Based Hospice.--

Step	Worksheet	Instructions
41	O-1, O-2, O-3, O-4	Read §4072.1. Complete entire worksheet, if applicable.
42	O	Read §4072. Complete entire worksheet, if applicable.
43	O-5	Read §4072.2. Complete entire worksheet, if applicable.
44	O-6, Parts I and II	Read §4072.3. Complete both worksheets in entirety, if applicable.
45	O-7	Read §4072.4. Complete entire worksheet, if applicable.
46	O-8	Read §4072.5. Complete entire worksheet, if applicable.

Part IV - Calculation of Reimbursement Settlement

Step	Worksheet	Instructions
1	E, Part A	Read §§4030 and 4030.1. Complete lines 1 through 71 for title XVIII for each applicable provider component subject to IPPS.
2	E-1, Part I	Read §4031.1. Complete this worksheet for title XVIII services corresponding to Worksheet E, Part A.
3	E, Part A	Complete the remainder of this worksheet, lines 72 through 75.
4	E, Part B	Read §4030.2. Complete lines 1 through 40 for title XVIII for each applicable provider component.
5	E-1, Part I	Read §4031.1. Complete this worksheet for title XVIII services corresponding to Worksheet E, Part B.
6	E, Part B	Complete the remainder of this worksheet, lines 41 through 44.
7	E-3, Part I	Read §§4033 and 4033.1. If applicable, complete lines 1 through 18 for title XVIII for each applicable provider component subject to TEFRA.
8	E-1, Part I	Read §4031.1. Complete this worksheet for title XVIII services corresponding to Worksheet E-3, Part I.
9	E-3, Part I	Complete the remainder of this worksheet, lines 19 through 22.
10	E-3, Part II	Read §4033.2. If applicable, complete lines 1 through 31 for title XVIII IPF PPS.
11	E-1, Part I	Read §4031.1. Complete this worksheet for title XVIII services corresponding to Worksheet E-3, Part II.
12	E-3, Part II	Complete the remainder of this worksheet, lines 32 through 35.

Part III - Calculation and Apportionment of Hospital-Based Facilities (Cont.)

Step	Worksheet	Instructions
13	E-3, Part III	Read §4033.3. If applicable, complete lines 1 through 32 for title XVIII IRF PPS.
14	E-1, Part I	Read §4031.1. Complete this worksheet for title XVIII services corresponding to Worksheet E-3, Part III.
15	E-3, Part III	Complete the remainder of this worksheet, lines 33 through 36.
16	E-3, Part IV	Read §4033.4. If applicable, complete lines 1 through 22 for title XVIII LTCH PPS.
17	E-1, Part I	Read §4031.1. Complete this worksheet for title XVIII services corresponding to Worksheet E-3, Part IV.
18	E-3, Part IV	Complete the remainder of this worksheet, lines 23 through 26.
19	E-3, Part V	Read §4033.5. If applicable, complete lines 1 through 30 for title XVIII reasonable cost reimbursed providers.
20	E-1, Part I	Read §4031.1. Complete this worksheet for title XVIII services corresponding to Worksheet E-3, Part V.
21	E-3, Part V	Complete the remainder of this worksheet, lines 31 through 34.
19	E-3, Part VI	Read §4033.6. If applicable, complete lines 1 through 15 for title XVIII reasonable cost reimbursed providers.
20	E-1, Part I	Read §4031.1. Complete this worksheet for title XVIII services corresponding to Worksheet E-3, Part VI.
21	E-3, Part VI	Complete the remainder of this worksheet, lines 16 through 19.
22	E-3, Part VII	Read §4033.7. If applicable, complete the entire worksheet for titles V and XIX providers.

Part V - Additional Data

Step	Worksheet	Instructions
1	G	Read §4040. All providers maintaining fund type accounting records must complete this worksheet. Nonproprietary providers which do not maintain fund type records complete the General Fund column only.
2	G-1	Read §4040.1. Complete entire worksheet.
3	G-2, Parts I and II	Read §4040.2. Complete entire worksheet.
4	G-3	Read §4040.3. Complete entire worksheet.
5	S-10 and S-10, Parts I and II	Read §4012 through 4012.2. Acute care hospitals and CAHs complete this worksheet.
6	E-1, Part II	Read §4031.2 Acute care hospitals and CAHs complete this worksheet.
7	S, Parts I, II, and III	Read §§4003.1 through 4003.3. Complete Part III, then complete Parts I and II.
8	E-5	Read §4035. Contractors complete this worksheet.

4002. SEQUENCE OF ASSEMBLY

The following examples of assembly of worksheets are provided so all providers are consistent in the order of submission of their annual cost report. All providers using Form CMS-2552-10 must adhere to this sequence. If worksheets are not completed because they are not applicable, do not include blank worksheets in the assembly of the cost report.

4002.1 Sequence of Assembly for Hospital and Hospital Health Care Complex Providers Participating in Medicare.--Cost report worksheets are assembled in alpha-numeric sequence starting with the "S" series, followed by A, B, C, etc.

Form CMS	Work-sheet	Part	Health Care Program (Title)	Component
2552-10	S	I, II, III		
2552-10	S-2	I, II		
2552-10	S-3	I, II, III, IV, V		
2552-10	S-4			Hospital-Based HHA
2552-10	S-5			Renal Dialysis Department
2552-10	S-6			Hospital-Based CMHC
2552-10	S-7			Hospital-Based SNF
2552-10	S-8			Hospital-Based RHC/FQHC
2552-10	S-9			Hospital-Based Hospice
2552-10	S-10*			Hospital & CAH
2552-10	S-10*	I and II		Hospital & CAH
2552-10	S-11	I, II, III		Hospital-Based FQHC
2552-10	A			
2552-10	A-6			
2552-10	A-7	I, II, III		
2552-10	A-8			
2552-10	A-8-1			
2552-10	A-8-2			
2552-10	A-8-3	I, II, III, IV, V, VI		
2552-10	B	I		
2552-10	B	II		
2552-10	B-1			
2552-10	B-2			
2552-10	C	I		Hospital
2552-10	C	II	V	Hospital
2552-10	C	II	XIX	Hospital
2552-10	D	I	V	Hospital
2552-10	D	II	V	Hospital
2552-10	D	III	V	Hospital
2552-10	D	IV	V	Hospital
2552-10	D	V	V	Hospital
2552-10	D	II	V	Subprovider
2552-10	D	V	V	Subprovider
2552-10	D	I	XVIII	Hospital
2552-10	D	II	XVIII	Hospital
2552-10	D	III	XVIII	Hospital
2552-10	D	IV	XVIII	Hospital
2552-10	D	V	XVIII	Hospital
2552-10	D	II	XVIII	Subprovider
2552-10	D	III	XVIII	Subprovider

* For cost reporting periods beginning prior to October 1, 2022, hospitals submit Worksheet S-10; for cost reporting periods beginning on or after October 1, 2022, hospitals submit Worksheet S-10, Parts I and II, as applicable.

Form CMS	Work-sheet	Part	Health Care Program (Title)	Component
2552-10	D	V	XVIII	Subprovider
2552-10	D	III	XVIII	Swing-Bed SNF
2552-10	D	III	XVIII	SNF
2552-10	D	I	XIX	Hospital
2552-10	D	II	XIX	Hospital
2552-10	D	III	XIX	Hospital
2552-10	D	IV	XIX	Hospital
2552-10	D	V	XIX	Hospital
2552-10	D	II	XIX	Subprovider
2552-10	D	V	XIX	Subprovider
2552-10	D-1	I, II, IV	V	Hospital
2552-10	D-1	I, II, IV	V	Subprovider
2552-10	D-1	I, III	V	SNF
2552-10	D-1	I, III	V	NF, ICF/IID
2552-10	D-1	I, II, IV	XVIII	Hospital
2552-10	D-1	I, II, IV	XVIII	Subprovider
2552-10	D-1	I, III	XVIII	SNF
2552-10	D-1	I, II, IV	XIX	Hospital
2552-10	D-1	I, II, IV	XIX	Subprovider
2552-10	D-1	I, III	XIX	SNF
2552-10	D-1	I, III	XIX	NF, ICF/IID
2552-10	D-2	I	V, XVIII, XIX	
2552-10	D-2	II	XVIII	
2552-10	D-2	III	XVIII	
2552-10	D-3		V	Hospital
2552-10	D-3		V	Subprovider
2552-10	D-3		V	Swing-Bed SNF
2552-10	D-3		V	Swing-Bed NF
2552-10	D-3		V	SNF
2552-10	D-3		V	NF, ICF/IID
2552-10	D-3		XVIII	Hospital
2552-10	D-3		XVIII	Subprovider
2552-10	D-3		XVIII	Swing-Bed SNF
2552-10	D-3		XIX	Hospital
2552-10	D-3		XIX	Subprovider
2552-10	D-3		XIX	Swing-Bed SNF
2552-10	D-3		XIX	Swing-Bed NF
2552-10	D-3		XIX	SNF
2552-10	D-3		XIX	NF, ICF/IID
2552-10	D-4	I, II, III, IV	XVIII	
2552-10	D-5	I	V, XVIII, XIX	
2552-10	D-5	II	V, XVIII, XIX	Hospital
2552-10	D-5	II	V, XVIII, XIX	Subprovider
2552-10	D-6	I, II, III	XVIII	
2552-10	E	A	XVIII	Hospital
2552-10	E	B	XVIII	Hospital
2552-10	E-1	Part I	XVIII	Hospital
2552-10	E-1	Part I	XVIII	IPF-Subprovider
2552-10	E-1	Part I	XVIII	IRF-Subprovider
2552-10	E-1	Part I	XVIII	Subprovider
2552-10	E-1	Part I	XVIII	Swing-Bed SNF
2552-10	E-1	Part I	XVIII	SNF

Form CMS	Work-sheet	Part	Health Care Program (Title)	Component
2552-10	E-1	II	HIT	Hospital and CAH
2552-10	E-2		V	Swing-Bed SNF
2552-10	E-2		V	Swing-Bed NF
2552-10	E-2		XVIII	Swing-Bed SNF
2552-10	E-2		XIX	Swing-Bed SNF
2552-10	E-2		XIX	Swing-Bed NF
2552-10	E-3	I, II, III, IV, V	XVIII	Hospital
2552-10	E-3	II, III	XVIII	Subprovider
2552-10	E-3	IV	XVIII	LTCH
2552-10	E-3	VI	XVIII	SNF
2552-10	E-3	VII	V, XIX	Hospital
2552-10	E-3	VII	V, XIX	Subprovider - IPF
2552-10	E-3	VII	V, XIX	Subprovider - IRF
2552-10	E-3	VII	V, XIX	NF, ICF/IID
2552-10	E-3	VII	V, XIX	SNF
2552-10	E-4		XVIII	Hospital
2552-10	E-5		XVIII	Hospital
2552-10	G			
2552-10	G-1			
2552-10	G-2			
2552-10	G-3			
2552-10	H			Hospital-based HHA
2552-10	H-1	I, II		Hospital-based HHA
2552-10	H-2	I, II		Hospital-based HHA
2552-10	H-3	I, II	V, XVIII, XIX	Hospital-based HHA
2552-10	H-4	I, II	V, XVIII, XIX	Hospital-based HHA
2552-10	H-5		XVIII	Hospital-based HHA
2552-10	I-1 - I-5			Renal Dialysis
2552-10	I-1 - I-5			Home Program Dialysis
2552-10	J-1 - J-2	I and II		CMHC
2552-10	J-3		V, XVIII, XIX	CMHC
2552-10	J-4		XVIII	CMHC
2552-10	K			Hospital-based Hospice
2552-10	K-1			Hospital-based Hospice
2552-10	K-2			Hospital-based Hospice
2552-10	K-3			Hospital-based Hospice
2552-10	K-4	I, II		Hospital-based Hospice
2552-10	K-5	I, II, III		Hospital-based Hospice
2552-10	K-6		XVIII, XIX	Hospital-based Hospice
2552-10	L	I, II, III	V, XVIII, XIX	Hospital
2552-10	L	I, II, III	V, XVIII, XIX	Subprovider
2552-10	L-1	I		Hospital
2552-10	L-1	II	V, XVIII, XIX	Hospital
2552-10	L-1	III	V, XVIII, XIX	Hospital
2552-10	L-1	III	V, XVIII, XIX	Subprovider
2552-10	M-1			Hospital-based RHC/FQHC
2552-10	M-2			Hospital-based RHC/FQHC
2552-10	M-3		V, XVIII, XIX	Hospital-based RHC/FQHC
2552-10	M-4		V, XVIII, XIX	Hospital-based RHC/FQHC
2552-10	M-5		XVIII	Hospital-based RHC/FQHC
2552-10	N-1			Hospital-based FQHC
2552-10	N-2		XVIII	Hospital-based FQHC
2552-10	N-3		XVIII	Hospital-based FQHC
2552-10	N-4		XVIII	Hospital-based FQHC
2552-10	N-5		XVIII	Hospital-based FQHC

Form CMS	Work-sheet	Part	Health Care Program (Title)	Component
2552-10	O			Hospital-based Hospice
2552-10	O-1			Hospital-based Hospice
2552-10	O-2			Hospital-based Hospice
2552-10	O-3			Hospital-based Hospice
2552-10	O-4			Hospital-based Hospice
2552-10	O-5			Hospital-based Hospice
2552-10	O-6	I, II		Hospital-based Hospice
2552-10	O-7			Hospital-based Hospice
2552-10	O-8			Hospital-based Hospice

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4003. WORKSHEET S - HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

4003.1 Part I - Cost Report Status.--This section is to be completed by the provider and contractor as indicated on the worksheet.

Lines 1 through 3, column 1--The provider must check the appropriate box to indicate on line 1 or 2, whether this cost report is prepared electronically or manually. Only providers submitting manually prepared cost reports, 1) reporting low Medicare utilization in accordance with CMS Pub. 15-2, chapter 1, §110, or 2) after demonstrating financial hardship in accordance with §133, may select line 2, manually prepared. For electronically prepared cost reports, indicate on line 1, the date and time corresponding to the creation of the electronic file. The date and time remain identifiers for the file by the contractor and are archived accordingly. This file is your original submission and is not to be modified. If this is an amended cost report, enter on line 3 the number of times the cost report has been amended.

Line 4, column 1--The provider must enter an "F" if this is a full cost report, an "L" for a low Medicare utilization (requires prior contractor approval, see CMS Pub. 15-2, chapter 1, §110 (B)), or an "N" for no Medicare utilization in accordance with CMS Pub. 15-2, chapter 1, §110(A).

Line 5, column 1--The contractor enters the Healthcare Cost Report Information System (HCRIS) cost report status code on line 5, column 1, that corresponds to the filing status of the cost report: 1=As submitted; 2=Settled without audit; 3=Settled with audit; 4=Reopened; or 5=Amended.

Line 6, column 2--The contractor enters the date (mm/dd/yyyy) an accepted cost report was received from the provider.

Line 7, column 2--The contractor enters the 5-position contractor number.

Lines 8 and 9, column 2--If this is an initial cost report, enter "Y" for yes in the box on line 8. If this is a final cost report, enter "Y" for yes in the box on line 9. If neither, enter "N".

An initial report is the very first cost report for a particular provider CCN. A final cost report is a terminating cost report for a particular provider CCN.

If the cost report is both initial and terminating in the same year (for example, the provider started Medicare and decided to leave the program in the same year), and the cost report is a full Medicare utilization report, the contractor must submit to HCRIS an as submitted and a final settled report. The as submitted extract is the initial report, and the final settled is the final report.

If the cost report is both initial and terminating in the same year, and the cost report is a No or Low Medicare utilization, the contractor must only submit to HCRIS a final settled with or without audit report. This is the only situation in which a HCRIS extract would be both initial and final.

Line 10, column 3--The contractor enters the Notice of Program Reimbursement (NPR) date (mm/dd/yyyy). The NPR date must be present if the cost report status code is 2 or 3.

Line 11, column 3--Enter software vendor code of the cost report software used by the contractor to process this HCRIS cost report file. Use "4" for HFS or "3" for KPMG.

Line 12, column 3--If this is a reopened cost report (response to line 5, column 1 is "4"), the contractor enters the number of times the cost report has been reopened.

4003.2 Part II - Certification by a Chief Financial Officer or Administrator.--The signatory, either a chief financial officer (CFO) or administrator of the hospital, reads, prepares, and signs this certification after cost report completion.

Line 1.--The signatory (administrator or Chief Financial Officer) must either:

- when signing electronically through the ECR software, sign in column 1 as provided in 42 CFR 413.24(f)(4)(iv)(C)(1); and in column 2, enter "Y" (for yes) to check the electronic signature checkbox to transmit the cost report electronically with an electronic signature; or
- when signing outside the ECR software, sign in column 1 as provided in 42 CFR 413.24(f)(4)(iv)(C)(1); and enter a check mark in column 2, to check the electronic signature checkbox to submit the cost report with an electronic signature; or
- sign in column 1 as provided in 42 CFR 413.24(f)(4)(iv)(C)(2); and make no entry in column 2 to submit the cost report with an original signature.

Lines 2, 3, and 4.--Enter the signatory name, the signatory title, and the date signed on lines 2, 3, and 4, respectively.

4003.3 Part III - Settlement Summary.--Enter the balance due to or due from the applicable program for each applicable component of the hospital or hospital healthcare complex. Transfer settlement amounts as follows:

	FROM				
Hospital/ Hospital Component	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX
Hospital	Wkst. E-3, Part VII, line 42	Wkst. E, Part A, line 74 or Wkst. E-3, Part I, line 21 or Wkst. E-3, Part II, line 34 or Wkst. E-3, Part III, line 35 or Wkst. E-3, Part IV, line 25 or Wkst. E-3, Part V, line 33	Wkst. E, Part B, line 43	Wkst. E-1, Part II, line 32	Wkst. E-3, Part VII, line 42
Hospital-PARHM		Wkst. E, Part A, Line 74.01 Wkst. E-3, Part V, Line 33.01	Wkst. E, Part B, Line 43.01		

	FROM				
Hospital/ Hospital Component	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX
Subprovider-IPF	Wkst. E-3, Part VII, line 42	Wkst. E-3, Part II, line 34	Wkst. E Part B, line 43		Wkst. E-3, Part VII, line 42
Subprovider-IRF	Wkst. E-3 Part VII, line 42	Wkst. E-3, Part III, line 35	Wkst. E Part B, line 43		Wkst E-3, Part VII line 42
Subprovider-Other					
Swing-Bed - SNF	Wkst. E-2, col. 1, line 22	Wkst. E-2, col. 1, line 22	Wkst. E-2, col. 2, line 22		Wkst. E-2, col. 1, line 22
Swing-Bed-PARHM		Wkst. E-2, col. 1, line 22.01	Wkst. E-2, col. 2, line 22.01		
Swing-Bed - NF	Wkst. E-2, col. 1, line 22	N/A	N/A		Wkst. E-2 col. 1, line 22
SNF	Wkst. E-3, Part VII, line 42	Wkst. E-3, Part VI, line 18	Wkst. E, Part B, line 43		Wkst. E-3, Part VII, line 42
NF, ICF/IID	Wkst. E-3, Part VII, line 42	N/A	N/A		Wkst. E-3, Part VII line 42
Home Health Agency	Wkst. H-4, Part II, sum of cols.1&2, line 34	Wkst. H-4, Part II, col. 1, line 34	Wkst. H-4, Part II, col. 2, line 34		Wkst. H-4, Part II, sum of cols.1 & 2, line 34
Outpatient Rehabilitation Providers	Wkst. J-3, line 29	N/A	Wkst. J-3, line 29		Wkst. J-3, line 29
Hospital-Based RHC/FQHC*	Wkst. M-3, line 29	N/A	Wkst. M-3, line 29		Wkst. M-3, line 29
Hospital-based FQHC**		N/A	Wkst. N-4, line 19		

*For hospital-based FQHCs for cost reporting periods beginning prior to October 1, 2014.
**For hospital-based FQHCs for cost reporting periods beginning on and after October 1, 2014.

4004. WORKSHEET S-2 - HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

This worksheet consists of two parts:

Part I - Hospital and Hospital Health Care Complex Identification Data
Part II - Hospital and Hospital Health Care Complex Reimbursement Questionnaire

4004.1 Part I - Hospital and Hospital Health Care Complex Identification Data.--The information required on this worksheet is needed to properly identify the provider. The responses to all lines are Yes or No unless otherwise indicated.

Line descriptions

Lines 1 and 2--Enter the street address, post office box (if applicable), the city, state, ZIP code, and county of the hospital.

Lines 3 through 18--Enter on the appropriate lines and columns indicated the component names, CMS certification numbers (CCN), core based statistical area (CBSA) codes of the physical location of the provider's primary operations (non-CBSA (rural) codes are assembled by placing the digits "999" in front of the two-digit state code, e.g., for the State of Maryland the non-CBSA code is 99921), provider type, and certification dates of the hospital and its various components, if any. Indicate for each health care program (titles V, XVIII, or XIX), the payment system applicable to the hospital and its various components by entering P, T, O, or N in the appropriate column to designate PPS, TEFRA, OTHER, or NOT APPLICABLE, respectively. The "PPS" payment systems include the Inpatient Prospective Payment System (IPPS), the Inpatient Psychiatric Facility Prospective Payment System (IPF PPS), the Long Term Care Hospital Prospective Payment System (LTCH PPS) and the Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS), and the Rural Emergency Hospital (REH) Outpatient Prospective Payment System (OPPS). The "TEFRA" payment system includes long term care hospitals (LTCH) classified as extended neoplastic disease care hospitals (previously referred to as "subclause (II)" LTCHs), children's hospitals, cancer hospitals, Religious Non-Medical Health Care Institutions (RNHCIs), and hospitals located outside the 50 States, the District of Columbia, and Puerto Rico (i.e., hospitals located in the U.S. Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa). The "OTHER" payment system includes cost reimbursed hospitals such as critical access hospitals (CAHs) and new TEFRA hospitals exempt from the rate of increase limits.

Column 4--Indicate, as applicable, the number listed below which best corresponds with the type of services provided.

1 = General Short Term (includes CAHs)
2 = General Long Term
3 = Cancer
4 = Psychiatric
5 = Rehabilitation
6 = Religious Non-Medical Health Care Institution
7 = Children
8 = Reserved for future use
9 = American Samoa Hospital
10 = Extended Neoplastic Disease Care
11 = Indian Health Service
12 = Rural Emergency Hospital

If your hospital services various types of patients, indicate "General - Short Term" or "General - Long Term," as appropriate.

NOTE: LTCHs are hospitals organized to provide long term treatment programs with average lengths of stay greater than 25 days. Some hospitals may be certified as other than LTCHs, but also have average lengths of stay greater than 25 days.

If your hospital cares for only a special type of patient (such as cancer patients), indicate the special group served.

Line 3--This is an institution which meets the requirements of §1861(e) or §1861(mm)(1) of the Act and participates in the Medicare program or is a federally controlled institution approved by CMS.

Line 4--The distinct part IPF is a portion of a hospital which has been issued a subprovider CCN because it offers a clearly different type of service from the remainder of the hospital with such services reimbursed under inpatient psychiatric PPS. Effective for cost reporting periods beginning on or after October 1, 2019, an IPF is permitted to have an IRF subunit, however, an IPF may not have an IPF subunit. (See 42 CFR 412.25(d).)

Line 5--The distinct part IRF is a portion of a hospital which has been issued a subprovider CCN because it offers a clearly different type of service from the remainder of the hospital with such services reimbursed under inpatient rehabilitation PPS. Effective for cost reporting periods beginning on or after October 1, 2019, an IRF is permitted to have an IPF subunit, however, an IRF may not have an IRF subunit. (See 42 CFR 412.25(d).)

Line 6--This is a portion of a general hospital defined as non-Medicare certified and not included in lines 4 through 18, which offers a clearly different type of service from the remainder of the hospital.

Line 7--Medicare swing-bed services are paid under the skilled nursing facility (SNF) PPS system (indicate payment system as "P"). CAHs are reimbursed on a cost basis for swing-bed services and should indicate "O" as the payment system. Rural hospitals with fewer than 100 beds may be approved by CMS to use these beds interchangeably as hospital and skilled nursing facility beds with payment based on the specific care provided, as authorized by §1883 of the Act. (See CMS Pub. 15-1, chapter 22, §§2230-2230.6.)

Line 8--Swing-bed NF services are not payable under the Medicare program but are payable under State Medicaid programs if included in the Medicaid State plan. Rural hospitals with fewer than 100 beds that have a Medicare swing-bed agreement approved by CMS and that are approved by the State Medicaid agency to use these beds interchangeably as hospital and other nursing facility beds, with payment based on the specific level of care provided, as authorized by §1913 of the Act.

Line 9--This is a distinct part SNF (including a distinct part SNF based in a REH) that has been issued an SNF identification number and which meets the requirements of §1819 of the Act. A hospital complex cannot contain more than one hospital-based SNF (includes a composite distinct part) or hospital-based NF. (See 42 CFR 483.5(2)(v).)

Line 10--This is a distinct part nursing facility which has been issued a separate identification number and which meets the requirements of §1905 of the Act. (See 42 CFR 441.400 for standards for other nursing facilities, for other than facilities for individuals with intellectual disabilities, and for facilities for individuals with intellectual disabilities.) If your State recognizes only one level of care (i.e., skilled), do not complete any lines designated as NF and report all activity on the SNF line for all programs. The NF line is used by facilities having two levels of care (i.e., either 100 bed facility all certified for NF and partially certified for SNF or 50 beds certified for SNF only and 50 beds certified for NF only). The contractor will reject a cost report attempting to report more than one nursing facility.

If the facility operates an intermediate care facility for individuals with intellectual disabilities (ICF/IID), subscript line 10 to 10.01 and enter the data on that line. Note: Subscripting is allowed only for the purpose of reporting an ICF/IID.

Line 11--This is any other hospital-based long term care facility not listed above. The beds in this unit are not certified for titles V, XVIII, or XIX. The data on this line cannot be used for Medicare reimbursement. Treat this as a nonreimbursable cost center since it is not part of the Medicare certified hospital.

Line 12--This is a distinct part HHA that has been issued an HHA identification number and which meets the requirements of §§1861(o) and 1891 of the Act. If you have more than one hospital-based HHA, subscript this line, and report the required information for each HHA.

Line 13--This is a distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization and which meets the conditions for coverage in 42 CFR 416, Subpart B. The ambulatory surgery center (ASC) operated by a hospital must be a separately identifiable entity which is physically, administratively, and financially independent and distinct from other operations of the hospital. (See 42 CFR 416.30(f).) Under this restriction, hospital outpatient departments providing ambulatory surgery (among other services) are not eligible. (See 42 CFR 416.120(a).)

Line 14--This is a distinct part hospice and separately certified component of a hospital which meets the requirements of §1861(dd) of the Act. No payment designation is required in columns 6, 7, and 8.

Lines 15 and 16--Enter the applicable information for hospital-based rural health clinics (RHCs) on line 15 and for hospital-based federally qualified health centers (FQHCs) on line 16. These lines are used by hospital-based RHCs and/or FQHCs which have been issued a CCN and meet the requirements of §1861(aa) of the Act. If you have more than one hospital-based RHC, report them on subscripts of line 15. If you have more than one hospital-based FQHC, report them on subscripts of line 16. Report the required information in the appropriate column for each.

Hospital-based RHCs and FQHCs may elect to file a consolidated cost report pursuant to CMS Pub. 100-02 (Medicare Claims Processing Manual), chapter 13, §80.2. Do not subscript lines 15 or 16 to report RHCs or FQHCs affiliated with the consolidated group that elects to file under the consolidated cost reporting method; report only the hospital-based primary RHC and/or hospital-based primary FQHC of the consolidated group on lines 15 and/or 16, as applicable. A new RHC/FQHC that begins after the start of a cost reporting period cannot be added to the consolidated worksheets until the subsequent full cost reporting period. A written request to consolidate the new RHC/FQHC must be submitted to the contractor in advance of the reporting period and must be approved by the contractor prior to the start of the reporting period to be reported as consolidated. In order to qualify for consolidated reporting, all RHCs/FQHCs in the group must be owned, leased, or through any other device, controlled by one organization. Once the election to use a consolidated cost report is made, the RHC/FQHC may not revert to individual reporting without the prior approval of the contractor. See §§4010 and 4010.1 for further instructions.

Line 17--This line is used by hospital-based community mental health centers (CMHCs). Subscript this line as necessary to accommodate multiple CMHCs (lines 17.00 through 17.09). Also subscript this line to accommodate CORFs (lines 17.10 through 17.19), OPTs (lines 17.20 through 17.29), OOTs (lines 17.30 through 17.39) and OSPs (line 17.40 through 17.49). (See §4095, Exhibit 2, Table 4, Part III.)

Line 18--If this facility operates a renal dialysis facility (CCN XX-2300 through XX-2499), a renal dialysis satellite (CCN XX-3500 through XX-3699), and/or a special purpose renal dialysis facility (CCN XX-3700 through XX-3799), enter in column 2 the applicable CCN. Subscript this line as applicable.

Line 19--For any component type not identified on lines 3 through 18, enter the required information in the appropriate column.

Line 20--Enter the inclusive dates covered by this cost report. In accordance with 42 CFR 413.24(f), you are required to submit periodic reports of your operations which generally cover a consecutive 12-month period of your operations. (See CMS Pub. 15-2, chapter 1, §§102.1-102.3, for situations where you may file a short period cost report.)

Line 21--Indicate the type of control under which the hospital operates:

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

Line 22--Does your facility qualify and is it currently receiving payments for disproportionate share (DSH) hospital adjustment, in accordance with 42 CFR 412.106? Enter in column 1, "Y" for yes or "N" for no. Is this facility subject to the provisions of 42 CFR 412.106(c)(2) (Pickle Amendment hospitals)? Enter in column 2, "Y" for yes or "N" for no.

Line 22.01--For cost reporting periods that overlap or begin on or after October 1, 2013, did this hospital receive interim uncompensated care payments (UCPs), including supplemental UCPs as described in 42 CFR 412.106(h)? Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period beginning on or after October 1. For cost reporting periods that begin on October 1, enter "N" for no in column 1 and complete column 2; however, when the cost reporting period begins on October 1 and overlaps October 1 of the subsequent year, complete column 1 for the first period (October 1 through September 30) and complete column 2 for the remainder of the cost reporting period.

Line 22.02--Is this a newly merged hospital that requires final UCPs to be determined at cost report settlement? Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on and after October 1. For a newly merged hospital as defined in the IPPS FY 2015 final rule, 79 FR 50022 (August 22, 2014), the final Factor 3 would be recalculated based on the Medicaid days and SSI days reported on the cost report used for the applicable fiscal year since the Factor 3 that was published in the final rule did not reflect the merger. For example, for a newly merged hospital that merged in FY 2015, the numerator of its Factor 3 would be recalculated based on the FY 2015 SSI days and the Medicaid days reported on its 2015 cost report. See 79 FR 50021 (August 22, 2014).

For the purpose of this question, a merger is defined as an acquisition where the Medicare provider agreement of one hospital is subsumed into the provider agreement of the surviving provider. We would not consider a merger to be an acquisition where a new owner voluntarily terminates the provider agreement of the hospital it purchased by rejecting assignment of the previous owner's provider agreement.

Line 22.03--Effective on and after October 1, 2014, the regulations at 42 CFR 412.102 specify that an urban hospital that was part of an MSA but was redesignated as rural as a result of the most recent OMB standards for delineating statistical areas adopted by CMS, may receive an adjustment to its rural Federal payment amount for operating costs for 2 successive fiscal years. Specifically, the regulations state that, in the first year after a hospital loses urban status, the hospital will receive an additional payment that equals 2/3 of the difference between the disproportionate share payments as applicable to the hospital before its redesignation from urban to rural and disproportionate share payments otherwise applicable to the hospital subsequent to its redesignation from urban to rural. In the second year after a hospital loses urban status, the hospital will receive an additional payment that equals 1/3 of the difference between the disproportionate share payments applicable to the hospital before its redesignation from urban to rural and disproportionate share payments otherwise applicable to the hospital subsequent to its redesignation from urban to rural. Did this hospital receive a geographic redesignation from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. Does this hospital contain at least 100, but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.

Line 22.04--For cost reporting periods ending on or after October 1, 2020, and before October 1, 2022, the FY 2021 IPPS final rule (CMS-1735-F; 85 FR 58746, September 18, 2020) provides for a 2-year transition (in accordance with 42 CFR 412.102) to a rural DSH payment amount from an urban DSH payment amount, for hospitals that received a geographic reclassification from urban to rural under the OMB standards for delineating statistical areas adopted by CMS in FY 2021. Impacted hospitals whose DSH payment adjustment exceeds 12 percent will receive 2/3 of the difference between the urban and rural operating DSH for FY 2021 and 1/3 of the difference between the urban and rural operating DSH for FY 2022. Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. Does this hospital contain at least 100, but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.

Line 22.05--Does this hospital receive a geographic reclassification from urban to rural in accordance with 42 CFR 412.103? Enter in column 1, "Y" for yes or "N" for no. If column 1 is Y, enter the effective date of the geographic reclassification in column 2.

Line 23--Indicate in column 1 the method used to capture Medicaid (title XIX) days reported on lines 24 and/or 25 of this worksheet during the cost reporting period by entering a "1" if days are based on the date of admission, "2" if days are based on census days (also referred to as the day count), or "3" if days are based on the date of discharge. Is the method of identifying the days in the current cost reporting period different from the method used in the prior cost reporting period? Enter in column 2, "Y" for yes or "N" for no.

NOTE **FOR LINES 24 AND 25:** Columns 1 through 6 are mutually exclusive. For example, if patient days are entered in column 1, those days may not be entered in any other column. Effective for cost reporting periods beginning on or after October 1, 2018, a cost report will be rejected when submitted without listings supporting the DSH eligible days reported on lines 24 and 25 (42 CFR 413.24(f)(5)). Exhibit 3A presents the standardized format for the information required for cost reporting periods beginning on or after October 1, 2022, to support the DSH eligible days reported (see 42 CFR 412.106(b)(4), and exhibit for instructions and listing presented at the end of §4004.1.) Submit separate listings for the DSH eligible days reported on lines 24 and 25. Report days for each column as follows:

Column 1: Enter the number of in-state Medicaid paid days. An in-state Medicaid paid day is an in-state day of inpatient care furnished to a patient eligible for inpatient benefits under an approved State Medicaid plan or eligible for inpatient benefits, or regarded as such, under a waiver authorized under section 1115(a)(2) of the Act on that day and for which the hospital received payment from Medicaid. These patients cannot also be entitled to Medicare Part A.

Column 2: Enter the number of in-state Medicaid eligible unpaid days. An in-state Medicaid eligible unpaid day is an in-state day of inpatient care furnished to a patient eligible for inpatient benefits under an approved State Medicaid plan or eligible for inpatient benefits, or regarded as such, under a waiver authorized under section 1115(a)(2) of the Act on that day and for which the hospital has not received payment from Medicaid. These patients cannot also be entitled to Medicare Part A. Reasons for non-payment could be related to the provider not billing timely, days that are beyond the number of days for which a State will pay, days that are utilized by a Medicaid beneficiary prior to an admission approval but for which a valid enrollment is determined within the prescribed period, and days for which payment is made by a third party.

Column 3: Enter the number of out-of-state Medicaid paid days. An out-of-state Medicaid paid day is an out-of-state day of inpatient care furnished to a patient eligible for inpatient benefits under an approved State Medicaid plan or eligible for inpatient benefits, or regarded as such, under a waiver authorized under section 1115(a)(2) of the Act on that day and for which the hospital received payment from Medicaid. These patients cannot also be entitled to Medicare Part A.

Column 4: Enter the number of out-of-state Medicaid eligible unpaid days. An out-of-state Medicaid eligible unpaid day is an out-of-state day of inpatient care furnished to a patient eligible for inpatient benefits under an approved State Medicaid plan or eligible for inpatient benefits, or regarded as such, under a waiver authorized under section 1115(a)(2) of the Act on that day and for which the hospital has not received payment from Medicaid. These patients cannot also be entitled to Medicare Part A. Reasons for non-payment could be related to the provider not billing timely, days that are beyond the number of days for which a State will pay, days that are utilized by a Medicaid beneficiary prior to an admission approval but for which a valid enrollment is determined within the prescribed period, and days for which payment is made by a third party.

Column 5: Enter the number of Medicaid health maintenance organization (HMO) days, both in-state and out-of-state. A Medicaid HMO day is a paid and/or eligible but unpaid day of inpatient care furnished to a Medicaid beneficiary who is eligible for Medicaid under a State plan approved under title XIX through a HMO or a managed care organization (MCO). These patients cannot also be entitled to Medicare Part A.

Column 6: Enter other Medicaid days. Other Medicaid days are only labor and delivery days reported on Worksheet S-3, Part I, column 7, line 32.

Line 24--If line 23, column 1, is "3" and this is an IPPS provider, enter the in-state Medicaid paid days in column 1 (report these days on Worksheet S-3, Part I, column 7, line 1, and lines 8 through 13, as applicable), the in-state Medicaid eligible but unpaid days in column 2 (report these days on Worksheet S-3, Part I, column 7, line 2, for adult and pediatric patients and line 13 for nursery patients, as applicable), the out-of-state Medicaid paid days in column 3 (report these days on Worksheet S-3, Part I, column 7, line 2, for adult and pediatric patients and line 13 for nursery patients, as applicable), the out-of-state Medicaid eligible but unpaid days in column 4 (report these days on Worksheet S-3, Part I, column 7, line 2, for adult and pediatric patients and line 13, for nursery patients, as applicable), the in-state and out-of-state Medicaid HMO paid and in-state and out-of-state Medicaid HMO eligible but unpaid days in column 5 (report these days on Worksheet S-3, Part I, column 7, line 2, for adult and pediatric patients and line 13, for nursery patients, as applicable). Enter only labor and delivery days (reported on Worksheet S-3, Part I, column 7, line 32) as "Other Medicaid days" in column 6. If line 23, column 1, is "1" or "2", enter the Medicaid days based on each column description; however, these days may not equal the Medicaid days reported by discharge on Worksheet S-3, Part I. Do not include swing-bed, observation or hospice days in any columns on this line. See 42 CFR 412.106(a)(1)(ii) and 412.106(b)(4).

Line 25--If line 23, column 1, is "3" and this provider is an IRF or contains an IRF unit, enter the in-state Medicaid paid days in column 1, (report IRF days on Worksheet S-3, Part I, column 7, line 1, or IRF unit days on Worksheet S-3, Part I, column 7, line 17), the in-state Medicaid eligible but unpaid days in column 2 (report IRF days on Worksheet S-3, Part I, column 7, line 2, or IRF unit days on Worksheet S-3, Part I, column 7, line 4), the out-of-state Medicaid paid days in column 3 (report IRF days on Worksheet S-3, Part I, column 7, line 2, or IRF unit days on Worksheet S-3, Part I, column 7, line 4), the out-of-state Medicaid eligible but unpaid days in column 4 (report IRF days on Worksheet S-3, Part I, column 7, line 2, or IRF unit days on Worksheet S-3, Part I, column 7, line 4), the in-state and out-of-state Medicaid HMO paid and in-state and out-of-state Medicaid HMO eligible but unpaid days in column 5 (report IRF days on Worksheet S-3, Part I, column 7, line 2, or IRF unit days on Worksheet S-3, Part I, column 7, line 4). Do not enter any days in column 6 for cost reporting periods beginning on or after October 1, 2012. If line 23, column 1, is "1" or "2", enter the Medicaid days based on each column description; however, these days may not equal the Medicaid days reported by discharge on Worksheet S-3, Part I. Do not include swing-bed, observation or hospice days in any columns on this line.

Line 26--For the Standard geographic classification (not wage), what is your status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.

Line 27--For the Standard geographic classification (not wage), what is your status at the end of the cost reporting period. Enter "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.

Lines 28 through 34--Reserved for future use.

Line 35--If this is a sole community hospital (SCH), enter the number of periods (0, 1, or 2) within this cost reporting period that SCH status was in effect.

Line 36--Enter the beginning and ending dates of SCH status during this cost reporting period. Subscript line 36 if more than one period is identified for this cost reporting period and enter multiple dates. Multiple dates are created where there is a break in the date between SCH status (i.e., for calendar year provider SCH status dates are 1/1/2010 through 6/30/2010 and 9/1/2010 through 12/31/2010).

Line 37--If this is a Medicare-dependent, small rural hospital (MDH), enter the number of periods within this cost reporting period that MDH status was in effect.

Line 37.01--Did this hospital lose their MDH status because they are no longer in a rural area due to the implementation of the new OMB delineations in FY 2015, and they did not reclassify from urban to rural under the regulations at §412.103 before January 1, 2016? Enter "Y" for yes or "N" for no. If yes, calculate the MDH transition payment on Worksheet E, Part A, for portions of the current cost reporting period that overlap or fall within January 1, 2016, and September 30, 2017. Do not respond to this question for cost reporting periods that begin on or after October 1, 2017.

Line 38--If line 37 is 1, enter the beginning and ending date of MDH status during this cost reporting period. If line 37 is greater than 1, subscript this line and enter the applicable beginning and ending dates accordingly.

Line 39--For cost reporting periods that overlap or begin on or after October 1, 2010, does the hospital qualify for the inpatient hospital adjustment for low-volume hospitals for a portion of the cost reporting period? Enter in column 1 "Y" for yes or "N" for no. If column 1 is "Y", does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2, "Y" for yes or "N" for no. Hospitals are required to request low-volume status in writing to their contractor and provide documentation that they meet the mileage criteria.

The response to these questions determines the completion of the low-volume calculation adjustment.

NOTE: 42 CFR 412.101(c)(1) provides for a low-volume adjustment for qualifying hospitals for federal fiscal years (FFYs) 2005 through 2010, and FFY 2026 and subsequent federal fiscal years. Qualifying hospitals, those hospitals more than 25 road miles from the nearest subsection (d) hospital and with fewer than 200 total discharges, receive a payment adjustment of an additional 25 percent for each Medicare discharge.

42 CFR 412.101(c)(2) provides for a temporary change in the low-volume adjustment for qualifying hospitals for FFYs 2011 through 2018:

- Those hospitals with 200 or fewer Medicare discharges will receive an adjustment of an additional 25 percent for each Medicare discharge; and,
- Those with more than 200 and fewer than 1,600 Medicare discharges will receive an adjustment of an additional percentage for each Medicare discharge. This adjustment is calculated using the formula [(4/14) - (Medicare discharges/5600)].

To qualify as a low-volume hospital, the hospital must meet both of the following criteria:

- Be more than 15 road miles from the nearest subsection (d) hospital; and,
- Have fewer than 1,600 Medicare discharges based on the latest available Medicare Provider Analysis and Review (MedPAR) data as determined by CMS.

42 CFR 412.101(c)(3) provides for a temporary change in the low-volume adjustment for qualifying hospitals for FFYs 2019 through FFY 2025, as follows:

- Those hospitals with 500 or fewer total discharges will receive an adjustment of an additional 25 percent for each Medicare discharge; and,
- Those with more than 500 and fewer than 3,800 total discharges will receive an adjustment of an additional percentage for each Medicare discharge. This adjustment is calculated using the formula [(95/330) - (total discharges/13,200)].

To qualify as a low-volume hospital, the hospital must meet both of the following criteria:

- Be more than 15 road miles from the nearest subsection (d) hospital; and,
- Have fewer than 3,800 total discharges based on the hospital's most recently submitted cost report.

Line 40--Section 3008 of the Affordable Care Act (ACA 2010) established the Hospital Acquired Condition (HAC) Reduction Program, beginning in FFY 2015. Enter in column 1, "Y" for yes or "N" for no if your hospital is subject to the HAC reduction adjustment for discharges occurring prior to October 1. For cost reporting periods that overlap October 1, 2014, enter "N" in column 1. Enter in column 2, "Y" for yes or "N" for no if your hospital is subject to the HAC reduction adjustment for discharges occurring on or after October 1.

Lines 41 through 44--Reserved for future use.

Line 45--Does your facility qualify and receive capital payments for disproportionate share in accordance with 42 CFR 412.320? Enter "Y" for yes and "N" for no.

Line 46--Are you eligible for the exception payment for extraordinary circumstances pursuant to 42 CFR 412.348(f)? Enter "Y" for yes or "N" for no. If yes, complete Worksheets L, Part III, and L-1.

Line 47--Is this a new hospital under 42 CFR 412.300(b) (PPS capital)? Enter "Y" for yes or "N" for no for the respective programs.

Line 48--If line 47 is yes, do you elect full federal capital payment? Enter "Y" for yes or "N" for no for the respective programs.

Lines 49 through 55--Reserved for future use.

NOTE: CAHs complete question 107 in lieu of question 57.

Line 56--Is this a hospital involved in training residents in approved graduate medical education (GME) programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), a hospital must enter "Y" for yes and report FTE residents on Worksheet E-4 if the hospital trained at least 1.0 FTE in an approved program(s) in the cost reporting period. Additionally, if the hospital trained less than 1.0 FTE residents in an approved program(s) and this training resulted from the hospital's participation in a Medicare GME affiliation agreement (as defined under 42 CFR 413.75(b)), then the hospital must also enter "Y" for yes and report FTE residents on Worksheet E-4. The BBRA provided that payments that are made to teaching hospitals for costs of direct GME associated with services to Medicare Advantage (MA) enrollees will be reduced by an estimated percentage in each calendar year (CY). For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and you are impacted by Change Request (CR) 11642 (or applicable CRs) MA direct GME payment reduction, enter "Y" for yes; otherwise, enter "N" for no in column 2.

Line 57--For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period in which you are training residents in approved programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, were residents training during the first month of the cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is yes, complete Worksheet E-4. If column 2 is "N", complete Worksheets D, Parts III and IV, and D-2, Part II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56, column 1, is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.

Line 58--If line 56, column 1, is "Y" for yes, did you elect cost reimbursement for physician direct medical and surgical services as defined in 42 CFR 415.160 and CMS Pub. 15-1, chapter 21, §2148? Enter "Y" for yes or "N" for no. If yes, complete Worksheet D-5.

Line 59--Are you claiming costs of interns and residents (I&R) in unapproved programs on Worksheet A, column 7, line 100? Enter "Y" for yes or "N" for no. If yes, complete Worksheet D-2, Part I.

Line 60--Are you claiming nursing and allied health education (NAHE) costs for any programs approved in accordance with 42 CFR 413.85(e)? Enter "Y" for yes or "N" for no in column 1. If your hospital does not have an approved NAHE program that meets the criteria in 42 CFR 413.85(e), or if all the NAHE costs are for educational activities treated as normal operating costs as defined in 42 CFR 413.85(h)(6), enter "N" for no. Additionally, 42 CFR 413.87 provides for additional payments to hospitals for costs of NAHE services to MA enrollees. If the response to column 1 is "Y", are you impacted by CR 11642 (or applicable CRs) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2. If the response to line 60 is no, do not complete subscripts for line 60.

Effective for cost reporting periods ending on or after September 30, 2017, if the response to line 60, column 1, is yes, subscript this line for each program, beginning with line 60.01. Enter in column 2, the Worksheet A line number on which the costs of the NAHE program were reported. Enter in column 3, the appropriate code that identifies the criterion under which the NAHE program costs qualify for pass-through payment or are treated as normal operating costs. Select from the following list:

(1) - NAHE program is a provider operated program that meets the criteria under 42 CFR 413.85(f).
(2) - NAHE program is a nonprovider operated program that meets the criteria under 42 CFR 413.85(g)(2). However, under 42 CFR 413.85(g)(2)(iii), the pass-through costs are limited to the percentage of total allowable provider cost attributable to NAHE clinical training costs reported in the most recent cost reporting period ending on or before October 1, 1989.
(3) - NAHE program is a nonprovider operated program that meets the criteria under 42 CFR 413.85(g)(3).
(4) - NAHE program is a nonprovider operated program where costs are treated as normal operating costs under 42 CFR 413.85(h)(6).

For each subscript of line 60 beginning with line 60.01, if the entry in column 3 is "1", "2", or "3", report the NAHE program costs in the applicable column of Worksheet D, Parts III and IV, to separately identify nursing program and allied health education costs from all other medical education costs. For any subscript of line 60 where the entry in column 3 is "4", do not transfer the costs to Worksheet D, Part III, or Part IV.

Requirements During Five Year Period Following Implementation of Increases to Hospitals' FTE Resident Caps Under Section 5503 of the Affordable Care Act (ACA), Line 61 and Subscripts--Section 5503 of the ACA states that a hospital that receives an increase to its FTE resident cap under section 5503 shall ensure, during the 5-year period beginning on July 1, 2011, that:

(I) The number of FTE primary care residents is not less than the average number of FTE primary care residents during the three most recent cost reporting periods ending prior to the date of enactment of section 5503; and,

(II) Not less than 75 percent of the positions attributable to such increase are in a primary care or general surgery residency.

Failure to comply with either of these two requirements, known as the 3-year primary care average requirement (I) and the 75 percent test (II), means permanent removal of all section 5503 slots from the earliest applicable cost reporting period under the regulations at 42 CFR 413.79(n)(2).

Line 61--Did your hospital receive FTE slots under section 5503 of the ACA? Enter "Y" for yes or "N" for no in column 1. If "Y", enter the number of IME section 5503 slots awarded in column 4 and direct GME section 5503 slots awarded in column 5. The number of IME and/or direct GME slots entered here should be the amounts on the award letter from CMS. Complete the subscripts of line 61 for portions of cost reporting periods occurring on or after July 1, 2011, and before July 1, 2016. If "N" for no, do not complete columns 4 or 5 and subscripts of line 61.

NOTE: Effective for portions of cost reporting periods occurring on or after July 1, 2011, do not complete line 61, columns 2 and 3. This information is now reported on line 61.01, columns 2 and 3.

Line 61.01--Effective for portions of cost reporting periods occurring on or after July 1, 2011, and before July 1, 2016, enter the average unweighted number of primary care FTE residents from the hospital's three most recent cost reports ending and submitted to the contractor before March 23, 2010. See 42 CFR 413.75(b) for the definition of "primary care resident". Enter the 3-year primary care average for IME in column 2. The source of the primary care IME FTE residents is the rotation schedules submitted by the provider to support its cost reports for the three most recent cost reports ending and submitted to the contractors prior to March 23, 2010. Any audit adjustments to these IME primary care FTE residents must be taken into account in computing the 3-year average. Exclude OB/GYN and general surgery FTE residents. This primary care average is based on the hospital's total primary care FTE count that would otherwise be allowable if not for the FTE resident cap for each year in the 3-year period. If any of the three cost reports is not a 12-month cost report, enter the 12-month equivalent FTE count.

Enter the average unweighted number of primary care FTE residents for direct GME in column 3. This primary care average is based on the hospital's total unweighted primary care FTE count that would otherwise be allowable if not for the FTE resident cap for each year in the 3-year period. If the hospital did not train any OB/GYN residents in its three most recent cost reports ending and submitted prior to March 23, 2010, convert the weighted primary care FTE counts from line 3.19 of Worksheet E-3, Part IV, of Form CMS-2552-96, to unweighted FTE counts, compute a 3-year average, and report the average in column 3. If the hospital did train OB/GYN FTE residents in its three most recent cost reports ending and submitted prior to March 23, 2010, subtract the OB/GYN FTE counts from line 3.19 of Worksheet E-3, Part IV, of Form CMS-2552-96, convert the remaining primary care FTE counts to unweighted FTE counts, compute a 3-year average, and report the average in column 3. Exclude general surgery FTE residents. If any of the three cost reports is not a 12-month cost report, enter the 12-month equivalent FTE count.

Line 61.02--Enter the current cost reporting period total unweighted primary care FTE count (excluding obstetrics and gynecology and general surgery), which is used to determine compliance with the 3-year primary care average requirement. In accordance with section 5503 of the ACA, which states that the 3-year primary care average requirement must be met by "excluding any additional positions" added as a result of the section 5503 FTE cap increase, also exclude from this unweighted primary care FTE count any primary care FTEs added in the current cost reporting period specific to new or expanded programs under section 5503 (see 75 FR 72198-72199 dated November 24, 2010). Enter the unweighted IME FTE count in column 2 and the direct GME FTE count in column 3. If the current cost report is not a 12-month cost report, enter the 12-month equivalent FTE count. These current cost reporting period unweighted primary care FTE counts are compared to the 3-year primary care average amounts in line 61.01.

Line 61.03--Enter the baseline FTE count for primary care and/or general surgery residents that is used for determining compliance with the 75 percent requirement. These primary care and/or general surgery FTEs would be a part of the unweighted allopathic and osteopathic FTE count from the hospital's 12-month (or prorated equivalent) cost report that immediately precedes the cost report that includes July 1, 2011. Report the IME primary care and/or general surgery baseline FTE count in column 2 and the direct GME baseline primary care and/or general surgery FTE count in column 3. (For example, the baseline cost report for June 30 providers would be July 1, 2010, through June 30, 2011; for December 31 providers, this would be January 1, 2010, through December 31, 2010; for September 30 providers, this would be October 1, 2009 through September 30, 2010). (On the Form CMS-2552-96, the baseline FTE primary care and/or general surgery count is included and commingled in the allopathic and osteopathic FTEs reported on line 3.08 of Worksheet E, Part A, and on line 3.05 of Worksheet E-3, Part IV. On the Form CMS-2552-10, the baseline primary care and/or general surgery FTE count is included and commingled in the allopathic and osteopathic FTEs reported on line 10 of Worksheet E, Part A, and on line 6 of Worksheet E-4). Use the rotation schedules from the hospital's 12-month (or prorated equivalent) cost report that immediately precedes the cost report that includes July 1, 2011, as the source for the primary care and/or general surgery FTEs.

Line 61.04--Enter the total number of unweighted primary care and/or general surgery allopathic and/or osteopathic FTEs in the current cost reporting period. If the cost report is not a 12-month cost report, enter the 12-month equivalent FTE count. Exclude OB/GYN FTEs. (These FTEs are part of the current year FTE count and are included on Form CMS-2552-10, line 10 of Worksheet E, Part A, and line 6 of Worksheet E-4). Report the unweighted IME FTE count in column 2 and the direct GME FTE count in column 3.

Line 61.05--Determination of Compliance with 75 Percent Requirement--For portions of cost reporting periods occurring on or after July 1, 2011, and before July 1, 2016, enter the difference between the baseline primary care and/or general surgery FTE counts and the current year primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). Report the IME FTE count difference in column 2 and the direct GME FTE count difference in column 3. (If the difference is less than or equal to zero, enter a zero).

The section 5503 FTE cap slots reported on Worksheet E, Part A, line 8.01 (for IME), and Worksheet E-4, line 4.01 (direct GME), are dependent upon this difference on line 61.05 (for portions of cost reporting periods occurring on or after July 1, 2011, and before July 1, 2016), because of the requirement that 75 percent of the section 5503 FTE cap award be **used** for primary care and/or general surgery FTEs in new or expanded programs. If the difference on line 61.05 is greater than zero, then it must be at least 75 percent of the section 5503 FTE cap award to be reported on Worksheet E, Part A, line 8.01 (for IME), and Worksheet E-4, line 4.01 (for direct GME). For example, if a hospital was awarded a total of 10 slots, but the difference reported on line 61.05 is 5, then the section 5503 FTE slots reported on Worksheet E, Part A, line 8.01 (for IME), and Worksheet E-4, line 4.01 (for direct GME), cannot be more than 6.67 (that is, 5 divided by 75 percent). Therefore, determine that the difference on line 61.05 is at least 75 percent of the section 5503 award amount that is reported on Worksheet E, Part A, line 8.01 (for IME), and Worksheet E-4, line 4.01 (for direct GME).

Line 61.06--Enter the amount of the ACA section 5503 award FTEs that are being used for cap relief, if any, and/or that are nonprimary care or non-general surgery FTEs. Report the IME amount in column 2 and the direct GME amount in column 3. For portions of cost reporting periods occurring on or after July 1, 2011, and before July 1, 2016, the amount reported on this line can be no more than 25 percent of the section 5503 FTE cap slots reported on Worksheet E, Part A, line 8.01 (for IME), and Worksheet E-4, line 4.01 (for direct GME). If the amount on line 61.05, columns 2 or 3, is greater than or equal to the section 5503 cap award reported on line 61, columns 4 or 5, respectively, report zero on this line.

If the amount on line 61.05 is less than the section 5503 cap award, and the hospital either is training FTE residents over its existing FTE cap or has added nonprimary care and non-general surgery FTEs in the current cost reporting period, report on this line the difference of the section 5503 cap slots on Worksheet E, Part A, line 8.01 (for IME), and Worksheet E-4, line 4.01 (for direct GME), and the amount reported on line 61.05. For example, if a hospital was awarded a total of 10 slots, and 5 is reported on line 61.05, and the section 5503 FTE slots reported on Worksheet E, Part A, line 8.01 (for IME), and Worksheet E-4, line 4.01 (for direct GME) is 6.67 FTEs, then the amount reported on line 61.06 cannot exceed 1.67 FTEs which is the difference between the amount on line 61.05, and the amount reported on Worksheet E, Part A, line 8.01 (for IME), and Worksheet E-4, line 4.01 (for direct GME). If 10 is reported on line 61.05, then report 0 (zero) on line 61.06. If 8 is reported on line 61.05 and the hospital added 2 or more nonprimary care FTEs in the current cost reporting period, then report 2 on this line.

Lines 61.07 through 61.09--Reserved for future use.

Line 61.10--Of the FTEs in line 61.05, specify each new primary care or general surgery program specialty, if any, and the number of FTE residents for each new program. Use subscripted lines 61.11 through 61.19 for each additional new program. Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 the direct GME FTE unweighted count.

Line 61.20--Of the additional FTEs in line 61.05, specify each expanded primary care or general surgery program specialty, if any, and the number of FTE residents for each program expansion. Use subscripted lines 61.21 through 61.29 for each additional program expansion. Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 the direct GME FTE unweighted count.

Lines 62 and 62.01--Provisions Affecting the Health Resources and Services Administration (HRSA)--These provisions are effective for the Health Resources and Services Administration (HRSA) Primary Care Residency Expansion (PCRE) program and the Teaching Health Center (THC) program.

Line 62--Effective for services rendered on or after September 30, 2010, enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding. (Sections 4002 and 5301 of the ACA.)

Line 62.01--Effective for services rendered on or after October 1, 2010, enter the number of FTE residents that rotated from a THC into your hospital during this cost reporting period under the HRSA THC program. (Section 5508 of the ACA and §301(c) of the Consolidated Appropriations Act of 2021 (CAA 2021).)

Line 63--Has your facility trained residents in a nonprovider setting during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. (See 75 FR 72139-72140 (November 24, 2010).) If column 1 is "Y" for yes, complete lines 64 through 67 and applicable subscripts. If "N" for no, but your facility trained residents in a nonprovider setting during the base year period (cost reporting period that begins on or after July 1, 2009, and before June 30, 2010), complete lines 64 and 65, and applicable subscripts effective for cost reporting periods beginning on or after July 1, 2010.

Lines 64 and 65--Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--The base year is your cost reporting period that begins on or after July 1, 2009, and before June 30, 2010.

Line 64--If line 63 is yes or your facility trained residents in the base year period, enter in column 1, for cost reporting periods that begins on or after July 1, 2009, and before June 30, 2010, the number of unweighted nonprimary care FTE residents attributable to rotations that occurred in all nonprovider settings. Enter in column 2, the number of unweighted nonprimary care FTE residents that trained in your hospital. Include unweighted OB/GYN, dental and podiatry FTEs on this line. Enter in column 3, the ratio of column 1 divided by the sum of columns 1 and 2.

Line 65--If line 63 is yes or your facility trained residents in the base year period, enter from your cost reporting period that begins on or after July 1, 2009, and before June 30, 2010, the number of unweighted primary care FTE residents for each primary care specialty program in which you train residents. (See 42 CFR 413.75(b) for the definition of "primary care resident.") Use subscripted lines 65.01 through 65.50 for each additional primary care program. Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations that occurred in nonprovider settings for each applicable program. Enter in column 4, the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5, the ratio of column 3 divided by the sum of columns 3 and 4. If you operated a primary care program that did not have FTE residents in a nonprovider setting, enter zero in column 3 and complete all other columns for each applicable program.

NOTE: The sum of the FTE counts on line 64, columns 1 and 2, and line 65, columns 3 and 4, should approximate the sum of the FTE counts on Form CMS-2552-96, Worksheet E-3, Part IV, lines 3.05 and 3.11, for your cost reporting period that begins on or after July 1, 2009, and before June 30, 2010.

Lines 66 and 67--Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010.

Line 66--If line 63 is yes, enter in column 1, the unweighted number of nonprimary care FTE residents attributable to rotations occurring in all nonprovider settings. Enter in column 2, the number of unweighted nonprimary care FTE residents in your hospital. Include unweighted OB/GYN, dental and podiatry FTEs on this line. Enter in column 3, the ratio of column 1 divided by the sum of columns 1 and 2.

Line 67--If line 63 is yes, then, for each primary care residency program in which you are training residents, enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations that occurred in nonprovider settings for each applicable program. Enter in column 4, the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5, the ratio of column 3 divided by the sum of columns 3 and 4. Use subscripted lines 67.01 through 67.50 for each additional primary care program.

If you operated a primary care program that did not have FTE residents in a nonprovider setting, enter zero in column 3 and complete all other columns for each applicable program.

NOTE: The sum of the FTE counts on line 66, columns 1 and 2, and line 67, columns 3 and 4, should approximate the sum of the FTE counts on Worksheet E-4, lines 6 and 10, for this current cost reporting period.

Line 68--For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the DGME formula in accordance with the FY 2023 IPPS final rule, 87 FR 49065-49072 (August 10, 2022)? Enter "Y" for yes; otherwise, enter "N" for no. Do not complete the question for cost reporting periods beginning on or after October 1, 2022.

Line 69--Reserved for future use.

Line 70--Are you an IPF or do you contain an IPF subprovider? Enter in column 1 "Y" for yes or "N" for no.

Line 71--For column 1, if this facility is an IPF or contains an IPF subprovider (response to line 70, column 1, is "Y" for yes), did the facility train residents in graduate medical education programs **in the most recent cost report filed on or before November 15, 2004?** Enter "Y" for yes or "N" for no.

For column 2, did the facility train residents in a new graduate medical education program in the current cost reporting period, or in a prior cost reporting period, in accordance with 42 CFR 412.424(d)(1)(iii)(D)? Enter in column 2, "Y" for yes or "N" for no. (Note: If column 1 is "Y," then column 2 must be "N." Columns 1 and 2 cannot be "Y" simultaneously; however, columns 1 and 2 can be "N" simultaneously.)

For column 3, if column 2 is yes, indicate which program year began in this cost reporting period. New programs that began before October 1, 2012, have a 3-year new program growth period for the first new program, while new programs that began on or after October 1, 2012, have a 5-year new program growth period for the first new program. For new programs that began before October 1, 2012 (see 42 CFR 413.79(e)(1)), enter a 1, 2, or 3, in column 3 to correspond to the I&R academic year in the first 3 program years of the first new program's existence that began during the current cost reporting period, or enter a 6 to indicate this cost reporting period includes the beginning of the program year following the 3-year new program growth period of the first new program, or the program is beyond the new program growth period. For new programs that began on or after October 1, 2012 (see 42 CFR 413.79(e)(1)), enter a 1, 2, 3, 4, or 5, in column 3 to correspond to the I&R academic year in the first 5 program years of the first new program's existence that began during the current cost reporting period, or enter a 6 to indicate this cost reporting period includes the beginning of the program year following the 5-year new program growth period of the first new program, or the program is beyond the new program growth period. If column 2 is no, make no entry in column 3.

Lines 72 through 74--Reserved for future use.

Line 75--Are you an IRF or do you contain an IRF subprovider? Enter in column 1 "Y" for yes or "N" for no.

Line 76--For column 1, if this facility is an IRF or contains an IRF subprovider (response to line 75, column 1, is "Y" for yes), did the facility train residents in graduate medical education programs **in the most recent cost reporting period ending on or before November 15, 2004?** Enter "Y" for yes or "N" for no.

For column 2, did the facility train residents in a new graduate medical education program in the current cost reporting period, or in a prior cost reporting period, in accordance with 70 FR 47929 (August 15, 2005)? Enter in column 2, "Y" for yes or "N" for no. (Note: If column 1 is "Y", then column 2 must be "N." Columns 1 and 2 cannot be "Y" simultaneously; however, columns 1 and 2 can be "N" simultaneously.)

For column 3, if column 2 is yes, indicate which program year began in this cost reporting period. New programs that began before October 1, 2012, have a 3-year new program growth period for the first new program, while new programs that began on or after October 1, 2012, have a 5-year new program growth period for the first new program. For new programs that began before October 1, 2012 (see 42 CFR 413.79(e)(1)), enter a 1, 2, or 3, in column 3 to correspond to the I&R academic year in the first 3 program years of the first new program's existence that began during the current cost reporting period, or enter a 6 to indicate this cost reporting period includes the beginning of the program year following the 3-year new program growth period of the first new program, or the program is beyond the new program growth period. For new programs that began on or after October 1, 2012 (see 42 CFR 413.79(e)(1)), enter a 1, 2, 3, 4, or 5, in column 3 to correspond to the I&R academic year in the first 5 program years of the first new program's

existence that began during the current cost reporting period, or enter a 6 to indicate this cost reporting period includes the beginning of the program year following the 5-year new program growth period of the first new program, or the program is beyond the new program growth period. If column 2 is no, make no entry in column 3.

Lines 77 through 79--Reserved for future use.

Line 80--Are you a freestanding LTCH? Enter in column 1 "Y" for yes or "N" for no. LTCHs can only exist as independent/freestanding facilities. To be considered as independent or a freestanding facility, a LTCH located within another hospital must meet the separateness (from the host/co-located provider) requirements identified in 42 CFR 412.22(e).

Line 81--Are you an independent or freestanding LTCH located within another hospital, subject to the special payment provisions of 42 CFR 412.534? Enter "Y" for yes or "N" for no. To be considered as independent or a freestanding facility, a LTCH located within another hospital must meet the separateness (from the host/co-located provider) requirements identified in 42 CFR 412.22.

Lines 82 through 84--Reserved for future use.

Line 85--Is this a new hospital under 42 CFR 413.40(f)(1)(i) (TEFRA)? Enter "Y" for yes or "N" for no.

Line 86--Have you established a new "Other" subprovider (excluded unit) under 42 CFR 413.40(f)(1)(ii)? Enter "Y" for yes or "N" for no in column 1. If there is more than one subprovider, subscript this line. Do not complete this line.

Line 87--Is this hospital a LTCH classified under section 1886(d)(1)(B)(vi) (referred to as extended neoplastic disease care hospitals)? Enter "Y" for yes or "N" for no.

Line 88--For a cost reporting period beginning on or after October 1, 2022, is this provider approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", in column 2, enter the number of approved permanent adjustments, and complete line 89. See CMS Pub. 15-1, chapter 30, §3004.1 and §3004.2, for clarification on permanent adjustments.

Line 89--If line 88, column 1, is yes, complete columns 1, 2, and 3, for the earliest (first) approved permanent adjustment. In column 1, enter the Worksheet A line number upon which the approval of the permanent adjustment to the TEFRA target amount per discharge was based; in column 2, enter the cost reporting period beginning date that the permanent adjustment to the TEFRA target amount per discharge was effective, if available; and in column 3, enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge approved as of the date in column 2. If the number on line 88, column 2, is greater than one (the hospital received multiple approvals for permanent adjustments to the TEFRA target amount per discharge), subscript this line consecutively as necessary to report each additional approved permanent adjustment in chronological order. Report the earliest (first) approved permanent adjustment on line 89, and report each subsequently approved permanent adjustment on lines 89.01, 89.02, etc. See CMS Pub. 15-1, chapter 30, §3004.1 and §3004.2, for clarification on permanent adjustments.

Lines 90--Do you provide title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.

Line 91--Is this hospital reimbursed for title V and/or XIX through the cost report in full or in part? Enter "Y" for yes or "N' for no in the applicable column.

Line 92--If all of the nursing facility beds were certified for title XIX, and there were also title XVIII certified beds (dual certified), were any of the title XVIII beds occupied by title XIX patients during the cost reporting period? Enter "Y" for yes or "N" for no in the applicable column. Complete a separate Worksheet D-1 for title XIX for each level of care.

Line 93--Do you operate an ICF/IID facility for purposes of title XIX? Enter "Y" for yes or "N" for no.

Line 94--Does title V and/or XIX reduce capital costs? Enter "Y" for yes or "N" for no in the applicable column.

Line 95--For each column, if line 94 is "Y" for yes, enter the percentage by which capital costs are reduced.

Line 96--Does title V and/or XIX reduce operating costs? Enter "Y" for yes or "N" for no in the applicable column.

Line 97--For each column, if line 96 is "Y" for yes, enter the percentage by which operating costs are reduced.

Line 98--Does title V or XIX follow Medicare for the interns and residents post step-down adjustments on Worksheet B, Part I, column 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.

Line 98.01--Does title V or XIX follow Medicare for the reporting of charges on Worksheet C, Part I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.

Line 98.02--Does title V or XIX follow Medicare for the calculation of observation bed costs on Worksheet D-1, Part IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.

Line 98.03--Does title V or XIX follow Medicare for a CAH reimbursed 101 percent of cost for inpatient services? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.

Line 98.04--Does title V or XIX follow Medicare for a CAH reimbursed 101 percent of cost for outpatient services? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.

Line 98.05--Does title V or XIX follow Medicare and add back the reasonable compensation equivalent (RCE) disallowance on Worksheet C, Part I, column 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.

Line 98.06--Does title V or XIX follow Medicare when cost reimbursed for Worksheet D, Parts I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.

Lines 99 through 104--Reserved for future use.

Line 105--If this hospital qualifies as a CAH, enter "Y" for yes in column 1. Otherwise, enter "N" for no, and skip to line 108. (See 42 CFR 485.606ff.)

Line 106--If line 105 is yes, has this CAH elected the all-inclusive method of payment for outpatient services? Enter "Y" for yes or "N" for no. If yes, an adjustment for the professional component is still required on Worksheet A-8-2.

NOTE: If the facility elected the all-inclusive method for outpatient services, professional component amounts are excluded from deductible and coinsurance amounts and are not included on Worksheet E-1.

Line 107--If line 105 is yes, is this CAH eligible for 101 percent reasonable cost reimbursement for I&R in approved training programs? Enter a "Y" for yes or an "N" for no in column 1. If column 1 is yes, the GME elimination is **not** made on Worksheet B, Part I, column 25, and the program is cost reimbursed. If yes, complete Worksheet D-2, Part II.

If column 1 is yes and line 70 and/or line 75 is yes, do I&Rs in approved medical education programs train in the CAH's excluded IPF and/or IRF unit? Enter a "Y" for yes or an "N" for no in column 2. If column 2 is yes, complete Worksheet E-4, to calculate GME reimbursement for CAH subproviders.

Line 107.01--If this facility is a REH (line 3, column 4, is "12"), is it eligible for cost reimbursement for I&R training programs? (See 42 CFR 419.92(d).) Enter "Y" for yes or "N" for no. If yes, the GME elimination is **not** made on Worksheet B, Part I, column 25, and the program is cost reimbursed.

Line 108--Is this a rural hospital qualifying for an exception to the certified registered nurse anesthetist (CRNA) fee schedule? (See 42 CFR 412.113(c).) Enter "Y" for yes or "N" for no, in column 1.

Line 109--If this hospital qualifies as a CAH (response to line 105 is yes) or is a cost reimbursed provider, are therapy services provided by outside suppliers? Enter "Y" for yes or "N" for no under the corresponding physical, occupational, speech and/or respiratory therapy services as applicable.

Line 110--Did this facility participate in the Rural Community Hospital Demonstration Project (also known as the §410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no. If "Y", complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, line 200 through 215, as applicable.

Line 111--If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response in column 1 is "Y", enter in column 2, the integration prong of the FCHIP demonstration in which this CAH is participating. Enter all that apply: "A" for ambulance services reimbursed at 101 percent of reasonable costs; "B" for additional beds used only for SNF and/or NF level of care; and/or "C" for telehealth services reimbursed at 101 percent of reasonable costs.

NOTE FOR LINE 111: If the entry in column 2 is "C", a telemedicine cost center must exist on Worksheet A, line 93 (Other Outpatient Service (specify)), or a subscript thereof, to report the telehealth originating site cost and/or telehealth destination site cost of CAHs participating in the FCHIP demonstration with a cost center code of "04050" (see §4095, Table 5).

Line 112--Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the cost reporting period? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", in column 2, enter the beginning date for the portion of the cost reporting period the hospital began participation in the PARHM demonstration; and, in column 3, enter the ending date for the portion of the cost reporting period the hospital ceased participation in the PARHM demonstration, when applicable. If the hospital participated in the PARHM demonstration for the entire cost reporting period enter the beginning and ending dates accordingly. The PARHM demonstration is effective for outpatient services and inpatient discharges ending on or after January 29, 2019.

If column 1 is "Y" and the hospital participated in the PARHM demonstration for the entire cost reporting period, complete all hospital worksheets by selecting the "PARHM Demonstration" indicator box at the top of each worksheet. If column 1 is "Y" and any portion of the cost reporting period the hospital did not participate in the PARHM demonstration, complete the hospital worksheets as "Hospital" for the period of non-participation and complete a separate set of hospital worksheets as "PARHM Demonstration" for the period of participation.

Lines 113 and 114--Reserved for future use.

Line 115--Is this an all-inclusive rate provider (see instructions in CMS Pub. 15-1, chapter 22, §2208). Enter "Y" for yes or "N" for no in column 1. If yes, enter the applicable method (A, B, or E only) in column 2. If column 2 is "E", enter the inpatient Medicare calculation percentage in column 3. Enter "93" for short-term hospitals where over 50 percent of all patients admitted stay less than 30 days or "98" for long-term hospitals where over 50 percent of all patients stay 30 days or more. (See CMS Pub. 15-1, chapter 22, §2208.1.E.)

Line 116--Are you classified as a referral center? Enter "Y" for yes or "N" for no. See 42 CFR 412.96.

Line 117--Are you legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no. Malpractice insurance, sometimes referred to as professional liability insurance, is insurance purchased by physicians and hospitals to cover the cost of being sued for malpractice.

Line 118--Is the malpractice insurance a claims-made or occurrence policy? A claims-made insurance policy covers claims first made (reported or filed) during the year the policy is in force for any incidents that occur that year or during any previous period during which the insured was covered under a "claims-made" contract. The occurrence policy covers an incident occurring while the policy is in force regardless of when the claim arising out of that incident is filed. If the policy is claims-made, enter 1. If the policy is occurrence, enter 2.

Line 118.01--Enter the total amount of malpractice premiums paid in column 1, enter the total amount of paid losses in column 2, and enter the total amount of self-insurance paid in column 3.

Line 118.02--Indicate if malpractice premiums and paid losses are reported in a cost center other than the Administrative and General (A&G) cost center. If yes, provide a supporting schedule and list the amounts applicable to each cost center.

Malpractice insurance premiums are money paid by the provider to a commercial insurer to protect the provider against potential negligence claims made by their patients/clients. Malpractice paid losses is money paid by the healthcare provider to compensate a patient/client for professional negligence. Malpractice self-insurance is money paid by the provider where the healthcare provider acts as its own insurance company (either as a sole or part-owner) to financially protect itself against professional negligence. Often providers will manage their own funds or purchase a policy referred to as captive insurance, which protects providers for excess protection that may be unavailable or cost-prohibitive at the primary level.

Line 119--This question is eliminated, and this line must not be used.

Line 120--If this is an SCH (or EACH), that qualifies for the outpatient hold harmless provision in accordance with ACA section 3121, enter "Y" for yes or "N" for no in column 1. If this is a rural hospital with 100 or fewer beds, that qualifies for the outpatient hold harmless provision in accordance with ACA section 3121, enter "Y" for yes or "N" for no in column 2. The ACA §3121 was amended by the Medicare and Medicaid Extenders Act (MMEA) of 2010, §108; the Temporary Payroll Tax Cut Continuation Act of 2011, §308; and the Middle Class Tax Relief and Job Creation Act of 2012, §3002. Note that for SCHs and EACHs, the outpatient hold harmless provision is effective for services rendered from January 1, 2010, through February 29, 2012, regardless of bed size, and from March 1, 2012, through December 31, 2012, for SCHs and EACHs with 100 or fewer beds. Rural hospitals with 100 or fewer beds are also extended through December 31, 2012. These responses impact the TOPs calculation on Worksheet E, Part B, line 8.

Line 121--Did this facility incur and report costs (direct or indirect) in the "Implantable Devices Charged to Patients" (line 72) cost center as indicated in the 73 FR 48462 (August 19, 2008), bearing the revenue codes established by the National Uniform Billing Committee (NUBC) for high cost implantable devices? Enter "Y" for yes or "N" for no.

Line 122--Does the cost report contain health care related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If the answer in column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.

Line 123--For a cost reporting period beginning on or after October 1, 2022, did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is yes, were the majority of the expenses (i.e., greater than 50 percent of the total professional services expenses) for services purchased from unrelated organizations located outside of the main hospital's local area labor market? In column 2, enter "Y" for yes or "N" for no.

Line 124--Did the hospital incur cost, either directly or through a contract with an outside supplier, to establish and maintain access to no less than a 6-month buffer stock of one or more essential medicines according to 42 CFR 412.113(g)? Enter "Y" for yes or "N" for no.

Line 125--Is this facility a Medicare-certified transplant center? Enter "Y" for yes or "N" for no in column 1. If yes, enter the certification date and, if applicable, the termination date on lines 126 through 132, as applicable.

Line 126--If this is a Medicare-certified kidney transplant program, enter the certification date in column 1, and, if applicable, the termination date in column 2. Also, complete Worksheet D-4.

Line 127--If this is a Medicare-certified heart transplant program, enter the certification date in column 1, and, if applicable, the termination date in column 2. Also, complete Worksheet D-4.

Line 128--If this is a Medicare-certified liver transplant program, enter the certification date in column 1, and, if applicable, the termination date in column 2. Also, complete Worksheet D-4.

Line 129--If this is a Medicare-certified lung transplant program, enter the certification date in column 1, and, if applicable, the termination date in column 2. Also, complete Worksheet D-4.

Line 130--If Medicare pancreas transplants are performed, enter the more recent date of July 1, 1999, (coverage of pancreas transplants) or the certification date for kidney transplants in column 1 and, if applicable, the termination date in column 2. Also, complete Worksheet D-4.

Line 131--If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1, and, if applicable, the termination date in column 2. Also, complete Worksheet D-4.

Line 132--If this is a Medicare-certified islet transplant program, enter the certification date in column 1, and, if applicable, the termination date in column 2. Also, complete Worksheet D-4.

Line 133--Removed and reserved.

Line 134--If this hospital operates a hospital-based organ procurement organization (OPO), enter the OPO CCN in column 1, and termination date, if applicable, in column 2.

Lines 135 through 139--Reserved for future use.

Line 140--Are there any related organization or home office costs claimed as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, complete Worksheet A-8-1. If this facility is part of a chain and you are claiming home office costs, enter in column 2, the home office chain number and complete lines 141 through 143. See CMS Pub. 15-1, chapter 21, §2150, for a definition of a chain organization.

Line 141--Enter the name of the chain home office in column 1, the home office contractor name in column 2, and the home office contractor number in column 3.

Line 142--Enter the street address and P. O. Box (if applicable) of the home office.

Line 143--Enter the city, State, and ZIP code, of the home office.

Line 144--Are provider-based physicians' costs included in Worksheet A? Enter "Y" for yes or "N" for no. If yes, complete Worksheet A-8-2.

Line 145--If costs for renal dialysis services are claimed on Worksheet A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. No response is required in column 1 or column 2 unless Worksheet A, column 7, line 74, is greater than zero. If column 1 is yes, or column 2 is no, do not complete Worksheet S-5 or the Worksheet I series for renal dialysis services.

Line 146--Have you changed your cost allocation methodology from the previously filed cost report? Enter "Y" for yes or "N" for no. If yes, enter the approval date in column 2.

Line 147--Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.

Line 148--Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.

Line 149--Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.

Lines 150 through 154--Reserved for future use.

Lines 155 through 161--If you are a hospital (public or non-public) that qualifies for an exemption from the application of the lower of cost or charges principle as provided in 42 CFR 413.13, indicate the component and/or services for titles V, XVIII and XIX that qualify for the exemption by entering in the corresponding box a "Y" for yes, if you qualify for the exemption, or an "N" for no, if you do not qualify for the exemption. Subscript as needed for additional components. For title XVIII providers, a response of "Y" does not subject the provider to the LCC principle.

Lines 162 through 164--Reserved for future use.

Line 165--Is the hospital part of a multi-campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no. (For purposes of this question, only answer yes if the main campus and the off-site campus(es) are classified as section 1886(d) hospitals, or they are located in Puerto Rico).

Line 166--If you responded "Y" for yes to question 165, enter information for each campus (including the main campus) as follows: name in column 0, county in column 1, State in column 2, ZIP code in column 3, geographic CBSA in column 4, and the FTE count for this campus in column 5. If additional campuses exist, subscript this line as necessary. Enter the information in columns 0 through 5 for the main campus first, and then enter the information in each column for the subordinate campuses, in any order. For example, for the main campus, enter on line 166 the name, county, state, ZIP code, geographic CBSA, and FTEs per campus. For the first subordinate campus, enter on line 166.01 the name, county, state, ZIP code, geographic CBSA, and FTEs per campus. Report only FTE information associated with IPPS areas and not the FTE information for excluded areas (i.e., hospital-based IPF and hospital-based IRF).

Line 167--Is this hospital/campus a meaningful user of electronic health record (EHR) technology in accordance §1886(n) of the Social Security Act as amended by the section 4102 of the American Recovery and Reinvestment Act (ARRA) of 2009 or the CAA of 2016, Division O, Title VI, §602? Enter "Y" for yes or "N" for no. A CAH that is not a meaningful user beginning in FFY 2015 is subject to a payment adjustment as defined in 42 CFR 413.70(a)(6)(i). A CAH may, on a case-by-case basis, be granted an exception from this adjustment if CMS or its Medicare contractor determines, on an annual basis, that a significant hardship exists, such as in the case of a CAH in a rural area without sufficient internet access. However, in no case may a CAH be granted an exception for more than 5 years.

Line 168--If this provider is a CAH (line 105 is "Y" for yes) and is also a meaningful EHR technology user (line 167 is "Y" for yes), enter, if applicable, the reasonable acquisition cost incurred for EHR assets either purchased or initially rented under a virtual purchase lease (see 42 CFR 413.130(b)(5) and (8), and CMS Pub. 15-1, chapter 1, §110.B.1.b) in the current cost reporting period. If applicable, also enter the un-depreciated cost (i.e., net book value) as of the beginning of the current cost reporting period, for assets purchased or initially rented under a virtual purchase lease in prior cost reporting period(s) which were used for EHR purposes in the current cost reporting period. Do not enter on this line any cost for EHR assets which was already claimed for the same assets in previous cost reporting period(s). The reasonable acquisition cost incurred is for depreciable assets such as computers and associated hardware and software necessary to administer certified EHR technology. (See 75 FR 44461 (July 28, 2010) and 42 CFR 495.106(a) and (c)(2).)

Additionally, if the amount on this line is greater than zero, submit a listing of the EHR assets showing the following information for each asset: (1) nature of each asset and acquisition cost; (2) an annotation whether the asset was purchased or leased under a virtual purchase lease (42 CFR 413.130(b)(8)); (3) date of purchase or date the virtual purchase lease was initiated; (4) name(s) of original purchaser (e.g., CAH, CAH's home office, group of unrelated providers); (5) information regarding the asset's use (i.e., indication whether the asset (hardware of software)) will be shared with CAH's non-EHR systems; and, (6) tag number and location (department unit). For cost reporting periods beginning on or after October 1, 2016, do not complete this line.

Line 168.01--If this provider is a CAH (line 105 is "Y") and is not a meaningful user (line 167 is "N"), does this provider qualify for a hardship exception under 42 CFR 413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. If no, the CAH is subject to a payment adjustment. The CAH's reasonable costs in providing inpatient services are adjusted as defined in 42 CFR 413.70(a)(6)(i) for cost reporting periods that begin in or after FFY 2015. Specifically, sections 1814(l)(4)(A) and (B) of the Act provide that, if a CAH does not demonstrate meaningful use of certified EHR technology for an applicable EHR reporting period, then for a cost reporting period beginning in FFY 2015, the CAHs reasonable costs shall be adjusted from 101 percent to 100.66 percent. For a cost reporting period beginning in FFY 2016, the CAH's reasonable costs shall be adjusted to 100.33 percent. For a cost reporting period beginning in FFY 2017 and each subsequent FFY, the CAH's reasonable costs shall be adjusted to 100 percent.

Line 169--If this is a §1886(d) provider that responded "N" for no to question 105 and "Y" for yes to question 167, enter the transition factor to be used in the calculation of your EHR incentive payment. For cost reporting periods where the transition factor is zero, enter "9.99" for software programming purposes. For hospitals that qualify for the EHR incentive payment under ARRA 2009, §4120, this question is not applicable for cost reporting periods beginning on or after October 1, 2016. For Puerto Rico hospitals that qualify for the EHR incentive payment under CAA 2016, §602, this question is not applicable for cost reporting periods beginning on or after October 1, 2021.

See 75 FR 44458-44460 (July 28, 2010) and CAA 2016, §602. The transition factor equals:

If a subsection (d) hospital first becomes a meaningful EHR user in fiscal year 2011, 2012 or 2013; or if a subsection (d) Puerto Rico hospital first becomes a meaningful EHR user in fiscal year 2016, 2017, or 2018:

- The first year transition factor is 1.00
- The second year transition factor is 0.75
- The third year transition factor is 0.50
- The fourth year transition factor is 0.25
- Any succeeding transition year is 0

If a subsection (d) hospital first becomes a meaningful EHR user in fiscal year 2014; or if a subsection (d) Puerto Rico hospital first becomes a meaningful EHR user in fiscal year 2019:

- The first year transition factor is 0.75
- The second year transition factor is 0.50
- The third year transition factor is 0.25
- Any succeeding transition year is 0

If a subsection (d) hospital first becomes a meaningful EHR user in fiscal year 2015; or if a subsection (d) Puerto Rico hospital first becomes a meaningful EHR user in fiscal year 2020:

- The first year transition factor is 0.50
- The second year transition factor is 0.25
- Any succeeding transition year is 0

Line 170--If line 167 is "Y", enter the EHR reporting period. Enter in column 1, the reporting period beginning date and, in column 2, the ending date in accordance with 42 CFR 495.4. The EHR reporting period may be a full federal fiscal year or, if this is the first payment year, any continuous 90-day period within a federal fiscal year. If the EHR reporting period ending date is on or after April 1, 2013, the EHR incentive payment will be subject to the 2 percent sequestration adjustment. The response to this question impacts the sequestration calculation on Worksheet E-1, Part II, line 9. For cost reporting periods beginning on or after October 1, 2016, do not complete this line except for Puerto Rico hospitals.

Line 171--If this provider is a meaningful EHR technology user (line 167 is "Y"), the days associated with individuals enrolled in section 1876 Medicare cost plans must be included in the calculation of the incentive payment. Indicate if you have section 1876 days included in the days reported on Worksheet S-3, Part I, line 2, column 6, by entering "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2.

Exhibit 3A -- Listing of Medicaid Eligible Days for a DSH Eligible Hospital

If reporting Medicaid days on Worksheet S-2, Part I, line 24, or line 25, for a cost reporting period beginning on or after October 1, 2022, complete a separate Exhibit 3A listing for each CCN. If a SCH is eligible to receive a DSH payment adjustment but Worksheet E, Part A, line 48, is greater than line 47, do not complete an Exhibit 3A listing; however, if Worksheet E, Part A, line 47, is greater than line 48, the SCH must submit an Exhibit 3A listing. Enter dates in the

MM/DD/YYYY format. Report data for a newborn baby on a separate line only when the newborn baby remains in the hospital after the mother's discharge; otherwise, report data for a newborn baby on the same line with the mother's data.

Enter the provider name, CCN, CRP beginning and ending dates, the line number of Worksheet S-2, Part I, that the listing supports, the sum of the days for columns 10 and 12, and the sum of the days for column 11.

Columns 1 through 5--From the Medicaid patient's claim, enter the patient name, dates of service, and patient account or unique identification number, that correlate to the Medicaid eligible days reported in columns 10 and 11, in columns 1 through 5, respectively.

Column 6--Enter the Medicaid recipient identification number that correlates to the Medicaid eligible days reported in columns 10 and 11. For a newborn baby born to a Medicaid eligible mother, enter the mother's Medicaid identification number that correlates to the Medicaid eligible days reported in columns 10 and 12.

Column 7--Enter the applicable State plan eligibility code number, if available. To report more than one code, report the additional State plan eligibility codes in column 18.

Column 8--Optional column. Enter a unique patient population code to identify a restricted or unrestricted Medicaid eligible day. For restricted eligibility, use code R1 for pregnancy/labor and delivery services; use code R2 for emergency services; or use a code R3 through R9 for user-defined restricted Medicaid eligibility and provide the definition for the code in column 18. For unrestricted Medicaid eligibility, use code U1 for general or use a code U2 through U9 for user-defined unrestricted Medicaid eligibility and provide the definition for the code in column 18.

Column 9--For each entry in columns 10 and 12, or column 11, enter the Worksheet S-2, Part I, column number where the days were reported.

Column 10--Enter the number of Medicaid eligible days during the dates of service entered in columns 3 and 4, including the number of days for a newborn baby remaining in the hospital after the Medicaid eligible mother's date of discharge (see column 12 instructions for reporting newborn baby days prior to the Medicaid eligible mother's date of discharge). (See §4004.1 "Note for lines 24 and 25" for definitions of the eligible Medicaid days.) The sum of the days in this column plus the sum of the days in column 12 must equal the sum of the days reported on Worksheet S-2, Part I, line 24 or 25, as applicable, columns 1 through 5. In addition, the sum of the days summarized by each column reported in column 9 must equal the days reported in the respective column on Worksheet S-2, Part I, line 24 or 25, as applicable. For example, if the listing supports days for Worksheet S-2, Part I, line 24, then the sum of the days reported in column 10 plus the sum of the days reported in column 12 of the exhibit must equal the days reported on Worksheet S-2, Part I, line 24, sum of columns 1 through 5; and, if the days reported on Worksheet S-2, Part I, line 24, column 3, equals 25, then the sum of the days entered in column 10 where column 9 is 3 plus the sum of the days reported in column 12 where column 9 is 3, must equal 25.

Column 11--Enter the number of labor and delivery days, defined as days during which a maternity patient is in the labor/delivery room ancillary area at midnight at the time of census taking; the maternity patient is not included in the census count of the inpatient routine care area because the patient has not occupied an inpatient routine bed at some time before admission (see CMS Pub. 15-1, chapter 22, §2205.2). Only include labor and delivery days in this column when the maternity patients were subsequently admitted to the hospital as an inpatient during the same stay. The days reported in this column must equal the number of days reported on Worksheet S-2, Part I, line 24, column 6.

Column 12--Enter the number of newborn baby days occurring prior to the Medicaid eligible mother's date of discharge for a baby born to a Medicaid eligible mother. These newborn baby days are in addition to the mother's days reported in column 10. If the Medicaid eligible mother was discharged and the newborn baby remained in the hospital, do not report the newborn baby days occurring after the date of the mother's discharge in this column; report the days on a separate line in column 10.

Columns 13 and 14--Enter in column 13 the name of the insurance company or other payer with primary responsibility for paying the claim. If applicable, enter in column 14 the name of the insurer or other payer with secondary responsibility.

Column 15--Enter either "A" or "B" to indicate the patient's Medicare eligibility during the dates of service in columns 3 and 4; otherwise, if the patient was eligible for neither Part A nor Part B, leave the column blank. If the patient was eligible for Medicare, enter "A" or "B" as follows:

- if eligible for only Medicare Part A, enter "A"
- if eligible for both Part A and Part B, enter "A"
- if eligible for only Medicare Part B, enter "B"

Columns 16 and 17--If the entry in column 15 is either "A" or "B", enter the date that the patient's Medicare eligibility started in column 16 and, if applicable, enter the date that the patient's Medicare eligibility ended in column 17.

Column 18--Enter optional comments and/or additional information as needed. To decrease patients' vulnerability to identity theft, do not report a patient's date of birth or social security number.

EXHIBIT 3A

TITLE	MEDICAID ELIGIBLE DAYS FOR A DSH ELIGIBLE HOSPITAL
PROVIDER NAME	
CCN	
CRP BEGINNING DATE	
CRP ENDING DATE	
WS S-2, PT. I, LINE #	
PREPARED BY	
DATE PREPARED	
TOTAL COLUMNS 10 &12	
TOTAL COLUMN 11	

PATIENT CLAIM INFORMATION							
PATIENT LAST NAME	PATIENT FIRST NAME	DATE OF SERVICE - FROM	DATE OF SERVICE - TO	PATIENT ACCOUNT NUMBER	MEDICAID NUMBER	STATE ELIGIBILITY CODE	PATIENT POPULATION CODE - OPTIONAL
1	2	3	4	5	6	7	8

MEDICAID DAYS				INSURANCE OR OTHER PAYER NAME		MEDICARE ELIGIBILITY			
WKST S-2, PART I COLUMN NUMBER	ELIGIBLE DAYS	LABOR & DELIVERY ROOM DAYS	NEWBORN BABY DAYS	PRIMARY	SECONDARY	A/B INDICATOR	START DATE	END DATE	COMMENTS
9	10	11	12	13	14	15	16	17	18

4004.2 Part II - Hospital and Hospital Health Care Complex Reimbursement Questionnaire.--The information required on Part II of this worksheet (formerly Form CMS-339) must be completed by all hospitals submitting cost reports to the Medicare contractor under title XVIII of the Act. Its purpose is to assist you in preparing an acceptable cost report, to minimize the need for direct contact between you and your contractor, and to expedite review and settlement of cost reports. It is designed to answer pertinent questions about key reimbursement concepts displayed in the cost reports and to gather information necessary to support certain financial and statistical entries on the cost report. The questionnaire is a tool used in arriving at a prompt and equitable settlement of your cost report.

Where the instructions for this worksheet direct you to submit documentation/information, mail or otherwise transmit to the contractor immediately after submission of the ECR. The contractor has the right under §§1815(a) and 1883(e) of the Act to request any missing documentation required to complete the desk review.

To the degree that the information in the questionnaire constitutes commercial or financial information which is confidential and/or is of a highly sensitive personal nature, the information will be protected from release under the Freedom of Information Act. If there is any question about releasing information, the contractor should consult with the CMS Regional Office.

Line Descriptions

NOTE: The responses on all lines are Yes or No unless otherwise indicated. If, in accordance with the following instructions, you are requested to submit documentation, indicate the line number for each set of documents you submit.

Lines 1 through 21 are required to be completed by all hospitals.

Line 1--Indicate whether the hospital has changed ownership immediately prior to the beginning of the cost reporting period. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the date the change of ownership occurred in column 2. Also, submit the name and address of the new owner and a copy of the sales agreement with the cost report.

Line 2--Indicate whether the hospital has terminated participation in the Medicare program. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the date of termination in column 2, and "V" for voluntary or "I" for involuntary in column 3.

Line 3--Indicate whether the hospital is involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships. Enter "Y" for yes or "N" for no. If "Y", submit a list of the individuals, the organizations involved, and a description of the transactions with the cost report.

Note: A related party transaction occurs when services, facilities, or supplies are furnished to the provider by organizations related to the provider through common ownership or control. (See CMS Pub. 15-1, chapter 10, and 42 CFR 413.17.)

Line 4--Indicate whether the financial statements were prepared by a certified public accountant. Enter "Y" for yes or "N" for no in column 1. If you answer "Y" in column 1, enter "A" for audited, "C" for compiled, or "R" for reviewed in column 2. Submit a complete copy of the financial statements (i.e., the independent public accountant's opinion, the statements themselves, and the footnotes) with the cost report. If the financial statements are not available for submission with the cost report enter the date they will be available in column 3.

If you answer no in column 1, submit a copy of the financial statements you prepared, and written statements of significant accounting policy and procedure changes affecting Medicare reimbursement which occurred during the cost reporting period. You may submit the changed accounting or administrative procedures manual in lieu of written statements.

Line 5--Indicate whether the total expenses and total revenues reported on the cost report differ from those on the filed financial statements. Enter "Y" for yes or "N" for no. If "Y", submit a reconciliation with the cost report.

Line 6--Indicate whether costs were claimed for a nursing program. Enter "Y" for yes or "N" for no in column 1. If you answer "Y" in column 1, enter "Y" for yes or "N" for no in column 2 to indicate whether the provider is the legal operator of the program.

Line 7--Indicate whether costs were claimed for allied health programs. Enter "Y" for yes or "N" for no. If "Y", submit a list of the program(s) with the cost report and annotate for each whether the provider is the legal operator of the program.

Note: For purposes of lines 6 and 7, the provider is the legal operator of a nursing program and/or allied health program if it meets the criteria in 42 CFR 413.85(f)(1) or (f)(2).

Line 8--Indicate whether approvals and/or renewals were obtained during the cost reporting period for nursing programs and/or allied health programs. Enter "Y" for yes or "N" for no. If "Y", submit a list of the program(s), and copies of the approvals and/or renewals with the cost report.

Line 9--Indicate whether costs for interns and residents in approved GME programs were claimed on the current cost report. Enter "Y" for yes or "N" for no. If "Y", submit the current year Intern-Resident Information System (IRIS) with the cost report in a password-encrypted file on a CD or flash drive, or by a contractor-approved means such as electronic mail or a secure website.

Line 10--Indicate whether intern and resident approved GME program(s) have been initiated or renewed during the cost reporting period. Enter "Y" for yes or "N" for no. If "Y", submit copies of the certification(s)/program approval(s) with the cost report. (See 42 CFR 413.79(l) for the definition of a new program.)

Line 11--Indicate whether GME costs were directly assigned to cost centers other than the Intern-Resident Services in an Approved Teaching Program on Worksheet A. Enter "Y" for yes or "N" for no. If "Y", submit a listing of the cost centers and amounts with the cost report.

Line 12--Indicate whether you are seeking reimbursement for bad debts resulting from Medicare deductible and coinsurance amounts that are uncollectible from Medicare beneficiaries. (See 42 CFR 413.89 for the criteria for an allowable Medicare bad debt.) Enter "Y" for yes or "N" for no in column 1. If you answer "Y" in column 1, submit listings supporting the bad debts claimed in the cost report. Effective for cost reporting periods beginning on or after October 1, 2018, a cost report will be rejected when submitted without listings that correspond to the amount of bad debt claimed (42 CFR 413.24(f)(5)). Exhibit 2 (for cost reporting periods beginning prior to October 1, 2022) and Exhibit 2A (for cost reporting periods beginning on or after October 1, 2022) present the information required to support the bad debt claimed. (See exhibits and instructions presented at the end of §4004.2.) If applicable, submit separate exhibits for each provider number in a hospital health care complex.

[Exhibit 2 and instructions moved to the end of §4004.2 with Exhibit 2A and instructions.]

Line 13--Indicate whether your bad debt collection policy changed during the cost reporting period. Enter "Y" for yes or "N" for no in column 1. If you answer "Y" in column 1, submit a copy of the policy with the cost report.

Line 14--Indicate whether patient deductibles and/or coinsurance amounts were waived. Enter "Y" for yes or "N" for no in column 1. If you answer "Y" in column 1, do not include the deductibles and/or coinsurance amounts that were waived on the bad debt listing (i.e., Exhibit 2 or Exhibit 2A).

Line 15--Indicate whether total available beds have changed from the prior cost reporting period. Enter "Y" for yes or "N" for no in column 1. If you answer "Y" in column 1, provide an analysis of available beds and explain any changes that occurred during the cost reporting period.

NOTE FOR LINE 15: For purposes of line 15, available beds are provider beds that are permanently maintained for lodging inpatients. They must be available for use and housed in patient rooms or wards (i.e., do not include beds in corridors or temporary beds). (See CMS Pub. 15-1, chapter 22, §2200.2.C., CMS Pub. 15-2, chapter 40, §4005.1, and 42 CFR 412.105(b).)

Line 16--Indicate whether the cost report was prepared using the Provider Statistical & Reimbursement Report (PS&R) only. Use columns 1 and 2 for Part A and columns 3 and 4 for Part B. Enter "Y" for yes or "N" for no in columns 1 and 3. If either column 1 or 3 is "Y", in columns 2 and 4, from the PS&R used to prepare this cost report, enter the "Paid Claims Verified Current As Of" date, if present; otherwise, enter the paid-through date. Also, submit a crosswalk between revenue codes and charges found on the PS&R to the cost center groupings on the cost report. This crosswalk will reflect a cost center to revenue code match only.

Line 17--Indicate whether the cost report was prepared using the PS&R for totals and provider records for allocation. Use columns 1 and 2 for Part A and columns 3 and 4 for Part B. Enter "Y" for yes or "N" for no in columns 1 and 3. If either column 1 or 3 is "Y", in columns 2 and 4, from the PS&R used to prepare this cost report, enter the "Paid Claims Verified Current As Of" date, if present; otherwise, enter the paid-through date. Also, submit a detailed crosswalk between revenue codes, departments and charges on the PS&R to the cost center groupings on the cost report. This crosswalk must show dollars by cost center and include which revenue codes were allocated to each cost center. The total revenue on the cost report must match the total charges on the PS&R (as appropriately adjusted for unpaid claims, etc.,) to use this method. Supporting workpapers must accompany this crosswalk to provide sufficient documentation as to the accuracy of the provider records. If the contractor does not find the documentation sufficient, the PS&R will be used in its entirety.

Line 18--If you entered "Y" on either line 16 or 17, columns 1 and/or 3, indicate whether adjustments were made to the PS&R data for additional claims that have been billed but not included on the PS&R used to file this cost report. Enter "Y" for yes or "N" for no in columns 1 and 3. If either column 1 or 3 is "Y", include a schedule which supports any claims not included on the PS&R. This schedule should include totals consistent with the breakdowns on the PS&R and should reflect claims that are unprocessed or unpaid as of the cut-off date of the PS&R used to file the cost report.

Line 19--If you entered "Y" on either line 16 or 17, columns 1 and/or 3, indicate whether adjustments were made to the PS&R data for corrections of other PS&R information. Enter "Y" for yes or "N" for no in columns 1 and 3. If either column 1 or 3 is "Y", submit a detailed explanation and documentation which provides an audit trail from the PS&R to the cost report.

Line 20--If you entered "Y" on either line 16 or 17, columns 1 and/or 3, indicate whether other adjustments were made to the PS&R data. Enter "Y" for yes or "N" for no in columns 1 and 3. If either column 1 or 3 is "Y", include a description of the other adjustments and documentation which provides an audit trail from the PS&R to the cost report.

Line 21--Indicate whether the cost report was prepared using provider records only. Enter "Y" for yes or "N" for no in columns 1 and 3. If either column 1 or 3 is "Y", submit detailed documentation of the system used to support the data reported on the cost report. If detail documentation was previously supplied, submit only necessary updated documentation with the cost report.

The minimum requirements are:

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

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

- Reconciliation of remittance totals to the provider's internal records.

- Include the name of the system used and indicate how the system was maintained (vendor or provider). If the provider maintained the system, include date of last software update.

NOTE FOR LINE 21: Additional information may be supplied such as narrative documentation, internal flow charts, or outside vendor informational material to further describe and validate the reliability of your system.

Lines 22 through 40 are required to be completed only by cost-reimbursed and TEFRA hospitals, i.e., hospitals excluded from PPS, (except Children's) and PPS hospitals with units excluded from PPS.

Line 22--Indicate whether assets have been re-lifed for Medicare purposes. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", submit a detailed listing of these specific assets, by class, as shown in the Fixed Asset Register with the cost report.

NOTE FOR LINE 22: "Class" means those depreciable asset groupings you use (e.g., land improvements, moveable equipment, buildings, fixed equipment).

Line 23--Indicate whether changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", submit a copy of the Appraisal Report and Appraisal Summary by class of asset with the cost report.

Line 24--Indicate whether new leases and/or amendments to existing leases were entered into during the cost reporting period. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", submit a listing of the new leases and/or amendments to existing leases if the annual rental cost of each of these leases is $50,000 or greater with the cost report. The listing should include the following information:

- Identify if the lease is new or a renewal.
- Parties to the lease.
- Period covered by the lease.
- Description of the asset being leased.
- Annual charge by the lessor.

NOTE FOR LINE 24: Providers are required to submit copies of the lease, or significant extracts, upon request from the contractor.

Line 25--Indicate whether new capitalized leases were entered into during the cost reporting period. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", submit a list of the individual assets by class, the department assigned to, and respective dollar amounts if the annual rental cost of these leases is $50,000 or greater with the cost report.

Line 26--Indicate whether assets subject to §2314 of DEFRA were acquired during the cost reporting period. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", submit a computation of the basis with the cost report.

Line 27--Indicate whether your capitalization policy changed during the cost reporting period. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", submit a copy with the cost report.

Line 28--Indicate whether new loans, mortgage agreements, or letters of credit were entered into during the cost reporting period. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", submit copies of the debt documents and amortization schedules with the cost report. Also, state the purpose of the borrowing.

Line 29--Indicate whether you have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", submit a detailed analysis of the funded depreciation account for the cost reporting period with the cost report. (See CMS Pub. 15-1, chapter 2, §226, and 42 CFR 413.153.)

Line 30--Indicate whether existing debt has been replaced prior to its scheduled maturity with new debt. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", submit a copy of the new debt document and a schedule calculating the allowable cost. (See CMS Pub. 15-1, chapter 2, §233.3, for description of allowable cost.)

Line 31--Indicate whether debt has been recalled before its scheduled maturity without the issuance of new debt. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", submit a detailed analysis supporting the debt cancellation costs and treatment of these expenses on the cost report. (See CMS Pub. 15-1, chapter 2, §215, for description and treatment of debt cancellation costs.)

Line 32--Indicate whether you have entered into new agreements or if changes occurred in patient care services furnished through contractual arrangements with suppliers of service. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", submit copies of the contracts in those instances where the cost of the individual's services exceeds $25,000 per year with the cost report.

Where you do not have written agreements for purchased services, submit a description listing the following information:

- Duration of the arrangement.
- Description of services.
- Financial arrangement.
- Name(s) of parties to the agreement furnishing the services.

Line 33--If you answered "Y" on line 32, were the requirements of CMS Pub. 15-1, chapter 21, §2135.2, pertaining to competitive bidding applied? Enter "Y" for yes or "N" for no in column 1. If column 1 is "N", submit an explanation with the cost report.

Line 34--Indicate whether services were furnished at your facility under an arrangement with provider-based physicians. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", submit Exhibit 1 (exhibit and instructions presented at the end of §4004.2), where applicable.

You may submit computer generated substitutes for these schedules provided they contain, at a minimum, the same information as in Exhibit 1. (This includes the signature on a substitute Exhibit 1.)

Allocation agreements (Exhibit 1) are required if physician compensation is attributable to both direct patient care and provider services. Allocation agreements are also required if all of the provider-based physician's compensation is attributable to provider services (i.e., departmental supervision and administration, quality control activities, teaching and supervision of Interns-Residents and/or Allied Health Students, and in the case of teaching hospitals electing cost reimbursement for teaching physicians' services, for compensation attributable to direct medical and surgical services furnished to individual patients, and the supervision of intern and residents furnishing direct medical and surgical services to individual patients). However, Exhibit 1 is not required if all of the provider-based physician's compensation is attributable to direct medical and surgical services to individual patients.

Physicians' compensation information is considered to be confidential, and therefore, qualifies for exemption from disclosure under the Freedom of Information Act, and specifically under 5 U.S.C. 552(b)(4). The compensation information also qualifies for exemption from disclosure under 5 U.S.C. 552(b)(6) which covers "personnel and medical files, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy." An individual's compensation is a personal matter, and its release would be an invasion of privacy. Accordingly, CMS will not release, or make available to the public, compensation information collected.

[Instructions for Exhibit 1 and sample form moved to the end of §4004.2.]

Line 35--If you answered "Y" on line 34, indicate whether new agreements or amendments to existing agreements were entered into during the cost reporting period. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", submit copies of the new agreements or the amendments to existing agreements with the cost report.

Line 36--Indicate whether home office costs are claimed on the cost report. Enter "Y" for yes or "N" for no in column 1.

Line 37--If you answered "Y" on line 36, indicate whether a home office cost statement was prepared by the home office. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", submit a schedule displaying the entire chain's direct, functional, and pooled costs as provided to the designated home office contractor as part of the home office cost statement.

Line 38--If you answered "Y" on line 36, indicate whether the fiscal year end of the home office is different from that of the provider. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the fiscal year end of the home office in column 2.

Line 39--If you answered "Y" on line 36, indicate whether the provider renders services to other components of the chain. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", submit a schedule listing the names of the entities, the services provided, and cost incurred to provide these services with the cost report.

Line 40--If you answered "Y" on line 36, indicate whether the provider renders services to the home office. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", submit a schedule listing the services provided, and cost incurred to provide these services with the cost report.

Line 41--Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.

Line 42--Enter the employer/company name of the cost report preparer.

Line 43--Enter the telephone number and email address of the cost report preparer.

NOTE: Exhibits 1 and 2 must be completed either manually (in hard copy) or via separate electronic/digital media as this information is not captured in the ECR file.

Exhibit 1 - Allocation of Physician Compensation Hours Instructions and Form

Complete this exhibit in accordance with CMS Pub. 15-1, chapter 21, §2182.3. The data elements shown are physicians' hours of service providing a breakdown between the professional and provider component.

Prepare a physician time allocation for each physician by department, who receives payment directly from you or a related organization for services rendered. This includes physicians paid through affiliated agreements. A weighted average for the entire department may be used where all physicians in the department are in the same specialty. Where a weighted average is submitted, individual time allocations need not be submitted. The physician or department head supplying this information must sign the schedule.

EXHIBIT 1

Allocation of Physician Compensation: Hours

Provider Name: _____
CCN: _____
Department: _____
Physician Name: _____

Cost Reporting Year: Beginning: _____ Ending: _____

Basis of Allocation: Time Study __/__/__ Other __/__/__ Describe: _____

Services	Total Hours
1. Provider Services - Teaching and Supervision of I/R's and other GME Related Functions.	
1A. Provider Services - Teaching and Supervision of Allied Health Students	
1B. Provider Services - Non Teaching Reimbursable Activities such as Departmental Administration, Supervision of Nursing, and Technical Staff, Utilization Review, etc.	
1C. Provider Services - Emergency Room Physician Availability (Do not include minimum guarantee arrangements for Emergency Room Physicians.)	
1D. Subtotal - Provider Administrative Services (Lines 1, 1A, 1B, 1C).	
2. Physician Services: Medical and Surgical Services to Individual Patients	
3. Nonreimbursable Activities: Research, Teaching of I/Rs in Non-Approved Programs, Teaching and Supervision of Medical Students, Writing for Medical Journals, etc.	
4. Total Hours: (Lines 1D, 2, and 3)	
5. Professional Component Percentage (Line 2 / Line 4)	
6. Provider Component Percentage - (Line 1D / Line 4)	

_____ _____
Signature: Physician or Physician Department Head Date

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NOTE: Exhibits 1 and 2 must be completed either manually (in hard copy) or via separate electronic/digital media as this information is not captured in the ECR file.

Exhibit 2 - Listing of Medicare Bad Debts and Appropriate Supporting Data Instructions and Form

If seeking reimbursement for bad debts resulting from Medicare deductible and coinsurance amounts that are uncollectible from Medicare beneficiaries (Worksheet S-2, Part II, line 12, is Y), for a cost reporting period beginning prior to October 1, 2022, complete Exhibit 2, or internal schedules that provide the same level of information as is requested on the exhibit, to support the bad debts claimed. If claiming bad debts for inpatient and outpatient services, complete a separate exhibit or internal schedule for each (one schedule for inpatient and one schedule for outpatient).

Exhibit 2 requires the following information:

Columns 1, 2, and 3 - Patient Names, Health Insurance Claim Number, and Dates of Service (From - To)--The documentation required for these columns is derived from the beneficiary's bill. Furnish the patient's name, health insurance claim number (HICN) or Medicare Beneficiary Identifier (MBI), and dates of service that correlate to the filed bad debt. (See 42 CFR 413.89.)

Column 4--Indigency/Medicaid Beneficiary--If the patient included in column 1 has been deemed indigent (either by virtue of being dual eligible for Medicare and Medicaid, or otherwise), place a check in the "yes" section of this column. If the patient included in this column has a valid Medicaid number, also include this number in the "Medicaid Number" section of this column. See the criteria in 42 CFR 413.89 for guidance on the billing requirements for indigent and Medicaid beneficiaries.

Columns 5 and 6--Date First Bill Sent to Beneficiary & Date Collection Efforts Ceased--This information should be obtained from the provider's files and should correlate with the beneficiary name, HIC number, and dates of service shown in columns 1, 2, and 3 of this exhibit. The date in column 6 represents the date that the unpaid account is deemed worthless, whereby all collection efforts, both internal and by an outside entity, ceased and there is no likelihood of recovery of the unpaid account. (See CFR 413.89(f).)

Column 7--Remittance Advice Dates--Enter in this column the remittance advice dates that correlate with the beneficiary name, HIC No., and dates of service shown in columns 1, 2, and 3 of this exhibit.

Columns 8 and 9--Deductibles & Coinsurance--Record in these columns the beneficiary's unpaid deductible and coinsurance amounts that relate to covered services.

Column 10--Total Medicare Bad Debts--Enter on each line of this column, the sum of the amounts in columns 8 and 9. Calculate the total bad debts by summing up the amounts on all lines of column 10. This total must agree with the bad debts claimed on the cost report. Attach additional supporting schedules, if necessary, for bad debt recoveries.

EXHIBIT 2

LISTING OF MEDICARE BAD DEBTS AND APPROPRIATE SUPPORTING DATA

PROVIDER NAME _____ PREPARED BY _____
CCN _____ DATE PREPARED _____
FYE _____ INPATIENT _____ OUTPATIENT _____

(1) Patient Name	(2) HICN / MBI	(3) DATES OF SERVICE		(4) INDIGENCY & MEDICAID BENEFICIARY (CK IF APPL)		(5) DATE FIRST BILL SENT TO BENE-FICIARY	(6) DATE COLLECTION EFFORTS CEASED	(7) MEDICARE REMITTANCE ADVICE DATES	(8)* DEDUCT	(9)* CO-INS	(10) TOTAL
		FROM	TO	YES	MEDICAID NUMBER						

* THESE AMOUNTS MUST NOT BE CLAIMED UNLESS THE PROVIDER BILLS FOR THESE SERVICES WITH THE INTENTION OF PAYMENT. SEE INSTRUCTIONS FOR COLUMN 4 - INDIGENCY/MEDICAID BENEFICIARY, FOR POSSIBLE EXCEPTION.

Exhibit 2A -- Listing of Medicare Bad Debts Instructions and Form

If seeking reimbursement for bad debts resulting from Medicare deductible and coinsurance amounts that are uncollectible from Medicare beneficiaries (Worksheet S-2, Part II, line 12, is Y) for a cost reporting period beginning on or after October 1, 2022, complete Exhibit 2A to support the bad debts claimed. Complete separate exhibits for bad debts resulting from inpatient services and outpatient services. A hospital healthcare complex claiming bad debts for multiple components must complete separate exhibits for each CCN. Enter dates in the MM/DD/YYYY format.

Exhibit 2A requires the following information:

Enter the provider name, CCN, subprovider CCN (if applicable), cost reporting period (CRP) beginning and ending dates, whether the listing represents Medicare bad debts for inpatient or outpatient services, the name of the preparer, the date prepared, the total of Medicare allowable bad debts (sum of column 23), and the total of dual-eligible Medicare bad debts (sum of amounts entered in column 23 where column 7 has an entry).

Columns 1, 2, 3, 4, 5, and 6--From the Medicare beneficiary's bill, enter the beneficiary's name, dates of service, patient account or identification number, and MBI or HICN, that correlate to the claimed bad debt. (See 42 CFR 413.89(f).)

Column 7--Enter the Medicare beneficiary's Medicaid number if the beneficiary was dually eligible (eligible for Medicare and some category of Medicaid benefits). If there is an entry in this column, there must be an entry in column 10.

Column 8--Enter "Y" for yes if the Medicare beneficiary was not eligible for Medicaid but the provider deemed them to be indigent; otherwise, enter "N" for no. (See 42 CFR 413.89(e)(2)(ii).)

Column 9--Enter the Medicare remittance advice date for the Medicare beneficiary information in columns 1 through 6.

Column 10--Enter the Medicaid remittance advice date or, when the provider does not receive a Medicaid remittance advice, enter "AD" for alternate documentation used to determine state liability (42 CFR 413.89(e)(2)(iii)(B)), that corresponds to the Medicare beneficiary information in columns 1 through 7.

Column 11--Enter the date a remittance advice was received from a secondary payer, if applicable. When a secondary payer does not accept liability, a denial or notification date may be entered.

Column 12--Enter the amount of coinsurance and deductible for which the Medicare beneficiary is responsible. If the beneficiary is a qualified Medicare beneficiary (QMB), enter "QMB." For a Medicare beneficiary who is dually eligible for Medicaid (not a QMB), enter the amount the beneficiary is required to pay under the state cost sharing agreement (42 CFR 413.89(e)(2)(iii)). For a Medicare beneficiary deemed indigent by the provider (column 8 is "Y"), enter zero.

Column 13--Enter the date that the first bill was sent to the Medicare beneficiary. If the beneficiary is a QMB, enter "QMB."

NOTE FOR COLUMNS 14 THROUGH 17: The dates reported in column 14 (the date that the Medicare beneficiary's liability was written off of the provider's accounts receivable), column 15 (the date that the collection agency ceased collection effort), column 16 (the date that all collection efforts ceased), and column 17 (the date that deductible and coinsurance amounts were written off as a Medicare bad debt), may be the same date.

Column 14--Enter the date the Medicare beneficiary's liability was written off of the accounts receivable (A/R) in the provider's financial accounting system. The date entered in this column may be the same as, or earlier than, the date the account was deemed worthless (written off as a Medicare bad debt).

Columns 15A and 15--In column 15A, enter "Y" for yes if the account was sent to a collection agency; otherwise, enter "N" for no. If column 15A, is "Y", in column 15, enter the date the collection agency returned the account (i.e., the date that the collection agency ceased collection effort on the account).

Column 16--Enter the date all collection efforts ceased, both internal and external, including efforts to collect from Medicaid and/or from a state for its cost sharing liability.

Column 17--Enter the date the deductible and coinsurance amounts were written off as a Medicare bad debt (i.e., the amount must have been written off as a bad debt against the A/R in the provider's financial accounting system); all collection effort, internal and external, against the Medicare beneficiary and/or other third parties ceased; and a Medicaid remittance advice was received from the state for Medicaid patients or alternate documentation exists as permitted under 42 CFR 413.89(e)(2)(iii)(B).

Column 18--Enter the amount of recoveries for amounts previously written off as an allowable Medicare bad debt in this or a prior cost reporting period. The amount reported in this column includes any payments received on an account after the account was written off as a bad debt, including payments received in the same year the account was written off when the payment was received after the date of the write off. (See 42 CFR 413.89(f).)

Column 19--If an amount is reported in column 18, enter the fiscal year end of the cost reporting period in which the Medicare bad debt (to which the recovery applies) was claimed and reimbursed. This column is optional; however, the date assists in identifying recovery amounts that must be offset. The fiscal year end entered in this column is a prior cost reporting period unless the write-off and recovery both occurred during this cost reporting period.

Column 20--Enter the Medicare deductible from the Medicare remittance advice (before any payments received from any party). Report deductible amounts only when the provider billed the patient with the expectation of payment. See 42 CFR 413.89(e)(2) for possible exception.

Column 21--Enter the Medicare coinsurance amount from the Medicare remittance advice (before any payments received from any party). Report coinsurance amounts only when the provider billed the patient with the expectation of payment. See 42 CFR 413.89(e)(2) for possible exception.

Column 22--Enter the amount of any payments received from the Medicare beneficiary, their estate, third party insurance, etc., before the account was written off, for any amounts reported in column 20 and/or column 21. For example, when a beneficiary had a liability from a prior year for a deductible of $2,500 and made payments totaling $1,500 in the prior and current years, the provider determined the remaining balance of $1,000 uncollectible and deemed worthless. The payments of $1,500 are reported in column 22, leaving the remaining $1,000 written off in the current period as an allowable bad debt.

Column 23--Enter the allowable Medicare bad debt amount. This amount must be less than or equal to the sum of the amounts in columns 20 and 21, less any payments in columns 18 and 22. If the fiscal year end in column 19 is prior to this cost reporting period, enter the recovery amount (reported in column 18) as a negative amount in this column. For each CCN, the sum of the amounts entered in this column on each listing, (inpatient and outpatient), as applicable, must equal the bad debts claimed for that CCN on the Medicare cost report. For example, CCN ##-0001, an inpatient acute care hospital, reported bad debts of $24,000 on the Exhibit 2A for inpatient and indicated that $12,000 on the Exhibit 2A for Medicaid eligible. The amount reported on Worksheet E, Part A, line 64, must equal $24,000. The amount reported on Worksheet E, Part A, line 66, must equal $12,000 (dual eligible).

Column 24--This column is for informational purposes. Enter any comments or additional information as needed.

EXHIBIT 2A

TITLE	MEDICARE BAD DEBTS
PROVIDER NAME	
CCN	
SUBPROVIDER CCN	
CRP BEGINNING DATE	
CRP ENDING DATE	
INPATIENT / OUTPATIENT	
PREPARED BY	
DATE PREPARED	
TOTAL COLUMN 23	
TOTAL DUAL ELIGIBLE	

PATIENT NAME LAST	PATIENT NAME FIRST	DATE OF SERVICE: FROM	DATE OF SERVICE: TO	PATIENT ACCOUNT NUMBER	MBI OR HICN	MEDI-CAID NUMBER	PROVIDER DEEMED INDI-GENT	MEDI-CARE REMIT-TANCE ADVICE DATE	MEDI-CAID REMIT-TANCE ADVICE DATE	SEC-ONDARY PAYER RA RE-CEIVED DATE	BENE-FICIARY RESPON-SIBILITY AMOUNT	DATE FIRST BILL SENT TO BENE
1	2	3	4	5	6	7	8	9	10	11	12	13

A/R WRITE OFF DATE	SENT TO COLLEC-TION AGENCY (Y/N)	RETURN FROM COLLEC-TION AGENCY DATE	COLLEC-TION EFFORT CEASED DATE	MEDI-CARE WRITE OFF DATE	RECOVER-IES ONLY: AMOUNT RECEIVED	RECOVER-IES ONLY: MCR FYE DATE	MEDI-CARE DE-DUCTIBLE AMOUNT	MEDI-CARE CO-INSUR-ANCE AMOUNT	PAYMENTS RECEIVED PRIOR TO WRITE-OFF	ALLOW-ABLE BAD DEBTS AMOUNT	COMMENTS
14	15A	15	16	17	18	19	20	21	22	23	24

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4005. WORKSHEET S-3 - HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA AND HOSPITAL WAGE INDEX INFORMATION

This worksheet consists of five parts:

Part I - Hospital and Hospital Health Care Complex Statistical Data
Part II - Hospital Wage Index Information
Part III - Hospital Wage Index Summary
Part IV - Hospital Wage Related Costs
Part V - Hospital Contract Labor and Benefit Costs

4005.1 Part I - Hospital and Hospital Health Care Complex Statistical Data.--This part collects statistical data regarding beds, days, FTEs, and discharges.

Column Descriptions

Column 1--Enter the Worksheet A line number that corresponds to the Worksheet S-3 component line description.

Column 2--Refer to 42 CFR 412.105(b) and 69 FR 49093-49098 (August 11, 2004) to determine the facility bed count. Indicate the number of beds available for use by patients at the end of the cost reporting period.

A bed means an adult bed, pediatric bed, portion of inpatient labor/delivery/postpartum (LDP) room (also referred to as birthing room) bed when used for services other than labor and delivery, or newborn ICU bed (excluding newborn bassinets) maintained in a patient care area for lodging patients in acute, long term, or domiciliary areas of the hospital. Beds in post-anesthesia, post-operative recovery rooms, outpatient areas, emergency rooms, ancillary departments (however, see exception for labor and delivery department), nurses' and other staff residences, and other such areas that are regularly maintained and utilized for only a portion of the stay of patients (primarily for special procedures or not for inpatient lodging) are not termed a bed for these purposes. (See CMS Pub. 15-1, chapter 22, §2205.)

For cost reporting periods beginning prior to October 1, 2012, beds in distinct ancillary labor and delivery rooms and the proportion of LDP room (birthing room) beds used for labor and delivery services are not a bed for these purposes. (See 68 FR 45420 (August 1, 2003).)

For cost reporting periods beginning on or after October 1, 2012, in accordance with 77 FR 53411-53413 (August 31, 2012), beds in distinct labor and delivery rooms, when occupied by an inpatient receiving IPPS-level acute care hospital services or when unoccupied, are considered to be part of a hospital's inpatient available bed count in accordance with 42 CFR 412.105(b) and are to be reported on line 32. Furthermore, the proportion of the inpatient LDP room (birthing room) beds used for ancillary labor and delivery services is considered part of the hospital's available bed count.

Column 3--Enter the total bed days available. Bed days are computed by multiplying the number of beds available throughout the period in column 2 by the number of days in the reporting period. If there is an increase or decrease in the number of beds available during the period, multiply the number of beds available for each part of the cost reporting period by the number of days for which that number of beds was available.

Column 4--CAHs report the aggregate number of hours all CAH patients spend in each category on lines 1 and 8 through 12. This data is for informational purposes only. REHs report on line 15.10 the aggregate number of hours all REH patients spend in the facility.

Columns 5 through 7--Enter on lines 1 through 14, 16 through 20, 24, 28, 32, 33, 33.01, and 34 the number of inpatient days or visits, where applicable, for each component by program. Enter on lines 15, 15.10, 22, 25, and 26, the number of outpatient visits, where applicable, for each component by program.

Do not include HMO days except where required (lines 2 through 4, columns 6 and 7; line 13, column 7), organ acquisition, or observation bed days in these columns. Nursery days (all the days during which a newborn infant occupies a nursery) are reported on line 13, column 7, and include the in-state paid Medicaid days; in-state Medicaid eligible but unpaid days; out-of-state Medicaid paid days; out-of-state Medicaid eligible but unpaid days paid; and Medicaid HMO paid and eligible but unpaid days. Observation bed days are reported in columns 5 (title V), 7 (title XIX), and 8 (total), line 28. For LTCH, enter in column 6, on the applicable line, the number of covered Medicare days (from the PS&R) and enter in column 6, line 33, the number of non-covered days (from provider's books and records) for Medicare patients. See line 33 for further discussion.

For a hospital that participated in the PARHM demonstration during this cost reporting period, subscript column 6 and report the program days associated with discharges occurring during the period of non-participation in column 6 and program days occurring during the PARHM demonstration in column 6.01. All PARHM demonstration program days are determined and reported based the on the discharge date. For instance, the hospital began participation in the PARHM demonstration for discharges occurring on or after January 29, 2019. A patient was admitted on January 26, 2019, and discharged on February 1, 2019. The patient's discharge date was on or after January 29, 2019; therefore, all the program days associated with the discharge are reported as PARHM demonstration days in column 6.01.

Report the program days for PPS providers (acute care hospital, IPF, IRF, and LTCH) in the cost reporting period in which the discharge is reported. This also applies to providers under the TEFRA/PPS blend. TEFRA providers should report their program days in the reporting period in which they occur.

NOTE for Column 7: Medicaid days for Medicaid recipients who are members of an HMO as well as out-of-state days, Medicaid secondary payer patient days, Medicaid eligible days for which no payment was received, and nursery days are reported on lines 2, 3, 4, or 13, in accordance with 42 CFR 412.106(b)(4)(ii). Therefore, Medicaid patient days reported on line 1, column 7, do not include days for Medicaid patients who are also members of an HMO, out-of-State Medicaid days, Medicaid secondary payer patient days, Medicaid eligible days for which no payment was received, and nursery days.

Column 8--Enter the number of inpatient days for all classes of patients for each component. Include organ acquisition and HMO days in this column. This amount will not equal the sum of columns 5 through 7, when the provider renders services to other than titles V, XVIII, or XIX patients.

Column 9--Enter the number of intern and resident FTEs in an approved program, determined in accordance with 42 CFR 412.105(f), for the indirect medical education adjustment. The FTE residents reported by an IPF PPS facility or an IRF PPS facility (whether freestanding or a unit reported on line 16 or 17, respectively, of an IPPS hospital's cost report) shall be determined in accordance with 42 CFR 412.424(d)(1)(iii) for IPFs, and in accordance with the 70 FR 47929-47930 (August 15, 2005) for IRFs.

Columns 10 and 11--The average number of FTE employees for the period may be determined either on a quarterly or semiannual basis. When quarterly data are used, add the total number of hours worked by all employees on the first week of the first payroll period at the beginning of each quarter, and divide the sum by 160 (4 times 40). When semiannual data are used, add the total number of paid hours on the first week of the first payroll period of the first and seventh months of the period. Divide this sum by 80 (2 times 40). Enter the average number of paid employees in column 10, and the average number of nonpaid workers in column 11, for each component, as applicable.

Columns 12 through 14--Enter the number of discharges including deaths (excluding newborn and DOAs) for each component by program. A patient discharge, including death, is a formal release of a patient. (See 42 CFR 412.4.) Enter the title XVIII Medicare Advantage (MA) discharges in column 13, line 2. For cost reporting periods ending on or after June 30, 2014, enter the title XIX managed care discharges in column 14, line 2. For columns 13 and 14, lines 2 and 33 are a subset of column 15, line 1. For cost reporting periods ending on or after October 1, 2014, enter the title XIX managed care discharges in column 14, lines 3 and 4, for the IPF and IRF subproviders. For column 14, lines 3 and 4 are subsets of column 15, line 16 and 17, respectively. Lines 2 through 4, column 14, are collected for informational purposes only. For LTCH, enter in column 13, line 1, the number of covered Medicare discharges (from the PS&R) and enter in column 13, line 33, the number of discharges associated with non-covered Medicare days (from provider's books and records). See line 33 for further discussion.

Column 15--Enter the number of discharges including deaths (excluding newborn and DOAs) for all classes of patients for each component.

Line Descriptions

Line 1--For cost reporting periods beginning before October 1, 2012, exclude from column 2 the portion of LDP room (birthing room) beds used for ancillary labor and delivery services, but include on this line beds used for routine adult and pediatric services (postpartum). In accordance with the instructions in 68 FR 45420 (August 1, 2003), compute this proportion (off the cost report) by multiplying the total number of occupied and unoccupied available beds in the LDP room by the percentage of time these beds were used for ancillary labor and delivery services. An example of how to calculate the "percentage of time" would be for a hospital to determine the number of hours for the cost reporting period during which each LDP room maternity patient received labor and delivery services and divide the sum of those hours for all such patients by the sum of the total hours (for both, ancillary labor and delivery services and for routine postpartum services) that all maternity patients spent in the LDP room during that cost reporting period. Alternatively, a hospital could calculate an average percentage of time maternity patients received ancillary labor and delivery services in an LDP room during a typical month.

For cost reporting periods beginning on or after October 1, 2012, include all the available LDP room (birthing room) beds in the available bed count in column 2. (See 77 FR 53411-53413 (August 31, 2012).) The proportion of available LDP room beds related to the ancillary labor and delivery services must not be excluded from column 2 for those cost reporting periods.

In columns 5, 6, 7 and 8, enter the number of adult and pediatric hospital days excluding the SNF and NF swing-bed, observation bed, and hospice days. In columns 6 and 7, also exclude HMO days. **Do not include in column 6 Medicare Secondary Payer/Lesser of Reasonable Cost (MSP/LCC) days**. Include these days only in column 8. However, do not include employee discount days in column 8. For cost reporting periods beginning on or after January 1, 2023, do not report REH data on line 1; report REH data on line 15.10.

Labor and delivery days (as defined in the instructions for Worksheet S-3, Part I, line 32) must not be included on this line.

Line 2--Enter in column 6, the title XVIII MA days and days for individuals enrolled in Medicare cost plans (§1876 of the Act). Enter in column 7 the title XIX Medicaid HMO days and other Medicaid eligible days not included on line 1, column 7.

Line 3--Enter in column 6, the title XVIII MA days and days for individuals enrolled in Medicare cost plans (§1876 of the Act) that pertain to IPF subprovider patients. Enter in column 7 the title XIX Medicaid HMO days and other Medicaid eligible days not included on line 16, column 7.

Line 4--Enter in column 6, the title XVIII MA days and days for individuals enrolled in Medicare cost plans (§1876 of the Act) that pertain to IRF subprovider patients. Enter in column 7 the title XIX Medicaid HMO days and other Medicaid eligible days not included on line 17, column 7.

Line 5--Enter the Medicare covered swing-bed days (which are considered synonymous with SNF swing-bed days) for all title XVIII programs where applicable. (See 42 CFR 413.53(a)(2).) Exclude all MA days from column 6, include the MA days in column 8.

Line 6--Enter the non-Medicare covered swing-bed days (which are considered synonymous with NF swing-bed days) for all programs where applicable. (See 42 CFR 413.53(a)(2).)

Line 7--Enter the sum of lines 1, 5, and 6.

Lines 8 through 13--Enter the appropriate statistic applicable to each discipline for all programs.

Line 14--Enter the sum of lines 7 through 13 for columns 2 through 8, and for columns 12 through 15, enter the amount from line 1. For columns 9 through 11, enter the total for each from your records. Labor and delivery days (as defined in the instructions for Worksheet S-3, Part I, line 32) must not be included on this line.

Line 15--Enter the number of outpatient visits for CAHs by program and total. An outpatient CAH visit is defined in 42 CFR 413.70(b)(3)(iii).

Line 15.10--Enter the number of outpatient visits for REHs by program and total from your books and records. An outpatient REH visit is defined in 42 CFR 485.502.

Line 16--Enter the applicable data for the IPF subprovider.

Line 17--Enter the applicable data for the IRF subprovider.

Line 18--Enter the applicable data for other than IPF or IRF subproviders. If you have more than one subprovider, subscript this line. Treat this area as a nonreimbursable cost center for Medicare since it is not part of the Medicare certified hospital.

Line 19--If your State recognizes one level of care, complete this line for titles V, XVIII, and XIX, however, do not complete line 20. If you answered yes to line 92 of Worksheet S-2, Part I, complete all columns.

Line 20--Enter nursing facility days if you have a separately certified nursing facility for title XIX or you answered yes to line 92 of Worksheet S-2, Part I. Make no entry if your State recognizes only SNF level of care. If you operate an ICF/IID, subscript this line to 20.01 and enter the ICF/IID days. Do not report any nursing facility data on line 20.01.

Line 21--Enter data for an other long term care facility. Treat this area as a nonreimbursable cost center for Medicare since it is not part of the Medicare certified hospital.

Line 22--If you have more than one hospital-based HHA, subscript this line.

Line 23--Enter data for an ASC. If you have more than one ASC, subscript this line.

Line 24--Enter days applicable to hospice patients in a distinct part hospice.

Line 24.10--Effective for cost reporting periods beginning on or after October 1, 2011, enter in column 8, the days applicable to hospice patients currently under a valid hospice election who occupy general inpatient routine beds under a contractual arrangement between the hospital and hospice to provide general inpatient hospice and/or respite care services.

Line 25--CMHCs enter the number of partial hospitalization days as applicable. For reporting of multiple facilities follow the same format used on Worksheet S-2, Part I, line 17.

Line 26--Enter the number of outpatient visits for FQHC and RHC. If you have both a hospital-based FQHC and a hospital-based RHC, or multiples of either one, subscript this line as follows:

> Report the first through twenty-fifth hospital-based RHCs on subscripted line numbers 26 through 26.24; the twenty-sixth through thirty-sixth hospital-based RHCs on subscripted line numbers 26.50 through 26.60; and the thirty seventh through fiftieth hospital-based RHCs on subscripted line numbers 26.72 through 26.85.
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> Report the first through twenty-fifth hospital-based FQHCs on subscripted line numbers 26.25 through 26.49 and the twenty-sixth through thirty-sixth hospital-based FQHCs on subscripted line numbers 26.61 through 26.71.

If the RHC/FQHC is approved to file a consolidated cost report, all data is reported in aggregate as a single provider. Report the consolidated primary RHC data on line 26 and consolidated primary FQHC data on subscripted line 26.25.

Line 28--Enter the total observation bed days in column 8. Divide the total number of observation bed hours by 24 and round up to the nearest whole day. These total hours should include the hours for observation of patients who are subsequently admitted as inpatients but only the hours up to the time of admission as well as the hours for observation of patients who are not subsequently admitted as inpatients but only the hours up to the time of discharge from the facility. Observation bed days only need to be computed if the observation bed patients are placed in a routine patient care area. The bed days are needed to calculate the cost of observation beds since it cannot be separately costed when the routine patient care area is used. If, however, you have a distinct observation bed area, it must be separately costed (as are all other outpatient cost centers), and this computation is not needed.

Line 29--Enter in column 6, the total number of ambulance trips, as defined by §4531(a)(1) of the BBA. Do not subscript this line.

Line 30--Enter in column 8, the employee discount days if applicable. These days are used on Worksheet E, Part A, line 31, in the calculation of the DSH adjustment and Worksheet E-3, Part III, line 3, in the calculation of the LIP adjustment. The days reported on this line must reflect hospital services provided in the beds reported on line 14, column 2.

Line 31--Enter in column 8, the employee discount days, if applicable, for IRF subproviders.

Line 32--Effective for cost reporting periods beginning on or after October 1, 2012, enter in column 2, the total number of available beds located in the distinct ancillary labor and delivery rooms. In accordance with 42 CFR 412.105(b) and 77 FR 53411-53413 (August 31, 2012), distinct ancillary labor and delivery room beds, when occupied by an inpatient receiving IPPS-level acute care hospital services or when unoccupied, are considered to be part of a hospital's inpatient available bed count. These beds are not included in the inpatient routine beds reported on line 1. Note that the available bed days reported in column 3 are reduced on Worksheet E, Part A, by the equivalent of outpatient labor and delivery days from line 32.01.

Effective for cost reporting periods beginning on or after October 1, 2013, enter in column 6, the number of labor/delivery inpatient days for title XVIII. (See 78 FR 50730-50733 (August 19, 2013).)

Effective for cost reporting periods beginning on or after October 1, 2009, enter in column 7, the number of labor/delivery inpatient days for title XIX, and in column 8, the total number of labor/delivery inpatient days for the entire hospital. (See 74 FR 43899-43901 (August 27, 2009).)

For the purposes of reporting on this line, labor and delivery days are defined as days during which a maternity patient is in the labor/delivery room ancillary area at midnight at the time of census taking, and is not included in the census of the inpatient routine care area because the patient has not occupied an inpatient routine bed at some time before admission (see CMS Pub. 15-1, chapter 22, §2205.2). Maternity patients must be admitted to the hospital as an inpatient for their labor and delivery days to be included on line 32. These days must not be reported on Worksheet S-3, Part I, line 1 or line 14. In the case where the maternity patient is in a single multipurpose labor/delivery/postpartum (LDP) room (also referred to as a birthing room), hospitals must determine the proportion of each inpatient stay that is associated with ancillary services (labor and delivery) versus routine adult and pediatric services (postpartum) and report the days associated with the labor and delivery portion of the stay on this line. An example of this would be for a hospital to determine the percentage of each stay associated with labor/delivery services and apply that percentage to the stay to determine the number of labor and delivery days of the stay. Alternatively, a hospital could calculate an average percentage of time maternity patients receive ancillary services in an LDP room during a typical month, and apply that percentage through the rest of the year to determine the number of labor and delivery days to report on line 32.

Line 32.01--Effective for cost reporting periods beginning on or after October 1, 2012, enter in column 8, the equivalent days for the entire hospital that are attributable to outpatient services provided in the distinct ancillary labor and delivery room. Calculate the number of days by dividing the total number of hours attributable to the outpatient services by 24, and round to the nearest whole day. These total outpatient hours include the hours for outpatients occupying the distinct ancillary labor and delivery room until they are admitted as inpatients or are discharged from the hospital. For example, one patient is admitted as an inpatient after first occupying the distinct ancillary labor and delivery room bed for 8 hours. Therefore, for this patient, 8 hours would be included in the sum of the total hours used to compute equivalent days to be entered on line 32.01. Another patient is admitted to the distinct ancillary labor and delivery room for monitoring of possible labor or for a sonogram. After spending 6 hours in this department (room), this patient is discharged from the hospital without being admitted as an inpatient. Therefore, for this patient, 6 hours would be included in the sum of the total hours used to compute the equivalent days to be entered on line 32.01. These outpatient labor and delivery days are used on Worksheet E, Part A, to reduce the available bed days reported on line 32 so that only those distinct ancillary labor and delivery room beds which are occupied by inpatients or are unoccupied are ultimately counted as "beds."

Line 33--Enter in column 6, the number of LTCH non-covered Medicare days (from the provider's books and records). These LTCH non-covered Medicare days are a subset of total patient days reported in column 8, line 14, and may be part of a covered or non-covered stay for Medicare covered services. Enter in column 13, the number of LTCH discharges for Medicare stays comprised exclusively of non-covered Medicare days (from the provider's books and records). These LTCH discharges are a subset of discharges reported in column 15, line 1, and do not include discharges for a covered stay, where a portion of the stay is non-covered and the discharge is already included in column 13, line 1, and reflected in the PS&R.

Line 33.01--Enter the LTCH site neutral days in column 6, and the LTCH site neutral discharges in column 13. NOTE: The data entered on this line is a subset of the data reported on line 1.

Line 34--Effective March 1, 2020, through May 11, 2023 (the official end of the COVID-19 public health emergency (PHE)), enter the number of temporary expansion COVID-19 PHE acute care beds in column 2 and the number of bed days available for temporary expansion COVID-19 PHE acute care beds in column 3. In columns 5, 6, 7, and 8, enter the number of inpatient days for temporary expansion COVID-19 PHE acute care beds for title V, title XVIII, title XIX, and all patients, respectively. The beds and days entered on this line are a subset of the beds and days that must be entered on line 1 and lines 8 through 12. The temporary expansion COVID-19 PHE acute care bed days available are excluded from the calculation of the IPPS hospital inpatient bed days available on Worksheet E, Part A, line 4. Do not complete this line **if you did not report** temporary expansion COVID-19 PHE acute care beds on line 1 and lines 8 through 12.

4005.2 Part II - Hospital Wage Index Information.--This worksheet provides for the collection of hospital wage data which is needed to update the hospital wage index applied to the labor-related portion of the national average standardized amounts of the PPS. It is important for hospitals to ensure that the data reported on Worksheet S-3, Parts II, III, and IV, are accurate. Beginning October 1, 1993, the wage index must be updated annually. (See §1886(d)(3)(E) of the Act.) Congress also indicated that any revised wage index must exclude data for wages incurred in furnishing SNF services. Complete Worksheet S-3, Parts II, III, and IV, for IPPS hospitals (see §1886(d)), any hospital with an IPPS subprovider, or any hospital that would be subject to the IPPS if not granted a waiver.

NOTE: Any line reference for Worksheets A and A-6 includes all subscripts of that line. For Worksheet A-6 reclassifications, see instructions for column 3 of this worksheet.

NOTE: Lines 4 and 22 apply to physician's Part A administrative costs.

NOTE: Capitalized labor costs (salaries, hours, and wage-related costs) including, but not limited to, capital projects associated with lines 1 and 2 of Worksheet A must not be included on Worksheet S-3, Parts II, and III.

Column 2

General instructions for completing column 2:

1. For each line item (except for wage-related costs on lines 17 through 25 or as otherwise indicated), report in column 2, the direct salaries and wages, including amounts for related paid vacation, holiday, sick leave, other paid-time-off (PTO), severance pay, and bonus pay for personnel associated with the line item.
2. Paid vacation, holiday, sick leave, other PTO, severance pay, and bonus pay must be reported in column 2, with related direct salaries and wages to be considered an allowable cost for the wage index.
3. Paid vacation, holiday, sick leave, other PTO, severance pay, and bonus pay must be reported in the same cost center as the related direct salaries and wages. For example, do NOT report the direct salaries and wages of an employee in one cost center and report the employee's paid vacation in a different cost center.
4. To be considered an allowable salary cost (i.e., direct salaries and wages plus paid vacation, holiday, sick leave, other PTO, and severance pay), the associated hours must also be reported in column 5. (See exceptions in column 5 instructions for bonus pay and overtime pay. Also, for wage-related costs, there are no associated hours.)
5. Bonus pay includes award pay and vacation, holiday, and sick pay conversion (pay in lieu of time off).

NOTE: Methodology for including and accruing direct salaries, paid vacation, paid holiday, paid sick, and other PTO in the wage index:

Salary cost--The required source for costs on Worksheet A is the general ledger (see §4013 and 42 CFR 413.24(e)). Worksheet S-3, Part II, (wage index) data are derived from Worksheet A; therefore, the proper source for costs for the wage index is also the general ledger. A hospital's current year general ledger includes both costs that are paid during the current year and costs that are expensed in the current year but paid in the subsequent year (current year accruals). Include on Worksheet S-3, Part II, the current year costs incurred from the general ledger; that is, both the current year costs paid and the current year accruals. (Costs that are expensed in the prior year but paid in the current year (prior year accruals) are not included on a hospital's current year general ledger; do not include on the hospital's current year Worksheet S-3, Part II.)

Hours--The source for paid hours on Worksheet S-3, Part II, is the provider's payroll report. Hours are included on the payroll report in the period the associated expense is paid. Include on Worksheet S-3, Part II, the hours from the current year payroll report,

including hours associated with costs expensed in the prior year but paid in the current year. The payroll report time period must cover the weeks that best match the provider's cost reporting period. (Hours associated with costs expensed in the current year but not paid until the subsequent year (current year accrual) are not included on the current year payroll report; do not include on the hospital's current year Worksheet S-3, Part II.) Although this methodology does not provide a perfect match between paid costs and paid hours for a given year, it approximates a match between costs and hours.

NOTE: The above methodology is recommended by CMS but does not preclude using a different approach that would produce a more accurate finding for purposes of the wage index. A hospital must obtain approval from its contractor to use a different methodology. For example, when the hospital is unable to match the general ledger and payroll report direct salaries and hours within the exact dates of its cost reporting period, they may request approval to accrue salaries and hours on Worksheet S-3, Part II (up to 15 days before the cost reporting period beginning date or 15 days after the cost reporting period ending date in order to include 365 or 366 days, depending on the year). Accrued costs must have associated hours and must be excluded from the subsequent Worksheet S-3, Part II.

Regardless of the methodology used, costs and hours reported must be consistent. That is, accrued costs must have associated hours reported in the same cost center and in the same cost reporting period. The hospital must ensure that supporting documentation for both salaries and hours are based on actual data maintained in a form that permits validation by the contractor. For example, the hospital must be able to provide a payroll report that is summarized by individual employee and type of pay, e.g., vacation, holiday, sick, etc.) so that the Medicare contractor can validate the hours reported. The use of estimates for these amounts is unacceptable for the wage index.

Line 1--Enter from Worksheet A, column 1, line 200, the direct salaries and wages, including the amounts for related paid vacation, holiday, sick leave, other PTO, severance pay, and bonus pay, paid to hospital employees. See Worksheet A instructions (§4013).

Lines 2 through 10--The amounts reported must be adjusted for vacation, holiday, sick, other paid time off, severance, and bonus pay if not already included. Do not include in lines 2 through 8 the salaries for employees associated with excluded areas lines 9 and 10.

Line 2--Enter the salaries for directly-employed Part A non-physician anesthetist (for rural hospitals that have been granted CRNA pass-through) to the extent these salaries are included in line 1. Add to this amount the costs for CRNA Part A services furnished under contract to the extent hours can be accurately determined. Report only the personnel costs associated with these contracts. DO NOT include costs for equipment, supplies, travel expenses, and other miscellaneous or overhead items. DO NOT include costs applicable to excluded areas reported on lines 9 and 10. Additionally, contract CRNA cost must be included on line 11. Report in column 5, the hours that are associated with the costs in column 4 for directly employed and contracted Part A CRNAs.

Line 3--Enter the non-physician anesthetist salaries included in line 1, subject to the fee schedule and paid under Part B by the contractor. Do not include salary costs for physician assistants, clinical nurse specialists, nurse practitioners, and nurse midwives.

Line 4--Enter the physician Part A administrative salaries, (excluding teaching physician salaries), that are included in line 1. Also, do not include I & R salary on this line. Report I & R salary on line 7. In accordance with 42 CFR 415.55(a) and 415.60, reasonable ER physician availability cost can be considered Part A services.

Line 4.01--Enter the Part A teaching physician salaries that are included in line 1.

Line 5--Enter the total physician, physician assistant, nurse practitioner and clinical nurse specialist on-call salaries and salaries associated with services that are billable under Part B that are included in line 1. Under Medicare, these services are related to direct patient care and can be billed separately under Part B. Also include physician salaries for patient care services reported for rural health clinics (RHC) and FQHCs included on Worksheet A, column 1, lines 88 and/or 89, as applicable. Do not include on this line amounts that are included on lines 9 and 10 for the SNF or excluded area salaries. Refer to CMS Pub. 15-1, §§2313.2.E. and 2182.3.E., for instructions related to keeping time studies to track time spent in Part A versus Part B activities. However, although §2313.2.E.2. states that, "A minimally acceptable time study must encompass at least one full week per month of the cost reporting period," the contractor makes the final determination on the adequacy of the records maintained. A 2-week semi-annual (every 6 months) time study can be adequate unless the contractor believes that a significant change in the pattern of physician time is likely to occur from one quarter to the next, in which case, the contractor may require more frequent time studies. Adequate documentation must be maintained to support total hours in a manner that is verifiable, and to serve as a condition of payment under Part A. In the absence of a written allocation agreement, the contractor assumes that 100 percent of the physician compensation cost is allocated to Part B services. Non-allowable services that are neither Part A nor Part B services (for example, research, teaching of residents in non-approved programs, teaching and supervision of medical students, writing for medical journals, reasonable availability services in departments/cost centers other than emergency room, etc.) are reported as nonreimbursable activities in the designated nonreimbursable cost centers (for example, Worksheet A, lines 190 through 194, see 42 CFR 415.60(b)(3)). Reasonable availability services for emergency rooms can be considered Part A in certain circumstances (see CMS Pub. 15-1, chapter 21, §2109.3.A. through C. for instances when emergency department physician availability services costs are allowable, and for the associated required documentation).

Line 6--Report on line 6 the non-physician on-call salaries and salaries reported for hospital-based RHC and FQHC services included on Worksheet A, column 1, lines 88 and/or 89, as applicable. Do not include on this line amounts that are included on lines 9 and 10 for the SNF or excluded area salaries.

Line 7--Enter from Worksheet A the salaries reported in column 1 of line 21 for interns and residents. Subscript this line and report salaries for contracted interns and residents in an approved program on line 7.01. Report only the personnel costs associated with these contracts. DO NOT include cost for equipment, supplies, travel expenses, and other miscellaneous or overhead items. DO NOT include costs applicable to excluded areas reported on lines 9 and 10. Additionally, contract intern and resident costs must be included on line 11. DO NOT include contract interns and residents costs on line 13. Report in column 5, the hours that are associated with the costs in column 4 for directly employed and contract interns and residents.

Line 8--If you are a member of a home office or related organization as defined in CMS Pub. 15-1, chapter 21, §2150, enter from your records, the wages and salaries for home office and/or related organization personnel that are included in line 1. Wage related costs are not included on this line.

Lines 9 and 10--Enter on line 9 the amount reported on Worksheet A, column 1, for line 44 for the SNF. On line 10, enter from Worksheet A, column 1, the sum of lines 20, 23, 40 through 42, 45, 45.01, 46, 94, 95, 98 through 101, 105 through 112, 114, 115 through 117, and 190 through 194. DO NOT include on lines 9 and 10 any salaries for general service personnel (e.g., housekeeping) which, on Worksheet A, column 1, may have been included directly in the SNF and the other cost centers detailed in the instructions for line 10.

General Instructions for Contract Labor:
Only contract labor costs reported on the provider's trial balance and, therefore, on Worksheet A, column 2, are included on Worksheet S-3, Part II. Do not include contract labor wages and hours on Worksheet S-3, Part II, line 1. Contract labor costs not reported in the proper cost center are disallowed from the wage index calculation. If hours cannot be accurately determined, the contract labor costs must not be included in the wage index. In general, for contract labor, the

minimum requirement for supporting documentation is the contract itself. If the wage costs, hours, and non-labor costs are not clearly specified in the contract, other supporting documentation is required, such as a representative sample of invoices that specify the wage costs, hours, and non-labor costs. Attestations or declarations from the vendor or hospital are not acceptable in lieu of supporting documentation for wages, hours, wage-related costs, and non-labor costs. Hospitals must be able to provide such documentation when requested by the contractor. Report only personnel costs associated with the contract. DO NOT include cost for equipment, supplies, travel expenses, and other miscellaneous or overhead items (non-labor costs).

Workers who are contracted solely for the purpose of providing services on-call can only be included on Worksheet S-3 when they actually work the on-call schedule. That is, they are actually delivering patient care at the hospital, or are at the hospital so as to be available to deliver patient care. If either of these latter two scenarios occur, then both the wages and associated hours actually worked must be included in the appropriate contract labor line on Worksheet S-3. For contractors that work a regular schedule in addition to being on-call, report the on-call wages, but not the hours associated with the time the contractors are on-call. Do not include wages or hours associated with Part B services.

Line 11--Enter the amount paid for services furnished under contract, rather than by employees, for direct patient care, as defined below. Do not include costs applicable to excluded areas reported on line 9 and 10. Include costs for contract CRNA and intern and resident services (these costs are also to be reported on lines 2 and 7.01, respectively). DO NOT include the costs for patient care services from the home office allocation and/or from related organizations. Include on this line contract pharmacy and laboratory wage costs as defined below.

Direct patient care services include, but are not limited to, nursing, diagnostic, therapeutic, and rehabilitative services. Report only personnel costs associated with these contracts. DO NOT apply the guidelines for contracted therapy services under §1861(v)(5) of the Act and 42 CFR 413.106. Direct patient care contracted labor, for purposes of this worksheet, DOES NOT include the following: services paid under Part B: (e.g., physician clinical services, physician assistant services), management and consultant contracts, billing services, legal and accounting services, clinical psychologist and clinical social worker services, housekeeping services, security personnel, planning contracts, independent financial audits, or any other service not directly related to patient care.

Contract pharmacy and laboratory services are furnished under contract, rather than by employees. These services include, but are not limited to, pharmacist, pharmacy assistant, medical technologist, laboratory technologist, laboratory technician, and other services directly related to patient care. These services exclude pathologist Part A. Instead, contract pathologist Part A services must be reported on line 13. DO NOT include the following services paid under Part B (e.g., physician clinical services, physician assistant services), management and consultant contracts, clerical and billing services, legal and accounting services, housekeeping services, security personnel, planning contracts, independent financial audits, or any other service not directly related to patient care. Report only personnel costs associated with the contracts.

If you have no contracts for direct patient care as defined above, enter a zero in column 2. If you are unable to accurately determine the number of hours associated with contracted labor, enter a zero in column 2.

Line 12--Enter the amount paid for **contracted top level management services, and other contract management and administrative services** furnished under contract, rather than by employees. Include on this line contract management and administrative services associated with cost centers other than those listed on lines 26 through 43 (and their subscripts) of this worksheet that are included in the wage index.

Contracted Top Level Management: Include the amount paid for **top level management services**, as defined below, furnished under contract rather than by employees. Contract management is limited to the personnel costs for those individuals who are working at the hospital facility in the capacity of chief executive officer, chief operating officer, chief financial officer, or nursing administrator. The titles given to these individuals may vary from the titles indicated above. However, the individual should be performing those duties customarily given these positions.

For purposes of this worksheet, contract top level management services DO NOT include the following: physician Part A services, consultative services, clerical and billing services, legal and accounting services, unmet physician guarantees, physician services, planning contracts, independent financial audits, or any services other than the top-level management contracts listed above. Per instructions on Worksheet S-2, Part II, for top level management contracts, submit to your Medicare contractor the aggregate wages and hours.

Other Contract Management and Administrative Services: Examples of other contract management and administrative services that would be reported on line 12 include department directors, administrators, managers, ward clerks, and medical secretaries. Report only those personnel costs associated with the contract. DO NOT include on line 12 any contract labor costs associated with lines 26 through 43 and subscripts for these lines.

Line 13--Enter from your records the amount paid under contract (in accordance with the general instructions for contract labor) for Part A physician services - administrative, excluding teaching physician services. DO NOT include contract I & R services (to be included on line 7). DO NOT include the costs for Part A physician services from the home office allocation and/or from related organizations (to be reported on line 15). Do not include wages or hours associated with Part B services. As stated in the General Instructions for Contract Labor, "the minimum requirement for supporting documentation is the contract itself. If the wage costs, hours, and non-labor costs are not clearly specified in the contract, other supporting documentation is required, such as a representative sample of invoices that specify the wage costs, hours, and non-labor costs." Refer to CMS Pub. 15-1, §§2313.2E and 2182.3.E, for instructions related to keeping time studies to track time spent in Part A versus Part B activities. Adequate documentation must be maintained to support total hours in a manner that is verifiable. Total hours worked by the physicians cannot be imputed. In the absence of a written allocation agreement, the contractor assumes that 100 percent of the physician compensation cost is allocated to Part B services. Services that are neither Part A nor Part B services (for example, research, non-allowable teaching of residents in non-approved programs, teaching and supervision of medical students, writing for medical journals, reasonable availability services in departments/cost centers other than emergency room, etc.) are not reported on line 13. Reasonable availability services for emergency rooms can be considered Part A in certain circumstances (see CMS Pub. 15-1, chapter 21, §2109.3.A. through C. for instances when emergency department physician availability services costs are allowable, and for the associated required documentation).

Line 14--For cost reporting periods beginning before October 1, 2015, enter the salaries and wage-related costs (as defined on lines 17 and 18) paid to personnel who are affiliated with a home office and/or related organization, who provide services to the hospital, and whose salaries are not included on Worksheet A, column 1. In addition, add the home office/related organization salaries included on line 8 and the associated wage-related costs. This amount must be based on recognized methods of allocating an individual's home office/related organization salary to the

hospital. Obtain this information from the home office cost statement to report wages and hours for your hospital. Report only wages and hours associated with your hospital. If no home office/related organization exists or if you cannot accurately determine the hours associated with the home office/related organization salaries that are allocated to the hospital, then enter a zero in column 2. All costs for any related organization (as defined in CMS Pub. 15-1, chapter 10; 42 CFR 413.17; and CMS Pub. 15-1, chapter 21, §2150ff through §2153ff), must be shown as the cost to the related organization. For cost reporting periods beginning on or after October 1, 2015, do not use this line but use lines 14.01 and/or 14.02.

Line 14.01--For cost reporting periods beginning on or after October 1, 2015, enter the salaries paid to personnel affiliated with a home office, who provide services to the hospital, and whose salaries are not included on Worksheet A, column 1, but are included in Worksheet A, column 2, column 4 (if reported on Worksheet A-6), and/or column 6 (if reported on Worksheet A-8-1). In addition, add the home office salaries included on line 8. The amounts reported on this line must be based on recognized methods of allocating an individual's home office salary to the hospital. Obtain this information from the home office cost statement to report wages and hours for your hospital. Report only wages and hours associated with your hospital (and not other providers in the chain). If no home office exists or if you cannot accurately determine the hours associated with the home office salaries that are allocated to the hospital, then enter a zero in column 2. All costs for any home office (as defined in 42 CFR 413.17; and CMS Pub. 15-1, chapter 21, §2150ff through §2153ff), must be shown as the cost to the home office. Report only home office salary costs on this line; report home office wage-related costs on line 25.50.

Line 14.02--For cost reporting periods beginning on or after October 1, 2015, enter the salaries paid to personnel affiliated with a related organization (other than home office), who provide services to the hospital, and whose salaries are not included on Worksheet A, column 1, but are included in Worksheet A, column 2, column 4 (if reported on Worksheet A-6), and/or column 6 (if reported on Worksheet A-8-1). In addition, add the related organization salaries, other than a home office, included on line 8. The amounts reported on this line must be based on recognized methods of allocating an individual's related organization salary to the hospital. If no related organization exists or if you cannot accurately determine the hours associated with the related organization salaries that are allocated to the hospital, then enter a zero in column 2. All costs for any related organization (as defined in CMS Pub. 15-1, chapter 10; and 42 CFR 413.17), must be shown as the cost to the related organization. Report only related organization salary costs on this line; report related organization wage-related costs on line 25.51.

NOTE: Do not include any costs for Part A physician services from the home office allocation and/or related organizations. These amounts are reported on line 15. Do not report any wages, wage-related costs, or hours associated with excluded areas (lines 9 and 10). Report the cost of home office services, whether employee or contract labor, in the most closely matched cost centers on Worksheet A (lines 4 through 17), column 2, and on the corresponding lines of Worksheet S-3, Part II (lines 26 through 43). Report allowable contract labor costs, if applicable, in accordance with instructions on lines 28, 33, or 35.

If a wage related cost associated with the home office is not "core" (as described in the Worksheet S-3, Part IV) and is not a category included in "other" wage related costs on line 18 (see Worksheet S-3, Part IV, and line 18 instructions below), the cost cannot be, included on line 14, or subscripts. For example, if a hospital's employee parking cost does not meet the criteria for inclusion as a wage-related cost on line 18, any parking cost associated with home office staff cannot be included on line 14, or subscripts.

Line 15--For cost reporting periods beginning before October 1, 2015, enter from your records the salaries, wage-related costs, and amount paid under contract for Part A physician services - administrative, excluding teaching physician Part A services, from the home office allocation and/or related organizations. For cost reporting periods beginning on and after October 1, 2015, report only the salary costs and amount paid under contract on this line and report the wage-related costs (as defined on lines 17 and 18) on line 25.52. For cost reporting periods beginning on or after October 1, 2022, do not use this line; instead, use lines 15.01 and/or 15.02.

Line 15.01--For cost reporting periods beginning on or after October 1, 2022, enter from your records the salaries for physician Part A administrative services from the home office allocation and/or related organizations. Report the wage-related costs (as defined on lines 17) on line 25.52.

Line 15.02--For cost reporting periods beginning on or after October 1, 2022, enter from your records the amount paid for physician Part A administrative services under contract from the home office allocation and/or related organizations.

Line 16--For cost reporting periods beginning before October 1, 2015, enter from your records the salaries and wage-related costs for teaching physician Part A services from the home office allocation and/or related organizations. Also report on this line Part A teaching physicians' salaries under contract.

For cost reporting periods beginning on and after October 1, 2015, and before October 1, 2017, for teaching physician Part A services from the home office allocation and/or related organizations, report only the salary costs on this line and report the wage-related costs (as defined on lines 17) on line 25.53. For Part A teaching physicians' salaries under contract, continue to report salaries and wage related costs on this line. Do not complete this line effective for cost reporting periods beginning on or after October 1, 2017.

Line 16.01--For cost reporting periods beginning on or after October 1, 2017, enter from your records the salaries for teaching physician Part A services from the home office allocation and/or related organizations. Report the wage-related costs (as defined on lines 17) on line 25.53.

Line 16.02--For cost reporting periods beginning on or after October 1, 2017, enter from your records the amount paid for Part A teaching physicians under contract from the home office allocation and/or related organizations.

Lines 17 through 25 and 25.50 through 25.53--In general, the amount reported for wage-related costs must meet the "reasonable cost" provisions of Medicare. For pension and executive deferred compensation costs see the instructions below in Part IV. NOTE: Wage-related costs on lines 25.50 through 25.53 are not tied to wage-related costs reported on Worksheet S-3, Part IV.

For those wage-related costs that are not covered by Medicare reasonable cost principles, a hospital shall use generally accepted accounting principles (GAAP). For example, for purposes of the wage index, disability insurance cost should be developed using GAAP. Hospitals are required to complete Worksheet S-3, Part IV, a reconciliation worksheet to aid hospitals and contractors in implementing GAAP when developing wage-related costs. Upon request by the contractor or CMS, hospitals must provide a copy of the GAAP pronouncement, or other documentation, showing that the reporting practice is widely accepted in the hospital industry and/or related field as support for the methodology used to develop the wage-related costs. If a hospital does not complete Worksheet S-3, Part IV, or, if the hospital is unable, when requested, to provide a copy of the standard used in developing the wage-related costs, the contractor may remove the cost from the hospital's Worksheet S-3 due to insufficient documentation to substantiate the wage-related cost relevant to GAAP.

NOTE: All costs for any related organization must be shown as the cost to the related organization. (For Medicare cost reporting principles, see CMS Pub. 15-1, chapter 10, §1000. For GAAP, see FASB 57.) If a hospital's consolidation methodology is not in accordance with GAAP or if there are any amounts in the methodology that cannot be verified by the contractor, the contractor may apply the hospital's cost-to-charge ratio to reduce the related party expenses to cost.

NOTE: All wage-related costs, including FICA, workers' compensation, and unemployment compensation taxes, associated with physician services are to be allocated according to the services provided; that is, those taxes and other wage-related costs attributable to Part A administrative services must be placed on line 22, to Part A teaching services must be placed on line 22.01, and to Part B (patient care services) must be placed on line 23. Line 17 must not include wage-related costs that are associated with physician services.

Line 17--Enter the core wage-related costs from Worksheet S-3, Part IV, line 24. (See note below for costs that are not to be included on line 17). Only the wage-related costs reported on Worksheet S-3, Part IV, line 24, are reported on this line. (Wage-related costs are reported in column 2, not column 1, of Worksheet A.)

NOTE: Do not include wage-related costs applicable to the excluded areas reported on lines 9 and 10. Instead, these costs are reported on line 19. Also, do not include the wage-related costs for physicians Parts A and B, non-physician anesthetists Parts A and B, interns and residents in approved programs, and home office/related party personnel. (See lines 14, 15, and 20 through 25, and 25.50 through 25.53.)

Health Insurance and Health-Related Wage Related Costs:

The following are the allowable health insurance and health-related costs for the wage index.

1) Purchased Health Insurance:
   - Premium costs.
   - Costs paid to external organizations for plan administration.
2) Self (or Self-Funded) Health Insurance:
   - Costs paid to external organizations for plan administration.
   - Without a Third-Party Administrator (TPA).
     - Costs the hospital incurs in providing services under the plan to its employees. (Domestic claim charges must be reduced to cost. Costs must also exclude any copayments and deductibles paid by employees.) Employee withholdings and contributions are employee costs, not hospital costs. Hospitals are not permitted to treat as hospital wage-related costs the amounts that their employees incur for their health insurance benefits.
     - Hospital's payment to unrelated health care providers for services rendered, under the plan, to hospital's employees.
   - With a TPA.
     - Amount the TPA pays to the hospital or other health care providers for services rendered under the plan. (For domestic claims, the hospital must provide documentation from its TPA to demonstrate that payments for services rendered to employees are based on a discount from full charges. Also, the payments must be reasonable; that is, the costs included for domestic claims must not exceed the amount that commercial insurers pay the hospital for the same services rendered to non-employees.) Employee withholdings and contributions are employee costs, not hospital costs. Hospitals are not permitted to treat as hospital wage-related costs the amounts that their employees incur for their health insurance benefits. Hospitals cannot claim additional net wage-related costs for employee claims not fully reimbursed by the TPA payment.

NOTE: Hospitals and contractors are not required to remove from domestic claims costs, the personnel costs that are associated with hospital staff who deliver the services to employees. Regardless of whether self-funded insurance is with or without a TPA, where hospitals provide healthcare services to their employees, hospitals cannot claim as a wage-related cost the amount by which the hospitals reduce copays or deductibles of employees receiving the health care services.

3) Health-Related Services: Inpatient and outpatient health services that are not covered under the hospital's health insurance plan, but are provided to employees at no cost or at a discount, for example, employee physicals, flu shots, smoking cessation, and weight control programs, are to be included as a core wage-related cost. (Domestic claim charges must be reduced to cost. Costs must also exclude any copayments and deductibles paid by employees.)

NOTE: Hospitals and contractors are not required to remove from domestic claims costs, the personnel costs that are associated with hospital staff who deliver the services to employees.

Line 18--Enter the total of "other" wage-related costs. Line 18, column 4, must equal the sum of Worksheet S-3, Part IV, line 25, and its subscripts. Complete instructions for Worksheet S-3, Part IV, line 25, are below in §4005.4. Do not complete this line effective for cost reporting periods beginning on or after October 1, 2015.

NOTE: Do not include wage-related costs applicable to the excluded areas reported on lines 9 and 10. Instead, these costs are reported on line 19. Also, do not include the wage-related costs for physician Parts A and B, non-physician anesthetists Parts A and B, interns and residents in approved programs, and home office personnel.

Line 19--Enter the total (core and other) wage-related costs applicable to the excluded areas reported on lines 9 and 10.

Lines 20 through 25, and 25.50 through 25.53--Enter from your records the core wage-related costs for each category of employee listed. Do not include the other wage-related costs reported on Worksheet S-3, Part II, line 18, and Worksheet S-3, Part IV, line 25. Do not include wage-related costs for excluded areas reported on line 19. Subscript line 22, and report the wage-related costs for Part A teaching physicians reported on line 4.01, on line 22.01. On line 23, do not include wage-related costs related to non-physician salaries reported for hospital-based RHCs and FQHCs services included on Worksheet A, column 1, lines 88 and/or 89, as applicable. These wage-related costs are reported separately on line 24.

Line 25.50--For cost reporting periods beginning on or after October 1, 2015, enter the core wage-related costs (as defined on line 17) paid to personnel who are affiliated with a home office whose salaries are reported on line 14.01.

Line 25.51--For cost reporting periods beginning on or after October 1, 2015, enter the core wage-related costs (as defined on line 17) paid to personnel who are affiliated with a related organization (other than home office) whose salaries are reported on line 14.02.

Line 25.52--For cost reporting periods beginning on or after October 1, 2015, enter the core wage-related costs (as defined on line 17) for Part A physician services - administrative, excluding teaching physicians Part A services, from the home office allocation and/or related organizations, whose salaries are reported on line 15.

Line 25.53--For cost reporting periods beginning on or after October 1, 2015, enter the core wage-related costs (as defined on line 17) for teaching physicians Part A services from the home office allocation and/or related organizations, whose salaries are reported on line 16, or for cost reporting periods beginning on or after October 1, 2017, line 16.01.

NOTE: For cost reporting periods beginning prior to October 1, 2015, other wage related costs associated with the home office are reported on Worksheet S-3, Part II, line 18, and on Worksheet S-3, Part IV, line 25, and its subscripts. For lines 25.50 through 25.53 of Worksheet S-3, Part II, if a wage-related cost associated with the home office is not "core" (as described in the Worksheet S-3, Part IV), the cost must not be included on line 14 and its subscripts, or on line 25 and its subscripts.

Lines 26 through 43--These lines provide for the collection of hospital wage data for overhead costs to properly allocate the salary portion of the overhead costs to the appropriate service areas for excluded units. Enter the direct salary and wages with related salary amounts for paid vacation, holiday, sick, other PTO, severance, and bonus pay from Worksheet A, column 1, for lines 26, 27, 29 through 32, 34, and 36 through 43. Enter the contract labor costs from Worksheet A, column 2, for lines 28, 33, and 35.

Line 26--Salaries and hours reported on this line correlate to the salaries reported on line 4, column 1, of Worksheet A, for the personnel working in the Employee Benefit Department, or the Human Resources Department. Do not report costs or hours associated with other hospital employees on this line.

Lines 28, 33, and 35--Enter the amount paid for services performed **under contract** (in accordance with the general contract labor instructions above), rather than by employees, for A&G, housekeeping, and dietary services, respectively. Continue to report on the standard lines (line 27, 32, and 34), the amounts paid for services rendered by employees not under contract. Only contract labor costs reported on Worksheet A, column 2, column 4 (if reported on Worksheet A-6), and/or column 6 (if reported on Worksheet A-8-1), are included on these lines. Contract labor costs not reported in the proper cost center on Worksheet A, are excluded from the wage index.

Line 28--Administrative and General (A&G) costs are expenses a hospital incurs in carrying out its administrative and/or general management functions. Include on line 28, the contract services that are included on Worksheet A, line 5, and subscripts, columns 2, 4 and/or 6 ("Administrative and General"). Contract information and data processing services, legal, tax preparation, cost report preparation, and purchasing services are examples of contract labor costs that would be included on this line and must not be reported on lines 11 or 12. Do not include on line 28 the costs for top level management contracts (these costs are reported on line 12). Do not include on this line contract labor which is more closely matched to another overhead cost center, such as, but not limited to, contract housekeeping or dietary services, which must be reported on line 33 or line 35.

Lines 32 through 35--All hospitals must incur costs for housekeeping and dietary services, either direct, under contract, or both. It is not acceptable to report zeroes for housekeeping or dietary services. Report wages and hours for housekeeping services on either line 32 (direct) or line 33 (contract), and for dietary services, on either line 34 (direct) or line 35 (contract). See 79 FR 49965 (August 22, 2014). Hospitals are encouraged to ensure that their contracts clearly specify the salaries, wages, and hours related to all of their contract labor. If, in rare instances, hours for these services cannot be determined exactly from the contract, determine the hours based on a reasonable estimation. Examples of reasonable estimates are regional average hourly rates, including an average of the wages and hours for dietary and housekeeping services of other hospitals in the same CBSA. Hospitals also may conduct time studies to determine hours worked. If regional averages or time studies cannot be used, data from the Bureau of Labor Statistics may be used to obtain average wages and hours for housekeeping and dietary services.

Column 3--Enter on each line, as appropriate, the **salary and wages** portion (as defined in column 2 instructions) of any reclassifications made on Worksheet A-6. NOTE: Adjust the hours in column 5 associated with the reclassified salary and wages. See the NOTE for column 5 below.

Column 4--Enter on each line the result of column 2 plus or minus column 3.

Column 5--Enter on each line the number of **paid** hours corresponding to the amounts reported in column 4. Paid hours include regular hours (including paid lunch hours), overtime hours, paid holiday, vacation and sick leave hours, paid time-off hours, and hours associated with severance pay. For Part II, lines 1 through 15 (including subscripts), lines 26 through 43 (including subscripts), and Part III, line 7, if the hours cannot be determined, then the associated salaries must not be included in columns 2 through 4.

> **NOTE:** The hours reported in column 5 must reflect any changes to salaries reported in column 3. Report the on-call wages for employees and contractors that work a regular schedule in addition to being on-call (not present at the hospital but off-site and ready to be called in if needed); however, do not report the on-call hours. Report both the wages and hours for on-call employees and contractors when they are called in to work. Overtime hours are calculated as one hour when an employee is paid time and a half. No hours are required for bonus pay. The intern and resident hours associated with the salaries reported on line 7 must be based on 2080 hours per year for each full-time intern and resident employee. The hours reported for salaried employees who are paid a fixed rate are recorded as 40 hours per week or the number of hours in your standard work week.

NOTE: Workers who are contracted solely for the purpose of providing services on-call can only be included on Worksheet S-3 when they actually work the on-call schedule; that is, they are actually delivering patient care at the hospital, or are at the hospital so as to be available to deliver patient care. If either of these latter two scenarios occur, then both the wages and associated hours actually worked must be included in the appropriate contract labor line on Worksheet S-3. Do not include wages or hours associated with Part B services.

Column 6--Enter on all lines (except lines 17 through 25) the average hourly wage resulting from dividing column 4 by column 5.

4005.3 Part III - Hospital Wage Index Summary.--This worksheet provides for the calculation of a hospital's average hourly wage (without overhead allocation, occupational mix adjustment, and inflation adjustment) as well as analysis of the wage data.

Columns 1 through 6--Follow the same instructions discussed in Part II, except for column 6, line 5.

Line 1--From Part II, enter the result of line 1 minus the sum of lines 2, 3, 4.01, 5, 6, 7, 7.01, and 8. Add to this amount lines: 28, 33, and 35.

Line 2--From Part II, enter the sum of lines 9 and 10.

Line 3--Enter the result of line 1 minus line 2.

Line 4--From Part II, enter the sum of lines 11, 12, 13, 14, 14.01, 14.02, and 15. (Line 16 is omitted from Part III, line 4, because physicians' teaching services are excluded from the wage index.)

Line 5--For cost reporting periods beginning prior to October 1, 2015, from Part II, enter the sum of lines 17, 18, 22, 25.50, 25.51, and 25.52. Enter on this line in column 6 the wage-related cost percentage computed by dividing Part III, column 4, line 5, by Part III, column 4, line 3. Round the result to two decimal places.

For cost reporting periods beginning on or after October 1, 2015, from Part II, enter the sum of lines 17, 22, 25.50, 25.51, and 25.52. Enter on this line in column 6 the wage-related cost percentage computed by dividing Part III, column 4, line 5, by Part III, column 4, line 3. Round the result to two decimal places.

Line 6--Enter the sum of lines 3 through 5.

Line 7--Enter from Part II above, the sum of lines 26 through 43. If the hospital's ratio for excluded area salaries to net salaries is greater than 5 percent, the hospital must complete all columns for this line. (See instructions in Part II, lines 26 through 43 for calculating the percentage.)

4005.4 Part IV - Wage Related Costs.--The hospital must provide the contractor with a complete list of all core wage related costs included in Part II (§4005.2), lines 17 and 19 through 25. This worksheet provides for the identification of such costs.

For lines 1 through 23, for wage related costs not covered by Medicare reasonable cost principles (excluding the reporting of certain defined benefit pension costs; see instructions below), a hospital shall use GAAP in reporting wage related costs. In addition, some costs such as payroll taxes, which are reported as a wage related cost(s) on Worksheet S-3, Part IV, are not considered fringe benefits for Medicare cost finding.

See instructions for line 25 on including "other" wage related costs in the wage index that are not a core wage related cost reported on lines 1 through 23.

Enter on each line as applicable the corresponding amount from your accounting books and/or records.

Line 3--Report pension cost for defined benefit pension plans that do not meet the applicable requirements for a qualified pension plan under section 401(a) of the Internal Revenue Code.

The policy adopted in the FFY 2012 IPPS final rule (CMS-1518-F; 76 FR 51586-51590, August 18, 2011) does not change the reporting basis for these costs.

NOTE: These plans generally are not funded by a funding vehicle that is for exclusive benefit of employees or their beneficiaries and do not qualify for special tax benefits, such as tax deferral of employer contributions. For such unfunded defined benefit plans, the costs of these plans are reported on a cash basis which recognizes benefit payments made during the current period. Typically, these plans supplement the basic qualified defined benefit plan or provide benefits to a select class of employees, such as executives.

Line 4--Commencing with cost reporting periods used for the FFY 2013 wage index, report pension cost for defined benefit pension plans which meet the applicable requirements for a qualified pension plan under §401(a) of the Internal Revenue Code for the wage index. The allowable pension costs to be reported for these defined benefit pension plans shall be determined in accordance with the policy adopted in the FY 2012 IPPS final rule (CMS-1518-F; 76 FR 51586-51590, August 18, 2011), modified in the FY 2016 IPPS final rule (CMS-1632-F; 80 FR 49505-49508, August 17, 2015) and as discussed below. Enter the pension costs from your records or from the Wage Index Pension Cost Schedule available for download from the CMS website at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Wage-Index-Files.html. (See CMS Pub. 15-1, chapter 21, §2142.)

Policy

Defined Benefit Pension Plan: A defined benefit pension plan is a type of deferred compensation plan, which is established and maintained by the employer primarily to provide systematically for the payment of definitely determinable benefits to its employees usually over a period of years, or for life, after retirement. Pension plan benefits are generally measured by, and based on, such factors as age of employees, years of service, and compensation received by employees. This section applies only to defined benefit pension plans which meet the applicable requirements for a qualified pension plan under §401(a) of the Internal Revenue Code. A qualified pension plan is for the exclusive benefit of employees or their beneficiaries and qualifies for special tax benefits, such as tax deferral of employer contributions.

Pension Contributions: Pension costs for a defined benefit pension plan are allowable only to the extent that costs are actually incurred by the provider Such costs are found to have been incurred only if paid directly to participants or beneficiaries under the terms of the plan or paid to a pension fund which meets the applicable tax qualification requirements under §401(a) of the Internal Revenue Code. For purposes of the wage index, provider pension payments shall be measured on a cash-basis without regard to CMS Pub. 15-1, chapter 23, §2305. Payment must be made by check or other negotiable instrument, cash, or legal transfer of assets such as stocks, bonds, and real property. A contribution payment shall be deemed to occur on the date it is credited to the fund established for the pension plan, or for provider payments made directly to a plan participant or beneficiary, on the date the provider's account is debited. Contributions made under a pension plan that covers multiple providers or employers shall be allocated on a basis consistent with plan records. If the plan records do not show a separate accounting of the actuarially determined cost estimates, contribution deposits, and/or assets attributable to each participating provider or employer, the allocation basis must represent a reasonable approximation of the funding attributable to each employer.

Source of Documentation for Pension Contributions: Providers are required to obtain contribution data from the pension trustee, insurance carrier, Schedule B or SB of IRS Form 5500, and if applicable, from accounting records showing the allocation of total plan contributions to each participating provider. These records must be maintained as needed for subsequent periods.

Reasonable Compensation: In order for pension costs to be allowable, the benefits payable under the plan (attributable to employer contributions) together with all other compensation paid to the employee must be reasonable in amount.

Defined Benefit Pension Plan Costs for the Wage Index**:** The annual pension to be included in the wage index shall be the average annual employer contributions made by or on behalf of the provider (on a cash basis) to all defined benefit plans covered under this section during the averaging period. Contribution payments must satisfy the allowability requirements outlined above; see "Pension Contributions" and "Reasonable Compensation" above. A reversion of plan assets shall be treated as a negative contribution payment and a negative pension cost resulting from a reversion of plan assets shall offset a provider's other wage related costs.

In the FY 2016 IPPS final rule and effective with the FY 2017 wage index, the averaging period used to compute the average defined benefit pension cost for the wage index was modified. Prior to this modification, the averaging period was generally the 36 consecutive calendar month period centered on the midpoint of the cost reporting period used for the wage index (the cost reporting period used for the wage index shall hereafter be referred to as the wage index cost reporting period). Beginning with the FY 2017 wage index, generally, the averaging period is based on the base cost reporting period, plus the prior two cost reporting years (36 months).

A provider who adopts a new defined benefit pension plan and has no other defined benefit plan in existence during the averaging period may elect to exclude from the averaging period all cost reporting periods ending prior to the date the new plan was adopted. No defined benefit pension cost is reportable for a wage index cost reporting period that is excluded from the averaging period in accordance with this paragraph. An election to claim costs for a newly adopted plan based on an averaging period of less than 36 months must be applied on a consistent basis for all wage index cost reporting periods for which the 36-month averaging period contains the plan effective date.

If the wage index cost reporting period does not represent a 12-month period, the annual pension cost otherwise determined in accordance with this section shall be prorated to reflect the number of months in the wage index cost reporting period.

For the FY 2013 through FY 2022 wage index only, a provider may include a prefunding installment as a component of pension cost regardless of whether or not the plan(s) which gave rise to the prefunding balance are still in existence. The annual prefunding installment shall equal $1/10^{th}$ of the prefunding balance. A prefunding installment that is not reflected in the pension cost for a wage index cost reporting period may not be reassigned and added to the pension cost reported for wage index purposes in any subsequent period. The prefunding balance equals the excess, if any, of (i) provider contributions made (on a cash-basis) to its defined benefit pension plans during the look-back period over (ii) the pension costs included in the wage-index for the same look-back period. A provider's share of the total contributions made under a pension plan that covers multiple providers or employers shall be determined on a basis consistent with the methodology used to determine the wage index pension costs for the cost reporting periods included in the prefunding balance. The look-back period shall consist of consecutive provider cost reporting periods commencing no earlier than October 1, 2002, and ending with the provider's cost reporting period immediately prior to the FY 2013 wage index cost reporting period. The look-back period may not include any cost reporting period for which the provider is unable to provide documentation of the contributions made or the pension costs included in the wage index;

all prior cost reporting periods must also be excluded in order to satisfy the requirement that the look-back period consist of consecutive cost reporting periods. A provider who establishes a prefunding balance must submit documentation to the Medicare contractor to support the calculation of the prefunding balance and annual prefunding installment. A prefunding worksheet with complete instructions is available for download from the CMS website at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Wage-Index-Files.html.

Pension Plan with Multiple Entities**:** If a hospital participates in a pension plan or retirement system that also covers other entities, the hospital must report its respective 3-year average pension cost (or prefunding balance) reflecting only the hospital's allocated share of total plan contributions, and not including any share of pension costs of other entities. For each hospital, this is accomplished by first determining the hospital's allocated portion of pension contribution for each year of the 3-year average, and then computing the 3-year average for that hospital based only on that hospital's respective allocated pension contributions. This is consistent with the regulations at 42 CFR 413.24(a), which state, in pertinent part, that providers must provide adequate cost data based on their financial and statistical records. Therefore, a provider may not claim as an allowable cost the costs of services associated with another entity. It is not appropriate to compute the 3-year average (or prefunding balance) based on the total contributions made to the plan by all participating entities and then determine a hospital's allocated portion of the 3-year average cost (or prefunding balance) because there are instances in which the 3-year average could be skewed because a hospital may be including pension costs from another entity in its 3-year average. Specifically, if the allocated percentage of total plan contributions for one or more of the participating entities changes during the 3-year average, the average will be skewed. The allocated percentage to each entity can change due to mergers, changes in plan coverage, or other factors. We also note that the allocation of contributions between the various entities participating in a pension plan or pension system should agree with the methodology used for plan reporting purposes and/or financial statement purposes, and the methodology used should be applied consistently over time. Furthermore, if wage index reporting is required for two or more hospitals covered under the same pension plan or retirement system, those hospitals must ensure that the allocation of plan contributions for each reporting period is determined on a consistent basis to avoid duplicate reporting of costs.

Examples

Example 1 (prefunding balance and prefunding installment):

- Provider’s FY 2017 wage index cost reporting period is 01/01/2013-12/31/2013. The look-back period ends with the cost reporting period immediately prior to the cost reporting period used for the FY 2013 wage index. Since the FY 2013 wage index was based on the providers 1/1/2009-12/31/2009 cost reporting period, the look-back period ends on 12/31/2008. Assuming the provider has always reported costs on a calendar year basis, the earliest possible cost reporting period in the look-back period is the period commencing 01/01/2003 (first cost reporting period commencing on or after 10/01/2002).

- The provider is able to document its pension contributions (on a cash basis), and the pension costs included in the wage index for all cost reporting periods except for the 2004 year. Therefore, 2004 and all prior cost reporting periods must be excluded from the look-back period. The data for 2005 through 2008 is as follows:

Cost Reporting Year	Cash Basis Contributions	Wage-Index Pension Costs
2005	$400,000	$500,000
2006	$800,000	$0
2007	$0	$600,000
2008	$650,000	$700,000

- Because the pension cost reported in the wage index for 2005 was higher than the cash contributions made during that same period, the provider may elect to drop 2005 (and all prior periods) from the look-back period.

- Although the contributions made in 2007 were also less than the pension cost reported for that same period, the provider cannot exclude 2007 without also excluding 2006 (look-back period must consist of consecutive cost reporting periods).

- Although the contributions made in 2008 were less than the pension cost reported in that same period, the provider cannot exclude 2008 since the look-back period must end with 2008 because that is the cost reporting period immediately prior to the FY 2013 wage index cost reporting period.

- The prefunding balance based on a 2006-2008 look-back period is $150,000 ($1,450,000 [$800,000+$0+$650,000] total contributions - $1,300,000 [$0 + $600,000 + $700,000] in wage index pension costs reported for the same period). The annual prefunding installment is $15,000 (1/10th of $150,000).

Example 2 (pension cost for a 12-month wage index cost reporting period):

- Provider's FY 2017 wage index cost reporting period is 12 months (01/01/2013 - 12/31/2013); the 36-month averaging period is 01/01/2011 to 12/31/2013, which includes the wage index cost reporting year and the prior two cost reporting periods.

- Contributions made during 01/01/2011 - 12/31/2011 = $500,000.

- Contributions made during 01/01/2012 - 12/31/2012 = $300,000.

- Contributions made in wage index cost reporting period 01/01/2013 - 12/31/2013 = $600,000.

- Total contributions made during the 36-month averaging period = $1,400,000.

- The provider has no prefunding balance or prefunding installment.

- The pension cost for the FY 2017 wage index cost reporting period is $466,667 ($1,400,000 total contributions divided by 36 months in the averaging period multiplied by 12 months in the wage index cost reporting period).

Example 3 (pension cost for a 7-month wage index cost reporting period):

- Provider's FY 2017 wage index cost reporting period is 7 months (01/01/2013 - 07/31/2013); the 36-month averaging period is 8/01/2010 to 07/31/2013 (begins 29 months prior to the Fiscal Year Begin Date of the wage index cost reporting period for a total of 36 months).
- Contributions made during 08/01/2010 - 12/31/2010 = $300,000.
- Contributions made during 01/01/2011 - 12/31/2011 = $500,000.
- Contributions made during 01/01/2012 - 12/31/2012 = $400,000.
- Contributions made in wage index cost reporting period 01/01/2013 - 07/31/2013 = $200,000.
- Total contributions made during the 36-month averaging period = $1,400,000.
- The provider has documented a prefunding balance of $1,000,000; the annual prefunding installment is therefore $100,000 ($1/10^{th}$ of prefunding balance).
- The pension cost for the FY 2017 wage index cost reporting period is $330,555 ($272,222 average pension cost [$1,400,000 total contributions divided by 36 months in the averaging period multiplied by 7 months in the wage index cost reporting period] plus $58,333 pro-rata prefunding installment [$100,000 annual prefunding installment multiplied by $7/12^{ths}$ to reflect a 7-month wage index cost reporting period]).

Example 4 (pension cost for a new plan):

- Provider's FY 2017 wage index cost reporting period is 12 months (01/01/2013 - 12/31/2013); the 36-month averaging period is 01/01/2011 to 12/31/2013, which includes the wage index cost reporting year and the prior two cost reporting periods.
- The provider adopted a new pension plan effective 07/01/2012 and had no other pension plan in effect prior to that date; therefore, there is no prefunding balance or prefunding installment.
- Contributions made during 01/01/2011 - 12/31/2011 = $0 (no plan in existence)
- Contributions made during 01/01/2012 - 12/31/2012 = $500,000.
- Contributions made in the wage index cost reporting period 01/01/2013 - 12/31/2013 = $1,200,000.
- Total contributions during the 36-month averaging period = $1,700,000.
- The provider did not report a pension cost attributable to the new plan based on a 36-month averaging period during any prior wage index cost reporting period; therefore, it may elect to exclude cost reporting periods ending prior to the 07/01/2012 plan effective date from the averaging period; the 36-month averaging period is, therefore, shortened to 24 months and excludes the period 01/01/2011 to 12/31/2011. The pension cost for the FY 2017 wage index cost reporting period would then be $850,000 ($1,700,000 total contributions divided by 24 months in the averaging period multiplied by 12 months in the wage index reporting period).

Lines 8, 8.01, 8.02, and 8.03--Effective for cost reporting periods beginning prior to October 1, 2015, complete line 8 if the hospital has purchased or self-funded insurance. Effective for cost reporting periods beginning on or after October 1, 2015, complete line 8.01 if the hospital has self-funded insurance without a TPA. Complete line 8.02 if the hospital has self-funded insurance with a TPA. Complete line 8.03 if the hospital purchases health insurance. (See the instructions under Worksheet S-3, Part II, regarding health insurance as a wage-related cost for the wage index).

Line 21--Report costs of executive deferred compensation plans and awards for executives. The policy adopted in the FFY 2012 IPPS final rule; 76 FR 51586-51590 (August 18, 2011) does not change the reporting basis for these costs. Examples of executive deferred compensation include special stock option or bonus plans and sum certain postemployment awards that are not available to other employees.

NOTE: Costs reported on line 21 exclude costs of executive deferred compensation that are defined contribution pension plans, tax-sheltered annuity plans, nonqualified defined benefit plans, and qualified defined benefit plans that are available to other employees that are reportable on lines 1 through 4, respectively.

Line 25--Enter each wage related cost that is considered an "other" wage related cost separately. Subscript this line for each "other" wage related cost in accordance with the following criteria. For line 25 and subscripts specify the type of each "other" wage related cost. The total of line 25 and its subscripts is reported on Worksheet S-3, Part II, line 18, column 4. Do not complete this line effective for cost reporting periods beginning on or after October 1, 2015.

A hospital may report an "other" wage related cost (defined as the value of the benefit) if it meets all of the following criteria:

- The costs are not listed on lines 1 through 23 "Wage Related Costs Core" of this worksheet or included in salaries reported on Worksheet S-3, Part II, column 4, line 17.
- The "other" wage related cost is greater than 1 percent of total salaries after the direct excluded salaries are removed. Line 25 and each subscript must independently meet this 1 percent test. See below for instructions to calculate the 1 percent test.
- The wage related cost is a fringe benefit as described by the IRS and is reported to the IRS on an employee's or contractor's W-2 or 1099 as taxable income.
- The wage related cost is not being furnished for the convenience of the provider or otherwise excludable from income as a fringe benefit (such as a working condition fringe).

NOTE: Direct salaries and wages, including amounts related to paid vacation, holiday, sick leave, etc., reported on line 1 of Worksheet S-3, Part II, must not be included as other wage related costs on this line, nor on line 18 of Worksheet S-3, Part II.

NOTE: Do not include wage related costs applicable to the excluded areas reported on Worksheet S-3, Part II, lines 9 and 10. Instead, these costs are reported on Worksheet S-3, Part II, line 19. Also, do not include on this line the wage related costs for physician Parts A and B, non-physician anesthetists Parts A and B, interns and residents in approved programs, and home office personnel.

Calculate the 1 percent test by dividing each individual category of the other wage related cost (that is, the numerator) by the sum of Worksheet S-3, Part III, lines 3 and 4, column 4, (that is, the denominator). The other wage related costs associated with contract labor and home office/related organization personnel are included in the numerator because these other wage related costs are allowed in the wage index (in addition to other wage related costs for direct employees), assuming the requirements for inclusion in the wage index are met. For example, if a hospital is including parking garage costs as an other wage-related cost that is reported on the W-2 or 1099 form, when running the 1 percent test, include in the numerator all the parking garage other wage related cost for direct salary employees, contracted employees, and home office employees, and divide by the sum of Worksheet S-3, Part III, lines 3 and 4, column 4.

Calculate the 1 percent test only one time for a category of other wage related costs, inclusive of other wage related costs for employees, contracted employees, and home office employees.

4005.5 Part V - Contract Labor and Benefit Costs.--This section identifies the contract labor costs and benefit costs for the entire hospital and hospital healthcare complex including all applicable subproviders and units. This section must be completed by all hospitals (e.g., IPPS hospitals, CAHs, IPFs, IRFs, cancer hospitals, children's hospitals, LTCHs, and RNHCIs).

Definitions:

Contract Labor Costs--Enter the amount paid for services furnished under contract, rather than by employees, for direct patient care, as defined in the instructions for Worksheet S-3, Part II, line 11. The amount of contract labor reported on S-3, Part II, line 11, should agree with the amount reported on S-3, Part V, line 2. This is only for the hospital (not including excluded areas). The remainder of Worksheet S-3, Part V, should reflect contract labor as defined on Worksheet S-3, Part II, line 11 (direct patient care for all of the excluded areas), with the aggregate total reported on line 1.

Benefit Costs--Enter the amount of employee benefit costs, also referred to as wage-related costs. Worksheet S-3, Part IV, provides a list of core wage-related costs. The core wage-related costs reported on S-3, Part IV, line 24, which is spread on Worksheet S-3, Part II, lines 17, and 19 through 25, must be reported by component on Worksheet S-3, Part V. The amount reported on Worksheet S-3, Part V, line 1, must agree to the allowable amount reported on Worksheet S-3, Part IV, line 24. Worksheet S-3, Part V, line 2, must agree to the amount reported on Worksheet S-3, Part II, line 17. Each excluded area must contain their share of wage-related costs so that lines 19 through 25 on Worksheet S-3, Part II, will agree to Worksheet S-3, Part V, lines 3 through 18.

Identify the contract labor costs and benefit costs for each component on the applicable line.

4006. WORKSHEET S-4 - HOSPITAL-BASED HOME HEALTH AGENCY 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 titles V, XVIII, and XIX. The statistics required on this worksheet pertain to a hospital-based HHA. The data maintained is dependent upon the services provided by the agency, number of program home health aide hours, total agency home health aide hours, program unduplicated census count, and total unduplicated census count. In addition, FTE data are required by employee staff, contracted staff, and total. Complete a separate Worksheet S-4 for each hospital-based HHA.

Line 1--Enter the number of hours applicable to home health aide services.

Line 2--Enter the unduplicated count of all individual patients and title XVIII patients receiving home visits or other care provided by employees of the agency or under contracted services during the reporting period. Count each individual only once. However, because a patient may be covered under more than one health insurance program, the total census count (column 5, line 2) may not equal the sum of columns 1 through 4, line 2. For purposes of calculating the unduplicated census, if a beneficiary has received healthcare in more than one CBSA, you must prorate the count of that beneficiary so as not to exceed a total of one (1). A provider is to also query the beneficiary to determine if he or she has received healthcare from another provider during the year, e.g., Maine versus Florida for beneficiaries with seasonal residence.

Lines 3 through 18--Lines 3 through 18 provide statistical data related to the human resources of the HHA. The human resources statistics are required for each of the job categories specified in lines 3 through 18.

Enter the number of hours in your normal work week.

Report in column 1 the FTE employees on the HHA's payroll. These are staff for which an IRS Form W-2 is used.

Report in column 2 the FTE contracted and consultant staff of the HHA.

Compute staff FTEs for column 1 as follows: Add all hours for which employees were paid and divide by 2080 hours. Round to two decimal places, e.g., .04447 is rounded to .04. Compute contract FTEs for column 2 as follows. Add all hours for which contracted and consultant staff worked and divide by 2080 hours.

If employees are paid for unused vacation, unused sick leave, etc., exclude these paid hours from the numerator in the calculations.

Line 19--Enter in column 1 the number of CBSAs that you serviced during this cost reporting period.

Line 20--Enter each five-digit CBSA and/or non-CBSA (rural) code where the reported HHA visits were performed. Subscript the line to accommodate the number of CBSAs you service. Rural CBSA codes are assembled by placing the digits "999" in front of the two-digit State code, e.g., for the State of Maryland the rural CBSA code is 99921.

PPS Activity Data--Applicable for Medicare Services.

In accordance with 42 CFR 413.20 and §1895 of the Act, HHAs transitioned from a cost-based reimbursement system to a PPS effective for home health services rendered on or after October 1, 2000.

The statistics required on this worksheet pertain to home health services furnished on or after October 1, 2000. The data to be maintained, depending on the services provided by the agency, includes the number of aggregate program visits furnished in each episode of care payment category for each covered discipline, the corresponding aggregate program charges imposed in each episode of care payment category for each covered discipline, total visits and total charges for each episode of care payment category, total number of episodes and total number of outlier episodes for each episode of care payment category, and total medical supply charges for each episode of care payment category.

HHA Visits--See CMS Pub. 15-2, chapter 32, §3205, for the definition of an HHA visit.

Episode of Care--Under home health PPS the 60-day episode is the basic unit of payment where the episode payment is specific to one individual beneficiary. Beneficiaries are covered for an unlimited number of non-overlapping episodes. The duration of a full-length episode will be 60 days. An episode begins with the start of care date and must end by the 60th day from the start of care.

Less than a full Episode of Care--When four or fewer visits are provided by the HHA in a 60-day episode period, the result is a low utilization payment adjustment (LUPA). In this instance, the HHA will be reimbursed based on a standardized per visit payment.

An episode may end before the 60th day in the case of a beneficiary elected transfer, or a discharge and readmission to the same HHA (including for an intervening inpatient stay). This type of situation results in a partial episode payment (PEP) adjustment.

Use lines 21 through 32 to identify the number of visits and the corresponding visit charges for each discipline for each episode payment category. Lines 33 and 35 identify the total number of visits and the total corresponding charges, respectively, for each episode payment category. Line 36 identifies the total number of episodes completed for each episode payment category. Line 37 identifies the total number of outlier episodes completed for each episode payment category. Outlier episodes do not apply to 1) Full Episodes without Outliers and 2) LUPA Episodes. Line 38 identifies the total medical supply charges incurred for each episode payment category. Column 5 displays the sum total of data for columns 1 through 4. The statistics and data required on this worksheet are obtained from the PS&R report.

When an episode of care is initiated in one fiscal year and concludes in the subsequent fiscal year, all statistical data, e.g., cost, charges, counts, etc.,) associated with that episode of care will appear on the PS&R of the fiscal year in which the episode of care is concluded. Similarly, all data required in the cost report for a given fiscal year must only be associated with services rendered during episodes of care that conclude during the fiscal year. Title XVIII visits reported on this worksheet will not agree with the title XVIII visits reported on Worksheet H-3, sum of columns 2 and 3, line 14.

Columns 1 through 4--Enter data pertaining to title XVIII patients only. Enter, as applicable, in the appropriate columns 1 through 4, lines 21 through 32, the number of aggregate program visits furnished in each episode of care payment category for each covered discipline and the corresponding aggregate program visit charges imposed for each covered discipline for each episode of care payment category. The visit counts and corresponding charge data are mutually exclusive for all episode of care payment categories. For example, visit counts and the corresponding charges that appear in column 4 (PEP only Episodes) will not include any visit counts and corresponding charges that appear in column 3 (LUPA Episodes) and vice versa. This is true for all episode of care payment categories in columns 1 through 4.

Line 33--Enter in columns 1 through 4 for each episode of care payment category, the sum total of visits from lines 21, 23, 25, 27, 29 and 31.

Line 34--Enter in columns 1 through 4 for each episode of care payment category, the charges for services paid under PPS and not identified on any previous lines.

Line 35--Enter in columns 1 through 4 for each episode of care payment category, the sum total of visit charges from lines 22, 24, 26, 28, 30, 32 and 34.

Line 36--Enter in columns 1 through 4 for each episode of care payment category, the total number of episodes (standard/non-outlier) of care rendered and concluded in the provider's fiscal year.

Line 37--Enter in columns 2 and 4 for each episode of care payment category identified, the total number of outlier episodes of care rendered and concluded in the provider's fiscal year. Outlier episodes do not apply to columns 1 and 3 (Full Episodes without Outliers and LUPA Episodes, respectively).

NOTE: Line 36 and 37 are mutually exclusive.

Line 38--Enter in columns 1 through 4 for each episode of care payment category, the total non-routine medical supply charges for services rendered and concluded in the provider's fiscal year.

Column 5--Enter on lines 21 through 37, the sum total of amounts from columns 1 through 4.

4007. WORKSHEET S-5 - HOSPITAL RENAL DIALYSIS DEPARTMENT 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 the renal dialysis department. The data maintained, depending on the services provided by the hospital, includes patient data, the number of treatments, number of stations, and home program data.

If you have more than one renal dialysis department, submit one Worksheet S-5 combining all of the renal dialysis departments' data. You must also have on file (as supporting documentation), a Worksheet S-5 for each renal dialysis department and the appropriate workpapers. File this documentation with exception requests in accordance with CMS Pub. 15-1, chapter 27, §2720. Also enter on the combined Worksheet S-5 the applicable data for each renal dialysis satellite for which you are separately certified (that is, a satellite for which you were issued a satellite CCN).

Section 153(b) of MIPPA amended section 1881(b) of the Act to require the implementation of an ESRD bundled payments system effective January 1, 2011. This new payment system is effectuated on Worksheets I-4 and I-5 (sections 4051 and 4052).

Column Descriptions

Columns 1 and 2--Include in these columns information regarding outpatient hemodialysis patients. **Do not include information regarding intermittent peritoneal dialysis.** In column 2, report information if you are using high flux dialyzers.

Columns 3 through 6--Report information concerning the provider's training and home programs. **Do not include intermittent peritoneal dialysis information in columns 3 and 5**.

Line Descriptions

Line 1--Enter the number of patients receiving dialysis at the end of the cost reporting period.

Line 2--Enter the average number of times patients receive dialysis per week. For CAPD and CCPD patients, enter the number of exchanges per day.

Line 3--Enter the average time for furnishing a dialysis treatment.

Line 4--Enter the average number of exchanges for CAPD.

Line 5--Enter the number of days dialysis is furnished during the cost reporting period.

Line 6--Enter the number of stations used to furnish dialysis treatments at the end of the cost reporting period.

Line 7--Enter the number of treatments furnished per day per station. This number represents the number of treatments that the facility can furnish not the number of treatments actually furnished.

Line 8--Enter your utilization. Compute this number by dividing the number of treatments furnished by the product of lines 5, 6, and 7. This percentage cannot exceed 100 percent.

Line 9--Enter the number of times your facility reuses dialyzers. This number is the average number of times patients reuse a dialyzer. If none, enter zero.

Line 10--Enter the percentage of patients that reuse dialyzers.

Line 10.01--Indicate whether your facility qualified and was approved as a low-volume facility for this cost reporting period. CMS adjusts the base rate for low-volume ESRD facilities. In order to receive this low-volume adjustment, a facility must attest in accordance with 42 CFR 413.232(f). Effective for cost reporting periods ending on or after June 30, 2015, if you operate multiple renal dialysis departments or home program dialysis departments and one of those facilities is eligible for low-volume, respond yes to this question and complete line 23.

Line 10.02--Indicate if your facility elected 100 percent PPS effective January 1, 2011. Enter "Y" for yes or "N" for no. This election must have been received by the ESRD facility's contractor by November 1, 2010. Requests received after this date will not be accepted regardless of postmark or delivery date.

New providers: ESRD facilities certified for Medicare participation on or after January 1, 2011, are paid based on 100 percent of the ESRD PPS payment. ESRD facilities certified for Medicare participation on or after January 1, 2011, enter "Y" for yes.

Line 10.03--If your facility did not elect to be paid based on 100 percent of the ESRD PPS payment and your cost reporting period is a December 31 fiscal year end, enter the transition period in column 2 as follows: For the fiscal year ending December 31, 2011, enter 1; for the fiscal year ending December 31, 2012, enter 2; for the fiscal year ending December 31, 2013, enter 3; and, for the fiscal year ending December 31, 2014, enter 4 for 100 percent ESRD PPS payment. Column 1 will be blank.

If your cost reporting period ends on a date other than December 31, indicate in column 1 the transition period effective for the portion of the cost reporting period prior to January 1. Indicate in column 2 the transition period effective for the portion of the cost reporting period on and after January 1. For example, a cost reporting period with a fiscal year ending October 31 would indicate the applicable transition periods as follows:

> Fiscal year ending October 31, 2011: Leave column 1 blank as this would be pre-bundled ESRD PPS, and enter 1 in column 2 for the period of January 1, 2011, through October 31, 2011.
> Fiscal year ending October 31, 2012: Enter 1 in column 1 for the period of November 1, 2011, through December 31, 2011, and enter 2 in column 2 for the period of January 1, 2012, through October 31, 2012.
> Fiscal year ending October 31, 2013: Enter 2 in column 1 for the period of November 1, 2012, through December 31, 2012, and enter 3 in column 2 for the period of January 1, 2013, through October 31, 2013.
> Fiscal year ending October 31, 2014: Enter 3 in column 1 for the period of November 1, 2013, through December 31, 2013, and enter 4 in column 2 for the period of January 1, 2014, through October 31, 2014.

For all cost reporting periods beginning on or after January 1, 2014, enter 4 in column 2 for 100 percent ESRD PPS payment. Column 1 will be blank.

Payments during the transition period 1 are a blend of 25 percent case-mix adjusted ESRD PPS and 75 percent basic case-mix adjusted composite rate (25/75). Payments during the transition period 2 are a blend of 50 percent case-mix adjusted ESRD PPS and 50 percent basic case-mix adjusted composite rate (50/50). Payments during the transition period 3 are a blend of 75 percent case-mix adjusted ESRD PPS and 25 percent basic case-mix adjusted composite rate (75/25). Payments for services rendered on and after January 1, 2014, are 100 percent ESRD PPS.

Line 11--Enter the number of patients who are awaiting a transplant at the end of the cost reporting period.

Line 12--Enter the number of patients who received a transplant during the fiscal year.

Line 13--Enter the direct product cost net of discount and rebates for Epoetin (EPO). Include all EPO cost for patients receiving outpatient, home (Method I or II (claims that would have been processed as Method II are processed as Method I for services rendered on or after January 1, 2011)), or training dialysis treatments. This amount includes EPO cost furnished in the renal department or any other department if furnished to an end stage renal disease dialysis patient. Report on this line the amount of EPO cost included in line 74 of Worksheet A. Effective for cost reporting periods ending after December 31, 2012, do not use this line; report these costs on line 22 (and subscripts), column 2.

Line 14--Based on the instructions contained on line 13, enter the amount of EPO included on line 94 (home dialysis program) from Worksheet A. Effective for cost reporting periods ending after December 31, 2012, do not use this line; report these costs on line 22 (and subscripts), column 3.

Erythropoiesis-Stimulating Agents (ESA) Statistics--Effective January 1, 2005, and prior to January 1, 2011, Medicare paid for ESAs based on the Average Sales Price Drug Pricing File. Effective January 1, 2011, payment for ESAs is included in the ESRD PPS payment.

Line 15--Enter the number of EPO units furnished relating to the renal dialysis department. Effective for cost reporting periods ending after December 31, 2012, do not use this line; report the number of ESA units furnished on line 22 (and subscripts), column 4.

Line 16--Enter the number of EPO units furnished relating to the home dialysis program. Effective for cost reporting periods ending after December 31, 2012, do not use this line; report the number of ESA units furnished on line 22, (and subscripts), column 5.

Line 17--Enter the direct product cost net of discount and rebates for darbepoetin alfa (Aranesp) Include all Aranesp cost for patients receiving outpatient, home (Method I or II (claims that would have been processed as Method II are processed as Method I for services rendered on or after January 1, 2011)), or training dialysis treatments. This amount includes Aranesp cost furnished in the renal department or any other department if furnished to an end stage renal disease dialysis patient. Report on this line the amount of Aranesp cost included in line 74 of Worksheet A. Effective for cost reporting periods ending after December 31, 2012, do not use this line; report these costs on line 22 (and subscripts), column 2.

Line 18--Based on the instructions contained on line 17, enter the dollar amount of Aranesp included on line 94 (home dialysis program) from Worksheet A. Effective for cost reporting periods ending after December 31, 2012, do not use this line; report these costs on line 22 (and subscripts), column 3.

Line 19--Enter the number of micrograms of Aranesp furnished relating to the renal dialysis department. Effective for cost reporting periods ending after December 31, 2012, do not use this line; report the number of ESA units furnished on line 22 (and subscripts), column 4.

Line 20--Enter the number of micrograms of Aranesp furnished relating to the home dialysis program. Effective for cost reporting periods ending after December 31, 2012, do not use this line; report the number of ESA units furnished on line 22 (and subscripts), column 5.

Line 21--Identify how physicians are paid for medical services provided to Medicare beneficiaries. Under the monthly capitation payment (MCP) methodology, contractors pay physicians for their Part B medical services. Under the initial method, the renal facility pays for physicians' Part B medical services. The facility's payment rate is increased in accordance with 42 CFR 414.313. There are a limited number of facilities electing this method.

Line 22--Identify each ESA separately on line 22 and subscripts. Complete this line effective for cost reporting periods ending after December 31, 2012. Enter in column 1, the name of the ESA

administered to renal dialysis patients. Enter in column 2, the direct product cost net of discounts and rebates for ESAs administered to renal dialysis patients. These costs are included in line 74 of Worksheet A. Include all ESA costs for patients receiving outpatient, home, or training dialysis treatments. This amount includes ESA costs furnished in the renal department or any other department if furnished to an end stage renal disease dialysis patient. Enter in column 3 the direct product cost net of discounts and rebates for ESAs administered to home dialysis patients. These costs are included in line 94 of Worksheet A.

Include all ESA costs for patients receiving self-care home dialysis treatments. This amount includes ESA costs furnished in the home dialysis program for an end stage renal disease dialysis patient. Enter in column 4, the total ESA units furnished to renal dialysis department patients during the cost reporting period. Enter in column 5, the total ESA units furnished to home program dialysis patients during the cost reporting period.

Line 23--If line 10.01 is yes, for cost reporting periods ending on or after June 30, 2015, enter on this line, and any applicable subscripts, the CCN and treatments for each renal facility. If this facility operates a renal dialysis facility (CCN XX-2300 through XX-2499), a renal dialysis satellite (CCN XX-3500 through XX-3699), and/or a special purpose renal dialysis facility (CCN XX-3700 through XX-3799), subscript this line and enter in column 1 each CCN from Worksheet S-2, Part I, line 18, and its subscripts. Enter in column 2, the total treatments corresponding to each CCN identified in column 1. The sum of all treatments reported on this line and its subscripts, column 2, must equal the total treatments reported on Worksheet I-4, line 12, column 1, for the renal dialysis department, plus the total treatments reported on Worksheet I-4, line 12, column 1, for the home program dialysis department.

4008. WORKSHEET S-6 - HOSPITAL-BASED COMMUNITY MENTAL HEALTH CENTER AND OTHER OUTPATIENT REHABILITATION PROVIDER STATISTICAL DATA

In accordance with 42 CFR 413.20(a), 42 CFR 413.24(a), and 42 CFR 413.24(c), maintain statistical records for proper determination of costs payable under the Medicare program. The statistics reported on this worksheet pertain to hospital-based community mental health centers (CMHCs), comprehensive outpatient rehabilitation facilities (CORFs), outpatient rehabilitation facilities (ORFs) which generally furnishes outpatient physical therapy (OPT), outpatient occupational therapy (OOT), or outpatient speech pathology (OSP). If you have more than one hospital-based component, complete a separate worksheet for each facility.

Additionally, only CMHCs are required to complete the corresponding Worksheet J series. However, all CMHCs, CORFs, ORFs, OPTs, OOTs, and OSPs must complete the applicable Worksheet A cost center for the purpose of overhead allocation.

This worksheet provides statistical data related to the human resources of the community mental health center. FTE data is required by employee staff, contracted staff, and total. The human resources statistics are required for each of the job categories specified on lines 1 through 17. Enter any additional categories needed on line 18.

Enter the number of hours in your normal work week in the space provided.

Report in column 1 the FTE employees on the CMHC or outpatient rehabilitation provider's payroll. These are staff for which an IRS Form W-2 was issued.

Report in column 2 the FTE contracted and consultant staff of the CMHC or outpatient rehabilitation provider.

Compute staff FTEs for column 1 as follows: Add hours for which employees were paid divided by 2080 hours, and round to two decimal places, e.g., round .04447 to .04. Compute contract FTEs for column 2 as follows. Add all hours for which contracted and consultant staff worked divided by 2080 hours, and round to two decimal places.

If employees are paid for unused vacation, unused sick leave, etc., exclude the paid hours from the numerator in the calculations.

4009. WORKSHEET S-7 - PROSPECTIVE PAYMENT FOR SKILLED NURSING FACILITIES 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. Public Law 105-33 (Balanced Budget Act of 1997) requires that all SNFs be reimbursed under PPS for cost reporting periods beginning on and after July 1, 1998.

Note: Do not complete this worksheet for cost reporting periods ending on or after October 1, 2019.

Line 1--If this facility contains a hospital-based SNF, if all patients were covered under managed care or if there was no Medicare utilization, enter "Y" for yes. If the response is yes, do not complete the rest of this worksheet.

Line 2--Does this hospital have an agreement under either section 1883 or 1913 of the Act for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter arrangement date (mm/dd/yyyy) in column 2.

Column Descriptions for Lines 3 through 200

Column 1--The case mix resource utilization group (RUGs) designations are already entered in this column.

Column 2--Enter the number of days associated with SNF services. All SNF payment data will be reported as a total amount paid under the RUG PPS payment system on Worksheet E-3, Part VI, line 1, and will be generated from the PS&R or your records.

Column 3--Enter the number of days associated with the swing beds. All swing-bed SNF payment data will be reported as a total amount paid under the RUG PPS payment system on Worksheet E-2, line 1, and will be generated from the PS&R or your records.

Column 4--Enter the sum total of columns 2 and 3.

Line 201--Enter in column 1, the CBSA code in effect at the beginning of the cost reporting period. Enter in column 2, the CBSA code in effect on or after October 1 of the current cost reporting period, if applicable.

Lines 202 through 206--A notice published in the 68 FR 46036-46072 (August 4, 2003), provided for an increase in RUG payments to hospital based SNFs for payments on or after October 1, 2003. Congress expects this increase to be used for direct patient care and related expenses. Lines 202 through 206 are identified as following: 202 - Staffing, 203 - Recruitment, 204 - Retention of Employees, 205 - Training, and 206 - Other. Enter in column 1 the direct patient care expenses and related expenses in accordance with the above referenced Federal Register citation. Enter in column 2, the ratio, expressed as a percentage, of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. For each line, indicate in column 3, whether the increased RUG payments received reflects increases associated with direct patient care and related expenses by responding "Y" for yes. Indicate "N" for no if there was no increase in spending in any of these areas. If the increased spending is in an area not previously identified in areas one through four, identify on the "Other (Specify)" line(s), the cost center(s) description and the corresponding information as indicated above.

4010. WORKSHEET S-8 - HOSPITAL-BASED RHC/FQHC 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 separate statistical records for proper determination of costs payable under the Medicare program. The statistics reported on this worksheet pertain to hospital-based RHCs/FQHCs. For each CCN reported on Worksheet S-2, Part I, line 15 and its subscripts, you must complete a separate Worksheet S-8. Hospital-based RHCs/FQHCs may elect to file a consolidated cost report pursuant to CMS Pub. 100-02, chapter 13, §80.2. Effective for cost reporting periods beginning on and after October 1, 2014, hospital-based FQHCs no longer complete Worksheet S-8 and must complete Worksheet S-11 to report statistical data.

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

Line 3--For hospital-based FQHCs only, enter your appropriate designation of "R" for rural or "U" for urban. See CMS Pub. 100-04, chapter 9, §20.6.2 for information regarding urban and rural designations. If you are uncertain of your designation, contact your contractor. Hospital-based 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--If the facility provides other than hospital-based RHC or FQHC services (e.g., laboratory or physician services), answer "Y" for yes and enter the type of operation on subscripts of line 11, otherwise enter "N" for no.

Line 11--Enter in columns 1 through 14 the starting and ending hours in the applicable columns for the days that the facility is available to provide hospital-based RHC/FQHC services. Enter the starting and ending hours in the applicable columns 1 through 14 for the days that the facility is available to provide other than hospital-based RHC/FQHC services. When entering time, do so as military time, e.g., 2:00 p.m. is 1400.

Line 12--Have you received an approval for an exception to the productivity standards? Enter a "Y" for yes or an "N" for no. For cost reporting periods ending after December 31, 2024, do not complete this line as productivity standards are no longer applicable.

Line 13--Is this worksheet prepared for a consolidated group of providers as defined in CMS Pub. 100-02, chapter 13, §80.2? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2, the number of providers included in the consolidated group, complete line 14, and complete only one M series of worksheets for the consolidated group. If column 1, is "Y", enter in column 3 a "G" if the consolidated group consists exclusively of grandfathered providers or an "N" if comprised exclusively of non-grandfathered providers.

Line 13.01--Removed and reserved.

Line 14--For each CCN reported on Worksheet S-2, Part I, line 15 and its subscripts, if line 13 is "Y" enter the clinic/center name and CCN number filing as consolidated under the component CCN listed, beginning with line 14 and subscripts of line 14, as needed.

4010.1. WORKSHEET S-11 - HOSPITAL-BASED FQHC IDENTIFICATION 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 hospital-based FQHCs and are effective for cost reporting periods beginning on or after October 1, 2014. Hospital-based FQHCs may elect to file a consolidated cost report pursuant to CMS Pub. 100-02, chapter 13, §80.2. If you have more than one hospital-based FQHC reported on Worksheet S-2, Part I, line 16, and its subscripts, complete a separate Worksheet S-11, Part I, for each, unless you have contractor approval to file a consolidated cost report.

This worksheet consists of three parts:

Part I - Hospital-Based FQHC Identification Data
Part II - Hospital-Based FQHC Consolidated Cost Report Participant Identification Data
Part III - Hospital-Based FQHC Statistical Data

4010.2. Part I - Hospital-Based FQHC Identification Data.--The information required on this worksheet is needed to properly identify the hospital-based FQHC(s) listed on Worksheet S-2, Part I, line 16, and its subscripts, or in the case of a consolidated cost report, the primary hospital-based FQHC. In the case of a consolidated cost report, only the primary FQHC completes the entire Worksheet S-11, Part I. All other hospital-based FQHCs filing under a consolidated cost report must be listed on line 9, and its subscripts, and must complete a separate Worksheet S-11, Part II.

Line 1--Enter the hospital-based FQHC site name in column 1. Indicate the type of control under which the hospital-based FQHC operates by entering a number from the list below in column 2.

1 = Voluntary Nonprofit, Corporation
2 = Voluntary Nonprofit, Other
3 = Proprietary, Individual
4 = Proprietary, Corporation
5 = Proprietary, Partnership
6 = Proprietary, Other
7 = Governmental, Federal
8 = Governmental, State
9 = Governmental, County
10 = Governmental, City
11 = Governmental, Other

Enter the date the hospital-based FQHC terminated its participation in the Medicare program (if applicable) in column 3. In column 4, enter a "V" for a voluntary termination or an "I" for an involuntary termination.

If the hospital-based FQHC changed ownership immediately prior to the beginning of the cost reporting period enter the date of the change of ownership in column 5. Also submit the name and address of the new owner and a copy of the sales agreement with the cost report.

Line 2--Enter the Hospital-based FQHC's street address in column 1 and the post office box in column 2 (if applicable).

Line 3--Enter the city in column 1, state in column 2, ZIP code in column 3, county in column 4, and the appropriate designation ("U" for urban or "R" for rural) in column 5. See CMS Pub. 100-04, chapter 9, §20.6.2, for information regarding urban and rural designations. If you are uncertain of your designation, contact your contractor.

Line 4--Indicate whether this hospital-based FQHC is owned, leased or controlled by an entity that operates multiple FQHCs. Enter a "Y" for yes or an "N" for no. If yes, complete lines 5 through 7. Otherwise, skip to line 8.

Lines 5 through 7--Enter the name of the entity that owns, leases or controls the hospital-based FQHC, the street address, post office box (if applicable), HRSA grant award number assigned to the organization, city, state, and ZIP code.

Line 8--Indicate whether this hospital-based FQHC is filing a consolidated cost report under CMS Pub. 100-02, chapter 13, §80.2. Enter "Y" for yes or "N" for no. If yes, enter in column 2, the date the hospital-based FQHC requested approval to file a consolidated cost report, in column 3, the date the contractor approved the hospital-based FQHCs request to file a consolidated cost report, and in column 4, the number of FQHCs included in this consolidated cost report other than the primary FQHC

Line 9--If the response to line 8, column 1, is yes, list on the subscripts of line 9, each hospital-based FQHC that is part of this consolidated cost report, excluding the primary hospital-based FQHC listed on line 1. Enter in column 1, the site name; column 2, the CCN; column 3, the CBSA; column 4, the date the hospital-based FQHC requested approval to file as part of a consolidated cost report; and column 5, the date the contractor approved the hospital-based FQHCs request to file as part of a consolidated cost report. Each hospital-based FQHC listed on the subscripts of line 9 must complete a separate Worksheet S-11, Part II.

Line 10--There are three types of organizations that are eligible to enroll in Medicare as a hospital-based FQHC. Indicate in column 1, the type of organization this hospital-based FQHC is by entering a number from the list below. If your response in column 1 is "1" or "3", enter any or all of the alpha character (s) associated with the response in column 2. For example, if you entered "1" in column 1, enter in column 2, "A", "B", "C" and/or "D." An organization receiving a grant under §330 of the Public Health Service (PHS) Act or an outpatient health program/facility can operate as any, or all, of the subcategories listed under the respective numeric options presented below.

1) An organization receiving a grant(s) under §330 of the PHS Act:
   A) Community Health Centers
   B) Migrant and Seasonal Agricultural Workers Health Centers
   C) Health Care for the Homeless Health Centers
   D) Health Centers for Residents of Public Housing
2) Health Center Program Look-Alikes; Organizations that have been identified by HRSA as meeting the definition of "Health Center" under §330 of the PHS Act, but not receiving grant funding under §330; or,
3) Outpatient health program/facility operated by:
   A) A tribe or tribal organization under the Indian Self-Determination Act
   B) An urban Indian organization under title V of the Indian Health Care Improvement Act
   C) Other

Line 11--Indicate if your hospital-based FQHC received a grant under §330 of the PHS Act during this cost reporting period. If this is a consolidated cost report, did the primary hospital-based FQHC reported on line 1, column 1, receive a grant under §330 of the PHS Act during this cost reporting period? Enter "Y" for yes or "N" for no.

Line 12--If the response to line 11 is yes, indicate in column 1, the type of grant that was awarded from the list below. Enter the date of the grant award in column 2 and enter the grant award number in column 3. If you received more than one grant subscript this line accordingly.

1 = Community Health Center (§330(e), PHS Act)
2 = Migrant and Seasonal Agricultural Workers Health Center (§330(g), PHS Act)
3 = Health Care for the Homeless Health Centers (§330(h), PHS Act)
4 = Health Centers for Residents of Public Housing (§330(i), PHS Act)
5 = Other

Line 13--Indicate if your hospital-based FQHC submitted an initial deeming or annual redeeming application for medical malpractice coverage to HRSA under the Federal Tort Claims Act (FTCA). Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the effective date of coverage in column 2.

Line 14--Indicate if the hospital-based FQHC received a THC development grant authorized under Part C of title VII of the PHS Act from HRSA for the purpose of establishing new accredited or expanded primary care residency programs. Enter "Y" for yes or "N" for no in column 1. If yes, enter the number of FTE residents your hospital-based FQHC trained using THC funding in column 2, and the total number of visits performed by such residents in column 3, during this cost reporting period.

4010.3. Part II - Hospital-Based FQHC Consolidated Cost Report Participant Identification Data--For each hospital-based FQHC that is included on Worksheet S-11, Part I, line 9, and its subscripts, a separate Worksheet S-11, Part II, must be completed in the identical sequence that the consolidated hospital-based FQHCs are reported on Worksheet S-11, Part I, line 9, and its subscripts. Do not complete this worksheet for the primary hospital-based FQHC reported on Worksheet S-11, Part I, line 1.

Line 1--Enter the hospital-based FQHC site name in column 1 and the certification date in column 2. Indicate the type of control under which the hospital-based FQHC operates by entering a number from the list below in column 3.

1 = Voluntary Nonprofit, Corporation
2 = Voluntary Nonprofit, Other
3 = Proprietary, Individual
4 = Proprietary, Corporation
5 = Proprietary, Partnership
6 = Proprietary, Other
7 = Governmental, Federal
8 = Governmental, State
9 = Governmental, County
10 = Governmental, City
11 = Governmental, Other

Enter the date the hospital-based FQHC terminated its participation in the Medicare program (if applicable) in column 4. In column 5, enter a "V" for a voluntary termination or an "I" for an involuntary termination.

If the hospital-based FQHC changed ownership immediately prior to the beginning of the cost reporting period enter the date of the change of ownership in column 6. Also submit the name and address of the new owner and a copy of the sales agreement with the cost report.

Line 2--Enter the hospital-based FQHC's street address in column 1 and the post office box in column 2 (if applicable).

Line 3--Enter the city in column 1, state in column 2, ZIP code in column 3, county in column 4, and the appropriate designation ("U" for urban or "R" for rural) in column 5. See CMS Pub. 100-04, chapter 9, §20.6.2, for information regarding urban and rural designations. If you are uncertain of your designation, contact your contractor.

Line 4--There are three types of organizations that are eligible to enroll in Medicare as a hospital-based FQHC. Indicate in column 1, the type of organization this hospital-based FQHC is by entering a number from the list below. If your response in column 1 is "1" or "3", enter any or all of the alpha characters associated with the response in column 2. For example, if you entered "1" in column 1, enter in column 2, "A", "B", "C" and/or "D". An organization receiving a grant under §330 of the PHS Act or an outpatient health program/facility can operate as any, or all, of the subcategories listed under the respective numeric options below.

1) An organization receiving a grant(s) under §330 of the PHS Act:
   A) Community Health Centers
   B) Migrant and Seasonal Agricultural Workers Health Centers
   C) Health Care for the Homeless Health Centers
   D) Health Centers for Residents of Public Housing
2) Health Center Program Look-Alikes; Organizations that have been identified by HRSA as meeting the definition of "Health Center" under §330 of the PHS Act, but not receiving grant funding under §330; or,
3) Outpatient health program/facility operated by:
   A) A tribe or tribal organization under the Indian Self-Determination Act
   B) An urban Indian organization under title V of the Indian Health Care Improvement Act
   C) Other

Line 5--Indicate if your hospital-based FQHC received a grant under §330 of the PHS Act during this cost reporting period. Enter "Y" for yes or "N" for no.

Line 6--If the response to line 5 is yes, indicate in column 1, the type of grant that was awarded from the list below. Enter the date of the grant award in column 2 and enter the grant award number in column 3. If you received more than one grant subscript this line accordingly.

1 = Community Health Center (§330(e), PHS Act)
2 = Migrant and Seasonal Agricultural Workers Health Center (§330(g), PHS Act)
3 = Health Care for the Homeless Health Center (§340(d), PHS Act)
4 = Health Centers for Residents of Public Housing ((§330(i), PHS Act)
5 = Other

Line 7--Indicate if this hospital-based FQHC submitted an initial deeming or annual redeeming application for medical malpractice coverage to HRSA under the FTCA. Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the effective date of coverage in column 2.

Line 8--Indicate if the hospital-based FQHC received a THC development grant authorized under Part C of title VII of the PHS Act from HRSA for the purpose of establishing new accredited or expanded primary care residency programs. Enter "Y" for yes or "N" for no in column 1. If yes, enter the number of FTE residents your FQHC trained using THC funding in column 2.

4010.4. Part III - Hospital-Based FQHC Statistical Data.--This part collects statistical data regarding the number and types of visits by title. If you have more than one hospital-based FQHC reported on Worksheet S-2, Part I, line 16, and its subscripts, complete a separate Worksheet S-11, Part III, for each. If you elected to file consolidated, complete one Worksheet S-11, Part III, for the primary hospital-based FQHC and all subcomponents.

Only those visits that qualify as a face-to-face encounter associated with a beneficiary receiving services under the Medicare fee for service program are included in column 2. However, visits attributable to beneficiaries enrolled in a Medicare Advantage plan must be included in column 4. For the purposes of the Medicare program, a beneficiary who receives care at a hospital-based FQHC can be seen for three types of visits:

- Medical Visit - A face-to-face encounter between an FQHC patient and one of the following: a physician, physician assistant, nurse practitioner, certified nurse midwife, visiting registered nurse, visiting licensed practical nurse, registered dietician, or certified DSMT/MNT educator.
- Medical Visit for Subsequent Illness or Injury.
- Mental Health Visit - A face-to-face encounter between an FQHC patient and one of the following practitioners: a clinical psychologist, clinical social worker, or a physician, physician assistant, nurse practitioner, certified nurse midwife, visiting registered nurse, visiting licensed practical nurse, for mental health services. In addition, the Consolidated Appropriations Act (CAA) of 2023, §4121, provides for the coverage of marriage and family therapists (MFT) and mental health counselors (MHC) for services rendered on or after January 1, 2024. (See CMS Pub. 100-2, Medicare Benefit Policy Manual, chapter 13, §40.)
- Intensive Outpatient Program (IOP) Visit - CAA of 2023, §4124, provides for the coverage of IOP services rendered on or after January 1, 2024, for visits with a practitioner as defined in Mental Health Visit.

Column 0--Use this column only when you are filing a consolidated cost report to identify each hospital-based FQHC listed on Worksheet S-11, Part I, line 9, and subscripts in the exact same order.

Columns 1 through 4--Enter the number of medical visits, mental health visits, and (for purposes of these columns) IOP visits, for each program (title V, title XVIII and title XIX) and visits paid by all other payers, e.g., private pay. Include dually eligible (Medicare/Medicaid) beneficiaries in column 2.

Line 1--Enter the number of medical visits applicable to columns 1 through 4. Each visit to the hospital-based FQHC by the beneficiary counts as a single visit, even in the case where a beneficiary returns to the hospital-based FQHC in the same day for a subsequent illness or injury. If you are filing under a consolidated cost report, line 1 must contain the medical visits exclusively for the primary CCN and you must subscript line 1 to report the number of medical visits for each additional hospital-based FQHC included in this consolidated cost report. Each subscript of line 1, column 0, must contain a corresponding CCN from Worksheet S-11, Part I, line 9, and subscripts, in the exact same order. Enter the number of medical visits applicable to columns 1 through 4, for each hospital-based FQHC listed on line 1 and its subscripts.

Line 2--Enter the total number of medical visits (sum of line 1 and its subscripts) for each applicable column.

Line 3--Enter the number of mental health visits applicable to columns 1 through 4. Each visit to the hospital-based FQHC by the beneficiary counts as a single visit, even in the case where a beneficiary returns to the hospital-based FQHC in the same day for a subsequent illness or injury. If you are filing under a consolidated cost report, line 3 must contain the mental health visits exclusively for the primary CCN and you must subscript line 3 to report the number of mental health visits for each additional hospital-based FQHC included in this consolidated cost report.

Each subscript of line 3, column 0, must contain a corresponding CCN from Worksheet S-11, Part I, line 9, and subscripts, in the exact same order. Enter the number of mental health visits applicable to columns 1 through 4, for each hospital-based FQHC listed on line 3, and its subscripts.

Line 4--Enter the total number of mental health visits (sum of line 3 and its subscripts) for each applicable column.

Line 5--Enter the number of IOP visits applicable to columns 1 through 4. Each visit to the hospital-based FQHC by a beneficiary counts as a single visit, even in the case where the beneficiary returns to the hospital-based FQHC in the same day for a subsequent illness or injury. If you are filing under a consolidated cost report, line 5 must contain the IOP visits exclusively for the primary CCN, and you must subscript line 5 to report the number of IOP visits for each additional hospital-based FQHC included in this consolidated cost report. Each subscript of line 5, column 0, must contain a corresponding CCN from Worksheet S-11, Part I, line 9, and subscripts, in the exact same order. Enter the number of IOP visits applicable to columns 1 through 4, for each hospital-based FQHC listed on line 5, and its subscripts.

Line 6--Enter the total number of IOP visits (sum of line 5 and its subscripts) for each applicable column.

Line 7.--Enter the total number of FQHC visits (sum of lines 2, 4, and 6) for each applicable column.

Column 5--Enter the sum of the total medical visits, mental health visits, and IOP visits, included in columns 1 through 4.

4011. WORKSHEET S-9 - HOSPITAL-BASED HOSPICE IDENTIFICATION DATA

In accordance with 42 CFR 418.310 hospice providers of service participating in the Medicare program are required to submit annual information for health care services rendered to Medicare beneficiaries. Also, 42 CFR 413.24(f) requires cost reports from providers on an annual basis. The data submitted on the cost reports supports management of Federal programs. The statistics required on this worksheet pertain to a hospital-based hospice. Complete a separate Worksheet S-9 for each hospital-based hospice.

4011.1 Part I - Enrollment Days for Cost Reporting Periods Beginning Before October 1, 2015.--

NOTE: Columns 1 and 2 contain the days identified in column 3 and 4. Columns 3 and 4 identify the SNF and NF days out of the total for titles XVIII and XIX.

Lines 1 through 4--Enter on lines 1 through 4 the enrollment days applicable to each level of care (LOC). Enrollment days are unduplicated days of care received by a hospice patient. A day is recorded for each day a hospice patient receives one of four levels of care. Where a patient moves from one LOC to another, count only one day of care for that patient for the last type of care rendered. For line 4, an inpatient care day should be reported only where the hospice provides or arranges to provide the inpatient care.

Line 5--Enter the total of columns 1 through 6 for lines 1 through 4.

For the purposes of the Medicare and Medicaid hospice programs, a patient electing hospice can receive only one of the following four types of care per day:

Hospice Continuous Home Care (HCHC) Day - A HCHC day is a day on which the hospice patient is not in an inpatient facility, and receives continuous care during a period of crisis in order to maintain the individual at home. A day consists of a minimum of 8 hours and a maximum of 24 hours of predominantly nursing care. For each day a beneficiary received 8 or more hours of predominantly nursing care, count the day as one HCHC day. Note: Do not count days by dividing the total hours by 24.

Hospice Routine Home Care (HRHC) Day - A HRHC day is a day on which the hospice patient is at home and not receiving HCHC.

Hospice Inpatient Respite Care (HIRC) Day - An HIRC day is a day on which the hospice patient receives care in an approved inpatient facility, to provide respite for the individual's family or other persons caring for the individual at home.

Hospice General Inpatient Care (HGIP) Day - A HGIP day is a day on which the hospice patient receives care in a Medicare certified hospice facility, hospital or SNF for pain control or acute or chronic symptom management which cannot be managed in other settings.

Column Descriptions

Column 1--Enter only the unduplicated Medicare days applicable to the four types of care. Enter on line 5 the total unduplicated Medicare days.

Column 2--Enter only the unduplicated Medicaid days applicable to the four types of care. Enter on line 5 the total unduplicated Medicaid days.

Column 3--Enter only the unduplicated days applicable to the four types of care for all Medicare hospice patients residing in a skilled nursing facility. Enter on line 5 the total unduplicated days.

Column 4--Enter only the unduplicated days applicable to the four types of care for all Medicaid hospice patients residing in a nursing facility. Enter on line 5, the total unduplicated days.

Column 5--Enter in column 5, only the days applicable to the four types of care for all other non-Medicare or Medicaid hospice patients. Enter on line 5 the total unduplicated days.

Column 6--Enter the total days for each type of care (i.e., sum of columns 1, 2, and 5). The amount entered in column 6, line 5, should represent the total days provided by the hospice.

NOTE: Convert continuous home care hours into days so that column 6, line 5, reflects the actual total number of days provided by the hospice.

4011.2 Part II - Census Data for Cost Reporting Periods Beginning Before October 1, 2015.--

NOTE: Columns 1 and 2 contain the days identified in columns 3 and 4. Columns 3 and 4 identify the SNF and NF days out of the total for titles XVIII and XIX.

Line 6--Enter the total number of patients receiving hospice care within the cost reporting period for the appropriate payer source.

The total under this line should equal the actual number of patients served during the cost reporting period for each program. Thus, if a patient's total stay overlapped two reporting periods, the stay should be counted once in each reporting period. The patient who initially elects the hospice benefit, is discharged or revokes the benefit, and then elects the benefit again within a reporting period is considered to be a new admission with a new election and should be counted twice.

A patient transferring from another hospice is considered to be a new admission and would be included in the count. If a patient entered a hospice under a payer source other than Medicare and then subsequently elects Medicare hospice benefit, count the patient once for each pay source.

The difference between line 6 and line 9 is that line 6 should equal the actual number of patients served during the reporting period for each program, whereas under line 9, patients are counted once, even if their stay overlaps more than one reporting period.

Line 7--Enter the total title XVIII Unduplicated Continuous Care hours billable to Medicare. When computing the Unduplicated Continuous Care hours, count only one hour regardless of number of services or therapies provided simultaneously within that hour.

Line 8--Enter the average length of stay for the reporting period. Include only the days for which a hospice election was in effect. The average length of stay for patients with a payer source other than Medicare and Medicaid is not limited to the number of days under a hospice election. Line 5 divided by line 6.

The statistics for a patient who had periods of stay with the hospice under more than one program is included in the respective columns. For example, patient A enters the hospice under Medicare hospice benefit, stays 90 days, revokes the election for 70 days (and thus goes back into regular Medicare coverage), then reelects the Medicare hospice benefits for an additional 45 days, under a new benefit period and dies (patient B).

Medicare patient C was in the program on the first day of the year and died on January 29 for a total length of stay of 29 days. Patient D was admitted with private insurance for 27 days, then their private insurance ended, and Medicaid covered an additional 92 days. Patient E, with private insurance, received hospice care for 87 days. The average length of stay (LOS) (assuming these are the only patients the hospice served during the cost reporting period) is computed as follows:

Medicare Days (90 & 45 & 29)	164 days
Patient (A, B & C)	
Medicare Patients	/3

Average LOS Medicare	54.67 Days
Medicaid Days Patient D (92)	92 Days
Medicaid Patient	1
Average LOS Medicaid	92 Days
Other (Insurance) Days (87 & 27)	114 Days
Other Payments (D & E)	2
Average LOS (Other)	54 Days
All Patients (90+45+29+92+87+27)	370 Days
Total number of patients	6
Average LOS for all patients	61.67 Days

Enter the hospice's average length of stay, without regard to payer source, in column 6, line 8.

Line 9--Enter the unduplicated census count of the hospice for all patients initially admitted and filing an election statement with the hospice within a reporting period for the appropriate payer source. Do not include the number of patients receiving care under subsequent election periods (see CMS Pub. 100-02, chapter 9, §20). However, the patient who initially elects the hospice benefit, is discharged or revokes the benefits, and elects the benefit again within the reporting period is considered a new admission with each new election and should be counted twice.

The total under this line should equal the unduplicated number of patients served during the reporting period for each program. Thus, you would not include a patient if their stay was counted in a previous cost reporting period. If a patient enters a hospice source other than Medicare and subsequently becomes eligible for Medicare and elects the Medicare hospice benefit, then count that patient only once in the Medicare column, even though he/she may have had a period in another payer source prior to the Medicare election. A patient transferring from another hospice is considered to be a new admission and is included in the count.

4011.3. Part III - Enrollment Days for Cost Reporting Periods Beginning On or After October 1, 2015.--This section collects unduplicated days data.

Lines 10 through 13--Enter the enrollment days applicable to each LOC in columns 1 through 3. Include dually eligible (Medicare/Medicaid) beneficiaries in column 1. Enrollment days are unduplicated days of care received by a hospice patient. Report a day for each day a hospice patient received one of four levels of care -- HCHC, HRHC, HIRC, or HGIP. When a patient was transferred from one LOC to another, count the day of transfer as one day of care at the LOC billed. Report an HIRC day on line 12, only when the hospice provided or arranged to provide the inpatient respite care.

Enter the total unduplicated days by LOC (sum of columns 1 through 3) in column 4.

Line 14--Enter the total unduplicated days (sum of lines 10 through 13) in each column, as applicable.

4011.4. Part IV - Contracted Statistical Data for Cost Reporting Periods Beginning On or After October 1, 2015.--This section collects unduplicated days data for inpatient services at a contracted facility. The days reported in Part IV are a subset of the days reported in Part III.

Lines 15 and 16--Enter the contracted inpatient service enrollment days applicable to each LOC in columns 1 through 3. Include dually eligible (Medicare/Medicaid) beneficiaries in column 1. Enrollment days are unduplicated days of care received by a hospice patient. Report a day for each day a hospice patient received HIRC or HGIP care at a contracted facility. When a patient was transferred from one LOC to another, count the day of transfer as one day of care at the LOC billed. Enter the total unduplicated days by LOC (sum of columns 1 through 3) in column 4.

4012. WORKSHEET S-10 - HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA.

Section 112(b) of the Balanced Budget Refinement Act (BBRA) requires that short-term acute care hospitals (§1886(d) of the Act) submit cost reports containing data on the cost incurred by the hospital for providing inpatient and outpatient hospital services for which the hospital is not compensated. Worksheet S-10 provides for the collection of the required data. Charity care charge data, as referenced in section 4102 of American Recovery and Reinvestment Act of 2009, may be used to calculate the EHR technology incentive payments made to §1886(d) hospitals and CAHs. Section 1886(n)(6)(B) of the Act, as added by section 602 of CAA 2016, adds subsection (d) Puerto Rico hospitals as eligible hospitals under the EHR incentive program. In addition, section 1886(r)(2) of the Act, as added by section 3133 of the ACA, requires an additional payment for uncompensated care for 1886(d) DSH eligible hospitals. Charity care charges, discounts given to uninsured patients that meet the hospital's written financial assistance policy/uninsured discount policy (hereinafter referred to as "financial assistance policy" or FAP), non-Medicare bad debt, and nonreimbursed Medicare bad debt may be used in the calculation of the UCP. CMS does not mandate the eligibility criteria that a hospital uses under its financial assistance policy. Section 1886(d) hospitals and CAHs are required to complete this worksheet.

Worksheet S-10 provides for the collection of uncompensated and indigent care data for the entire hospital complex. Effective for cost reporting periods beginning on or after October 1, 2022, Worksheet S-10 is Worksheet S-10, Part I; and, effective for cost reporting periods beginning on or after October 1, 2022, Worksheet S-10, Part II, provides for the collection of uncompensated and indigent care data for inpatient and outpatient services billable under the hospital CCN. The data reported on Part II is a subset of the data reported on Part I.

For additional information on uncompensated care and completing the Worksheet S-10, see MLN Matters SE17031 and the CMS Questions and Answers for Worksheet S-10, available on the CMS web site (cms.gov).

Definitions.--

Charity Care and Uninsured Discounts--Charity care and uninsured discounts result from a hospital's policy to provide all or a portion of medically necessary health care services free of charge to patients who meet the hospital's charity care policy or FAP. Charity care and uninsured discounts can include full or partial discounts. If a patient is not eligible for discounts under the hospital's charity care policy or FAP, then any discounts or reductions given to the standard managed care rate must not be accounted for as charity care or an uninsured discount. Discounts given to patients for prompt payment must not be included as charity care. For Medicare purposes, charity care is not reimbursable and unpaid amounts associated with charity care are not considered as an allowable Medicare bad debt. A hospital cannot claim as charity care amounts of unpaid deductibles and co-insurance for which it has received reimbursement from Medicare (reimbursed Medicare bad debt). (Additional guidance provided in the instruction for line 20.) Hospitals that received HRSA-administered Uninsured Provider Relief Fund (PRF) payments, as authorized by the Coronavirus Aid, Relief, and Economic Security (CARES) Act (Pub. L. 116-136), for services provided to uninsured COVID-19 patients, must not include the patient charges for those services. Under the terms and conditions of the PRF, payments are considered payment in full for such care or treatment.

Courtesy Allowances--Courtesy allowances are reductions in charges by a provider in the form of allowances to persons such as physicians, clergy, members of religious orders, and others as may be approved by the governing body of the provider, for services received from the provider. Courtesy allowances also include discounts for prompt payment, friends and family discounts, and employee discounts. Courtesy allowances are not charity care charges, nor are they Medicare bad debts, and must not be included on this worksheet. Reductions in charges made as employee fringe benefits, such as hospitalization and personnel health programs, are not courtesy allowances or charity care and must not be included on this worksheet.

Inferred contractual relationship--For Worksheet S-10 purposes, a contractual relationship between an insurer and a provider will be inferred where a provider accepts an amount from an insurer as payment, or partial payment, on behalf of an insured patient (for example, payments from workman's compensation funds, payments from an automobile insurer for medical benefits, or payments from an insurer for out-of-network services).

Medicare bad debt--When furnishing services to a Medicare beneficiary, a provider incurs costs in furnishing such covered services. A Medicare beneficiary may be responsible for paying a share of those costs as part of their applicable deductible and/or coinsurance amounts. When a Medicare beneficiary, or other responsible party, fails to pay the deductible and/or coinsurance amounts, the provider has incurred costs of furnishing services that are unrecovered. If the unpaid deductible and coinsurance amounts meet the criteria of 42 CFR 413.89, then these amounts may be allowable as Medicare bad debt. Amounts reimbursed as a Medicare bad debt cannot be claimed as charity care.

Non-Medicare bad debt--Charges for health services for which a hospital determines the non-Medicare patient has a financial responsibility to pay, but the non-Medicare patient does not pay. These amounts are subject to the cost-to-charge ratio (CCR). (Additional guidance provided in the instructions for lines 28 and 29.)

Nonreimbursable Medicare bad debt--The amount of allowable Medicare coinsurance and deductibles considered to be uncollectible but not reimbursed by Medicare under the requirements of 42 CFR 413.89(h). (Additional guidance provided in the instructions for lines 27 and 27.01.)

Net revenue--Actual payments received or expected to be received from a payer (including coinsurance payments from the patient) for services delivered during this cost reporting period. Net revenue will typically be charges (gross revenue) less contractual allowance. (Applies to lines 2, 9, and 13.)

Public Programs--Federal, State, and/or local government programs paying, in full or in part, for health care (e.g., Medicare, Medicaid, CHIP and/or other Federal, State, or locally operated programs).

Uncompensated care--Consists of charity care and uninsured discounts, non-Medicare bad debt, and nonreimbursable Medicare bad debt. Uncompensated care does not include courtesy allowances, discounts given to patients that do not meet the hospital's charity care policy, or discounts given to uninsured patients that do not meet the hospital's FAP, or bad debt reimbursed by Medicare.

4012.1 Part I - Hospital and Hospital Health Care Complex.--

Uncompensated and Indigent Care Cost-to-Charge Ratio--

Line 1--Enter the CCR resulting from Worksheet C, Part I, line 202, column 3, divided by Worksheet C, Part I, line 202, column 8.

For all inclusive rate no-charge-structure providers, enter your ratio as calculated in accordance with CMS Pub. 15-1, chapter 22, §2208.

Medicaid--The amounts reported on lines 2 through 8 are mutually exclusive of the amounts reported on lines 17 and 18.

Line 2--Enter the inpatient and outpatient payments received or expected for title XIX covered services delivered during this cost reporting period. Include payments for an expansion Children's Health Insurance Program (CHIP) program that covers recipients who would have been eligible for coverage under title XIX. Include payments for all covered services except physician or other professional services, and include payments received from Medicaid managed care programs. If not separately identifiable, disproportionate share (DSH) and supplemental payments are included in this line. For these payments, report the amount received or expected for the cost reporting period, net of associated provider taxes or assessments.

Line 3--Enter "Y" for yes if you received or expect to receive any DSH or supplemental payments from Medicaid relating to this cost reporting period. Otherwise enter "N" for no.

Line 4--If you answered yes to question 3, enter "Y" for yes if all of the DSH and/or supplemental payments you received from Medicaid are included in line 2. Otherwise enter "N" for no and complete line 5.

Line 5--If you answered no to question 4, enter the DSH and/or supplemental payments the hospital received or expects to receive from Medicaid relating to this cost reporting period that were not included in line 2, net of associated provider taxes or assessments.

Line 6--Enter all charges (gross revenue) for title XIX covered services delivered during this cost reporting period. These charges relate to the services for which payments were reported on line 2.

Line 7--Calculate the Medicaid cost by multiplying line 1 by line 6.

Line 8--Enter the difference between net revenue and costs for Medicaid by subtracting the sum of lines 2 and 5 from line 7. If line 7 is less than the sum of lines 2 and 5, then enter zero.

Children's Health Insurance Program--The amounts reported on lines 9 through 12 are mutually exclusive of the amounts reported on lines 17 and 18.

Line 9--Enter all payments received or expected for services delivered during this cost reporting period that were covered by a stand-alone CHIP program. Stand-alone CHIP programs cover recipients who are not eligible for coverage under title XIX. Include payments for all covered services except physician or other professional services, and include any payments received from CHIP managed care programs.

Line 10--Enter all charges (gross revenue) for services delivered during this cost reporting period that were covered by a stand-alone CHIP program. These charges relate to the services for which payments were reported on line 9.

Line 11--Calculate the stand-alone CHIP cost by multiplying line 1 by line 10.

Line 12--Enter the difference between net revenue and costs for stand-alone CHIP by subtracting line 9 from line 11. If line 11 is less than line 9, then enter zero.

Other state or local indigent care program--The amounts reported on lines 13 through 16 are mutually exclusive of the amounts reported on lines 17 and 18.

Line 13--Enter all payments received or expected for services delivered during this cost reporting period for patients covered by a state or local government indigent care program (other than Medicaid or CHIP), where such payments and associated charges are identified with specific patients and documented through the provider's patient accounting system. Include payments for all covered services, except physician or other professional services, and include payments from managed care programs.

Line 14--Enter all charges (gross revenue) for services delivered during this cost reporting period for patients covered by a state or local government program, where such charges and associated payments are documented through the provider's patient accounting system. These charges should relate to the services for which payments were reported on line 13.

Line 15--Calculate the costs for patients covered by a state or local government program by multiplying line 1 by line 14.

Line 16--Calculate the difference between net revenue and costs for patients covered by a state or local government program by subtracting line 13 from line 15. If line 15 is less than line 13, then enter zero.

Grants, donations and total unreimbursed cost for Medicaid, CHIP, and state/local indigent care--The amounts reported on lines 17 and 18 are mutually exclusive of the amounts reported on lines 2 through 16.

Line 17--Enter the value of all non-government grants, gifts and investment income received during this cost reporting period that were restricted to funding uncompensated or indigent care. Include interest or other income earned from any endowment fund for which the income is restricted to funding uncompensated or indigent care.

Line 18--Enter all grants, appropriations or transfers received or expected from government entities for this cost reporting period for purposes related to operation of the hospital, including funds for general operating support as well as for special purposes (including but not limited to funding uncompensated care). Include funds from the Federal Section 1011 program, if applicable, which helps hospitals finance emergency health services for undocumented aliens. While Federal Section 1011 funds were allotted for federal fiscal years 2005 through 2008, any unexpended funds will remain available after that time period until fully expended even after federal fiscal year 2008. If applicable, report amounts received from charity care pools net of related provider taxes or assessments. Do not include funds from government entities designated for non-operating purposes, such as research or capital projects.

Line 19--Calculate the total unreimbursed cost for Medicaid, CHIP, and state and local indigent care programs by entering the sum of lines 8, 12, and 16.

Uncompensated care cost--

Line 20--Enter the charity care charges and uninsured discount amounts determined in accordance with the hospital's charity care criteria/policy or FAP for the cost reporting period as described in A, B, or C. Do not reduce charges in columns 1 or 2 by any payments made for the patient liability (see instructions for line 22 to report payment amounts). All amounts reported on line 20, columns 1 and 2, other than amounts for deductible, coinsurance, or co-payment for hospital services, are subject to the CCR on line 1 when calculating costs on line 21. Do not include in columns 1 or 2:

- amounts that do not meet the hospital's charity care policy of FAP;
- Medicaid shortfalls, contractual allowances, or amounts for patients given courtesy allowances;
- deductible and coinsurance amounts claimed as Medicare bad debts;
- charges for physician and other professional services; and
- charges reported in a previous cost reporting period.

Effective for cost reporting periods beginning on or after October 1, 2018, a cost report is rejected when submitted without listings supporting the charity care amounts claimed on line 20 (42 CFR 413.24(f)(5)). Exhibit 3B presents the standard format for the information required to support the charity care amounts claimed and must be submitted with cost reports for periods beginning on or after October 1, 2022. (See exhibit and instructions presented at the end of §4012.7.)

A. For cost reporting periods beginning prior to October 1, 2016, and for subsection (d) Puerto Rico hospitals under §1886(n)(6)(B) for cost reporting periods beginning on or after October 1, 2016, enter the total initial payment obligation, measured at full charges, for patients, including uninsured patients, who are given a full or partial discount based on the hospital's charity care policy or FAP for medically necessary health care services delivered during this cost reporting period for the entire facility.

Column 1 (Uninsured Patients): Enter the sum of charges for:

- uninsured patients; and
- patients with coverage from an entity/insurer that does not have a contractual relationship with the provider; and
- insured patients that were determined uninsured for the entire hospital stay; and
- non-covered services provided to patients eligible for Medicaid or other indigent care programs, if such inclusion is specified in the hospital's charity care policy or FAP and the patient meets the hospital's policy criteria.

Column 2 (Insured Patients): Enter the sum of:

- amounts for deductible and coinsurance required by the payer for insured patients covered by a public program or private insurer with which the provider has a contractual relationship that were written off to charity care; and
- non-covered charges for days exceeding a length-of-stay limit for patients covered by Medicaid or other indigent care programs, if such inclusion is specified in the hospital's charity care policy or FAP and the patient meets the hospital's policy criteria (such amounts must also be included on line 25).

Column 3: Enter the sum of columns 1 and 2.

B. For cost reporting periods beginning on or after October 1, 2016, and for subsection (d) Puerto Rico hospitals under §1886(n)(6)(B) beginning on or after October 1, 2020, through cost reporting periods beginning prior to October 1, 2022, enter the actual charge amounts for the entire facility for patients, including uninsured patients who were given full or partial discounts that were determined in accordance with the hospital's charity care criteria/policy or FAP, and written off during this cost reporting period, regardless of when the services were provided.

Column 1 (Uninsured Patients): Enter the sum of:

- total charges, or the portion of the total charges for uninsured patients; and
- total charges, or the portion of total charges for patients with coverage from an entity/insurer that does not have a contractual relationship with the provider; and
- total charges, or the portion of total charges for insured patients that were determined uninsured for the entire hospital stay; and
- charges for non-covered services provided to patients eligible for Medicaid or other indigent care programs, if such inclusion is specified in the hospital's charity care policy or FAP and the patient meets the hospital's policy criteria.

NOTE FOR COLUMN 1: The total charges or the portion of total charges is the amount the patient is not responsible for paying (e.g., 100 percent of charges if the patient qualified for 100 percent discount or 70 percent of charges if the patient qualified for a 70 percent discount).

Column 2 (Insured Patients): Enter the sum of amounts written off to charity care for:

- deductible and coinsurance required by the payer for insured patients covered by a public program or private insurer with which the provider has a contractual relationship; and
- non-covered charges for days exceeding a length-of-stay limit for patients covered by Medicaid or other indigent care programs, if such inclusion is specified in the hospital's charity care policy or FAP and the patient meets the hospital's policy criteria (such amounts must also be included on line 25).

Column 3: Enter the sum of columns 1 and 2.

C. For cost reporting periods beginning on or after October 1, 2022, including subsection (d) Puerto Rico hospitals under §1886(n)(6)(B), enter the actual charges for the entire facility for patients, including uninsured patients, who were given full or partial discounts that were written off during this cost reporting period, regardless of when the services were provided.

Column 1 (Uninsured Patients): Enter amounts written off to charity care for:

- total charges, or the portion of total charges, for uninsured patients; and
- total charges, or the portion of total charges, for patients with coverage from an entity/insurer that does not have a contractual or inferred contractual relationship with the provider; and
- total charges, or the portion of total charges, for insured patients that were determined uninsured for the entire hospital stay; and
- charges for non-covered services provided to patients eligible for Medicaid or other indigent care programs, if such inclusion is specified in the hospital's charity care policy or FAP and the patient meets the hospital's policy criteria.

NOTE FOR COLUMN 1: The total charges or the portion of total charges is the amount the patient is not responsible for paying (e.g., 100 percent of charges if the patient qualified for 100 percent discount or 70 percent of charges if the patient qualified for a 70 percent partial discount).

Column 2 (Insured Patients): Enter amounts written off to charity care for:

- deductible, coinsurance, and co-payment amounts for hospital services required by the payor for insured patients covered by a public program or private insurer with which the provider has a contractual or inferred contractual relationship; and
- non-covered charges for days exceeding a length-of-stay limit for patients covered by Medicaid or other indigent care programs, if such inclusion is specified in the hospital's charity care policy or FAP and the patient meets the hospital's policy criteria (such amounts are subject to the CCR and must be included on line 25); and
- charges, or the portion of charges, other than deductible, coinsurance, and co-payment amounts that represent the insured patient's liability for medically necessary hospital services (such amounts are subject to the CCR and must be included on line 25.01). These charges include a patient's liability from a contractual or inferred contractual relationship between a public program or private insurer and the provider.

Column 3: Enter the sum of columns 1 and 2.

Line 21--Calculate the cost for charity care and uninsured discounts. In column 1, calculate the cost of uninsured patients approved for charity care and uninsured discounts by multiplying line 20, column 1, by the CCR on line 1. In column 2, calculate the cost of insured patients approved for charity care in accordance with A or B. In column 3, enter the sum of columns 1 and 2.

A. For cost reporting periods beginning prior to October 1, 2022: enter the sum of the deductibles and coinsurance not subject to the CCR on line 1 for insured patients approved for charity care (line 20, column 2, minus line 25) plus the non-covered charges for insured patients for days exceeding a length-of-stay limit that are subject to the CCR on line 1 (line 25 multiplied by line 1).

B. For cost reporting periods beginning on or after October 1, 2022, enter the sum of the deductibles and coinsurance not subject to the CCR on line 1 for insured patients approved for charity care (line 20, column 2, minus lines 25 and 25.01) plus the non-covered charges for insured patients for days exceeding a length-of-stay limit and charges for insured patients' liability that are subject to the CCR on line 1 (lines 25 and 25.01, multiplied by line 1).

Line 22--Enter payments received from patients for amounts previously written off as charity care. Payments entered on this line must not exceed charity care or uninsured discount amounts written off in the cost reporting period. Do not include:

- payments from payers;
- grants or other mechanisms of funding for charity care;
- payments for physician or other professional services; and
- payments received that represent a patient's liability, or amounts that were not previously written off on line 20 as charity care or uninsured discounts.

A. For cost reporting periods beginning prior to October 1, 2016, and for subsection (d) Puerto Rico hospitals under §1886(n)(6)(B) beginning on or after October 1, 2016, enter the sum of payments received and payments expected to be received for the entire facility from patients who have been approved for charity care or uninsured discounts for health care services delivered during this cost reporting period. In column 1, enter payments from uninsured patients and patients with coverage from an entity that does not have a contractual relationship with the provider. In column 2, enter payments from patients covered by a public program or private insurer with which the provider has a contractual relationship. In column 3, enter the sum of columns 1 and 2.

B. For cost reporting periods beginning on or after October 1, 2016, (except subsection (d) Puerto Rico hospitals under §1886(n)(6)(B) as those hospitals continue to follow the instructions in A), through cost reporting periods beginning prior to October 1, 2022, enter all payments for the entire facility received from patients during this cost reporting period, regardless of when the services were provided, for amounts previously written off on line 20 as charity care or uninsured discounts. In column 1, enter payments received from uninsured patients and patients with coverage from an entity that does not have a contractual relationship with the provider. In column 2, enter payments received from patients covered by a public program or a private insurer with which the provider has a contractual relationship. In column 3, enter the sum of columns 1 and 2.

C. For cost reporting periods beginning on or after October 1, 2022, enter the sum of payments received from patients during this cost reporting period for the entire facility for amounts previously written off on line 20 as charity care or uninsured discounts. In column 1, enter payments received from uninsured patients and patients with coverage from an entity that does not have a contractual or inferred contractual relationship with the provider. In column 2, enter payments received from patients covered by a public program or a private insurer with which the provider has a contractual or inferred contractual relationship. Payments entered on this line must not exceed charity care or uninsured discount amounts written off in the cost reporting period. In column 3, enter the sum of columns 1 and 2.

Line 23--Calculate the cost of charity care for columns 1 and 2 by subtracting line 22 from line 21. In column 1, enter the cost for uninsured patients and patients with coverage from an entity that does not have a contractual relationship (or an inferred contractual relationship for cost reporting periods beginning on or after October 1, 2022) with the provider. In column 2, enter the cost for patients covered by a public program or private insurer with which the provider has a contractual relationship (or an inferred contractual relationship for cost reporting periods beginning on or after October 1, 2022). For columns 1 and 2, if the amount on line 22 is greater than line 21, enter zero. In column 3, enter the sum of columns 1 and 2.

Line 24--Enter "Y" for yes if any charges for patient days beyond a length-of-stay limit imposed on patients covered by Medicaid or other indigent care program are included in the amount reported on line 20, column 2, and complete line 25. Otherwise, enter "N" for no.

Line 25--If you answered yes to question 24, enter charges for patient days beyond a length-of-stay limit imposed on patients covered by Medicaid or other indigent care program, if such inclusion is specified in the hospital's charity care policy or FAP and the patient meets the hospital's policy criteria, for services delivered during this cost reporting period. The charges entered on this line are subject to the CCR and must also be reported in the amount on line 20, column 2.

Line 25.01--For cost reporting periods beginning on or after October 1, 2022, enter the charges that represent the insured patient's liability for medically necessary hospital services, other than deductible, coinsurance, and co-payment amounts. The charges entered on this line are subject to the CCR and must also be reported in the amount on line 20, column 2.

Line 26--For cost reporting periods beginning prior to October 1, 2022, enter the amount of bad debts (Medicare bad debts and non-Medicare bad debts), net of recoveries, written off during this cost reporting period on balances owed by patients for the entire facility regardless of the date of service. Do not include:

- bad debts for physician and other professional services; and
- amounts from line 20; and
- amounts for privately insured patients that were the obligation of an insurer rather than the patient.

For cost reporting periods beginning on or after October 1, 2022, enter the amount of Medicare and non-Medicare bad debts/implicit price concessions (pursuant to the Accounting Standards Update, Topic 606) written off during this cost reporting period, net of recoveries, that relate to balances owed by patients, regardless of the date of service, for the entire facility. Submit Exhibit 3C to support the bad debt amount claimed. Do not include:

- bad debts for physician and other professional services; and
- amounts from line 20; and
- amounts for privately insured patients that were the obligation of an insurer rather than the patient.

Line 27--Enter the Medicare reimbursable (also referred to as adjusted) bad debts, for the entire facility, including PARHM demonstration, pursuant to 42 CFR 413.89(h). The amount must be the sum of the amounts reported on Worksheets E, Part A, line 65; E, Part B, line 35; E-2, line 17, columns 1 and 2 (line 17.01, columns 1 and 2, for cost reporting periods that begin on or after October 1, 2012); E-3, Part I, line 12; E-3, Part II, line 24; E-3, Part III, line 25; E-3, Part IV, line 15; E-3, Part V, line 26; E-3, Part VI, line 10; I-5, line 11; H-4, line 27.01, column 2; J-3, line 21 (line 22 for cost reporting periods that begin on or after October 1, 2012); M-3, line 23 (line 23.01 for cost reporting periods that begin on or after October 1, 2012); and N-4, line 10.

Line 27.01-- Enter the Medicare allowable bad debts, for the entire facility, including PARHM demonstration. The amount must be the sum of the amounts reported on Worksheets E, Part A, line 64; E, Part B, line 34; E-2, line 17, columns 1 and 2; E-3, Part I, line 11; E-3, Part II, line 23; E-3, Part III, line 24; E-3, Part IV, line 14; E-3, Part V, line 25; E-3, Part VI, line 8; H-4, line 27, column 2; I-5, line 5.05, column 2; J-3, line 21; M-3, line 23; and N-4, line 9.

Line 28--For cost reporting periods beginning before October 1, 2013, calculate the non-Medicare bad debt amount by subtracting line 27 from line 26. For cost reporting periods beginning on or after October 1, 2013, calculate the non-Medicare bad debt amount by subtracting line 27.01 from line 26.

Line 29--Calculate the non-Medicare and nonreimbursable Medicare bad debt amount.

A. For cost reporting periods beginning before October 1, 2013, calculate the non-Medicare and nonreimbursable Medicare bad debt amount by multiplying line 28 by the CCR on line 1.

B. For cost reporting periods beginning on or after October 1, 2013, calculate the non-Medicare and nonreimbursable Medicare bad debt amount as the sum of:

- non-Medicare bad debt amount on line 28 multiplied by the CCR on line 1, plus
- nonreimbursable Medicare bad debt amount calculated by subtracting line 27 from line 27.01 (this amount is not multiplied by the CCR on line 1).

Line 30--Calculate the cost of uncompensated care by entering the sum of line 23, column 3, and line 29.

Line 31--Calculate the cost of unreimbursed and uncompensated care as the sum of lines 19 and 30.

4012.2 Part II - Hospital.--This part provides for the collection of uncompensated and indigent care data only for inpatient and outpatient services billable under the 1886(d) hospital CCN. The data reported on this part is a subset of the data reported on Part I. For a cost reporting period beginning on or after October 1, 2022, an §1886(d) hospital, including a subsection (d) Puerto Rico hospital under §1886(n)(6)(B), reports uncompensated and indigent care data for the hospital CCN only. Do not include data for services provided by any other part of the hospital complex, e.g., psychiatric unit, SNF, HHA, ESRD, etc. Do not complete this Part II if the hospital is a CAH.

Uncompensated and Indigent Care Cost-to-Charge Ratio--

Line 1--Enter the CCR resulting from Worksheet C, Part I, line 202, column 3, minus lines 40, 41, 42, 44, 45, 46, 88, 89, 94, 99, 101, 115, and 116, column 3; divided by Worksheet C, Part I, line 202, column 8, minus lines 40, 41, 42, 44, 45, 46, 88, 89, 94, 99, 101,115, and 116, column 8.

For all inclusive rate no-charge-structure providers, enter your ratio as calculated in accordance with CMS Pub. 15-1, chapter 22, §2208.

Lines 2 through 19--Do not complete.

Uncompensated care cost--

Line 20--Enter, in columns 1 and 2, the portion of the charity care charges and uninsured discount amounts reported on Worksheet S-10, Part I, line 20, for the general short-term hospital inpatient and outpatient services billed under the hospital CCN. In column 3, enter the sum of columns 1 and 2.

Line 21--Calculate the cost for charity care and uninsured discounts. In column 1, calculate the cost of uninsured patients approved for charity care and uninsured discounts by multiplying line 20, column 1, by the CCR on line 1. In column 2, enter the cost of insured patients approved for charity care calculated as the sum of the deductibles and coinsurance not subject to the CCR on line 1 for insured patients approved for charity care (line 20, column 2, minus lines 25 and 25.01) plus the non-covered charges for insured patients for days exceeding a length-of-stay limit and charges for insured patients' liability that are subject to the CCR on line 1 (lines 25 and 25.01, multiplied by line 1). In column 3, enter the sum of columns 1 and 2.

Line 22--Enter, in columns 1 and 2, the portion of the payments reported on Worksheet S-10, Part I, line 22, for the general short-term hospital inpatient and outpatient services billed under the hospital CCN. In column 3, enter the sum of columns 1 and 2.

Line 23--Calculate the cost of charity care for columns 1 and 2 by subtracting line 22 from line 21. For columns 1 and 2, if the amount on line 22 is greater than line 21, enter zero. In column 3, enter the sum of columns 1 and 2.

Line 24--Enter "Y" for yes if any charges for patient days beyond a length-of-stay limit imposed on patients covered by Medicaid or other indigent care program are included in the amount reported on line 20, column 2, and complete line 25. Otherwise, enter "N" for no.

Line 25--If you answered yes to question 24, enter the portion of the charges reported on Worksheet S-10, Part I, line 25, for the general short-term hospital inpatient and outpatient services billed under the hospital CCN. The charges entered on this line are subject to the CCR and must also be reported in the amount on line 20, column 2.

Line 25.01--Enter the portion of the charges reported on Worksheet S-10, Part I, line 25.01, for the general short-term hospital inpatient and outpatient services billed under the hospital CCN. The charges entered on this line are subject to the CCR and must also be reported in the amount on line 20, column 2.

Line 26--Enter the portion of the charges reported on Worksheet S-10, Part I, line 26, for the general short-term hospital inpatient and outpatient services billed under the hospital CCN.

Line 27--Enter the Medicare reimbursable (also referred to as adjusted) bad debts, including PARHM demonstration, pursuant to 42 CFR 413.89(h). The amount reported must be the sum of the amounts reported on the hospital Worksheet E, Part A, line 65; PARHM demonstration Worksheet E, Part A, line 65; the hospital Worksheet E, Part B, line 35; and PARHM demonstration Worksheet E, Part B, line 35.

Line 27.01--Enter the Medicare allowable bad debts, including PARHM demonstration. The amount reported must be the sum of the amounts reported on the hospital Worksheet E, Part A, line 64; the PARHM demonstration Worksheet E, Part A, line 64; the hospital Worksheet E, Part B, line 34; and the PARHM demonstration Worksheet E, Part B, line 34.

Line 28--Calculate the non-Medicare bad debt amount by subtracting line 27.01 from line 26.

Line 29--Calculate the non-Medicare and nonreimbursable Medicare bad debt amount as the sum of:

- non-Medicare bad debt amount on line 28 multiplied by the CCR on line 1, plus
- nonreimbursable Medicare bad debt amount calculated by subtracting line 27 from line 27.01 (this amount is not multiplied by the CCR on line 1).

Line 30--Calculate the cost of uncompensated care by entering the sum of line 23, column 3, and line 29.

Line 31--Calculate the cost of unreimbursed and uncompensated care as the sum of line 19 and line 30.

Exhibit 3B -- Charity Care Listing Instructions and Form

Exhibit 3B presents the charity care listing information required to support the charity care amounts claimed on Worksheet S-10, Part I, line 20, and must be submitted with cost reports for cost reporting periods beginning on or after October 1, 2022. For each CCN in the hospital healthcare complex, submit a listing of patients, identified as uninsured or insured, that received charity care.

Enter dates in the MM/DD/YYYY format.

If a SCH is eligible to receive a DSH payment adjustment but Worksheet E, Part A, line 48, is greater than line 47, do not complete an Exhibit 3B listing; however, if Worksheet E, Part A, line 47, is greater than line 48, the SCH must submit an Exhibit 3B listing.

The sum of column 20 amounts for uninsured patients (insurance status code 1 or 2) on charity care listings for all of the hospital and hospital healthcare complex CCNs must equal Worksheet S-10, Part I, line 20, column 1. The sum of column 20 amounts for insured patients (insurance status code 3) on charity care listings for all of the hospital and hospital healthcare complex CCNs must equal Worksheet S-10, Part I, line 20, column 2. The sum of column 20 amounts for uninsured patients on the charity care listing for the hospital CCN must equal Worksheet S-10, Part II, line 20, column 1; and the sum of column 20 amounts for insured patients must equal Worksheet S-10, Part II, line 20, column 2.

Enter the provider name, hospital CCN and component CCN (only if the listing presents the charity care for a component of the hospital), CRP beginning and ending dates, the name of the preparer and the date prepared. Also enter the sum of the uninsured amounts (insurance status 1 or 2) in column 20, and the sum of the insured amounts (insurance status 3) in column 20.

Columns 1, 2, 3, 4, and 5--From the patient's bill, enter the patient's last name, first name, dates of service, and patient account or identification number that correlate to the claimed charity care charges.

Column 6--Enter 1, 2, or 3, to indicate the patient's insurance status at the time services were provided, as follows:

- Enter 1 to indicate the patient was uninsured (did not have any insurance coverage).
- Enter 2 to indicate the patient was insured but not covered when the patient:
  - had insurance coverage through an insurance company with which you do not have a contractual relationship,
  - had insurance coverage and the services provided were medically necessary but not covered,
  - had insurance coverage and the patient had exhausted their benefits, or
  - had general coverage through Medicaid but was not covered for this particular stay due to exhausted benefits or noncoverage.
- Enter 3 to indicate the patient was insured.

Column 7--For insured patients, enter the name of the primary payor, e.g., Medicaid, HMO Medicaid, BCBS, Aetna, State Farm, etc., regardless of whether you have a contractual (or inferred contractual) relationship with the insurer.

Column 8--For insured patients, enter the name of the secondary payor (e.g., Medicaid, HMO Medicaid, BCBS, Aetna, State Farm, etc.), regardless of whether you have a contractual (or inferred contractual) relationship with the insurer.

Column 9--Enter the total charges (excluding physician/professional charges) for the claim that correlates to the claimed charity care charges.

Column 10--If the total charges in column 9 include amounts for physician/professional charges, enter those physician/professional charges in this column.

Column 11--Enter the amount of deductible, coinsurance, and copayment owed by the patient according to their medical insurance coverage, if applicable.

Column 12--Enter the total amounts received from third party payors (any entity paying medical claims on behalf of the insured such as government agencies, insurance companies, and HMOs).

Column 13--Complete this column only for insured patients; do not complete this column for uninsured patients. Enter the amount of the contractual allowance for the insured patient (i.e. the difference between the hospital's billed charges and the amount contractually paid by an insurer after deductible and coinsurance for an insured patient, if applicable). Report the sum of contractual allowance amounts for primary and secondary payors, if applicable.

Column 14--Enter the sum of other unpaid non-allowable amounts including:

- non-covered charges for medically necessary services not included in the hospitals written charity care policy or FAP
- non-covered charges for services not medically necessary
- courtesy discounts
- administrative adjustments
- denial adjustments

Column 15--Enter all payments received from patients (or individuals responsible for payment). (Charity care is determined as column 9 minus columns 10, 12, 13, 14, 15, and 16, and is reported in column 17, 18, or 19).

Column 16--Enter the amounts written off as a patient bad debt (i.e., written off as a bad debt or implicit price concession) against the A/R (considered a reduction in revenue) in the provider's financial accounting system, regardless of the date, for this claim.

Column 17--Complete this column only for uninsured patients; do not complete this column for insured patients. Enter the amount of the uninsured discount given to the uninsured patient pursuant to the hospital's written charity care policy or FAP.

Column 18--For insured patients, enter the portion of the medically necessary non-covered charges considered for charity care, if such inclusion is specified in the hospital's written charity care policy or FAP and the patient meets the hospital's policy criteria, as follows:

- enter the charges for non-covered services provided to patients eligible for Medicaid or other indigent care programs.
- enter the charges for non-covered days exceeding a length-of-stay limit for patients covered by Medicaid or other indigent care programs.
- enter the portion of charges where the patient has exhausted their benefits.

Column 19--Enter any other allowable charges (not reported in column 17 or column 18) and written off as charity care pursuant to the provider's written charity care policy or FAP.

Column 20--Enter the sum of the amounts in columns 17, 18, and 19.

Column 21-- Enter the date the charity care amount or uninsured discount was written off.

EXHIBIT 3B

TITLE	CHARITY CARE CHARGES
PROVIDER NAME	
HOSPITAL CCN	
COMPONENT CCN	
CRP BEGINNING DATE	
CRP ENDING DATE	
PREPARED BY	
DATE PREPARED	
UNINSURED COLUMN 20	
INSURED COLUMN 20	

PATIENT CLAIM INFORMATION										
PATIENT NAME - LAST	PATIENT NAME - FIRST	DATE OF SERVICE - FROM	DATE OF SERVICE - TO	PATIENT ACCOUNT NUMBER	INSURANCE STATUS	PRIMARY PAYOR	SECONDARY PAYOR	TOTAL CHARGES FOR CLAIM	PHYSICIAN / PROFES-SIONAL CHARGES	DEDUCT-IBLE / COINSUR / COPAY AMOUNTS
1	2	3	4	5	6	7	8	9	10	11

TOTAL THIRD PARTY PAYMENTS	INSURED CONTRAC-TUAL ALLOWANCE AMOUNT	OTHER NON-ALLOWABLE AMOUNTS	TOTAL PATIENT PAYMENTS	AMOUNTS WRITTEN OFF AS BAD DEBT	UNINSURED DISCOUNT AMOUNTS	CHARITY CARE NON-COVERED CHARGES	OTHER CHARITY CARE CHARGES	AMOUNTS WRITTEN OFF TO CHARITY CARE AND UNINSURED DISCOUNTS	WRITE OFF DATE
12	13	14	15	16	17	18	19	20	21

Exhibit 3C -- Listing of Total Bad Debts Instructions and Form

For cost reporting periods beginning on or after October 1, 2022, IPPS hospitals eligible for DSH and UCC must complete an Exhibit 3C listing to support the amount of Medicare and non-Medicare bad debts, or implicit price concessions, reported on Worksheet S-10, Part I, line 26.

If a SCH is eligible to receive a DSH payment adjustment but Worksheet E, Part A, line 48, is greater than line 47, do not complete an Exhibit 3C listing; however, if Worksheet E, Part A, line 47, is greater than line 48, the SCH must submit an Exhibit 3C listing.

Complete a separate exhibit for the hospital and each component of the hospital complex (each CCN) and, on each listing, report only the data related to inpatient and outpatient services billed under that CCN. The sum of the amounts in column 17 for all the CCNs of the hospital complex bad debt listings must correspond to the amount reported on Worksheet S-10, Part I, line 26. The sum of the amounts in column 17 for the hospital CCN bad debt listing must correspond to the amount reported on Worksheet S-10, Part II, line 26. The bad debt of a Medicare beneficiary may be included on this listing even when their unpaid deductible and coinsurance amounts do not meet the Medicare bad debt criteria for inclusion on the Medicare bad debt listing (not included on Worksheet E, Parts A or B) for this cost reporting period.

Enter dates in the MM/DD/YYYY format.

Exhibit 3C requires the following information:

Enter the provider name, hospital CCN (even when the listing presents the bad debts for a component of the hospital), component CCN (only if the listing presents the bad debts for the component of the hospital), CRP beginning and ending dates, name of the preparer, date prepared, and sum of the amounts in column 17.

Columns 1, 2, 3, 4, and 5--From the patient's bill, enter the patient's last name, first name, dates of service, and patient account or identification number that correlate to the claimed bad debt.

Column 6--Enter 1, 2, or 3, to indicate the patient's insurance status at the time services were provided, as follows:

- Enter 1 to indicate the patient was uninsured (did not have any insurance coverage).
- Enter 2 to indicate the patient was insured but not covered when the patient:
  - had insurance coverage through an insurance company with which you do not have a contractual relationship,
  - had insurance coverage and the services provided were medically necessary but not covered, or
  - had insurance coverage and the patient had exhausted their benefits.
- Enter 3 to indicate the patient was insured.

Column 7--Enter the patient's primary payor at the time services were provided, e.g., BCBS, AARP, or Medicare.

Column 8--Enter the patient's secondary payor at the time services were provided, e.g., BCBS, AARP, or Medicare.

Column 9--Enter IP for inpatient or OP for outpatient to indicate the type of service provided to the patient.

Column 10--Enter the total charges for services provided to the patient.

Column 11----If the total charges in column 10 include amounts for physician/professional charges, enter those physician/professional charges in this column.

Column 12-- Enter all payments received from patients (or individuals responsible for payment), for amounts currently or previously written off to bad debt.

Column 13--Enter the total amounts received from third party payors, including amounts for Medicare cross-over claims for dual eligible beneficiaries.

Columns 14--Enter the portion of the patient's charges written off to charity care. For charity care determined in a year prior to the bad debt determination, ensure that the amount reported in this column relates to the charges reported in column 10, regardless of the charity care write off date.

Column 15--Enter contractual allowances, and other amounts such as insurance write-offs, courtesy discounts, and employee discounts. These amounts are not charity care or bad debt but must be included in determining the amount of allowable bad debt.

Column 16--Enter the date the amounts were written off as a bad debt (i.e., written off as a bad debt or implicit price concession) against the A/R (reduction in revenue) in the provider's financial accounting system.

Column 17--Calculate the net patient bad debt amount by computing the ratio of total charges to total charges plus physician/professional charges (column 10 divided by the sum of columns 10 and 11). Apply the ratio to the total payments, discounts, and allowances (columns 12 through 15) and subtract the resulting amount from total charges (column 10).

EXHIBIT 3C

TITLE	TOTAL BAD DEBTS
PROVIDER NAME	
HOSPITAL CCN	
COMPONENT CCN	
CRP BEGINNING DATE	
CRP ENDING DATE	
PREPARED BY	
DATE PREPARED	
TOTAL COLUMN 17	

PATIENT CLAIM INFORMATION					INSURANCE STATUS	PRIMARY PAYOR	SECONDARY PAYOR
PATIENT LAST NAME	PATIENT FIRST NAME	DATE OF SERVICE - FROM	DATE OF SERVICE - TO	PATIENT ACCT NUMBER			
1	2	3	4	5	6	7	8

SERVICE INDICATOR (IP / OP)	TOTAL CHARGES	TOTAL PHYS-ICIAN / PROFES-SIONAL CHGS	TOTAL PATIENT PAYMENTS	TOTAL THIRD PARTY PAYMENTS	PATIENT CHARITY CARE AMOUNT	CONTRACTUAL ALLOWANCE / OTHER AMOUNT	A/R WRITE OFF DATE	PATIENT BAD DEBT WRITE OFF AMOUNT
9	10	11	12	13	14	15	16	17

4012.50 WORKSHEET S-12 - WEIGHTED MEDIAN MEDICARE ADVANTAGE ORGANIZATION PAYER-SPECIFIC NEGOTIATED CHARGE DATA

Effective for cost reporting periods ending on or after January 1, 2026, subsection (d) hospitals, as defined at section 1886(d)(1)(B) of the Social Security Act (the Act), and subsection (d) Puerto Rico hospitals, as defined at section 1886(d)(9)(A) of the Act, must report the weighted median of the payer-specific negotiated charges the hospital has negotiated with each Medicare Advantage Organization (MAO) for each MS-DRG.

Hospitals exempted from completing this worksheet include:

- *Hospitals that do not negotiate payment rates and only receive non-negotiated payments, for example, hospitals operated by an Indian Health Program as defined in section 4(12) of the Indian Health Care Improvement Act, or federally owned and operated facilities.*
- *Hospitals paid under the Maryland Total Cost of Care Model during the performance period of that model.*

Definitions--

Items and services--All items and services, including service packages, provided by a hospital to a patient for an inpatient admission for which the hospital established a standard charge.

Machine-Readable File (MRF)--The price transparency file the hospital makes available to the public in accordance with 45 CFR 180.40(a).

Medicare Advantage Organization (MAO)--A public or private entity organized and licensed by a State as a risk-bearing entity, with the exception of provider-sponsored organizations receiving waivers, certified by CMS as meeting the MA contract requirements (42 CFR 422.2).

MAO payer-specific negotiated charge --The payer-specific negotiated charge that the hospital has negotiated with an MAO for inpatient items and services and made public under 45 CFR 180.50(b)(2)(ii), as listed in the hospital's most recent MRF as of the hospital's cost report filing date.

Medicare Severity Diagnosis Related Group (MS-DRG)--The classification of inpatient hospital discharges established under section 1886(d)(4) of the Act.

Payer-specific negotiated charge--The charge a hospital has negotiated with a third party payer for an item or service (45 CFR 180.20).

Weighted median MAO payer-specific negotiated charge--The weighted median of the MAO payer-specific negotiated charges weighted by the number of inpatient discharges for those payers that occurred during the cost reporting period.

Line 1 through 997--For each line, report the weighted median MAO payer-specific negotiated charge for each MS-DRG with discharges during the cost reporting period, determined as outlined below.

Some hospitals negotiate MAO payer-specific charge based on a non-MS-DRG system. When such a hospital identifies non-MS-DRG codes (in Step 1(b) below), or reports discharges not classified to MS-DRGs (in Step 2 below), the hospital must crosswalk those codes or classify those discharges to MS-DRGs. Hospitals can utilize the CMS Grouper and associated definitions manual for this purpose. Hospitals can access the publicly available version of the CMS Grouper used to group ICD-10 diagnosis and procedure codes to MS-DRGs (see https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/ms-drg-classifications-and-software). The hospital can use this software and accompanying definition manual to crosswalk the code in the MRF or classify the discharge to an MS-DRG code.

Step 1--Using its most recent MRF as of the cost report filing date, the hospital identifies the following:

(a) Each MAO payer-specific negotiated charge. For each MAO payer-specific negotiated charge based on a percentage or algorithm, the hospital must identify and substitute the dollar amount in the MRF required under 45 CFR 180.50(b)(2)(ii)(C) for the percentage or algorithm. Exclude any payer-specific negotiated charges that represent a capitated payment.

(b) The code under 45 CFR 180.50(b)(2)(iv)(A) for each payer-specific negotiated charge.

Step 2--For the cost reporting period, sum the number of inpatient discharges for each MAO for each MS-DRG. Exclude inpatient discharges where the hospital received payment on a capitated basis.

Step 3--For each MS-DRG, list each MAO payer-specific negotiated charge (from Step 1) once for each inpatient discharge that occurred during the cost reporting period for that MAO (from Step 2).

Step 4--For each MS-DRG, compute the median of the MAO payer-specific negotiated charges in the list from Step 3 by first ordering the list in Step 3 from the lowest to the highest MAO payer-specific negotiated charge; the hospital finds the median by identifying the middle value when the list contains an odd number of charges, or by calculating the mean of the two middle values when the list contains an even number of charges.

Example:

A hospital with a cost reporting period ending on September 30, 2026, negotiated MAO payer-specific negotiated charges for MS-DRG 123 for five MAOs, MA1, MA2, MA3, MA4, and MA5, during that cost reporting period.

The hospital filed its cost report on February 28, 2027.

The hospital made available to the public its price transparency MRF on January 1, 2027. This MRF did not contain MAO payer-specific negotiated charges for MA5 because the hospital stopped contracting with MA5 and began contracting with a new MAO, MA6.

Step 1--The hospital identified the following MAO payer-specific negotiated charge information for MS-DRG 123 from its January 1, 2027, MRF:

- *MA1: $7,400*
- *MA2: $7,200*
- *MA3: $7,500*
- *MA4: $7,300 (algorithm-based)*
- *MA6: $7,400*

As the MAO payer-specific negotiated charge for MA4 was based on an algorithm, the hospital substituted the dollar amount in the MRF required under 45 CFR 180.50(b)(2)(ii)(C) for the algorithm.

Step 2--The hospital summed the number of inpatient discharges that occurred during the cost report period ending September 30, 2026, for each MAO for MS-DRG 123.

- *MA1: 2 discharges*
- *MA2: 1 discharge*
- *MA3: 1 discharge*
- *MA4: 3 discharges*
- *MA5: 2 discharges*

Step 3--The hospital listed each MAO payer-specific negotiated charge (from Step 1) the number of times as inpatient discharges that occurred during the cost reporting period for that MAO (from Step 2).

- *MA1: $7,400, $7,400*
- *MA2: $7,200*
- *MA3: $7,500*
- *MA4: $7,300, $7,300, $7,300*

The hospital listed the MRF charge of $7,400 for MA1 twice because two MA1 discharges for MS-DRG 123 occurred during the cost report period ending September 30, 2026. The hospital listed the MRF charge of $7,200 for MA2 once because one MA2 discharge for MS-DRG 123 occurred during the cost report period ending September 30, 2026. The hospital listed the MRF charge of $7,500 for MA3 once because one MA3 discharge for MS-DRG 123 occurred during the cost report period ending September 30, 2026. The hospital listed the MRF charge of $7,300 for MA4 three times because three MA4 discharges for MS-DRG 123 occurred during the cost report period ending September 30, 2026. The hospital listed no MRF charge for MA5 as the hospital no longer contracted with MA5 and the hospital excluded the MRF charge of $7,400 for MA6 as no MA6 discharges occurred during the cost reporting period.

Step 4--The hospital listed the seven amounts from Step 3 in order from the lowest to the highest MAO payer-specific negotiated charge. The median value is $7,300 (as there is an odd number of items in the list the median is the middle number in the list).

- *$7,200 - MA2*
- *$7,300 - MA4*
- *$7,300 - MA4*
- *$7,300 - MA4*
- *$7,400 - MA1*
- *$7,400 - MA1*
- *$7,500 - MA3*

The hospital reported the weighted median MAO payer-specific negotiated charge of $7,300 for MS-DRG 123 on the Weighted Median MAO Payer-Specific Negotiated Charge Data Worksheet.

This page is reserved for future use.

4013. WORKSHEET A - RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

In accordance with 42 CFR 413.20, the methods of determining costs payable under title XVIII involve using data available from the institution's basic accounts, as usually maintained, to arrive at equitable and proper payment for services. Worksheet A provides for recording the trial balance of expense accounts from your accounting books and records. It also provides for the necessary reclassifications and adjustments to certain accounts. The cost centers on this worksheet are listed in a manner that facilitates the transfer of the various cost center data to the cost finding worksheets (e.g., on Worksheets A, B, C, and D, the line numbers are consistent). While providers are expected to maintain their accounting books and general ledger in a manner consistent with the standard cost centers/departments identified on this worksheet, not all of the cost centers listed apply to all providers using these forms. For example, IPPS providers may contain a Burn Intensive Care Unit, where CAHs may not furnish this type of service.

Do not include on this worksheet items not claimed in the cost report because they conflict with the regulations, manuals, or instructions but which you wish nevertheless to claim and contest. Enter amounts on the appropriate settlement worksheet (Worksheet E, Part A, line 75; Worksheet E, Part B, line 44; Worksheet E-2, line 23; and Worksheet E-3, Parts I, II, III, IV, V, VI, and VII, lines 22, 35, 36, 26, 34, 19, and 43, respectively). For provider based-facilities, enter the protested amounts on line 35 of Worksheet H-4, Part II, for HHAs; line 30 of Worksheet J-3 for CMHCs; and line 30 of Worksheet M-3 for RHC/FQHC providers.

If the cost elements of a cost center are separately maintained on your books, maintain a reconciliation of the costs per the accounting books and records to those on this worksheet. This reconciliation is subject to review by your contractor.

Standard (i.e., preprinted) CMS line numbers and cost center descriptions cannot be changed. If you need to use additional or different cost center descriptions, add (subscript) additional lines to the cost report. Where an added cost center description bears a logical relationship to a standard line description, the added label must be inserted immediately after the related standard line. The added line is identified as a numeric subscript of the immediately preceding line. For example, if two lines are added between lines 7 and 8, identify them as lines 7.01 and 7.02. If additional lines are added for general service cost centers, add corresponding columns for cost finding. Lines 24 through 29, 47 through 49, 78 through 87, 102 through 104, 119 through 189, and 195 through 199, are reserved for future use; do not use these lines.

Also, submit the working trial balance of the facility with the cost report. A working trial balance is a listing of the balances of the accounts in the general ledger to which adjustments are appended in supplementary columns and is used as a basic summary for financial statements.

Cost center coding is a methodology for standardizing the meaning of cost center labels as used by health care providers on the Medicare cost reports. Form CMS-2552-10 provides preprinted cost center descriptions on Worksheet A. In addition, a space is provided for a cost center code. The preprinted cost center labels are automatically coded by CMS approved cost reporting software. These cost center descriptions are hereafter referred to as the standard cost centers. Additionally, nonstandard cost center descriptions have been identified through analysis of frequently used labels.

The use of this coding methodology allows providers to continue to use labels for cost centers that have meaning within the individual institution. The five-digit cost center codes that are associated with each provider-assigned cost center label in their electronic file provide standardized meaning for data analysis. You are required to compare any added or changed label to the descriptions offered on the standard or nonstandard cost center tables. A description of cost center coding and the table of cost center codes are in §4095, Table 5**.**

Columns 1, 2, and 3--**The expenses listed in these columns must be the same as listed in your accounting books and records and/or trial balance.**

Enter on the appropriate lines in columns 1, 2, and 3, the total expenses incurred during the cost reporting period. These expenses are detailed between salaries (column 1) and other than salaries (column 2).

Column 1--Report in each cost center only direct salaries and wages plus related salary amounts for paid vacation, holiday, sick, other paid-time-off (PTO), severance, and bonus pay. Refer to the instructions at Worksheet S-3, Part II, column 2, line 1, for the definition of bonus pay and PTO salary cost.

NOTE: Paid vacation, holiday, sick, other PTO, severance, and bonus pay must be reported with related direct salaries or wages in column 1. Do not report wage-related costs, as defined in §4005.4, in column 1.

Column 2--Report in each cost center all other costs other not reported in column 1, including both wage and wage-related contract labor cost for services contracted by the hospital, the home office, or related organizations. If necessary, reclassify contract labor costs to the cost center benefiting from the contract labor services (see column 4 instructions).

Column 3--For each line, enter the sum of column 1 plus column 2. The sum of column 1 plus the sum of column 2 equals the sum of column 3. Record any needed reclassifications and/or adjustments in columns 4 and 6, as appropriate.

Column 4--With the exception of the reclassification of capital-related costs which are reclassified via Worksheet A-7, all reclassifications in this column are made via Worksheet A-6. Worksheet A-6 need not be completed by all providers and is completed only to the extent that the reclassifications are needed and appropriate in the particular circumstance. Show reductions to expenses as negative numbers.

The net total of the entries in column 4 must equal zero on line 200.

Column 5--Adjust the amounts entered in column 3 by the amounts in column 4 (increase or decrease) and extend the net balances to column 5. Column 5, line 200, must equal column 3, line 200.

Column 6--Enter on the appropriate lines in column 6 the amounts of any adjustments to expenses indicated on Worksheet A-8, column 2. The total on Worksheet A, column 6, line 200, equals Worksheet A-8, column 2, line 50.

Column 7--Adjust the amounts in column 5 by the amounts in column 6 (increase or decrease), and extend the net balances to column 7. Transfer the amounts in column 7 to the appropriate lines on Worksheet B, Part I, column 0.

Line Descriptions

The trial balance of expenses is broken down into general service, inpatient routine service, ancillary service, outpatient service, other reimbursable, special purpose, and nonreimbursable cost center categories to facilitate the transfer of costs to the various worksheets. The line numbers on Worksheet A are used on subsequent worksheets, for example, the categories of ancillary service cost centers, outpatient service cost centers, and other reimbursable cost centers appear on Worksheet C, Part I, using the same line numbers as on Worksheet A.

NOTE: The category titles do not have line numbers. Only cost centers, data items, and totals have line numbers.

Lines 1 through 23--These lines are for the general service cost centers. These costs are expenses incurred in operating the facility as a whole that are not directly associated with furnishing patient care such as, but not limited to mortgage, rent, plant operations, administrative salaries, utilities, telephone charges, computer hardware and software costs, etc. General service cost centers furnish services to both general service areas and to other cost centers in the provider.

Lines 1 and 2--The capital cost centers on lines 1 and 2 include depreciation, leases and rentals for the use of facilities and/or equipment, and interest incurred in acquiring land or depreciable assets used for patient care.

NOTE: **Do not** include in these cost centers costs incurred for the repair or maintenance of equipment or facilities; amounts specifically included in rentals or lease payments for repair and/or maintenance agreements; interest expense incurred to borrow working capital or for any purpose other than the acquisition of land or depreciable assets used for patient care; general liability insurance or any other form of insurance to provide protection other than the replacement of depreciable assets; or taxes other than those assessed on the basis of some valuation of land or depreciable assets used for patient care. However, if no amount of the lease payment is identified in the lease agreement for maintenance, you are not required to carve out a portion of the lease payment to represent the maintenance portion. Thus, the entire lease payment is considered a capital-related cost subject to the provisions of 42 CFR 413.130(b).

When you are dealing with a related organization, you are essentially dealing with yourself, and Medicare considers the costs to you equal to the cost to the related organization. Therefore, for costs applicable to services, facilities, and supplies furnished by organizations related by common ownership or control (see 42 CFR 413.17 and CMS Pub. 15-1, chapter 10), the reimbursable cost includes the costs for these items at the cost to the supplying organization unless the exception provided in 42 CFR 413.17(d) and CMS Pub. 15-1, chapter 10, §1010, is applicable, not to exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere in the open market.

The policy of cost incurred from related organizations applies to capital-related and non-capital-related costs. If you include costs incurred by a related organization on your cost report, the nature of the costs (e.g., capital-related or operating costs) do not change. Treat capital-related costs incurred by the related organization as capital-related costs to you.

If the price of comparable services, facilities, or supplies that could be purchased elsewhere in the open market is lower than the cost to the supplying related organization; if the exception in CFR 413.17(d) and CMS Pub. 15-1, chapter 10, §1010, applies; or if the supplying organization is not related to you, then no part of the charge to you is a capital-related cost unless the services, facilities, or supplies are capital-related in nature.

In the case of leased equipment, the fact that the lease or rental is for a depreciable asset is sufficient for consideration as a capital-related item, but a distinction must be made between the lease of equipment and the purchase of services. A lease of equipment is considered a capital-related cost while a purchase of service is considered an operating cost. Generally, for the agreement to be considered a lease or rental (and therefore a capital-related cost), the agreement must convey to the provider the possession, use, and enjoyment of the asset. Each agreement must be examined on its own merits. Factors that would weigh in favor of treating a particular agreement as a lease of equipment include the following:

- The equipment is operated by personnel employed by the provider, or an organization related to the provider within the meaning of CMS Pub. 15-1, chapter 10.
- The physicians who perform the services with or interpret the tests from the equipment are associated with the provider.
- The agreement is memorialized in one document rather than in two or more documents (e.g., one titled a "Lease Agreement" and one titled a "Service Agreement").
- The document memorializing the agreement is titled a “lease agreement.” If one or more of the documents memorializing the agreement are titled “Service Agreements,” this indicates a purchase of services.
- The provider holds the certificate of need (CON) for the services furnished with the equipment.
- The basis for determining the lease payment is units of time and is not volume sensitive (e.g., numbers of scans).
- The provider attends to such matters as utilization review, quality assurance, and risk management for the services involving the equipment.
- The provider schedules the patients for services involving the equipment.
- The provider furnishes any supplies required to be used with the equipment.
- The provider’s access to the equipment is not subject to interruption without notice or interruption on very short notice.

If the supplying organization is not related to you (see 42 CFR 413.17), no part of the charge to you is a capital-related cost unless the services, facilities, or supplies are capital-related in nature.

Under certain circumstances, costs associated with minor equipment are considered capital-related costs. See CMS Pub. 15-1, chapter 1, §106, for three methods of writing off the cost of minor equipment. Amounts treated as expenses under method (a) are not capital-related costs because they are treated as operating expenses. Amounts included in expense under method (b) are capital-related costs because such amounts represent the amortization of the cost of tangible assets over a projected useful life. Amounts determined under method (c) are capital-related costs because method (c) is a method of depreciation.

Section 1886(g) of the Act, as implemented by 42 CFR 412, Subpart M, requires that the reasonable cost-based payment methodology for hospital inpatient capital-related costs be replaced with an inpatient prospective payment methodology for hospitals paid under the IPPS, effective for cost reporting periods beginning on or after October 1, 1991. Hospitals and hospital distinct part units (IPFs, IRFs, and LTCH) excluded from the IPPS pursuant to 42 CFR 412, Subpart B, are paid for capital-related costs under their respective PPS payment systems. Also, CAHs are reimbursed on a reasonable cost basis under 42 CFR 413.70.

Lines 1 and 2--Capital costs are defined as all allowable capital-related costs for land and depreciable assets, with additional recognition of costs for capital-related items and services that are legally obligated by an enforceable contract (See CMS Pub. 15-1, chapter 28, §2800.) Betterment or improvement costs related to capital are included in capital assets. (See 42 CFR 412.302.) Capital costs incurred as a result of extraordinary circumstances are included in capital. (See 42 CFR 412.348(g).) Direct assignment of capital costs must be done in accordance with CMS Pub. 15-1, chapter 23, §§2307 and 2313.

Capital costs include the following:

1. Allowable depreciation on assets based on the useful life guidelines used to determine depreciation expense in the hospital's base period, which cannot be subsequently changed.

2. Allowable capital-related interest expense. Except as provided in subsections a through c below, the amount of allowable capital-related interest expense recognized as capital is limited to the amount the hospital was legally obligated to pay.

a. An increase in interest expense is recognized if the increase is due to periodic fluctuations of rates in variable interest rate loans or to periodic fluctuations of rates at the time of conversion from a variable rate loan to a fixed rate loan when no other changes in the terms of the loan are made.

b. If the terms of a debt instrument are revised, the amount of interest recognized associated with the original capital cannot exceed the amount that would have been recognized during the same period prior to the revision of the debt instrument.

c. Investment income (excluding income from funded depreciation accounts and other exclusions from investment income offset cited in CMS Pub. 15-1, chapter 2, §202.2) is used to reduce capital interest expense based in each cost reporting period.

3. Allowable capital-related lease and rental costs for land and depreciable assets.

a. The cost of lease renewals and the acquisition of assets continuously leased (e.g., capitalized leases) are recognized provided that the same asset remains in use, the asset has a useful life of at least 3 years, and the annual lease payment is $1,000 or more for each item or service.

b. If a hospital-owned asset is sold or given to another party and that same asset is then leased back by the hospital, the amount of allowable capital-related costs recognized as capital costs is limited to the amount allowed for that asset in the last cost reporting period during which it was owned by the hospital.

4. The appropriate portion of the capital-related costs of related organizations under 42 CFR 413.17 that would be recognized as capital costs if these costs had been incurred directly by the hospital.

Unless there is a change of ownership, the hospital must continue the same cost finding methods for capital costs. This includes its practices for the direct assignment of capital-related costs and its cost allocation bases in. If there is a change of ownership, the new owners may request that the contractor approve a change in order to be consistent with their established cost finding practices.

If a hospital desires to change its cost finding method for the direct assignment of capital costs, the request for change must be made in writing to the contractor prior to the beginning of the cost reporting period for which the change is to apply. The request must include justification as to why the change will result in more accurate and more appropriate cost finding. The contractor does not approve the change unless it determines that there is reasonable justification for the change.

Line 3--In accordance with 42 CFR 412.302(b)(4), enter all other capital-related costs, including but not limited to taxes, insurance, and license and royalty fees on depreciable assets. This line also includes any directly allocated home office other capital cost. After reclassifications in column 4 and adjustments in column 6, the balance in column 7 must equal zero. This line cannot be subscripted.

PPS providers paid 100 percent Federal complete line 3, column 2, and Worksheet A-7, Parts I (if applicable), II, and III.

Line 4--Enter in column 1, the direct salaries and salary amounts for paid vacation, holiday, sick, other paid-time-off (PTO), severance, and bonus pay incurred only for employees in the employee benefits department and/or the human resources department. In accordance with CMS Pub. 15-1, chapter 23, §2307, if your accounting system directly allocates employee benefits to individual cost centers, enter in column 2 the employee benefits cost of employees in the employee benefits and/or human resources department. If your accounting system does not directly allocate all or a portion of the employee benefits to all the individual cost centers, then enter in column 2 the total employee benefits cost and/or residual employee benefits costs of all hospital employees.

Line 5--Enter A&G costs on this line. A&G includes a wide variety of provider administrative costs such as but not limited to cost of executive staff, legal and accounting services, facility administrative services (not already included in other general service cost centers), etc. If this line is componentized into more than one cost center, eliminate line 5. Componentized A&G lines must begin with subscripted line 5.01 and continue in sequential and consecutive order except where this manual specifies otherwise.

Line 6--Maintenance and repairs are any activity to maintain the facility and grounds such as, but not limited to, costs of routine painting, plumbing and electrical repairs, mowing, and snow removal.

Line 7--Operation of plant includes the cost such as, but not limited to, the internal hospital environment including air conditioning (both heating and cooling systems and ventilation) and other mechanical systems.

Line 8--Laundry and linen services include the cost of routine laundry and linen services whether performed in-house or by outside contractors.

Line 9--Housekeeping includes the cost of routine housekeeping activities such as mopping, vacuuming, cleaning restrooms, lobbies, waiting areas and otherwise maintaining patient and non-patient care areas.

Line 10--Dietary includes the cost of preparing meals for patients.

Line 11--Cafeteria includes the cost of preparing food for provider personnel, physicians working at the provider, visitors to the provider.

Line 12--Maintenance of personnel includes the cost of room and board furnished to employees. (See CMS Pub. 15-1, chapter 7, §704.3.)

Line 13--Nursing administration normally includes only the cost of nursing administration. The salary cost of direct nursing services, including the salary cost of nurses who render direct service in more than one patient care area, is directly assigned to the various patient care cost centers in which the services were rendered. Direct nursing services include gross salaries and wages of head nurses, registered nurses, licensed practical and vocational nurses, aides, orderlies, and ward clerks.

However, if your accounting system fails to specifically identify all direct nursing services to the applicable patient care cost centers, then the salary cost of all direct nursing service is included in this cost center.

Line 14--Central services and supply includes the costs of operating this department (e.g., salaries of staff), the cost of supplies and services which are requested by departments throughout the provider, and costs of including medical supplies charged to patients.

Line 15--Pharmacy includes the cost related to the operation of the pharmacy (e.g., salaries of pharmacists and other staff) as well as the cost of drugs and pharmacy supplies requested by patient care departments and cost of drugs charged to patients. (See instruction for line 73.)

Line 16--Medical records and medical records library include the direct costs of the medical records cost center including the medical records library. The general library and the medical library are not included in this cost center but are reported in the A&G cost center.

Line 17--Social service includes the cost of explaining health care resources and policies to patients, family and professional staff; assistance in planning for post-hospital patient needs; assisting patients and families receive needed follow-up care by referral to health care resources and providing advocacy through appropriate organizations.

Line 19--The services of a non-physician anesthetist generally are paid for by the Part B contractor based on a fee schedule rather than on reasonable cost basis through the cost report. As such, the salary and fringe benefit costs included on line 19 generally are not reimbursed through the cost report.

NOTE: Any costs are included on this line are limited to salary and employee benefit costs.

However, payment for the non-physician anesthetists on a fee basis may not apply to a qualified rural hospital or CAH if the facility employed or contracted with not more than one FTE (2080 hours) non-physician anesthetist and, if (1) the hospital had 800 or fewer surgical procedures (including inpatient and outpatient procedures) requiring anesthesia services, and (2) each non-physician employed by or under contract with the hospital has agreed not to bill under Part B of title XVIII for professional services furnished. (See 42 CFR 412.113(c)(2)(i)).

Payment under the fee schedule applies to qualified hospitals and CAHs unless the hospital establishes, before the beginning of each calendar year, that it did not exceed 800 surgical procedures requiring anesthesia in the previous year. (See 42 CFR 412.113(c)(2)(ii)).

Hospitals which do not qualify for the exception and are therefore subject to the fee schedule payment method must remove the salary and fringe benefit costs from line 19. The total amount is reported on Worksheet A-8, line 28 and in column 6, line 19, of this worksheet. This removes these costs from the cost reported in column 7.

Lines 20 and 23--If you have an approved nursing or allied health education program that meets the criteria of 42 CFR 413.85(e), classroom and clinical portions of the costs may be allowable as pass-through costs as defined in 42 CFR 413.85(d)(2).

Classroom costs are those costs associated with formal, didactic instruction on a specific topic or subject in a classroom that meets at regular, scheduled intervals over a specific time period (e.g., semester or quarter) and for which a student receives a grade. (See 42 CFR 413.85(c).)

Clinical training is defined as involving the acquisition and use of the skills of a nursing or allied health profession or trade in the actual environment in which these skills will be used by the student upon graduation. While it may involve occasional or periodic meetings to discuss or analyze cases, critique performance, or discuss specific skills or techniques, it involves no classroom instruction. (See 42 CFR 413.85(c).)

If your program is a nonprovider-operated program under 42 CFR 413.85(g)(2), the classroom portion of the costs is not allowable as a pass-through cost and must not be reported on these lines. The clinical portions of these nonprovider-operated program costs are allowable as pass-through costs if the following conditions as set forth in 42 CFR 413.85(g)(2) are met:

1. The hospital must have claimed and have been paid for clinical costs (described above) during its latest cost reporting period that ended on or before October 1, 1989. (See 42 CFR 413.85(g)(2)(ii).)

2. In any cost reporting period, the pass-through costs are limited to the percentage of total allowable provider costs attributable to allowable clinical training costs reported in the provider's most recent cost reporting period ending on or before October 1, 1989. (See 42 CFR 413.85(g)(2)(iii).)

3. The hospital receives a benefit for the support it furnishes to the education program through the provision of clinical services by nursing and allied health students participating in the program. (See 42 CFR 413.85(g)(2)(iv).)

4. The clinical training costs must be incurred by the provider or by an educational institution related to the provider by common ownership or control as defined by 42 CFR 413.17(b) and CMS Pub. 15-1, chapter 10, §1002 (cost to related organizations). Costs incurred by a third party, regardless of its relationship to either the provider or the educational institution, are not allowed. (See 42 CFR 413.85(g)(2)(v).)

5. The costs incurred by the hospital for the program do not exceed the costs that would have been incurred by the hospital if the program had been operated by the hospital. (See 42 CFR 413.85(g)(2)(vi).)

6. The clinical training must occur on the premises of the hospital (i.e., in the hospital itself or in the physical area immediately adjacent to the hospital buildings or in other areas and structures located within 250 yards of the main buildings). (See 42 CFR 413.85(g)(2)(i).)

If your nonprovider-operated program was originally a provider operated program and you continued incurring the costs after the program was transferred to a wholly-owned subsidiary educational institution prior to October 1, 2003, the clinical training costs and classroom costs are eligible for pass-through payment under 42 CFR 413.85(g)(3)(ii) and (g)(3)(iii) if all of the following conditions in 42 CFR 413.85(g)(3) are met:

1. The program must have originally been provider-operated according to the criteria set forth in 42 CFR 413.85(f). (See 42 CFR 413.85(g)(3)(i).)

2. The program was transferred to a wholly owned subsidiary educational institution in order to meet accreditation standards prior to October 1, 2003. (See 42 CFR 413.85(g)(3)(i).)

3. The hospital has continuously incurred the costs of both the classroom and clinical training portions of the program at the educational institution. (See 42 CFR 413.85(g)(3)(i).)

4. The hospital received Medicare reasonable cost payment for the NAHE program both prior and subsequent to the date the hospital transferred operation of the program to its wholly owned subsidiary educational institution (and the program ceased to be provider-operated according to the criteria under 42 CFR 413.85(f). (See 42 CFR 413.85(g)(3)(ii).)

Line 20--Establish a separate cost center for each nursing program that meets the requirements of 42 CFR 413.85(e) by subscripting line 20 for each nursing program. If the direct costs of a nursing program are not included in the costs on line 20, column 3, or applicable subscripts, reclassify the costs to line 20, or applicable subscripts, through a Worksheet A-6 reclassification.

Line 21--Enter the cost of intern and resident salaries and salary-related fringe benefits. Do not include salary and salary-related fringe benefits applicable to teaching physicians which are included in line 22.

Line 22--Enter the other costs applicable to interns and residents in an approved teaching program.

Line 23--Establish a separate cost center for each allied health/paramedical education program that meets the requirements of 42 CFR 413.85(e) (e.g., one for pharmacy, another for pastoral education, etc.) by subscripting line 23 for each allied health education program. If the direct costs of an allied health education program are not included in the costs on line 23, column 3, or applicable subscripts, reclassify the costs to line 23, or applicable subscripts, through a Worksheet A-6 reclassification.

Lines 24 through 29--Reserved for future use.

Lines 30 through 46--These lines are for the inpatient routine service cost centers.

Line 30--The purpose of this cost center is to accumulate the incurred routine service cost applicable to adults and pediatrics (general routine care) in a hospital. Do not include incurred costs applicable to subproviders or any other cost centers which are treated separately.

Lines 31 through 35--Use lines 31 through 35 to record the cost applicable to intensive care type inpatient hospital units. (See 42 CFR 413.53(b) and (d) and CMS Pub. 15-1, chapter 22, §2202.7.) Label line 35 appropriately to indicate the purpose for which it is being used.

Lines 36 through 39--Reserved for future use.

Line 40--Use this line to record the IPF service costs of a subprovider. Hospital units that are excluded units from the IPPS are treated as subproviders for cost reporting purposes.

Line 41--Use this line to record the IRF service costs of a subprovider. Hospital units that are excluded units from the IPPS are treated as subproviders for cost reporting purposes.

Line 42--Use this line to record the inpatient routine service costs of other subproviders as applicable.

Line 43--Use this line to record the costs associated with the nursery.

Line 44--Use this line to record the costs of SNFs certified for titles V, XVIII, or XIX if your State accepts one level of care.

Line 45--Use this line to record the cost of NFs certified for title V or title XIX but not certified as an SNF for title XVIII. Subscript this line to record the cost of ICF/IID. Do not report nursing facility costs on this subscripted line.

Line 46--Use this cost center to accumulate the direct costs incurred in maintaining long term care services not specifically required to be included in other cost centers. A long term care unit refers to a unit where the average length-of-stay for all patients is greater than 25 days. The beds in this unit are not certified for title XVIII. Treat this area as a nonreimbursable cost center for Medicare since it is not part of the Medicare certified hospital.

Lines 47 through 49--Reserved for future use.

Lines 50 through 78--Use for ancillary service cost centers.

Line 57--Use this line to record direct costs associated with computed tomography (CT) services.

Line 58--Use this line to record direct costs associated with magnetic resonance imaging (MRI) services.

Line 59--Use this line to record direct costs associated with cardiac catheterization services.

Line 60--Use this line to record direct costs associated with laboratory services.

Line 61--Use this line to record costs when a pathologist continues to bill non-program patients for clinical laboratory tests and is compensated by you for services related to such tests for program beneficiaries. When you pay the pathologist an amount for administrative and supervisory duties for the clinical laboratory for program beneficiaries only, include the cost in this cost center.

NOTE: No overhead expenses are allocated to this cost center since it relates to services for program beneficiaries only. The cost reporting treatment is similar to that of services furnished under arrangement to program beneficiaries only. (See CMS Pub. 15-1, chapter 23, §2314.) These costs are apportioned among the various programs on the basis of program charges for provider clinical laboratory tests for all programs for which you reimburse the pathologist.

Line 62--Include the direct expenses incurred in obtaining blood directly from donors as well as obtaining whole blood and packed red blood cells from suppliers. Do not include in this cost center the processing fee charged by suppliers. The processing charge is included in the blood storing, processing, and transfusion cost center. Identify this line with the appropriate cost center code (06250) (Table 5 - Electronic Reporting Specifications) for the cost of administering blood clotting factors to hemophiliacs. (See §4452 of BBA 1997, OBRA 1989 & 1993.)

Line 63--Include the direct expenses incurred for processing, storing, and transfusing whole blood, packed red blood cells, and blood derivatives. Also include the processing fee charged by suppliers.

Line 71--Include on this line medical supplies charged to patients other than the high cost implantable devices reported on line 72. Obtain the expense amounts from your records as follows depending on how you accumulate these expenses in your general ledger (GL). (1) If the expenses for chargeable medical supplies are accumulated together with non-chargeable medical supplies in the "Central Services" GL account and are reported in that cost center (line 14 on Worksheet A), do not include the chargeable medical supplies expenses on Worksheet A, line 71. Rather, allocate the costs in column 14 of Worksheet B to line 71 (and other lines) using the recommended "costed requisitions" statistics. (2) If the expenses for chargeable medical supplies are reported in a separate GL account, include these expenses on Worksheet A, line 71, column 2. (3) If the expenses for chargeable medical supplies are reported in a specific subaccount(s) under the GL accounts for various routine and ancillary departments(i.e., operating room, adults and pediatrics, or clinic), report the sum of the balances in that subaccount(s) on Worksheet A, line 71, column 2. If you reported the total balance (i.e., including the amounts for chargeable medical supplies) of the various GL accounts (i.e., operating room, adults and pediatrics, or clinic) in those respective cost centers in column 2 of Worksheet A, reclassify the cost of the chargeable medical supplies from those cost centers to the "medical supplies charged to patients" cost center (line 71). (See CMS Pub. 15-1, chapter 22, §2200.1, and 42 CFR 413.53(a)(1).)

Line 72--Include on this line high cost implantable devices charged to patients bearing the revenue codes established by the NUBC as indicated in the 73 FR 48462 (August 19, 2008), and not reported on line 71. Obtain the expense amounts from your records as follows depending on how you accumulate these expenses in your general ledger (GL). (1) If the expenses for chargeable implantable devices are accumulated together with non-chargeable implantable devices in the "Central Services" GL account and are reported in that cost center (line 14 on Worksheet A), do not include the high cost chargeable implantable devices expenses on Worksheet A, line 72. Rather, allocate the costs in column 14 of Worksheet B to line 72 (and other lines) using the recommended "costed requisitions" statistics. (2) If the expenses for high cost chargeable implantable devices are reported in a separate GL account, include these expenses on Worksheet A, line 72, column 2. (3) If the expenses for high cost chargeable implantable devices are reported in a specific subaccount(s) under the GL accounts for various routine and ancillary departments (i.e., operating room, adults and pediatrics, or clinic), report the sum of the balances in that subaccount(s) on Worksheet A, line 72, column 2. If you reported the total balance (i.e., including the amounts for high cost chargeable implantable devices) of the various GL accounts (i.e., operating room, adults and pediatrics, or clinic) in those respective cost centers in column 2 of Worksheet A, reclassify the cost of the high cost chargeable implantable devices from those cost centers to the "implantable devices charged to patients" cost center (line 72). (See CMS Pub. 15-1, chapter 22, §2200.1, and 42 CFR 413.53(a)(1).)

Line 73--This cost center includes the costs of drugs charged to patients from your records. If your financial system (working trial balance and GL) directly allocates (see CMS Pub. 15-1, chapter 23, §2313) the costs of non-chargeable drugs to the departments/cost centers in which they are used and these expenses are reported in those cost centers on Worksheet A rather than in the pharmacy cost center (line 15), report the expenses included in the GL account/sub-account identified as chargeable drugs in column 2. (Do not report any expenses associated with the non-chargeable drugs on this line.) In this situation, only the operating costs of the pharmacy (e.g., salaries of pharmacists and staff, etc.) will remain in the pharmacy cost center on Worksheet A, line 15, and will be equitably allocated in column 15 of Worksheet B to line 73 (Drugs Charged to Patients) and other cost centers that used the non-chargeable drugs using the recommended statistical allocation basis of costed requisitions. If your financial system does not directly allocate the costs of non-chargeable drugs to the departments/cost centers in which they are used, do not include the chargeable drug expenses on Worksheet A, line 73. Rather, leave these chargeable drug expenses in the pharmacy cost center (line 15) together with the operating expenses of the pharmacy and the non-chargeable drug expenses and, using the recommended statistical allocation basis of costed requisitions, allocate them on Worksheet B, column 15. Such costs are generally allocated from general service cost centers (e.g., pharmacy, A&G, etc.) through the allocation process on Worksheet B, or are reclassified from other cost centers on Worksheet A. Include all costs for drugs and vaccines provided to patients including the cost of osteoporosis drugs pneumococcal, influenza, and COVID-19 vaccines and monoclonal antibody products for treatment of COVID-19 not subject to deductibles and coinsurance.

Line 74--If you furnish renal dialysis treatments, account for such costs by establishing this separate ancillary service cost center. In accumulating costs applicable to the cost center, include no other ancillary services even though they are routinely administered during the course of the dialysis treatment. However, if you physically perform a few minor routine laboratory services associated with dialysis in the renal dialysis department, such costs remain in the renal dialysis cost center. Outpatient maintenance dialysis services are reimbursed under the composite rate reimbursement system. For purposes of determining overhead attributable to ESAs, include the cost of the drug in this cost center. The drug costs will be removed on Worksheet B-2 after stepdown.

Effective for services rendered on or after January 1, 2011, ESRD services are paid under the ESRD PPS.

NOTE: ESRD physician supervisory services are not included as your costs under the composite rate reimbursement system or ESRD PPS. Supervisory services are included in the physician's monthly capitation rate.

Line 75--Enter the cost of ASCs that are not separately certified as a distinct part, but which have a separate surgical suite. Do not include the costs of the ancillary services provided to ASC patients. Include only the surgical suite costs (i.e., those used in lieu of operating or recovery rooms).

Line 77--Effective for services rendered on or after January 1, 2017, enter the hospital acquisition costs for allogeneic (stem cells obtained from a donor other than the recipient) hematopoietic stem cell transplants (HSCT) as defined in 42 CFR 412.113(e), CMS Pub. 100-04, chapter 3, §90.3.1, and CMS Pub. 100-04, chapter 4, §231.11. This includes direct costs and costs of services purchased under arrangements and registry fees for national donor registries (42 USC 274k), if applicable. Do not reclassify costs from the routine and ancillary cost centers; rather compute the acquisition costs on Worksheet D-6, Part I, including acquisition costs associated with the acquisition services in cases that do not result in transplant (i.e., due to death of the intended recipient or other causes). Do not include costs for the allogeneic hematopoietic stem cell transplants on this line. Do not include acquisition costs, other than the cost of tissue typing, for recipients on this line. Do not include any costs related to autologous (stem cells obtained from the recipient) hematopoietic stem cell acquisition or transplants on this line (CMS Pub. 100-04, chapter 3, §90.3.2, and 100-04, chapter 4, §231.10).

Line 78--Effective for cost reporting periods beginning on or after October 1, 2022, enter the hospital costs for procuring, storing, and processing chimeric antigen receptor T-cells (CAR T-cell) for immunotherapy infusion (FDA-approved CAR T-cell immunotherapies only). This includes the cost of the CAR T-cell manufactured biologic (i.e., the cost paid to the manufacturer). Do not include costs for CAR T-cell immunotherapy transplants or the medication cost of the non-CAR T-cell drugs used for CAR T-cell immunotherapy complications, e.g., cytokine release syndrome, on this line.

Lines 79 through 87--Reserved for future use.

Lines 88 through 93--Use these lines for outpatient service cost centers.

NOTE: For lines 88 through 90 and 93, any ancillary service billed as clinic, RHC, and FQHC services must be reclassified to the appropriate ancillary cost center, e.g., radiology-diagnostic, laboratory.

Line 88--Use this line to report the costs of hospital-based RHCs. If more than one is maintained, subscript the line. See Table 5 in §4095 for the proper cost center code for hospital-based RHCs.

In accordance with CMS Pub. 100-04, chapter 9, §40A, compensation paid to a physician for RHC services rendered in a hospital-based RHC is cost-reimbursed. Where the physician agreement compensates for RHC services as well as non-RHC services, or services furnished in the hospital, the related compensation must be eliminated on Worksheet A-8 and billed to the Part B contractor. If not specified in the agreement, a time study must be used to allocate the physician compensation.

Line 89--Use this line to report the costs of hospital-based FQHCs. If more than one is maintained, subscript the line. See Table 5 in §4095 for the proper cost center code for FQHCs.

In accordance with CMS Pub. 100-04, chapter 9, §40, compensation paid to a physician for FQHC services rendered in a hospital-based FQHC is cost-reimbursed. Where the physician agreement compensates for FQHC services as well as non-FQHC services, or services furnished in the hospital, the related compensation must be eliminated on Worksheet A-8 and billed to the Part B contractor. If not specified in the agreement, a time study must be used to allocate the physician compensation.

Line 90--Enter the cost applicable to the clinic not included on lines 88 and 89. If you have two or more clinics which are separately costed, separately report each such clinic. Subscript this line to report each clinic. If you do not separately cost each clinic, you may combine the cost of all clinics on the clinic line.

Line 91--Enter the costs of the emergency room cost center.

Line 92--Do not use this line on this worksheet. If you have a distinct part area specifically designated for observation (e.g., where observation patients are not placed in a general acute care area bed), report this on a subscripted line 92.01. REHs report the costs associated with observation beds on subscripted line 92.01.

NOTE: It is possible to have both a distinct observation bed area and a non-distinct area (for example, where your distinct part observation bed area is only staffed from 7:00 a.m. to 10:00 p.m. Patients entering your hospital needing observation bed care after 10:00 p.m. and before 7:00 a.m. are placed in a general inpatient routine care bed). If patients entering the distinct part observation bed area are charged differently than the patients placed in the general inpatient routine care bed, separate the costs into distinct observation bed costs and non-distinct observation bed costs. However, if the charge is the same for both patients, report all costs and charges as distinct part observation beds.

Line 93--Use this line to report the costs of other outpatient services not previously identified on lines 88 through 90. If more than one other service is offered, subscript the line. See Table 5 in §4095 for the proper cost center code for this line.

Line 93.99--Effective for cost reporting periods ending on or after September 30, 2017, enter the costs of providing hospital-based partial hospitalization program (PHP) services as defined in the Act §1861(ff). Effective for services rendered on or after January 1, 2024, in accordance with the CAA 2023, §4124, also include, as applicable, intensive outpatient program (IOP) costs incurred for IOP services rendered to hospital outpatients.

Lines 94 through 98 and 100--Use these lines for other reimbursable cost centers (other than HHA and CMHC).

Line 94--Use this line to accumulate the direct costs incurred for self-care home dialysis. For purposes of determining overhead attributable ESAs, include the cost of the drug in this cost center. The drug costs will be removed on Worksheet B-2 after stepdown.

A Medicare beneficiary dialyzing at home has the option to deal directly with the Medicare program and make individual arrangements for securing the necessary supplies and equipment to dialyze at home. Under this arrangement, the beneficiary is responsible for dealing directly with the various suppliers and the Medicare program to arrange for payment. The beneficiary is also responsible to the suppliers for the deductible and 20 percent Medicare coinsurance requirement. You do not receive composite rate payment for a patient who chooses this option. However, if you provide any direct home support services to a beneficiary who selects this option, you are reimbursed on the same reasonable cost basis for these services as for other outpatient services. These costs are entered on line 93 and are notated as cost reimbursed. You may service Medicare beneficiaries who elect this option and others who deal directly with you. In this case, set up two home program dialysis cost centers (using a subscript for the second cost center) to properly classify costs between the two categories of beneficiaries (those subject to cost reimbursement and those subject to the composite rate).

Effective for services rendered on or after January 1, 2011, ESRD services are paid under the ESRD PPS.

Line 95--Report all ambulance costs on this line for both owned and operated services and services under arrangement. No subscripting is allowed for this line.

Lines 96 and 97--Use these lines to report durable medical equipment (DME) rented or sold, respectively. Enter the direct expenses incurred in renting or selling DME items to patients. Also, include all direct expenses incurred by you in requisitioning and issuing DME to patients.

For a hospital-based SNF, report support surfaces by subscripting line 97, and use the proper cost center code.

Line 99--This cost center accumulates the direct costs for outpatient rehabilitation providers (CORFs and OPTs) and CMHCs. However, only CMHCs complete the J series worksheets. Use lines 99 through 99.09 for CMHCs, lines 99.10 through 99.19 for CORFs, lines 99.20 through 99.29 for OPTs, lines 99.30 through 99.39 for OOTs, and lines 99.40 through 99.49 for OSPs. If you have multiple components, subscript this line using the proper cost center code.

Line 100--Use this line if your hospital operates an intern and resident program not approved by Medicare. For the services of a resident who is not in an approved GME program, payment is made to the hospital on a Part B reasonable cost basis regardless of whether the services are furnished to hospital inpatients or outpatients. (See 42 CFR 415.202.) Enter the costs of residents' services; however, do not include other costs such as administrative costs related to teaching activities of a physician as these costs are not allowable.

Line 101--This cost center accumulates costs specific to HHA services. If you have more than one certified hospital-based HHA, subscript line 101 for each HHA.

Provider-based HHAs are operated and managed in a variety of ways within the context of the health care complexes of which they are components. In some instances, there are discrete management and administrative functions pertaining to the HHA, the cost of which is readily identifiable from the books and records.

Hospital-based HHAs are operated and managed in a variety of ways within the context of the health care complexes of which they are components. In some instances, there are discrete management and administrative functions pertaining to the HHA, the cost of which is readily identifiable from the books and records.

In other instances, the administration and management of the hospital-based HHA is integrated with the administration and management of the health care complex to such an extent that the cost of administration and management of the HHA can be neither identified nor derived from the books and records of the health care complex. In other instances, the cost of administration and management of the HHA is integrated with the administration and management of the health care complex, but the cost of the HHA administration and management can be derived through cost finding. However, in most cases, even when the cost of HHA administration and management can be either identified or derived, the extent to which the costs are applicable to the services furnished by the hospital-based HHA is not readily identifiable.

Even when the costs of administration and management of a provider-based HHA can be identified or derived, such costs do not generally include all of the general service costs (i.e., overhead costs) applicable to the HHA. Therefore, allocation of general service costs through cost finding is necessary for the determination of the full costs of the hospital-based HHA.

When the hospital-based HHA can identify discrete management and administrative costs from its books and records, these costs are included on line 101.

Similar situations occur for the services furnished by the hospital-based HHA. For example, in some instances, physical therapy services are furnished by a discrete HHA physical therapy department. In other instances, physical therapy services are furnished to the patient of the hospital-based HHA by an integrated physical therapy department of a hospital health care complex in such a manner that the direct costs of furnishing the physical therapy services to the patients of the hospital-based HHA cannot be readily identified or derived. In other instances, physical therapy services are furnished to patients of the hospital-based HHA by an integrated physical therapy department of a hospital health care complex in such a manner that the costs of physical therapy services furnished to patients of the hospital-based HHA can be readily identified or derived.

When you maintain a separate therapy department for the HHA apart from the hospital therapy department furnishing services to other patients of the hospital health care complex or when you are able to reclassify costs from an integrated therapy department to an HHA therapy cost center, make a reclassification entry on Worksheet A-6 to the appropriate HHA therapy cost center. Make a similar reclassification to the appropriate line for other ancillaries when the HHA costs are readily identifiable.

NOTE: This cost report provides separate HHA cost centers for all therapy services. If services are provided to HHA patients from a shared hospital ancillary cost center, make the cost allocation on Worksheet H-1, Part II.

Line 102--Effective for cost reporting periods ending on or after January 1, 2022, enter the cost of services furnished by the hospital's Medicare-enrolled opioid treatment program as defined in the Act §1861(jjj) and as described in CMS Pub. 100-02, Medicare Benefit Policy Manual, chapter 17, for the treatment of Opioid Use Disorder.

Lines 103 and 104--Reserved for future use.

Lines 105 through 117--Use these lines for special purpose cost centers. Special purpose cost centers include kidney, heart, liver, lung, pancreas, intestinal, and islet acquisition costs as well as costs of other organ acquisitions which are nonreimbursable but which CMS requires for data purposes, cost centers which must be reclassified but which require initial identification, and ASC and hospice costs which are needed for rate setting purposes.

NOTE: Prorate shared acquisition costs (e.g., coordinator salaries, donor awareness programs) among the type of organ acquisitions. Generally, this is done based on the number of organs procured. Further, if multiple organs have been procured from a community hospital or an independent organ procurement organization, prorate the cost among the type of acquisitions involved.

These cost centers include the cost of services purchased under arrangement or billed directly to the hospital in connection with the acquisition of organs. Such direct costs include but are not limited to:

- Fees for physician services (preadmission for transplant donor and recipient tissue-typing and all tissue-typing services performed on cadaveric donors);
- Cost for organs acquired from other providers or organ procurement organizations;
- Transportation costs of organs;
- Organ recipient registration fees;
- Surgeons' fees for excising cadaveric donor organs; and
- Tissue-typing services furnished by independent laboratories.

NOTE: No amounts or fees paid to a donor, their estate, heirs, or assigns in exchange for an organ or for the right to remove or transplant an organ are included in organ acquisition costs. Also, such amounts or fees are not included in any other revenue producing or general service cost center.

Only hospitals which are certified transplant centers are reimbursed directly by the Medicare program for organ acquisition costs. All such costs are accumulated on Worksheet D-4.

Hospitals which are not certified transplant centers are not reimbursed by the Medicare program for organ acquisition costs. Such hospitals sell any organs excised to a certified transplant center or an organ procurement organization. The costs are accumulated in the applicable organ acquisition cost center and flow through cost finding to properly allocate overhead costs to this cost center. However, only a certified transplant center completes Worksheet D-4.

Line 105--Record any costs in connection with kidney acquisitions. This cost center flows through cost finding and accumulates any appropriate overhead costs.

Line 106--Record any costs in connection with heart acquisitions. This cost center flows through cost finding and accumulates any appropriate overhead costs.

Line 107--Record any costs in connection with liver acquisitions. This cost center flows through cost finding and accumulates any appropriate overhead costs.

Line 108--Record any costs in connection with lung acquisitions. This cost center flows through cost finding and accumulates any appropriate overhead costs.

Line 109--Record any costs in connection with pancreas acquisitions. This cost center flows through cost finding and accumulates any appropriate overhead costs.

Line 110--Record any costs in connection with intestinal acquisitions. This cost center flows through cost finding and accumulates any appropriate overhead costs.

Line 111--Record the costs associated with the acquisition of the pancreas that is used to isolate the islet cells that are used for transplant. Do not include in this cost any costs associated with the isolation of the islet cells as these costs will be included as an add-on to the DRG payment. (See CR 5505, dated March 2, 2007).

Line 112--Record any costs related to organ acquisitions, which are not already recorded on lines 105 through 111 and subscripts. This cost center flows through cost finding and accumulates any appropriate overhead costs.

Line 113--Enter all interest paid by the facility. After reclassifications in column 4 and adjustments in column 6, the balance in column 7 must equal zero. This line cannot be subscripted.

NOTE: If capital-related and working capital interest are commingled on this line, reclassify working capital interest to A&G expense. Reclassify capital-related interest to lines 1 and 2, as appropriate, in accordance with the instructions for those lines.

Line 114--Include only utilization review costs of the hospital-based SNF. All costs are either reclassified or adjusted in total depending on the scope of the review. If the scope of the review covers all patients, all allowable costs are reclassified in column 4 to A&G expenses (line 5). If the scope of the review covers only Medicare patients or Medicare, title V, and title XIX patients, then (1) in column 4, reclassify to A&G expenses all allowable costs other than physicians' compensation and (2) deduct in column 6 the compensation paid to the physicians for their personal services on the utilization review committee. The amount reported on Worksheet E-2, column 1, line 7, must equal the amount adjusted on Worksheet A-8.

Line 115--Enter the direct costs of an ASC as defined in 42 CFR 416.2. An ASC operated by a hospital must be a separately identifiable entity, physically, administratively, and financially independent and distinct from other operations of the hospital. In addition, the ASC must have an agreement with CMS as required by 42 CFR 416.25. Under this restriction, hospital outpatient departments providing ambulatory surgery (among other services) are not eligible to be classified as ASCs. Those ASCs which meet the definition in 42 CFR 416.2 and are currently treated as an outpatient cost center on the hospital's Medicare cost report are reimbursed through a prospectively determined standard overhead amount. For cost reporting purposes, an eligible ASC is treated as a nonreimbursable cost center to ensure that overhead costs are properly allocated since the cost is not reimbursable in this cost report.

Line 116--Record the costs applicable to hospice care for terminally ill Medicare beneficiaries who elect to receive care from a participating hospice. If you have a contractual arrangement with a hospice for the use of general inpatient routine beds, do not to report those costs on this line. Rather, report the contractual arrangement costs on line 30, Adults and Pediatrics (General Routine Care). Additionally, report amounts received under the contract with the hospice on Worksheet A-8, line 30.99, and enter the applicable days on Worksheet S-3, Part I, line 24.10.

Line 117--Enter other special purpose cost centers not previously identified. Review Table 5 in §4095 for the proper cost center code.

Lines 119 through 189--Reserved for future use.

Lines 190 through 194--Record the costs applicable to nonreimbursable cost centers to which general service costs apply. If additional lines are needed for nonreimbursable cost centers other than those shown, subscript one or more of these lines with a numeric code. The subscripted lines must be appropriately labeled to indicate the purpose for which they are being used. However, when the expense (direct and all applicable overhead) attributable to any nonallowable cost area is so insignificant as not to warrant establishment of a nonreimbursable cost center, these expenses are adjusted on Worksheet A-8. (See CMS Pub. 15-1, chapter 23, §2328.)

Line 194--Establish a nonreimbursable cost center to accumulate the cost incurred by you for services related to the physicians' private practice. Such costs include depreciation costs for the space occupied, movable equipment used by the physicians' offices, administrative services, medical records, housekeeping, maintenance and repairs, operation of plant, drugs, medical supplies, and nursing services. Do not include costs applicable to services rendered to hospital patients by hospital-based physicians since such costs may be included in hospital costs.

Lines 195 through 199--Reserved for future use.

Line 200--Sum of lines 118 through 199.

4014. WORKSHEET A-6 - RECLASSIFICATIONS

This worksheet provides for the reclassification of certain costs to effect proper cost allocation under cost finding. For each reclassification adjustment, assign an alpha character in column 1 to identify each reclassification entry, e.g., A, B, C. DO NOT USE NUMERIC DESIGNATIONS. All reclassification entries must have a corresponding Worksheet A line number reference in columns 3 and 7. In column 10, indicate the column of Worksheet A-7 impacted by the reclassification, where applicable. If more than one column on Worksheet A-7 is impacted by one reclassification, report each entry as a separate line to properly report each column impacted on Worksheet A-7. If you directly assign the capital-related costs (i.e., insurance, taxes, and other), reclassify these costs to line 3. Do not reclassify other capital-related costs reported or reclassified to line 3 of Worksheet A back to the capital lines 1 or 2, of Worksheet A. This is accomplished through Worksheet A-7.

Submit with the cost report copies of any workpapers used to compute the reclassifications effected on this worksheet.

Identify any reclassifications made as salary and other costs in the appropriate column. However, when transferring to Worksheet A, transfer the sum of the two columns.

NOTE: Salary amounts paid to an employee in addition to direct salaries or wages (such as paid vacation, holiday, sick, other paid-time-off (PTO), severance, and bonus pay) must be reported on Worksheet A, column 1, of the same cost center as the employees' direct salaries and wages. For example, if the indirect salaries (such as paid vacation, holiday, sick, other paid-time-off (PTO), severance, and bonus pay) are reported in the "Employee Benefits" cost center or in column 2 of the cost where the related direct salary and wages are reported, a reclassification entry must be made to reclassify them to column 1 of the cost center(s) in which the related direct salaries and wages are reported.

If there is any reclassification to general service cost centers for compensation of provider-based physicians, make the appropriate adjustment for RCE limitation on Worksheet A-8-2. (See §4018.)

Examples of reclassifications that may be needed are:

- Reclassification of related organization rent expenses included in the A&G cost center which are applicable to lines 1 and 2 of Worksheet A. See instructions for Worksheet A-8-1 for treatment of rental expenses for related organizations.

- Reclassification of interest expense included on Worksheet A, column 3, line 113, which is applicable to funds borrowed for A&G purposes (e.g., operating expenses) or for the purchase of buildings and fixtures or movable equipment. Allocate interest on funds borrowed for operating expenses with A&G expenses.

- Reclassification of employee benefits expenses (e.g., employee health service, hospitalization insurance, workers compensation, employee group insurance, social security taxes, unemployment taxes, annuity premiums, past service benefits, and pensions) included in the A&G cost center.

- Reclassification of utilization review cost applicable to the hospital-based SNF to A&G costs. If the scope of the utilization review covers the entire population, reclassify the total allowable utilization review cost included on Worksheet A, column 3, line 114. However, if the scope of the utilization review in the hospital-based SNF covers only Medicare patients or Medicare and title XIX patients, only the allowable utilization review costs included on Worksheet A, column 3, line 114 (other than the compensation of physicians for their personal services on utilization review committees), are reclassified to A&G costs.

The appropriate adjustment for physicians' compensation is made on Worksheet A-8. For further explanations concerning utilization review in skilled nursing facilities, see CMS Pub. 15-1, chapter 21, §2126.2.

- Reclassification of any dietary cost included in the dietary cost center which is applicable to the cafeteria, nursery, and to any other cost centers such as gift, flower, coffee shops, and canteen.

- Reclassification of any direct expenses included in the central service and supply cost center which are directly applicable to other cost centers such as intern-resident service, intravenous therapy, and oxygen (inhalation) therapy.

- Reclassification of any direct expenses included in the laboratory cost center which are directly applicable to other cost centers such as whole blood and packed red blood cells or electrocardiology.

- Reclassification of any direct expenses included in the radiology-diagnostic cost center which are directly applicable to other cost centers such as radiology-therapeutic, radioisotope, or electrocardiology.

- When you purchase services (e.g., physical therapy) under arrangements for Medicare patients but do not purchase such services under arrangements for non-Medicare patients, your books reflect only the cost of the Medicare services. However, if you do not use the grossing up technique for purposes of allocating overhead and if you incur related direct costs applicable to both Medicare and non-Medicare patients (e.g., paramedics or aides who assist a physical therapist in performing physical therapy services), reclassify the related costs on Worksheet A-6 from the ancillary service cost center. Allocate them as part of A&G expense. However, when you purchase services that include performing administrative functions such as completion of medical records, training, etc., as described in CMS Pub. 15-1, chapter 14, §1412.5, the overall charge includes the provision of these services. Therefore, for cost reporting purposes, these related services are NOT reclassified to A&G.

- If a beneficiary receives outpatient renal dialysis for an extended period of time and you furnish a meal, the cost of this meal is not an allowable cost for Medicare. Make an adjustment on Worksheet A-8. However, the dietary counseling cost attributable to a dialysis patient is an allowable cost. Reclassify this cost from the dietary cost center, line 10, to the renal dialysis cost center, line 74.

- When interns and residents are employed to replace anesthetists, you must reclassify the related direct costs from the intern and resident cost center to the anesthesiology cost center. (See 49 FR 208 (January 3, 1984).)

  NOTE: These interns and residents do not qualify for the IME adjustment and must be excluded for the intern and resident FTE for that purpose. (See 42 CFR 412.113(c).)

- If you incur costs for an unpaid guarantee for emergency room physician availability, attach a separate worksheet showing the computation of the necessary reclassification. (See CMS Pub. 15-1, chapter 21, §2109.)

- Reclassification of the costs of malpractice insurance premiums, self-insurance fund contributions, and uninsured malpractice losses incurred either through deductible or coinsurance provisions, as a result of an award in excess of reasonable coverage limits, or as a government provider to the A&G cost center.

4015. WORKSHEET A-7 - RECONCILIATION OF CAPITAL COST CENTERS

This worksheet consists of three parts:

Part I - Analysis of Changes in Capital Asset Balances.
Part II - Reconciliation of amounts from Worksheet A, column 2, lines 1 and 2.
Part III - Reconciliation of Capital Cost Centers.

See the instructions for Worksheet A for a definition of capital. All providers must complete Parts I, II, and III.

NOTE: Include assets which are directly allocated to the provider from the home office or related organization and the related other capital costs in Parts I and II of this worksheet.

The intent of Worksheet A-7, Part I, is to reflect assets which relate to the hospital. However, examine the cost finding elections made at the time you submit the cost report to consider the cost finding treatment of SNF, HHA, hospice, subproviders, CORF, CMHC, the physician office building, and any other nonallowable cost centers.

Where you have elected to cost find any of these areas through the cost report, related assets must be included in Worksheet A-7, Part I, as appropriate, to properly allocate the related insurance, taxes, etc.

4015.1 Part I - Analysis of Changes in Capital Asset Balances.--This part enables the Medicare program to analyze the changes that occurred in your capital asset balances during the current reporting period. Complete this worksheet only once for the entire hospital complex (certified and non-certified components). However, only include in Part I assets that relate to hospital services or are commingled and cannot be separated.

Columns 1 and 6--Enter the balance recorded in your books of accounts at the beginning of your cost reporting period (column 1) and at the end of your cost reporting period (column 6). You must submit a reconciliation demonstrating that the amount reported on Part I, column 6, line 10, agrees with the total fixed assets on Worksheet G, plus any directly allocated assets from the home office or related organization, less any assets not allocated through the cost finding method on Worksheet B. Include fully depreciated assets still used for patient care.

Columns 2 through 4--Enter the cost of capital assets acquired by purchase in column 2 and the fair market value at date acquired of donated assets in column 3. Enter the sum of columns 2 and 3 in column 4.

NOTE: The amounts in Part I, column 2, must also include transfers of assets from a change of ownership.

Column 5--Enter the cost or other approved basis of all capital assets sold, retired, or disposed of in any other manner during your cost reporting period.

Column 6--Enter the sum of columns 1 and 4, minus column 5.

Column 7--Enter the initial acquisition cost of fully depreciated assets for each category. An asset that is fully depreciated and continues to be used in the facility must be recorded in this column. There will be no depreciation expense recorded after the asset is fully depreciated.

Line Descriptions

Line 7--If you acquired certified health information technology (HIT) assets and are an EHR technology meaningful user (Worksheet S-2, Part I, line 167, is yes) in accordance with ARRA 2009, §4102, and CAA 2016, §602, enter the corresponding amounts on this line.

Line 9--If you have included in lines 1 through 7 of Part I any of the following, enter those amounts on line 9.

- Capitalized a lease in accordance with generally accepted accounting principles (GAAP) and included it in the assets reported on Worksheet G,
- Excess of amounts paid for the acquisition of assets over their fair values, or the amount recognized under §2314 of DEFRA for transactions after July 18, 1984, or
- Construction in progress at the end of the cost reporting period.

Line 10--Enter line 8 minus line 9.

4015.2 Part II - Reconciliation of Amounts From Worksheet A, Column 2, Lines 1 and 2.--The purpose of this worksheet is to segregate and specifically identify the depreciation and capital-related costs which are directly assigned to Worksheet A, column 2, lines 1 and 2.

Columns 9 through 14--Enter in columns 9 through 14, the depreciation and other capital-related costs. (Do not report in columns 12 through 14 any amounts previously reported in Part III, columns 5 through 7). The sum of columns 9 through 14 of this part, which is reported in column 15, lines 1 and 2, must agree with the amounts reported on Worksheet A, column 2, lines 1 and 2.

4015.3 Part III - Reconciliation of Capital Cost Centers.--Use this part to allocate allowable insurance, taxes, and other capital expenditures (not including depreciation, lease, and interest expense) to the capital-related cost centers. This part also summarizes the amounts in the capital-related cost centers on Worksheet A, lines 1 and 2, column 7.

Lines 1 and 2--The allowable costs for other capital-related expenses (including but not limited to taxes, insurance, and license and royalty fees on depreciable assets) are apportioned by applying the ratio of the hospital's capital related building and fixtures and capital related movable equipment gross asset value to total asset value in each cost reporting period. These lines compute the appropriate gross asset ratios used in allocating other capital-related costs in columns 5 through 7.

Line 3--Enter the sum of lines 1 and 2. Column 4 must equal 1.000000.

Columns 1 through 4, Lines 1 and 2--Use these columns and lines to compute ratios of capital related building and fixtures and capital related movable equipment gross asset values to total gross asset values. Use these ratios on columns 5 through 7 to allocate other capital costs (insurance, taxes, and other) to the capital-related cost center lines (Worksheet A, lines 1 and 2).

Column 1--Enter on line 1 your gross asset value (asset value before accumulated depreciation) for buildings and fixtures (which also includes old land and land improvements). Enter on line 2 your gross asset value for movable equipment.

NOTE: Part III, column 1, line 3, must agree with the sum of Part I, column 6, line 8.

Column 2--Enter in column 2, line as appropriate, any amounts that you have included in column 1, lines 1 and 2, and which were reported on line 8 of Part I, as appropriate.

Column 3--Enter column 1 less column 2.

Column 4--Enter on lines 1 and 2 the amount in column 3, lines as applicable, divided by the amount in column 3, line 3. Round the resulting ratio to six decimal places.

Columns 5 through 7--These columns provide for the allocation of other capital-related costs (taxes, insurance, and other) to the capital-related cost center lines (Worksheet A, lines 1 and 2).

Line 3--Enter in column 5 capital expenditures relating to insurance. Enter in column 6 capital expenditures relating to State and local taxes on property and equipment. Enter in column 7 other capital expenditures (not including taxes, insurance, depreciation, lease, and interest expense). Enter in column 8, the sum of the amounts reported in columns 5 through 7.

Lines 1 and 2--Apply the ratios developed in column 4, line as applicable, to allocate the other capital costs reported in line 3.

Column 8--Line 3 must be equal to or less than the amount on Worksheet A, line 3, column 3. The amount reported becomes the reclassification entry on Worksheet A, column 4, which will zero-out the balance on line 3. If you directly assign other capital-related costs, see Part II for proper disclosure of these costs.

Columns 9 through 15--These lines summarize the amounts in the capital-related cost centers (Worksheet A, lines 1 and 2, column 7).

NOTE: The amount entered in these columns must be net of reclassifications and adjustments identified on Worksheets A-6, A-8 and A-8-1.

Column 9--Enter the amount reported in Part II above, from column 9, lines 1 and 2, adjusted by the amounts identified on Worksheets A-6, A-8 and A-8-1.

Column 10--Enter the amount reported in Part II, column 10, lines 1 and 2, relating to capital-related lease expense, adjusted by the amounts identified on Worksheets A-6, A-8, and A-8-1. (See CMS Pub. 15-1, chapter 28, §2806.1.) Report insurance, taxes, and license and royalty fees associated with leased assets in columns 12, 13, and 14 of this worksheet, respectively.

Column 11--Enter the amount reported in Part II, column 11, lines 1 and 2, relating to capital-related interest expense, adjusted by the amounts identified on Worksheets A-6, A-8, and A-8-1.

Column 12--Enter the amount from column 5 plus any additional amounts reported in Part II, column 12 adjusted by amounts identified on Worksheets A-6, A-8, and A-8-1.

Column 13--Enter the amount from column 6 plus any additional amounts reported in Part II, column 13 adjusted by amounts identified on Worksheets A-6, A-8, and A-8-1.

Column 14--Enter the amount from column 7 plus any additional amounts reported in Part II, column 14 adjusted by amounts identified on Worksheets A-6, A-8, and A-8-1.

Column 15--Enter the sum of columns 9 through 14. The amounts from column 15, lines 1 and 2, must equal the amounts on Worksheet A, column 7, lines 1 and 2.

4016. WORKSHEET A-8 - ADJUSTMENTS TO EXPENSES

In accordance with 42 CFR 413.9(c)(3), if your operating costs include amounts not related to patient care, these amounts are not reimbursable under the program. If your operating costs include amounts flowing from the provision of luxury items or services (i.e., those items or services substantially in excess of or more expensive than those generally considered necessary for the provision of needed health services), such amounts are not allowable.

This worksheet provides for the adjustments in support of those listed on Worksheet A, column 6. These adjustments, required under the Medicare principles of reimbursement, are made on the basis of cost or amount received (revenue) only if the cost (including direct cost and all applicable overhead) cannot be determined. If the total direct and indirect cost can be determined, enter the cost. Submit with the cost report a copy of any work papers used to compute a cost adjustment. Once an adjustment to an expense is made on the basis of cost, you may not determine the required adjustment to the expense on the basis of revenue in future cost reporting periods. Enter the following symbols in column 1 to indicate the basis for adjustment: "A" for cost or "B" for amount received. Line descriptions indicate the more common activities which affect allowable costs or result in costs incurred for reasons other than patient care and, thus, require adjustments.

Types of adjustments entered on this worksheet include (1) those needed to adjust expenses to reflect actual expenses incurred; (2) those items which constitute recovery of expenses through sales, charges, fees, etc.; (3) those items needed to adjust expenses in accordance with the Medicare principles of reimbursement; and (4) those items which are provided for separately in the cost apportionment process.

If an adjustment to an expense affects more than one cost center, record the adjustment to each cost center on a separate line on Worksheet A-8.

NOTE: When adjustments affect capital, they must be appropriately identified as impacting capital related building and fixtures, or capital related movable equipment. If these adjustments affect other capital-related costs, indicate in column 5, the capital-related cost category shown on Worksheet A-7, Part III, columns 9 through 14.

Enter additional costs as positive amounts. Enter reductions of cost as a negative number. Enter a net total (if a reduction of cost) as a negative number.

Line Descriptions

Lines 1 through 3--Enter the investment income to be applied against interest expense. (See CMS Pub. 15-1, chapter 2, §202.2, for an explanation.)

Line 7--For patient telephones, make an adjustment on this line or establish a nonreimbursable cost center. When this line is used, base the adjustment on cost. Revenue is not used. (See CMS Pub. 15-1, chapter 23, §2328.)

Line 10--Enter the total provider-based physician adjustments for personal patient care services and RCE limitations. Obtain this amount from Worksheet A-8-2, column 18, sum of all lines.

NOTE: Make the adjustment to Worksheet A, column 6, for each applicable cost center from Worksheet A-8-2, column 18, line as appropriate.

Line 12--Obtain this amount from section A, column 6 of Worksheet A-8-1.

NOTE: Worksheet A-8-1 represents the detail of the various cost centers on Worksheet A which must be adjusted.

Line 19--For each NAHE program on Worksheet A, line 20, and its subscripts, and Worksheet A, line 23, and its subscripts, enter the revenue adjustments (for tuition, fees, books, etc.) to be applied against total allowable costs that are directly related to the approved NAHE activities. Subscript this line to separately report the revenue offset for each NAHE program reported on line 20 and line 23. (See CMS Pub. 15-1, chapter 4, §414, and 42 CFR 413.85(d)(2)(i).)

Line 21--Enter the cash received from the imposition of interest, finance, or penalty charges on overdue receivables. Use this income to offset the allowable administration and general costs. (See CMS Pub. 15-1, chapter 21, §2110.2.)

Line 22--Enter the interest expense imposed by the contractor on Medicare overpayments. Also, enter interest expense on borrowing made to repay Medicare overpayments.

Line 23--Enter, if applicable, the amount from Worksheet A-8-3, line 65.

Line 24--Enter, if applicable, the amount from Worksheet A-8-3, line 65.

Line 25--This line pertains to the hospital-based SNF only. When the utilization review covers only Medicare patients or Medicare and title XIX patients, allocate 100 percent of the reasonable compensation paid to the physicians for their services on utilization review committees to the health care programs. Apportion all other allowable costs applicable to utilization review which cover only health care program patients among all users of the hospital-based SNF. Reclassify such other costs on Worksheet A-6. Enter the physicians' compensation for service on utilization review committees which cover only health care program patients in the hospital-based SNF. The amount entered equals the amount shown on Worksheet A, column 6, line 114. (See CMS Pub. 15-1, chapter 21, §2126.2.) If the utilization review costs pertain to more than one program, the amount entered on Worksheet E-2, column 1, line 7, must equal the amount adjusted on Worksheet A-8.

Lines 26 and 27--When depreciation expense computed in accordance with the Medicare principles of reimbursement differs from depreciation expenses per your books, enter the difference on lines 26 and 27, as applicable. Use line 26 capital related buildings and fixtures costs and line 27 for new capital related movable equipment costs. Personal use of assets requires adjustment to depreciation expense, e.g., automotive used 50 percent for business and 50 percent personal.

Line 28--This adjustment is required for salaries and fringe benefits paid to non-physician anesthetists reimbursed on a fee schedule. (See the instructions for Worksheet A, line 19.)

Line 29--Sections 1861(s)(2)(K), 1842(b)(6)(C), and 1842(b)(12) of the Act provide for coverage of and separate payment for services performed by a physician assistant. The physician assistant is an employee of the hospital and payment is made to the employer of the physician assistant. Make an adjustment on Worksheet A-8 for any payments made directly to the physician assistant for services rendered. This avoids any duplication of payments.

Line 30--Enter, if applicable, the amount from Worksheet A-8-3, line 65, for occupational therapy services rendered.

Line 31--Enter, if applicable, the amount from Worksheet A-8-3, line 65, for speech pathology services rendered.

Line 32--For CAHs, where applicable in accordance with ARRA of 2009, section 4102, remove the current year depreciation expense associated with purchased assets for which the total cost or remaining un-depreciated cost was reimbursed either in the current or prior cost reporting period as EHR incentive payment if such depreciation was included on Worksheet A, line 2 (capital-related movable equipment), or any other line. This includes the depreciation expense for EHR assets purchased in the current cost reporting period, as well as depreciation expense related to the remaining net book value (i.e., un-depreciated basis), of EHR assets purchased in prior cost reporting periods which were not fully depreciated at the beginning of the current cost reporting period.

Also, use this line to remove that portion of the annual rent/lease expense applicable to EHR assets leased under a virtual purchase lease which equals the depreciation expense for this asset since the total cost of the asset (or the un-depreciated cost if the lease was initiated in a prior cost reporting period), was claimed as EHR incentive payment. Also remove any portion of the total

rental charge which exceeds the actual cost of ownership of the EHR asset. (See CMS Pub. 15-1, chapter 1, §110.B.2.) In accordance with CMS Pub. 15-1, chapter 1, §110.B.2, the actual cost of ownership of an asset leased under a virtual purchase lease includes not only the depreciation expense, but insurance and interest as well. For example, if the depreciation for the asset is $50,000 per year, the insurance is $3,000 per year, the interest is $10,000 per year, and the rental charge is $70,000 per year, the rental expense must be limited to the cost of ownership which in this example is $63,000. Since the adjustment to limit the rent expense to the cost of ownership is $7,000, the actual adjustment on this line will be to reduce the allowable rent expense for this EHR asset by $57,000 (i.e., $50,000 depreciation portion and $7,000 excess rental charge over the cost of ownership).

Lines 33 through 49--Enter any additional adjustments which are required under the Medicare principles of reimbursement. Label the lines appropriately to indicate the nature of the required adjustments. If the number of blank lines is not sufficient, subscript lines 33 through 49. The grossing up of costs in accordance with provisions of CMS Pub. 15-1, chapter 23, §2314, is an example of an adjustment entered on these lines and is explained below.

If you furnish ancillary services to health care program patients under arrangements with others but simply arrange for such services for non-health care program patients and do not pay the non-health care program portion of such services, your books reflect only the costs of the health care program portion. Therefore, allocation of indirect costs to a cost center which includes only the cost of the health care program portion results in excessive assignment of indirect costs to the health care programs. Since services were also arranged for the non-health care program patients, allocate part of the overhead costs to those groups.

In the foregoing situation, do not allocate indirect costs to the cost center unless your contractor determines that you are able to gross up both the costs and the charges for services to non-health care program patients so that both costs and charges for services to non-health care program patients are recorded as if you had provided such services directly. See the instructions for Worksheet C, Part I, for grossing up of your charges.

Meals furnished by you to an outpatient receiving dialysis treatment also require an adjustment. These costs are nonallowable for title XVIII reimbursement. Therefore, the cost of these meals must be adjusted.

In accordance with CMS Pub. 100-04, chapter 9, §40, compensation paid to a physician for RHC services rendered in a hospital-based RHC is cost reimbursed. Where the physician agreement compensates for RHC services as well as non-RHC services, or services furnished in the hospital, the related compensation must be eliminated on Worksheet A-8 and billed to the Part B contractor. If not specified in the agreement, a time study must be used to allocate the physician compensation.

If the hospital performs ESRD services and costs are reported on either line 74, 94, or both, these costs should include the cost of all ESAs. Do not report the cost of these drugs claimed in any other cost center. These costs will be removed later on Worksheet B-2.

If the hospital pays membership dues to an organization that performs lobbying and political activities, the portion of the dues associated with these non-allowable activities must be removed from costs.

Line 30.99 (hardcoded)--When the hospital enters into a contractual arrangement with a hospice for the use of general inpatient routine beds, enter the amount received under contract from the hospice. This amount must be used to offset general inpatient routine care costs on Worksheet A, line 30.

Line 50--Enter the sum of lines 1 through 49. Transfer the amounts in column 2 to the appropriate lines on Worksheet A, column 6.

4017. WORKSHEET A-8-1 - STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

In accordance with 42 CFR 413.17, costs applicable to services, facilities, and supplies furnished to you by organizations related to you by common ownership or control are includable in your allowable cost at the cost to the related organization, except for the exceptions outlined in 42 CFR 413.17(d). This worksheet provides for the computation of any needed adjustments to costs applicable to services, facilities, and supplies furnished to the hospital by organizations related to you or costs associated with the home office. In addition, it shows certain information concerning the related organizations with which you have transacted business as well as home office costs. (See CMS Pub. 15-1, chapter 10, and §2150, respectively.)

Part A--Cost applicable to home office costs, services, facilities, and supplies furnished by organizations related to you by common ownership or control are includable in your allowable cost at the cost to the related organizations. However, such cost must not exceed the amount a prudent and cost-conscious buyer pays for comparable services, facilities, or supplies that are purchased elsewhere. Costs for services provided by a home office or related party, including employee or contract labor, must be assigned to the most closely matched cost centers on Worksheet A (lines 4 through 17). When portions of home office or related party costs, including employee or contract labor costs, pertain to more than A&G, assign the applicable costs to the corresponding most closely matched cost centers on lines 4 through 17 of Worksheet A. For example, if the home office cost included contracted housekeeping services, the contract labor costs must be reported on Worksheet A, line 9, and reflected on Worksheet A-8-1, referencing Worksheet A, line 9, in column 1.

Columns 1, 2, and 3--Enter in columns 1 and 3, respectively, the Worksheet A line number and specific expense category from your books and/or records associated with the acquisition of services, facilities, and/or supplies from related organizations. Column 2 (Worksheet A cost center description) is automatically completed based on the cost center in column 1.

Column 4--Enter the allowable cost from the books and/or records of the related organization which includes only the actual cost incurred by the related organization for services, facilities, and/or supplies and excludes any markup, profit or amounts that otherwise exceed the acquisition cost of such items.

Column 5--Enter the amount included on Worksheet A for services, facilities, and/or supplies acquired from related organizations.

Column 6--Enter the result of column 4 minus column 5.

Column 7--Enter the specific column of Worksheet A-7, Part III, columns 9 through 14, impacted by the adjustment.

Part B--Use this part to show your relationship to organizations for which transactions were identified in Part A. Show the requested data relative to all individuals, partnerships, corporations, or other organizations having either a related interest to you, a common ownership with you, or control over you as defined in CMS Pub. 15-1, chapter 10, in columns 1 through 6, as appropriate.

Complete only those columns which are pertinent to the type of relationship which exists.

Columns 1 and 2--Enter in column 1, the appropriate symbol which describes your relationship to the related organization. If the symbol A, D, E, F, or G is entered in column 1, enter the name of the related individual in column 2.

Column 3--If the individual indicated in column 2 or the organization indicated in column 4 has a financial interest in you, enter the percent of ownership as a ratio.

Column 4--Enter the name of the related corporation, partnership, or other organization.

Column 5--If you or the individual indicated in column 2 has a financial interest in the related organizations, enter the percent of ownership in such organization as a ratio.

Column 6--Enter the type of business in which the related organization engages (e.g., medical drugs and/or supplies, laundry and linen service).

4018. WORKSHEET A-8-2 - PROVIDER-BASED PHYSICIAN ADJUSTMENTS

In accordance with 42 CFR 413.9, 42 CFR 415.55, 42 CFR 415.60, 42 CFR 415.70, and 42 CFR 415.102(d), you may claim as allowable cost only those costs which you incur for physician services that benefit the general patient population of the provider or which represent availability services in a hospital emergency room under specified conditions. (See 42 CFR 415.150 and 42 CFR 415.164 for an exception for teaching physicians under certain circumstances.) 42 CFR 415.70 imposes limits on the amount of physician compensation which may be recognized as a reasonable provider cost.

Worksheet A-8-2 provides for the computation of the allowable provider-based physician cost you incur. 42 CFR 415.60 provides that the physician compensation paid by you must be allocated between services to individual patients (professional services), services that benefit your patients generally (provider services). Effective for cost reporting periods ending on or after October 1, 2021, any nonreimbursable services such as research must be reported in the designated nonreimbursable cost center and not included on this worksheet. Effective for cost reporting periods ending prior to October 1, 2021, if nonreimbursable costs such as research are included in column 3 those costs must also be included in column 4 as professional services in order to be properly removed from Worksheet A. Only provider services are reimbursable to you through the cost report. This worksheet also provides for the computation of the RCE limits required by 42 CFR 415.70. The methodology used in this worksheet applies the RCE limit to the total physician compensation attributable to provider services reimbursable on a reasonable cost basis. Enter the total provider-based physician adjustment for personal care services and RCE limitations applicable to the compensation of provider-based physicians directly assigned to or reclassified to general service cost centers. RCE limits are not applicable to a medical director, chief of medical staff, or to the compensation of a physician employed in a capacity not requiring the services of a physician, e.g., controller. RCE limits also do not apply to CAHs; however, the professional component must still be removed on this worksheet. CAHs need only complete columns 1 through 5 and 18.

NOTE: 42 CFR 415.70(a)(2) provides that limits established under this section do not apply to costs of physician compensation attributable to furnishing inpatient hospital services paid for under the PPS implemented under 42 CFR 412.

Limits established under this section apply to inpatient services subject to the TEFRA rate of increase ceiling (see 42 CFR 413.40), outpatient services for all titles, and to title XVIII, Part B inpatient services.

Since the methodology used in this worksheet applies the RCE limit in total, make the adjustment required by 42 CFR 415.70(a)(2) on Worksheet C, Part I. Base this adjustment on the RCE disallowance amounts entered in column 17 of Worksheet A-8-2.

Where several physicians work in the same department, see CMS Pub. 15-1, chapter 21, §2182.6C, for a discussion of applying the RCE limit in the aggregate for the department versus on an individual basis to each of the physicians in the department.

NOTE: The RCEs are not applied to Medicare nonreimbursable or Medicare non-certified areas of the hospital and the adjustments generated from this worksheet for physician compensation are limited to the cost centers on Worksheet A, lines 4 through 41, 43, 50 through 78, 90 through 99, 102, 105 through 111, and 115, and subscripts as allowed.

Column Descriptions

Columns 1 and 10--Enter the line numbers from Worksheet A for each cost center that contained compensation for physicians who are subject to RCE limits.

Columns 2 and 11--Enter the description of the cost center used on Worksheet A. When RCE limits are applied on an individual basis to each physician in a department, list each physician on successive lines directly under the cost center description line, or list the first physician on the same line as the cost center description line and then each successive line below for each additional physician in that cost center.

List each physician using an individual identifier (not the physician's name, NPI, UPIN or social security number of the individual), but rather, Dr. A, Dr. B, Dr. AA, Dr. BB, etc. However, the identity of the physician must be made available to your contractor/contractor upon audit. When RCE limits are applied on a departmental basis, insert the word "aggregate" (instead of the physician identifiers) on the line below the cost center description.

Columns 3 through 9 and 12 through 18--When the aggregate method is used, enter the data for each of these columns on the aggregate line for each cost center. When the individual method is used, enter the data for each column on the individual physician identifier lines for each cost center.

Column 3--Enter the total physician compensation paid by you for each cost center. Physician compensation means monetary payments, fringe benefits, deferred compensation, costs of physician membership in professional societies, continuing education, malpractice, and any other items of value (excluding office space or billing and collection services) that you or other organizations furnish a physician in return for the physician's services. (See 42 CFR 415.60(a).) Include the compensation in column 3 of Worksheet A or, if necessary, through appropriate reclassifications on Worksheet A-6 or as a cost paid by a related organization through Worksheet A-8-1.

Column 4--Enter the amount of total remuneration included in column 3 applicable to the physician's services to individual patients (professional component). These services are reimbursed on a reasonable charge basis by the Part B contractor in accordance with 42 CFR 415.102(a). The written allocation agreement between you and the physician specifying how the physician spends his or her time is the basis for this computation. (See 42 CFR 415.60(f).)

Column 5--Enter the amount of the total remuneration included in column 3, for each cost center, applicable to general services to you (provider component). The written allocation agreement is the basis for this computation. (See 42 CFR 415.60(f).)

NOTE: 42 CFR 415.60(b) requires that physician compensation be allocated between physician services to patients, the provider, and nonallowable services such as research. Physicians' nonallowable services must not be included in columns 3, 4, or 5.

Column 6--For each line of data, enter the RCE limit applicable to the physician's compensation included in that cost center. Obtain the RCE limit from the applicable chart in the Federal Register as listed below. If the physician specialty is not identified in the chart, use the RCE for the "Total" category (from the same chart).

Cost Reporting Period Beginning On or After	Federal Register	Note
January 1, 2004	68 FR 45459 (August 1, 2003)	Your location governs which of the three geographical categories are applicable: non-metropolitan areas, metropolitan areas less than one million, or metropolitan areas greater than one million.
January 1, 2015	79 FR 50162 (August 22, 2014)	Not applicable.

Column 7--Enter for each line of data, the physician's hours allocated to provider services. For example, if a physician works 2080 hours per year and 50 percent of his/her time is spent on provider services, then enter 1040 in this column. The hours entered are the actual hours for which the physician is compensated by you for furnishing services of a general benefit to your patients. If the physician is paid for unused vacation, unused sick leave, etc., exclude the hours so paid from the hours entered. Time records or other documentation that supports this allocation must be available for verification by your contractor upon request. (See CMS Pub. 15-1, chapter 21, §2182.3E.)

Column 8--Enter the unadjusted RCE limit for each line of data. This amount is the product of the RCE amount entered in column 6 and the ratio of the physician's provider component hours entered in column 7 to 2080 hours.

Column 9--Enter, for each line of data, five percent of the amounts entered in column 8.

Column 12--You may adjust upward, up to five percent of the computed limit (column 9), to take into consideration the actual costs of membership for physicians in professional societies and continuing education paid by you.

Enter for each line of data the actual amounts of these expenses paid by you.

Column 13--Enter for each line of data the result of multiplying column 5 by column 12, and dividing that amount by column 3.

Column 14--You may also adjust upward the computed RCE limit in column 8 to reflect the actual malpractice expense incurred by you for the services of a physician or group of physicians to your patients.

Enter for each line of data the actual amounts of these malpractice expenses paid by you.

Column 15--Enter for each line of data the result of multiplying column 5 by column 14, and dividing that amount by column 3.

Column 16--Enter for each line of data the sum of columns 8 and 15, plus the lesser of column 9 or 13.

Column 17--Compute the RCE disallowance for each cost center by subtracting the RCE limit in column 16 from your component remuneration in column 5. If the result is a negative amount, enter zero. Transfer the amounts for each cost center to Worksheet C, Part I, column 4, for all hospitals subject to PPS. (See 42 CFR 412.)

Column 18--The adjustment for each cost center entered represents the PBP elimination from costs entered on Worksheet A-8, column 2, line 10, and on Worksheet A, column 6, to each cost center affected. Compute the amount by deducting, for each cost center, the lesser of the amounts recorded in column 5 (provider component remuneration) or column 16 (adjusted RCE limit) from the total remuneration recorded in column 3. For CAHs, transfer the amount from column 4 (professional component remuneration) to column 18.

NOTE: If you incur cost for unpaid guarantee for emergency room physician availability, attach a separate worksheet showing the computation of the necessary reclassification. (See CMS Pub. 15-1, chapter 21, §2109.)

Line Descriptions

Line 200--Enter the total of lines 1 through 11 for columns 3 through 5, 7 through 9, and 12 through 18.

4019. WORKSHEET A-8-3 - REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

This worksheet provides for the computation of any needed adjustments to costs applicable to therapy services furnished by outside suppliers in CAHs. Therapy services rendered by non-CAH providers are either subject to fee schedule reimbursement or the corresponding PPS reimbursement. Consequently, only CAHs complete this worksheet. The information required on this worksheet provides, in the aggregate, all data for therapy services furnished by all outside suppliers in determining the reasonableness of therapy costs.

If you contract with an outside supplier for therapy services, the potential for limitation and the amount of payment you receive depend on several factors:

- An initial test to determine whether these services are categorized as intermittent part time or full-time services;
- The location where the services are rendered (i.e., at your site or an alternate site).
- Whether detailed time and mileage records are maintained by the outside supplier;
- Add-ons for supervisory functions, aides, overtime, equipment and supplies; and
- Contractor determinations of reasonableness of rates charged by the supplier compared with the going rates in the area.

4019.1 Part I - General Information.--This part provides for furnishing certain information concerning therapy services furnished by outside suppliers.

Line 1--Enter the number of weeks that services were performed on site. Count only those weeks during which a supervisor, therapist or an assistant was on site. (See CMS Pub. 15-1, chapter 14.)

Line 2--Multiply the amount on line 1 by 15 hours per week. This calculation is used to determine whether services are full-time or intermittent part-time.

Line 3--Enter the number of days in which the supervisor or therapist (only report the therapists for respiratory therapy) was on site. Count only one day when both the supervisor and therapist were at the site during the same day.

Line 4--Enter the number of days in which the therapy assistant (PT, OT, or SP only) was on site. Do not include days when either the supervisor or therapist was also at the site during the same day.

NOTE: Count an unduplicated day for each day the contractor has at least one employee on site. For example, if the contractor furnishes a supervisor, therapist and assistant on one day, count one therapist day. If the contractor provides two assistants on one day (and no supervisors or therapists), count one assistant day.

Line 5--Enter the number of unduplicated visits made by the supervisor or therapist. Count only one visit when both the supervisor and therapist were present during the same visit.

Line 6--Enter the number of unduplicated visits made by the therapy assistant. Do not include in the count the visits when either the supervisor or therapist was present during the same visit.

Line 7--Enter the standard travel expense rate applicable. (See CMS Pub. 15-1, chapter 14.)

Line 8--Enter the optional travel expense rate applicable. (See CMS Pub. 15-1, chapter 14.) Use this rate only for services for which time records are available.

Line 9--Enter in the appropriate columns the total number of hours worked for each category.

Line 10--Enter in each column the appropriate adjusted hourly salary equivalency amount (AHSEA). This amount is the prevailing hourly salary rate plus the fringe benefit and expense factor described in CMS Pub. 15-1, chapter 14. This amount is determined on a periodic basis for appropriate geographical areas and is published as an exhibit at the end of CMS Pub. 15-1, chapter 14. Use the appropriate exhibit for the period of this cost report.

Enter in column 1 the supervisory AHSEA, adjusted for administrative and supervisory responsibilities. Determine this amount in accordance with the provisions of CMS Pub. 15-1, chapter 14, §1412.5. Enter in columns 2, 3, and 4 (for therapists, assistants, aides, and trainees respectively), the AHSEA from either the appropriate exhibit found in CMS Pub. 15-1, chapter 14 or from the latest publication of rates. If the going hourly rate for assistants in the area is unobtainable, use no more than 75 percent of the therapist AHSEA. The cost of services of a therapy aide or trainee is evaluated at the hourly rate, not to exceed the hourly rate paid to your employees of comparable classification and/or qualification, e.g., nurses' aides. (See CMS Pub. 15-1, chapter 14, §1412.2.)

Line 11--Enter the standard travel allowance equal to one half of the AHSEA. Enter in columns 1 and 2, one half of the amount in column 2, line 10. Enter in column 3, one half of the amount in column 3, line 10. (See CMS Pub. 15-1, chapter 14, §1402.4.)

Lines 12 and 13--Enter the number of travel hours and number of miles driven, respectively, if time records of visits are kept. (See CMS Pub. 15-1, chapter 14, §§1402.5 and 1403.1.) Subscript this line into two categories of provider site and provider offsite as necessary. For example, report line 12 - provider site and line 12.01 - provider offsite.

NOTE: There is no travel allowance for aides employed by outside suppliers.

4019.2 Part II - Salary Equivalency Computation.--This part provides for the computation of the full-time or intermittent part-time salary equivalency.

When you furnish therapy services from outside suppliers to health care program patients but simply arrange for such services for non-health care program patients and do not pay the non-health care program portion of such services, your books reflect only the cost of the health care program portion. Where you can gross up costs and charges in accordance with provisions of CMS Pub. 15-1, chapter 23, §2314, complete Part II, lines 14 through 20, and 23, in all cases and lines 21 and 22, where appropriate. See §4016 and CMS Pub. 15-1, chapter 23, §2314 for instructions regarding grossing up costs and charges. However, where you cannot gross up costs and charges, complete lines 14 through 20, and 23.

Line 14 through 20--To compute the total salary equivalency allowance amounts, multiply the total hours worked (line 9) by the adjusted hourly salary equivalency amount for supervisors, therapists, assistants, aides and trainees (for respiratory therapy only).

Line 17--Enter the sum of lines 14 and 15 for respiratory therapy, or sum of lines 14 through 16 for all others.

Line 20--Enter the sum of lines 17 through 19 for respiratory therapy, or sum of lines 17 and 18 for all other.

Lines 21 and 22--If the sum of hours in columns 1 and 2 for respiratory therapy, or columns 1 through 3 for all others, line 9**,** is less than or equal to the product found on line 2, complete these lines. (See the exception above where you cannot gross up costs and charges, and services are provided to program patients only.)

Line 21--Enter the result of line 17 divided by the sum of columns 1 and 2, line 9, for respiratory therapy, or columns 1 through 3, line 9, for all others.

Line 22--Enter the result of line 2 times line 21.

Line 23--If there are no entries on lines 21 and 22, enter the amount on line 20. Otherwise, enter the sum of the amounts on lines 18, 19, and 22 for respiratory therapy, or lines 18 and 22 for all others.

4019.3 Part III - Standard and Optional Travel Allowance and Travel Expense Computation - Provider Site.--This part provides for the computation of the standard and optional travel allowance and travel expense for services rendered on site.

Lines 24 through 28--Complete these lines for the computation of the standard travel allowance and standard travel expense for therapy services performed at your site. One standard travel allowance is recognized for each day an outside supplier performs skilled therapy services at your site. For example, if a contracting organization sends three therapists to you each day, only one travel allowance is recognized per day. (See CMS Pub. 15-1, chapter 14, §1403.1, for a discussion of standard travel allowance and §1412.6 for a discussion of standard travel expense.)

Line 24--Include the standard travel allowance for supervisors and therapists. This standard travel allowance for supervisors does not take into account the additional allowance for administrative and supervisory responsibilities. (See CMS Pub. 15-1, chapter 14, §1402.4.)

Line 25--Include the standard travel allowance for assistants for physical therapy, occupational therapy, and speech pathology.

Line 26--Enter the amount from line 24 for respiratory therapy, or the sum of lines 24 and 25 for physical therapy, occupational therapy, or speech pathology.

Line 27--Enter the result of line 7 times line 3 for respiratory therapy, or line 7 times the sum of lines 3 and 4 for all others.

Lines 29 through 35--Complete these lines for computing the optional travel allowance and expense when proper records are maintained.

Line 31--Enter the amount on line 29 for respiratory therapy or the sum of lines 29 and 30 for all others.

Line 32--Enter the result of line 8 times the sum of columns 1 and 2, line 13, for respiratory therapy, or columns 1, 2, and 3, line 13, for all other.

Lines 33 through 35--Enter an amount in one of these lines depending on the method utilized.

4019.4 Part IV - Standard and Optional Travel Allowance and Standard Travel Expense Computation - Services outside Provider Site.--This part provides for the computation of the standard travel allowance, the standard travel expense, the optional travel allowance, and the optional travel expense. (See CMS Pub. 15-1, chapter 14, §§1402ff, 1403.1, and 1412.6.)

Lines 36 through 39--Complete these lines for the computation of the standard travel allowance and standard travel expense for therapy services performed in conjunction with offsite visits. Only use these lines if you do not use the optional method of computing travel. A standard travel allowance is recognized for each visit to a patient's residence. If services are furnished to more than one patient at the same location, only one standard travel allowance is permitted, regardless of the number of patients treated.

Lines 40 through 43--Complete the optional travel allowance and optional travel expense computations for physical therapy, occupational therapy, and speech pathology services in conjunction with home health services only. Compute the optional travel allowance on lines 40 through 42. Compute the optional travel expense on line 43.

Lines 44 through 46--Choose and complete only one of the options on lines 44 through 46. However, use lines 45 and 46 only if you maintain time records of visits. (See CMS Pub. 15-1, chapter 14, §1402.5.)

4019.5 Part V - Overtime Computation.--This part provides for the computation of an overtime allowance when an individual employee of the outside supplier performs services for you in excess of your standard work week. No overtime allowance is given to a therapist who receives an additional allowance for supervisory or administrative duties. (See CMS Pub. 15-1, chapter 14, §1412.4.)

Line 47--Enter in the appropriate columns the total overtime hours worked. Where the total hours in column 5 are either zero or, equal to or greater than 2080, the overtime computation is not applicable. Make no further entries on lines 48 through 55 (If there is a short period prorate the hours). Enter zero in each column of line 56. Enter in column 5 the sum of the hours recorded in columns 1, 3 and 4 for respiratory therapy, and columns 1 through 3 for physical therapy, speech pathology, and occupational therapy.

Line 48--Enter in the appropriate column the overtime rate (the AHSEA from line 10, column as appropriate, multiplied by 1.5).

Line 50--Enter the percentage of overtime hours by class of employee. Determine this amount by dividing each column on line 47 by the total overtime hours in column 5, line 47.

Line 51--Use this line to allocate your standard work year for one full-time employee. Enter the numbers of hours in your standard work year for one full-time employee in column 5. Multiply the standard work-year in column 5 by the percentage on line 50 and enter the result in the corresponding columns.

Line 52--Enter in columns 1 through 3 for physical therapy, speech pathology, and occupational therapy the AHSEA from Part I, line 10, columns 2 through 4, as appropriate. Enter in columns 1, 3, and 4, the AHSEA from Part I, line 10, columns 2, 4, and 5, for respiratory therapy.

Line 56--Enter in column 5, the sum of the amounts recorded in columns 1, 3, and 4, for respiratory therapy, and columns 1 through 3, for physical therapy, speech pathology, and occupational therapy.

4019.6 Part VI - Computation of Therapy Limitation and Excess Cost Adjustment.--This part provides for the calculation of the adjustment to the therapy service costs in determining the reasonableness of therapy cost.

Line 58--Enter the amount reported on lines 33, 34, or 35.

Line 59--Enter the amount reported on lines 44, 45, or 46.

Lines 61 and 62--When the outside supplier provides the equipment and supplies used in furnishing direct services to your patients, the actual cost of the equipment and supplies incurred by the outside supplier (as specified in CMS Pub. 15-1, chapter 14, §1412.1) is considered an additional allowance in computing the limitation.

Line 64--Enter the amounts paid and/or payable to the outside suppliers for the hospital, if applicable, for therapy services rendered during the period as reported in the cost report. This includes any payments for supplies, equipment use, overtime, or any other expenses related to supplying therapy services for you. Add all subscripted lines together for purposes of calculating the amount to be entered on this line.

Line 65--Enter the excess cost over the limitation (i.e., line 64 minus line 63). If the amount is negative, enter a zero. Transfer this amount to Worksheet A-8, line 23, for respiratory therapy; line 24, for physical therapy; line 30, for occupational therapy; and line 31, for speech pathology.

4020. WORKSHEET B, PART I - COST ALLOCATION - GENERAL SERVICE COSTS AND WORKSHEET B-1 - COST ALLOCATION - STATISTICAL BASIS

Base cost data on an approved method of cost finding and on the accrual basis of accounting except where government institutions operate on a cash basis of accounting. (See 42 CFR 413.24(a).) Cost data based on such basis of accounting is acceptable subject to appropriate treatment of capital expenditures. Cost finding is the process of recasting the data derived from the accounts ordinarily kept by you to ascertain costs of the various types of services rendered. It is the determination of these costs by the allocation of direct costs and proration of indirect costs. The various cost finding methods recognized are outlined in 42 CFR 413.24. Worksheets B, Part I, and B-1 have been designed to accommodate the stepdown method of cost finding.

The provider can elect to change the order of allocation and/or allocation statistics, as appropriate, for the current cost reporting period if a request is received by the contractor, in writing, 90 days prior to the end of that reporting period. The contractor has 60 days to make a decision and notify the provider of that decision or the change is automatically accepted. The change must be shown to more accurately allocate the overhead or should demonstrate simplification in maintaining the changed statistics. If a change in statistics is requested, the provider must maintain both sets of statistics until an approval is made. If both sets are not maintained and the request is denied, the provider reverts back to the previously approved methodology. The provider must include with the request all supporting documentation and a thorough explanation of why the alternative approach should be used. (See CMS Pub. 15-1, chapter 23, §2313.)

Simplified Cost Allocation Methodology

As an alternative approach to the cost finding methods identified in CMS Pub. 15-1, chapter 23, §2306, the provider may request a simplified cost allocation methodology. This methodology reduces the number of statistical bases a provider maintains. It may result in reducing Medicare reimbursement. A comparison is recommended if the possible loss reimbursement is surpassed by the reduced costs of maintaining voluminous statistics. The following statistical bases must be used for purposes of allocating overhead cost centers. There can be no deviation of the prescribed statistics, and it must be utilized for all the following cost centers.

Cost Center	Statistical Basis
Buildings and Fixtures	Square Footage
Movable Equipment	Square Footage
Maintenance and Repairs	Square Footage
Operation of Plant	Square Footage
Housekeeping	Square Footage
Employee Benefits	Salaries
Cafeteria*	Salaries
Administrative and General	Accumulated Costs
Laundry and Linen	Patient Days
Dietary**	Patient Days
Social Service	Patient Days
Maintenance of Personnel	Eliminated and moved to A&G for simplified cost finding
Nursing Administration	Nursing Salaries
Central Services and Supply	Costed Requisitions
Pharmacy	Costed Requisitions
Medical Records and Library	Gross Patient Revenue
Nursing Program*	Assigned Time
Interns and Residents	Assigned Time
Paramedical Education	Assigned Time
Nonphysician Anesthetists	100 percent to Anesthesiology

NOTE: The election of the alternative method discussed above cannot result in inappropriately shifting costs.

*Contract labor is not included and is not grossed up.
**If this is a meals on wheels program, a Worksheet A-8 adjustment is required.

Once the simplified method is elected, the provider must continue to use this method for no less than 3 years, unless a change of ownership occurs.

The 90-day and 60-day rule previously discussed in this section still applies (CMS Pub. 15-1, chapter 23, §2313).

Continuation of the Standard Allocation Methodology Instructions

Worksheet B, Part I, provides for the allocation of the expenses of each general service cost center to those cost centers which receive the services. The cost centers serviced by the general service cost centers include all cost centers within your organization, other general service cost centers, inpatient routine service cost centers, ancillary service cost centers, outpatient service cost centers, other reimbursable cost centers, special purpose cost centers, and nonreimbursable cost centers. Obtain the total direct expenses from Worksheet A, column 7.

All direct GME costs (inpatient and outpatient in approved programs) are reimbursed based on a specific amount per resident as computed on Worksheet E-4. Costs applicable to interns and residents must still be allocated in columns 21 and 22. These costs are, however, eliminated from total costs in column 25, unless you qualify for an exception. See the instructions for column 25 for a more detailed explanation.

Worksheet B-l provides for the proration of the statistical data needed to equitably allocate the expenses of the general service cost centers on Worksheet B, Part I. To facilitate the allocation process, the general format of Worksheets B, Part I, and B-1 is identical. Each general service cost center has the same line number as its respective column number across the top. Also, the column and line numbers for each general service cost center are identical on the two worksheets. In addition, the line numbers for each routine service, ancillary outpatient service, other reimbursable, special purpose, and nonreimbursable cost center are identical on the two worksheets. The cost centers and line numbers are also consistent with Worksheet A. If you have subscripted any lines on Worksheet A, subscript the same lines on these worksheets.

NOTE: General service columns 1 through 23 and subscripts thereof must be consistent on Worksheets B, Parts I and II; H-2, Part I; J-1, Part I; K-5, Part I; and L-1, Part I.

The statistical basis shown at the top of each column on Worksheet B-1 is the recommended basis of allocation of the cost center indicated which must be used by all providers completing this form. If a different basis of allocation is used, you must indicate the basis of allocation actually used at the top of the column subject to the applicable provisions of CMS Pub. 15-1, chapter 23, §2313. Additionally, the following overhead cost center statistics can be substituted for the recommended statistics printed on Worksheet B-1 subject to the applicable provisions of CMS Pub. 15-1, chapter 23, §2313.

Cost Center	Statistical Basis
Housekeeping	Square Footage
Cafeteria	FTEs
Maintenance of Personnel	Eliminate and move to A&G
Medical Records	Gross Patient Revenue

Most cost centers are allocated on different statistical bases. However, for those cost centers with the same basis (e.g., square feet), the total statistical base over which the costs are allocated differs because of the prior elimination of cost centers that have been closed.

The general service cost centers are ordered sequentially such that the cost centers that render the most services to and receive the least services from other cost centers are listed first. When closing the general service cost centers, first close the cost centers that render the most services to and receive the least services from other cost centers. List the cost centers in this sequence from left to right on the worksheets. However, your circumstances may be such that a more accurate result is obtained by allocating to certain cost centers in a sequence different from that followed on these worksheets.

NOTE: General service cost centers are not allocated to provider-based physician (PBP) clinical lab service (line 61) because this cost center is treated as a purchased service under arrangements provided only to program beneficiaries.

If the amount of any cost center on Worksheet A, column 7, has a credit balance, show this amount as a credit balance on Worksheet B, Part I, column 0. Allocate the costs from the applicable overhead cost centers in the normal manner to the cost center showing a credit balance. After receiving costs from the applicable overhead cost centers, if a general service cost center has a credit balance at the point it is allocated, do not allocate the general service cost center. Rather, enter the credit balance in parentheses on line 201 as well as on the first line of the column and on line 202. This enables column 24, line 202, to cross foot to columns 0 and 4A, line 202, if the provider has intern & resident costs or a post step-down adjustment in column 25. However, column 26 will cross foot to columns 0 and 4A if the provider has no interns and residents costs or a post step-down adjustment in column 25. After receiving costs from the applicable overhead cost centers, if a revenue producing cost center has a credit balance on Worksheet B, Part I, column 26, do not carry forward a credit balance to any worksheet.

On Worksheet B-1, enter on the first line in the column of the cost center being allocated the total statistical base over which the expenses are allocated (e.g., in column 1, capital-related cost - building and fixtures, enter on line 1 the total square feet of the building on which depreciation was taken). For all cost centers to which the capital-related cost is allocated, enter that portion of the total statistical base applicable to each. The sum of the statistical base applied to each cost center receiving the services rendered must equal the total base entered on the first line. Use accumulated cost for allocating A&G expenses.

Do not include any statistics related to services furnished under arrangements except if:

- Both Medicare and non-Medicare costs of arranged for services are recorded in your records; or

- Your contractor determines that you are able to (and do) gross up the costs and charges for services to non-Medicare patients so that both cost and charges are recorded as if you had furnished such services directly to all patients. (See CMS Pub. 15-1, chapter 23, §2314.)

Enter on line 202 of Worksheet B-l the total expenses of the cost center being allocated. Obtain this amount from Worksheet B, Part I, from the same column and line number used to enter the statistical base on Worksheet B-1. (In the case of capital-related costs - buildings and fixtures, this amount is on Worksheet B, Part I, column 1, line 1.)

Divide the amount entered on line 202 by the total statistic entered in the same column on the first line. Enter the resulting unit cost multiplier on line 203. Round the unit cost multiplier to six decimal places.

Multiply the unit cost multiplier by that portion of the total statistics applicable to each cost center receiving the services rendered. Enter the result of each computation on Worksheet B, Part I, in the corresponding column and line. (See §4000.1 for rounding standards.)

After applying the unit cost multiplier to all the cost centers receiving the services rendered, the total cost (line 202) of all the cost centers receiving the allocation on Worksheet B, Part I, must equal the amount entered on the first line. Perform the preceding procedures for each general service cost center. Complete the column for each cost center on both Worksheets B, Part I, and B-1 before proceeding to the column for the next cost center.

If a general service cost center has a credit balance at the point it is allocated on Worksheet B, Part I, do not allocate the general service cost centers. However, display the statistic departmentally, but do not calculate a unit cost multiplier for lines 203 and 205 on Worksheet B-1. Use line 204 of Worksheet B-1 in conjunction with the allocation of capital-related costs on Worksheet B, Part II. Complete line 204 for all columns after Worksheets B, Part I, and B-1 are completed and the amount of direct and indirect capital-related cost is determined on Worksheet B, Part II, column 2A. Use line 205 for all columns in allocating the direct and indirect capital-related cost on Worksheet B, Part II. Compute the unit cost multiplier (after the amount entered on line 204 has been determined) by dividing the capital-related costs recorded on line 204 by the total statistic entered in the same column on the first line. Round the unit cost multipliers to six decimal places. (See instructions for Worksheet B, Part II, for the complete methodology and exceptions.)

Do not use line 200 to allocate costs on Worksheet B, Part I.

Since intern and resident costs are segregated into two cost centers, properly allocate general service costs applicable to each center. A listing of general service cost centers which may be applicable and the appropriate allocation to the separate cost centers for the intern and resident costs is presented below.

Cost Center	Salary & Salary Related Fringe Benefits	Other
Capital Related Costs - Bldgs. & Fixtures		X
Capital Related Costs - Movable Equipment		X
Employee Benefits	X	X
Administrative and General	X	X
Maintenance and Repair		X
Operation of Plant		X
Housekeeping		X
Cafeteria	X	X
Maintenance of Personnel		X

After the costs of the general service cost center have been allocated on Worksheet B, Part I, enter in column 24, the sum of the costs in columns 4A through 23, for lines 30 through 201. Once overhead is allocated to these cost centers, they are closed, and the costs are not further allocated to the revenue producing cost centers.

Since costs applicable to direct GME costs (inpatient and outpatient in approved programs) are reimbursed based on a specific amount per resident, exclude these costs from the total costs in column 26. Enter on each line in column 25 the sum of the amounts shown on each line in columns 21 and 22. If you qualify for the exception (cost reimbursed hospital such as CAHs do not offset I&R costs), enter only the amounts from Worksheet B-2.

In addition, when an adjustment to expenses is required after cost allocation, enter the amount applicable to each cost center in column 25 of Worksheet B, Part I. Corresponding adjustments to Worksheet B, Part II, may be applicable for capital-related cost adjustments. Submit a supporting worksheet showing the computation of the adjustments in addition to completing Worksheet B-2.

NOTE: The amount reported in column 25 must equal both the sum of the amounts shown in columns 21 and 22, unless you qualify for the exception and the amounts on Worksheet B-2, excluding adjustments with a worksheet code of "4." See the instructions for column 25 for a more detailed explanation.

Other examples of adjustments to expenses which may be required after cost allocation are (1) the allocation of available costs between the certified portion and the non-certified portion of a distinct part provider, and (2) costs attributable to unoccupied beds in a hospital with a restrictive admission policy. (See CMS Pub. 15-1, chapter 23, §§2342-2344.3.)

After the adjustments have been entered on Worksheet B, Part I, column 25, subtract the amounts in column 25 from the amounts in column 24, and enter the resulting amounts in column 26 for each line. The cost subtotal entered in column 24, line 202, must equal the total costs entered in column 0, line 202.

Transfer the totals in column 26, lines 30 through 46 (inpatient routine service cost centers), lines 50 through 78 (ancillary service cost centers), lines 88 through 93 (outpatient service cost centers), lines 94 through 101 (other reimbursable cost centers), and lines 105 through 117 (special purpose cost centers), to Worksheet C, Parts I and II, column l, lines 30 through 117. For cost reporting periods beginning before October 1, 2014, hospital-based RHC/FQHCs transfer the total costs from column 26, lines 88 and 89, respectively, to Worksheet M-2. For cost reporting periods beginning on or after October 1, 2014, hospital-based RHCs transfer the total costs from column 26, line 88, to Worksheet M-2. For cost reporting periods beginning on or after October 1, 2014, hospital-based FQHCs see instructions for Worksheet N-2, column 4.

Transfer the total cost in column 26, line 100 (intern/resident services not in approved teaching program) to Worksheet D-2, Part I, column 2, line 1.

The total outpatient rehabilitation costs in column 26, line 93, and subscripts, must agree with Worksheet J-1, Part I, column 26, line 22, for each provider type.

Do not transfer ASC costs from column 26, line 115. Do not transfer the nonreimbursable cost center totals (lines 190 through 193).

NOTE: Do not transfer negative numbers.

Column Descriptions

Column 1--Include only capital costs for building and fixtures. See the instructions for Worksheet A, line 1, for a discussion capital-related costs for building and fixtures.

Column 2--Include only capital costs for movable equipment. See the instructions for Worksheet A, line 2, for a discussion capital-related costs for movable equipment.

Column 20--All nursing program costs that are considered normal operating costs in 42 CFR 413.85(h)(6) (and identified as criterion code 4 in column 3 of Worksheet S-2, Part I, subscripts of line 60) do not transfer to Worksheet D, Part III, and Part IV.

Column 23--All paramedical/allied health costs that are considered normal operating costs in 42 CFR 413.85(h)(6) (and identified as criterion code 4 in column 3 of Worksheet S-2, Part I, subscripts of line 60) do not transfer to Worksheet D, Part III, and Part IV.

Worksheet B, Part I, Column 25--Hospitals other than CAHs and REHs--Accumulate in this column the costs for interns and residents. Except as provided in 42 CFR 413.77(e)(1) for cost reporting periods beginning prior to December 27, 2020, the costs of interns and residents (direct GME costs for inpatient and outpatient in approved programs) for PPS and TEFRA hospitals are paid on a per resident amount (PRA) through Worksheet E-4. (The exception at 42 CFR 413.77(e)(1) for payment of direct GME costs on a reasonable cost basis no longer applies for cost reporting periods beginning on or after December 27, 2020). In order to avoid duplicate payments of interns and residents costs, enter the sum of the amounts reported on each line in columns 21 and 22 in the appropriate line of column 25. When an adjustment to expenses is required after cost allocation, enter on the appropriate lines in this column the amounts from Worksheet B-2, excluding adjustments with a worksheet code of "4." The total of columns 21 and 22 and the applicable lines on Worksheet B-2, must equal the total of column 25.

NOTE: For cost reporting periods beginning prior to December 27, 2020, in accordance with 42 CFR 413.77(e), if a hospital did not have any approved medical residency programs or did not participate in Medicare during the base period but either condition changes in a cost reporting period beginning on or after October 1, 2006 and the residents are not on duty during the first month of the cost reporting period in which the hospital first begins to train residents, the contractor establishes a PRA using information from the first cost reporting period immediately following the cost reporting period during which the hospital participates in Medicare and residents began training at the hospital. Any intern and resident costs incurred during the cost reporting period, prior to the base period used to calculate the PRA, are reimbursed as pass-through costs based on reasonable costs on Worksheets D, Parts III and IV, and D-2, Part II, if applicable. If Worksheet S-2, Part I, line 57, column 1, is "Y" and column 2 is "N", do not include in column 25 the interns and residents costs from columns 21 and 22.

If Worksheet S-2, Part I, line 57, column 1, contains an "N" or column 2 contains a "Y", include in column 25 the interns and residents in approved programs costs from columns 21 and 22 because these costs will be reimbursed on a PRA basis through Worksheet E-4. For cost reporting periods beginning on or after December 27, 2020, if line 56, column 1, is "Y", then these costs are reimbursed on a PRA basis through Worksheet E-4.

CAHs and REHs--If you are CAH and responded "Y" to Worksheet S-2, Part I, line 107 (indicating that you have an I&R training program), or if you are a REH and responded "Y" to Worksheet S-2, Part I, line 107.01 (indicating that you have an I&R training program), the GME elimination is not performed. Consequently, do not include in column 25 the intern and resident costs from columns 21 and 22.

Worksheet B-1, Column 5A--Enter the costs attributable to the difference between the total accumulated cost reported on Worksheet B, Part I, column 4A, line 202, and the accumulated cost reported on Worksheet B-1, column 5, line 5. Enter any amounts reported on Worksheet B, Part I, column 4A, for (1) any service provided under arrangements to program patients and which is not grossed up and (2) negative balances. Enter a negative one (-1) in the accumulated cost column to identify the cost center which should be excluded from receiving any A&G costs.

If some of the costs from that cost center are to receive A&G costs, then enter in the reconciliation column the amount not to receive A&G costs to assure that only those costs to receive overhead receive the proper allocation. Including a statistical cost which does not relate to the allocation of A&G expenses causes an improper distribution of overhead. In addition, report on line 5 the A&G costs reported on Worksheet B, Part I, column 5, line 5, since these costs are not included on Worksheet B-1, column 5, as an accumulated cost statistic.

For componentized A&G cost centers, the accumulated cost center line number must match the reconciliation column number. Include in the column number the alpha character "A" (i.e., if the accumulated cost center for A&G is line 5.03 (Other A&G), the reconciliation column designation must be 5A.03).

Worksheet B-1, Column 5--The A&G expenses are allocated on the basis of accumulated costs. Therefore, the amount entered on Worksheet B-l, column 5, line 5, is the difference between the amounts entered on Worksheet B, Part I, column 4A and Worksheet B-1, column 5A. A negative cost center balance in the statistics for allocating A&G expenses causes an improper distribution of this overhead cost center. Exclude negative balances from the allocation statistics.

Worksheet B-1, Column 20--Enter the appropriate statistics for each nursing program based on assigned time. Nursing program costs reported on line 20, and its subscripts, may not be allocated to another program listed on line 20, or its subscripts.

Worksheet B-1, Column 23--Enter the appropriate statistics for each paramedical education/allied health program based on assigned time. If, however, the use of assigned time is not appropriate for that paramedical education program (i.e., a non-direct patient care cost center), a different statistical basis may be used. For example, if you have a paramedical education program for hospital administration, using assigned time as the statistical basis may be inappropriate. Use accumulated costs as the statistical basis for allocating hospital administrative paramedical education program costs. Paramedical education/allied health program costs reported on line 23, and its subscripts, may not be allocated to another program listed on line 23, or its subscripts.

Worksheet B-1, Columns 20 and 23, Lines 206 (NAHE Adjustment Amount to be Allocated) and 207 (NAHE Unit Cost Multiplier)--For each line on Worksheet B-2, where column 2, is "4" (indicating a post stepdown adjustment for nursing program education costs and/or allied health/paramedical education costs), enter on line 206 in the corresponding column 20 and/or 23, and applicable subscripts, the adjustment amount (as a positive number) from the corresponding line of Worksheet B-2, column 4.

Enter on line 207 the NAHE unit cost multiplier by dividing the adjustment amount on line 206, by the total statistic at the top of the applicable column. Calculate the NAHE post step-down adjustment by multiplying the NAHE unit cost multiplier by the applicable cost center statistic and enter the resulting amount in the corresponding cost center on Worksheet D, Part III, columns 1A and 2A, and Worksheet D, Part IV, columns 2A and 3A, as appropriate. Since the NAHE adjustment columns on Worksheets D, Parts III and IV, are not subscriptable, combine the NAHE adjustment amounts on Worksheet D, Part III columns 1A and 2A, respectively, and Worksheet D, Part IV, columns 2A and 3A, respectively, when Worksheet B-1, columns 20 and/or 23, are subscripted. See the instructions for Worksheets D, Parts III and IV, for further information.

4021. WORKSHEET B, PART II - ALLOCATION OF CAPITAL-RELATED COSTS

This worksheet provides for the determination of direct and indirect capital-related costs allocated to those cost centers which receive the services. The cost centers serviced by the general service cost centers include all cost centers within your organization, other general service cost centers, inpatient routine service cost centers, ancillary service cost centers, outpatient service cost centers, other reimbursable cost centers, special purpose cost centers, and nonreimbursable cost centers. Hospitals receiving 100 percent Federal rate for IPPS capital payments complete Worksheet B, Part II in its entirety.

NOTE: Unless there is a change in ownership or the provider has elected the alternative method described in §4017, the hospital must continue the same cost finding methods (including its cost finding bases) in effect in the hospital's prior cost reporting period. If there is a change in ownership, the new owners may request that the contractor approve a change in order to be consistent with their established cost finding practices. (See CMS Pub. 15-1, chapter 23, §2313.)

Part II is completed by all IPPS hospitals and IPPS excluded hospitals which were part of a complex subject to IPPS. Freestanding hospitals excluded from IPPS are not required to complete Part II.

See the instructions for Worksheet A, lines 1 and 2, for a discussion of capital-related costs.

Use these worksheets in conjunction with Worksheets B, Part I and B-1. The format and allocation process employed are identical to that used on Worksheets B, Part I, and B-1. Any cost centers, subscripted lines, and/or columns added to Worksheet A are also added to Worksheet B, Part II, in the same sequence.

Column 0--Where capital-related costs have been directly assigned to specific cost centers on Worksheet A, column 7, in accordance with CMS Pub. 15-1, chapter 23, §2307, enter in this column those amounts directly assigned from your records. Where you include cost incurred by a related organization, the portion of these costs that are capital-related costs is considered directly assigned capital-related costs of the applicable cost center. For example, if you are part of a chain organization that includes some costs incurred by the home office of the chain organization in your A&G cost center, the amount so included represents capital-related costs included in this column.

Columns l and 2--Obtain the amounts entered in columns l and 2, lines 4 through 199, from the corresponding columns and lines on Worksheet B, Part I.

Column 2A--Enter the sum of columns 0 through 2 for each line.

Enter on line 204 of Worksheet B-l for each column the capital-related costs allocated. Report these costs on the first line of each column on Worksheet B, Part II. (See exceptions below.) Complete a unit cost multiplier for each column by dividing the amount on line 204 of Worksheet B-l by the statistic reported on the first line of the same column. Enter the unit cost multiplier on line 205 and round to six decimal places, e.g., .0622438 is rounded to .062244. The allocation process on Worksheet B, Part II, is identical to that used on Worksheets B, Part I, and B-l.

Multiply the unit cost multipliers on line 205 by the portion of the total statistic on Worksheet B-1 applicable to each cost center. Enter the result of each computation on Worksheet B, Part II, respectively, in the corresponding column and line.

After the unit cost multipliers have been applied to all the cost centers, the total cost on Worksheet B, Part II, line 202**,** of all the cost centers receiving the allocation must equal the amount allocated on the first line of the column. However, this is not true in circumstances described in the second paragraph of exceptions below. Perform these procedures for each general service cost center. Complete the column for each cost center on Worksheets B-1 and B, Part II, before proceeding to the column for the next cost center.

EXCEPTIONS: When a general service cost center is not allocated on Worksheet B, Part I, because it has a negative balance at the point it is to be allocated, the capital-related cost for the same general service cost center on Worksheet B, Part II, is not allocated. Enter the total capital-related cost on line 201, the negative cost center line. This enables column 2A, line 202, to cross foot to column 26, line 202, if no intern and resident cost or post step-down adjustments are identified in column 25. Otherwise, column 2A, line 202, will cross foot to line 24.

When a general service cost center has a negative direct cost balance on Worksheet B, Part I, column 0, and the negative balance becomes positive through the cost allocation process, adjust the amount of capital-related cost determined on Worksheet B, Part II, for that general cost center to reflect the amount allocated on Worksheet B, Part I. Determine the adjusted amounts of capital-related cost allocated on Worksheet B, Part II, by dividing the capital-related cost by the total indirect cost allocated to the specific cost center on Worksheet B, Part I. (Do not include the negative direct cost.) Then multiply that ratio by the net amount allocated on Worksheet B, Part I, for that specific cost center. For cross footing purposes, enter the adjusted capital-related costs on the first line of the column and the differences between the total capital-related cost and the adjusted capital-related cost on line 201 of Worksheet B, Part II. This enables column 2A, line 202, to cross foot to column 26, line 202, if no intern and resident cost or post step-down adjustments are identified in column 25. Otherwise, column 2A, line 202, will cross foot to line 24.

After all the capital-related costs of the general service cost centers have been allocated on Worksheet B, Part II, enter in column 24, the sum of columns 2A through 23, for lines 30 through 201.

When an adjustment to expenses is required after cost allocation, show the amount applicable to each cost center in column 25 of Worksheet B, Part II. Submit a supporting worksheet showing the computation of the adjustment in addition to completing Worksheet B-2.

Adjustments to expenses which may be required after cost allocation include (1) the allocation of available costs between the certified portion and the noncertified portion of a distinct part provider, and (2) costs attributable to unoccupied beds of a hospital with a restrictive admission policy. (See CMS Pub. 15-1, chapter 23, §§2342-2344.3.)

After the adjustments have been entered on Worksheet B, Part II, column 25, subtract the amounts in column 25 from the amounts in column 24, and enter the resulting amounts in column 26 for each line. The total costs entered in column 26, line 202, must equal the total costs entered in column 2A, line 202, if no intern and resident cost or post step-down adjustments are identified in column 25, otherwise column 2A, line 202, will equal line 24.

On Worksheet B, Part II, columns 19 through 23, lines 30 through 194, are shaded because the full amount of nonphysician anesthetists and medical education costs is obtained from Worksheet B, Part I, columns 19 through 23. Enter these amounts on line 200 for cross footing purposes. If column 20 is subscripted for additional education cost centers qualifying as educational pass-through costs (see the instructions for Worksheet A, lines 20 through 23), the subscripted column(s) must be shaded similarly to column 20.

Since capital-related cost, non-physician anesthetists, and approved education programs are not included in the operating cost per discharge, columns 19 through 23, lines 30 through 194, are shaded on Worksheet B, Part II, for all lines except lines 19 through 23, 200, 201, and 202. These are the only lines and columns where an approved educational cost center can be shown. For purposes of this paragraph only, the statistic for line 200 is the sum of the statistics on lines 30 through 117 and lines 190 through 194 on Worksheet B-1 for the same column. Enter these amounts on line 200 for cross footing purposes. Use line 200 of Worksheet B-1, columns 19 through 23, for this purpose in the allocation of capital-related cost on Worksheet B, Part II. Use the statistic on line 200 together with the statistics on lines 19 through 23 of Worksheet B-1 to allocate columns 19 through 23 of Worksheet B, Part II. If column 20 is subscripted for additional education cost centers qualifying as educational pass-through costs (see the instructions for Worksheet A, lines 20 through 23), the subscripted column(s) must be shaded similarly to columns 20 through 23.

The total for each column includes lines 200 and 201 for cross footing purposes.

Transfer:

From Worksheet B, Part II, Column 26	To Worksheet D, Part I
Line 30 - Adults and Pediatrics	Column l, line 30 for the hospital
Lines 31 through 35 - Intensive Care Type Inpatient Hospital Units	Column 1, lines 31 through 35
Line 40 - IPF Subprovider	Column l, line 40
Line 41 - IRF Subprovider	Column l, line 41
Line 42 - Subprovider	Column l, line 42
Line 43 - Nursery	Column 1, line 43 for titles V and XIX

From Worksheet B, Part II, Column 26	To Worksheet D-l, Part III
Line 44 - SNF	Line 75 for the SNF
Sum of lines 44 and 45	Line 75 for the NF

From Worksheet B, Part II, Column 26	To Worksheet D, Part II
Lines 50 through 78 - Ancillary Services	Column l, lines 50 through 77
Lines 90, 91, 92 and its subscripts, and 93 - Outpatient Service Cost and its subscripts	Column l, lines 90, 91, 92 and its subscripts, and 93 and its subscripts
Lines 94, 95 , and 98 - Other Reimbursable Cost Centers	Column l, lines 94, 95, and 98

From Worksheet B, Part II, Column 26	To Worksheet C, Part II, Column 2
Lines 50 through 98	Lines 50 through 98

4022. WORKSHEET B-2 - POST STEP-DOWN ADJUSTMENTS

This worksheet provides an explanation of the post step-down adjustments reported in column 25 of Worksheets B, Parts I and II; D, Parts III and IV; and L-1, Part I.

Column Descriptions

Column 1--Enter a brief description of the post step-down adjustment.

Column 2--Make post step-down adjustments on Worksheets B, Parts I and II; D, Parts III and IV; and L-1, Part I. Enter the worksheet code to which the post step-down adjustment applies. For lines 74 and/or 94, remove the amount for ESAs (i.e., Epoetin and Aranesp) reported on Worksheet S-5, lines 13, 14, 17, 18, and subscripts of line 22, columns 2 and 3.

Use the codes below to identify the worksheet in which the adjustment applies:

Code	Worksheet
1	B, Part I
2	B, Part II
3	L-1, Part I
4	D, Part III and D, Part IV

Column 3--Enter the worksheet line number to which the adjustment applies.

Column 4--Enter the amount of the adjustment. Transfer these amounts to the appropriate lines on Worksheets B, Parts I and II, or L-1, Part I, column 25.

Line Descriptions

Line 1--Enter the amount of the EPO adjustment for the renal dialysis inpatient department from Worksheet S-5, line 13. Do not use this line effective for cost reporting periods ending after December 31, 2012.

Line 2--Enter the amount of the EPO adjustment for the home dialysis program from Worksheet S-5, line 14. Do not use this line effective for cost reporting periods ending after December 31, 2012.

Line 3--Enter the amount of the Aranesp adjustment for the renal dialysis inpatient department from Worksheet S-5, line 17. Do not use this line effective for cost reporting periods ending after December 31, 2012.

Line 4--Enter the amount of the Aranesp adjustment for the home dialysis program from Worksheet S-5, line 18. Do not use this line effective for cost reporting periods ending after December 31, 2012.

Line 5--Enter the amount of the ESA adjustment for the renal dialysis inpatient department from Worksheet S-5, sum of the subscripts of line 22, column 2. Complete this line effective for cost reporting periods ending after December 31, 2012.

Line 6--Enter the amount of the ESA adjustment for the home dialysis program from Worksheet S-5, sum of the subscripts of line 22, column 3. Complete this line effective for cost reporting periods ending after December 31, 2012.

Lines 7 through 59--Enter any additional adjustments that are required under the Medicare principles of reimbursement. Label the lines appropriately to indicate the nature of the required adjustments. If the number of blank lines is not sufficient, use additional Worksheets B-2.

For cost reporting periods ending on or after September 30, 2017, report a post step-down adjustment, if applicable, for each nonprovider operated NAHE program identified on Worksheet S-2, subscripts of line 60, with a code of "2" or "3" in column 3:

1. for the portion of program cost that exceeds the percentage of total allowable provider cost attributable to NAHE clinical training costs reported in the most recent cost reporting period ending on or before October 1, 1989, as defined in 42 CFR 413.85(g)(2)(iii).
2. for the portion of program costs that the provider did not incur for courses that were included in the program as defined in 42 CFR 413.85(g)(3)(iii).

For each nonprovider operated NAHE program, enter a brief description of the post step-down adjustment in column 1. Enter in column 2 the worksheet code "4." These post step-down adjustments are applied to Worksheet D, Parts III, and IV. Enter the Worksheet A line number of the NAHE program being adjusted in column 3. Column 3 must be either nursing program (line 20, or a subscript of line 20) or paramedical education/allied health (line 23, or a subscript of line 23). Enter the post step-down adjustment amount in column 4.

For example: The provider qualifies for pass-through payment under 42 CFR 413.85(g)(2) for a nonprovider operated nursing program reported on Worksheet A, line 20. The pass-through cost for the program is limited to a percentage of allowable cost attributable to the clinical training cost in the provider's most recent cost reporting period ending on or before October 1, 1989. The provider's capped percentage in the current cost reporting period, based on the cost reporting period ending on or before October 1, 1989, is 10 percent, calculated in accordance with 42 CFR 413.85(g)(2)(iii). The post step-down adjustment would be calculated as follows:

Current year total allowable costs (W/S A, col. 7, line 118):	$1,500,000
Times 10 percent (1989 cap):	$150,000
Current year nursing program clinical training costs (W/S A, col. 7, line 20):	$180,000
Current year cost in excess of cap ($180,000-$150,000):	$30,000
Percentage of cost in excess of cap ($30,000/$180,000):	17%
Current year nursing program clinical training costs (W/S B, Part I, col. 20, line 20):	$225,000
W/S B-2 post step-down adjustment needed ($225,000 x 17%):	$38,250

NOTE: Do not use this worksheet to reduce the total allowable costs that are directly related to the NAHE programs by the revenue received from tuition and student fees. Use Worksheet A-8 to offset NAHE program costs by tuition and student fees (42 CFR 413.85(d)(2)(i)). Do not use a post step-down adjustment.

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4023. WORKSHEET C - COMPUTATION OF RATIO OF COST TO CHARGES AND OUTPATIENT CAPITAL REDUCTION

4023.1 Part I - Computation of Ratio of Cost to Charges.--This worksheet computes the ratio of cost to charges for inpatient services, ancillary services, outpatient services, and other reimbursable services. All charges entered on this worksheet must comply with CMS Pub. 15-1, chapter 22, §§2202.4 and 2203. This ratio is used on Worksheet D, Part V, for titles V and XIX, and for title XVIII; Worksheet D-3; Worksheet D-4; Worksheet H-3, Part II; and Worksheet J-2, Part II, to determine the program's share of ancillary service costs in accordance with 42 CFR 413.53. This worksheet is also needed to determine the adjusted total costs used on Worksheet D-1 because of your status as IPPS, TEFRA, or other.

42 CFR 413.106(f)(3) provides that the costs of therapy services furnished under arrangements to a hospital inpatient are exempt from the guidelines for physical therapy and respiratory therapy if such costs are subject to the provisions of 42 CFR 413.40 (rate of increase ceiling) or 42 CFR 412 (inpatient prospective payment). However, therapy services furnished under arrangements to CAHs are subject to the provisions of 42 CFR 413.106.

42 CFR 415.70(a)(2) provides that RCE limits do not apply to the costs of physician compensation attributable to furnishing inpatient hospital services (provider component) paid for under 42 CFR 412ff.

To facilitate the cost finding methodology, apply the therapy limits and RCE limits to total departmental costs. This worksheet provides the mechanism for adjusting the costs after cost finding to comply with 42 CFR 413.106(f)(3) and 42 CFR 415.70(a)(2). This is done by computing a series of ratios in columns 9 through 11. In column 9, a ratio referred to as the "cost or other ratio" is computed based on the ratio of total reasonable cost to total charges. This ratio is used by you or your components not subject to the IPPS or TEFRA (e.g., hospital-based SNFs and CAHs). Also use this ratio for Part B services still subject to cost reimbursement. In column 10, compute a TEFRA inpatient ratio. This ratio reflects the add-back of respiratory therapy/physical therapy (RT/PT) limitations to total cost since TEFRA inpatient costs are not subject to these limits. (TEFRA inpatient services are subject to RCE limits.) In column 11, compute an IPPS inpatient ratio. This ratio reflects the add-back of RT/PT and RCE limitations to total cost since inpatient hospital services covered by the IPPS are not subject to any of these limitations.

Column Descriptions

The following provider components may be subject to 42 CFR 413.40 or 42 CFR 412.1(a)ff:

- Hospital Part A inpatient services for title XVIII,
- Hospital subprovider Part A inpatient services for title XVIII,
- Hospital inpatient services for titles V and XIX, and
- Hospital subprovider services for titles V and XIX.

All components or portions of components not subject to IPPS, IPF PPS, IRF PPS, LTC PPS, or TEFRA, e.g., CAH services, are classified as "Cost or Other."

The following matrix summarizes the columns completed for Cost or Other, TEFRA Inpatient, and IPPS:

	Columns		
Type of Service Inpatient	Cost or Other	TEFRA Inpatient	IPPS, IPF-PPS, IRF-PPS
Inpatient routine service cost centers (lines 30-46)	1-3	1-3	1-5

Type of Service Inpatient (Cont.)	Columns 1 Cost or Other	Columns 2 TEFRA Inpatient	Columns 3 IPPS, IPF-PPS, IRF-PPS
Inpatient ancillary (lines 50-93)	1, 8, 9	1-3, 8-10	1-9, 11
Other Reimbursable (lines 94-98)	1, 8, 9	1-3, 8-10	1-9, 11
Other Reimbursable (lines 99-101)	1, 8	1-3, 8	1-8
Special Purpose (lines 105-117)	1, 8	1-3, 8	1-8

Column 1--Enter on each line the amount from the corresponding line of Worksheet B, Part I, column 26. Transfer the amount on line 92 from Worksheet D-1, Part IV, line 89, if you do not have a distinct observation bed area. If you have a distinct observation bed area, subscript line 92 into line 92.01, and transfer the appropriate amount from Worksheet B, Part I, column 26. In a complex comprised of an acute care hospital with an excluded unit(s) (excluded from the IPPS), only the acute care hospital may report observation bed costs. Any services provided by the RHC/FQHC outside the benefits package for those clinics are reported by the hospital in its appropriate ancillary cost center, but not in the RHC/FQHC cost center lines 88 and 89. Do not bring forward any cost center with a credit balance from Worksheet B, Part I, column 26.

Column 2--Enter the amount of therapy limits applied to the cost center on lines 65 to 68. Obtain these amounts from Worksheet A-8, lines 23, 24, 30, and 31 respectively.

NOTE: Complete this column only when the hospital or subprovider is subject to PPS or TEFRA rate of increasing ceiling (see 42 CFR 412, Subparts N and P, and 42 CFR 413.40, respectively). If the hospital and all subproviders have correctly indicated that their payment system is in the "other" category on Worksheet S-2, do not complete columns 2 through 5, 10, and 11.

Column 3--Enter on each cost center line the sum of columns 1 and 2.

Column 4--Only complete this section if you or your subproviders are subject to IPPS, IPF PPS, IRF PPS, or LTC PPS. Enter on each line the amount of the RCE disallowance. Obtain these amounts from the sum of the amounts for the corresponding line on Worksheet A-8-2, column 17.

Column 5--Complete this section only if you or your subproviders are subject to a PPS. Enter on each cost center line the sum of the amounts entered in columns 3 and 4.

Columns 6 and 7--Enter on each cost center line the total inpatient and outpatient gross patient charges including charges for charity care patients and, where applicable, standard customary charges for items reimbursed on a fee schedule (e.g., DME, oxygen, prosthetics, and orthotics). Also include the total inpatient and outpatient gross charges for cost centers which have a credit balance on Worksheet B, Part I, column 26, and, therefore, do not contain "cost" in column 1 of Worksheet C, Part I.

Total charges on Worksheet C, Part I, for each department are for provider services only. Therefore, Medicare charges on Worksheets D, Parts II and IV, D-2, D-3, and D-4, must also include provider services only. When reporting charges for a complex, e.g., hospital, subprovider, SNF, charges for like services must be uniform. (See CMS Pub. 15-1, chapter 22, §2203.)

When certain services are furnished under arrangements and an adjustment is made on Worksheet A-8 to gross up costs, gross up the related charges entered on Worksheet C, Part I, in accordance with CMS Pub. 15-1, chapter 23, §2314. If no adjustment is made on Worksheet A-8, show only the charges you actually billed on Worksheet C, Part I.

NOTE: Any cost center that includes CRNA charges must exclude these charges unless the hospital qualifies for the rural exception as outlined in §4013. All cost centers for which CRNA costs are excluded on Worksheet A-8 must also exclude the charges associated with these costs.

NOTE: Any charges for ancillary services provided to clinic, RHC and FQHC patients must be reclassified to the appropriate ancillary cost center, e.g., radiology-diagnostic, laboratory. A similar adjustment must be made to program charges.

Report on line 92 all charges for observation bed services provided in the inpatient routine care area of the hospital. The charges relate to all payer classes and include those observation bed charges for patients released as outpatients and those patients admitted as inpatients. If you have a distinct observation bed unit, report your gross charges on line 92.01 (which was subscripted on Worksheet A).

Column 8--Enter the total of columns 6 and 7.

Column 9 through 11--Cost to charge ratios are not calculated for lines 99 through 117. The corresponding locations on Worksheet C, Part I, are shaded.

Column 9, lines 50 through 98--Always complete this column. Divide the cost for each cost center in column 1 by the total charges for the cost center in column 8 to determine the ratio of total cost to total charges (referred to as the "Cost or Other" ratio) for that cost center. Enter the resultant departmental ratios in this column. Round ratios to 6 decimal places.

Column 10, lines 50 through 98--Complete this section only when the hospital or its subprovider is subject to the TEFRA rate of increase ceiling. (See 42 CFR 413.40.) Divide the amount reported in column 3 (which represents the total cost adjusted for the add-back of amounts excluded on Worksheet A-8 for the RT/PT limits) for each cost center by the total charges for the cost center in column 8.

This computation determines the RT/PT adjusted ratio of cost to charges (referred to as the TEFRA inpatient ratio) for each cost center. Enter the resultant departmental ratio. Round ratios to 6 decimal places.

Column 11, lines 50 through 98--Complete this section only when the hospital is subject to the IPPS or the LTC PPS or when its subprovider is subject to its respective PPS reimbursement methodology. (See 42 CFR 412.1(a) through 412.125, and 42 CFR 412, Subparts O, N, and P, respectively). Divide the amount reported in column 5 (which represents the total cost adjusted for the add-back of amounts excluded on Worksheet A-8 for the RT/PT and the RCE limits) for each cost center by the total charges for the cost center in column 8.

This computation determines the RCE/RT/PT adjusted ratio of cost to charges (referred to as the PPS inpatient ratio) for each cost center. Enter the resultant departmental ratio. Round ratios to 6 decimal places.

Line Descriptions

Lines 30 through 117--These cost centers have the same line numbers as the respective cost centers on Worksheets A, B, and B-1. This design facilitates referencing throughout the cost report.

Therefore, if you have subscripted any lines on those worksheets, you must subscript the same lines on this worksheet.

NOTE: The worksheet line numbers start at line 30 because of the line referencing feature.

Line 200--For each of the columns 1 through 5 (total costs), respectively, enter the sum of lines 30 through 199 for all unshaded lines in accordance with Worksheet C, Part I.

For each of the columns 6, 7, and 8 (total charges), respectively, enter the sum of lines 30 through 60, and 62 through 199, for all unshaded lines in accordance with Worksheet C, Part I. Since the charges on line 61 are also included on line 60 (laboratory), the charges on line 61 must be excluded to avoid overstating total charges.

Line 201--Enter the amounts from line 92 for columns 1, 3, and 5. Calculate the observation bed cost on line 92 using the routine cost per diem from Worksheet D-1 because it is part of routine costs and as such has been included in the amounts reported on line 30 for the hospital. Therefore, in order to arrive at the total allowable costs, subtract this cost to avoid reporting these costs twice.

Line 201, columns 6, 7, and 8, are shaded.

Line 202--For columns 1, 3, and 5, subtract line 201 from line 200, and enter the result.

Transfer Referencing

Costs--The costs of the inpatient routine service cost centers are transferred:

From Worksheet C, Column 1, 3, or 5:	To
Line 30	Wkst. D-1, Part I, line 21
Lines 31 through 35	Wkst. D-1, Part II, lines 43 through 47
Line 40, 41, 42 and subscripts	Separate Wkst. D-1, Part I, line 21
Line 43 (titles V and XIX only)	Wkst. D-1, Part II, line 42
Line 44 (title XVIII only)	Separate Wkst. D-1, Part I, line 21
Line 45 and subscripts (titles V and XIX only)	Separate Wkst. D-1, Part I, line 21

Charges--Transfer the total charges for each of lines 50 through 98, column 8, to Worksheet D, Part IV, column 7, lines as appropriate.

Ratios

Cost or Other Ratios--The "Cost or Other" ratio is transferred from column 9:

For	To
Inpatient ancillary services for titles V, XVIII, Part A, and XIX furnished by the hospital, subprovider, SNF, NF, swing-bed SNF, and swing-bed NF	Wkst. D-3, column 1, for each cost center
Ancillary services furnished by the hospital-based HHA	Wkst. H-3, Part II, column 1, line as appropriate
Hospital-based CMHC (titles V, XVIII, and XIX) shared ancillary services	Wkst. J-2, Part II, column 3, line as appropriate

TEFRA Inpatient Ratio--Transfer the TEFRA inpatient ratio on lines 50 through 94 and lines 96 through 98 from column 10 for hospital or subprovider components for titles V; XVIII, Part A; and XIX; inpatient services subject to the TEFRA rate of increase ceiling (see 42 CFR 413.40) to Worksheet D-3, column 1, for each cost center.

PPS Inpatient Ratio--Transfer the PPS inpatient ratio on lines 50 through 94 and lines 96 through 98 from column 11, for hospital or subprovider components for titles V; XVIII, Part A; and XIX; inpatient services subject to the IPPS (see 42 CFR 412.1(a) through 412.125) to Worksheet D-3, column 1, for each cost center. The transfer of the PPS inpatient ratio also applies when the facility is an IPF subject to IPF PPS, a LTCH subject to LTCH PPS, or an IRF subject to IRF PPS (see 42 CFR 412, Subparts N, O, and P, respectively).

4023.2 Part II - Calculation of Outpatient Services Cost-to-Charge Ratios Net of Reductions for Medicaid Only.--This worksheet is not applicable for title XVIII. It is only applicable for select state Medicaid programs. This worksheet computes the outpatient cost-to-charge ratios reflecting the following:

- The percentage of capital reduction as identified on Worksheet S-2, Part I, line 95, the applicable column.
- The reduction in reasonable costs of hospital outpatient services (other than the capital-related costs of such services (also known as operating reduction)) is based upon the percentage entered on Worksheet S-2, Part I, line 97, the applicable column.

Column Descriptions

Column 1--Enter the amounts for each cost center from Worksheet B, Part I, column 26, as appropriate. Transfer the amount on line 92 from Worksheet D-1, Part IV, line 89, for the hospital and if you use inpatient routine beds as observation beds. If you have a distinct observation bed area, add subscripted line 92.01 and transfer the appropriate amount from Worksheet B, Part I, column 26. Do not bring forward costs in any cost center with a credit balance from Worksheet B, Part I, column 26.

Column 2--Enter the sum of the amounts for each cost center from Worksheet B, Part II, as appropriate. Do not bring forward costs in any cost center with a credit balance on Worksheet B, Part I, or Worksheet B, Part II. For line 92, enter the amounts from Worksheet D-1, Part IV, column 5, line 90. Combine the hospital and subprovider amounts if applicable.

Column 3--For each line, subtract column 2 from column 1 and enter the result.

Column 4--Multiply column 2 by the appropriate capital reduction percentage, and enter the result.

Column 5--Multiply column 3 by the outpatient reasonable cost reduction percentage and enter the result.

Column 6--Subtract columns 4 and 5 from column 1 and enter the result.

Column 7--Enter the total charges from Worksheet C, Part I, column 8.

Column 8--Divide column 6 by column 7 and enter the result.

4024. WORKSHEET D - COST APPORTIONMENT

Worksheet D consists of the following five parts:

Part I - Apportionment of Inpatient Routine Service Capital Costs
Part II - Apportionment of Inpatient Ancillary Service Capital Costs
Part III - Apportionment of Inpatient Routine Service Other Pass-Through Costs
Part IV - Apportionment of Inpatient/Outpatient Ancillary Service Other Pass-Through Costs
Part V - Apportionment of Medical and Other Health Services Costs

At the top of each part, indicate by checking the appropriate boxes the health care program, provider component or PARHM Demonstration, and the payment system, as applicable, for which the part is prepared.

If Worksheet S-2, Part I, line 112, column 1, is "Y" and (1) the hospital participated in the PARHM demonstration for the entire cost reporting period, select the "PARHM Demonstration" box only and complete Worksheet D, Parts I through IV; or (2) the hospital participated in the PARHM demonstration for a portion of the cost reporting period, select the "PARHM Demonstration" box and complete Worksheet D, Parts I through IV, for the portion of the cost reporting period, included in the demonstration. Select the "Hospital" box and complete a separate set of Worksheet D, Parts I through IV, for the portion of the cost reporting period not included in the demonstration. See §4024.5 for specific instructions for Worksheet D, Part V.

NOTE: Only hospital components subject to PPS (including the PARHM Demonstration) or TEFRA complete Worksheet D, Parts I through IV. New children's and new cancer hospitals complete only Worksheet D, Parts III and IV (line 85 of Worksheet S-2, Part I, has a "Y" response). CAHs do not complete Parts I through IV. REHs do not complete Parts I through III, and only complete Part IV, column 4, if Worksheet S-2, Part I, line 107.01, is yes. Hospital-based SNF and NF providers are added to the Worksheet D, Part III, and will also complete a separate Worksheet D, Part IV. Effective for cost reporting periods beginning on or after April 1, 2019 (see CR 10962, dated November 2, 2018), complete a separate Worksheet D, Part IV, for swing-bed SNFs that claim cost reimbursement for CRNA services.

Line Descriptions for Parts I through V

Lines 30 through 43 (for Parts I and III), lines 44 and 45 (for Part III), and lines 50 through 98 (for Parts II, IV, and V)--These cost centers have the same line numbers as the respective cost centers on Worksheets A, B, B-1, and C. This design facilitates referencing throughout the cost report. Therefore, any lines subscripted on those worksheets, must subscripted on this worksheet.

4024.1 Part I - Apportionment of Inpatient Routine Service Capital Costs.--This part computes the amount of capital-related costs applicable to hospital inpatient routine service costs. Complete only one Worksheet D, Part I (*), for each title. Report hospital and subprovider information on the same worksheet, lines as appropriate. Complete this part for all payment methods.

* Hospitals that participated in the PARHM demonstration must complete Worksheet D, Part I, for the portion of the cost reporting period not included in the PARHM demonstration and a separate Worksheet D, Part I, for the portion of the cost reporting period included in the PARHM demonstration.

Column 1--Enter on each line the capital-related cost for each cost center, as appropriate. Obtain this amount from Worksheet B, Part II, column 26.

Column 2--Compute the amount of the swing-bed adjustment. If you have a swing-bed agreement or have elected the swing-bed optional method of reimbursement, determine the amount for the cost center in which the swing-beds are located by multiplying the amounts in column 1 by the ratio of the amount entered on Worksheet D-1, line 26, to the amount entered on Worksheet D-1, Part I, line 21.

Column 3--For each line, subtract the amount, if any, in column 2 from the amount in column 1, and enter the result.

Column 4--Enter on each line the total patient days, excluding swing-bed days, for that cost center. For line 30, enter the total days reported on Worksheet S-3, Part I, column 8, the sum of lines 1 and 28. For lines 31 through 43, enter the days from Worksheet S-3, Part I, column 8, lines 8 through 12, 13, and 16 through 18 (as applicable).

Column 5--Divide the capital costs of each cost center in column 3 by the total patient days in column 4 for each line to determine the capital per diem cost. Enter the resultant per diem cost in column 5.

Column 6--Enter the program inpatient days for the applicable cost centers. For line 30, enter the days reported on Worksheet S-3, Part I, columns 5, 6, or 7, as appropriate, line 1. For lines 31 through 43, enter the days from Worksheet S-3, Part I, columns 5, 6, or 7, as appropriate, lines 8 through 12, 13, and 16 through 18 (as applicable), respectively.

For the PARHM demonstration complete column 6 as follows. For line 30, enter the days reported on Worksheet S-3, Part I, columns 5, 6.01, or 7, as appropriate, line 1. For lines 31 through 35, and line 43, enter the days from Worksheet S-3, Part I, columns 5, 6.01, or 7, as appropriate, lines 8 through 12, and line 13, respectively.

NOTE: When you place overflow general care patients temporarily in an intensive care type inpatient hospital unit because all beds available for general care patients are occupied, count the days as intensive care type inpatient hospital days for purposes of computing the intensive care type inpatient hospital unit per diem. However, count the program days as general routine days in computing program reimbursement. (See CMS Pub. 15-1, chapter 22, §2217.) Add any program days for general care patients of the component who temporarily occupied beds in an intensive care or other special care unit to line 30 and decrease the appropriate intensive care or other special care unit by those days.

Column 7--Multiply the per diem in column 5 by the inpatient program days in column 6 to determine the program's share of capital costs applicable to inpatient routine services, as applicable.

4024.2 Part II - Apportionment of Inpatient Ancillary Service Capital Costs.--This part computes the amount of capital costs applicable to hospital (*) inpatient ancillary services for titles V; XVIII, Part A; and XIX. Complete a separate copy of this worksheet for each subprovider for titles V; XVIII, Part A; and XIX; as applicable.

* Hospitals that participated in the PARHM demonstration must complete Worksheet D, Part II, for the portion of the cost reporting period not included in the PARHM demonstration and a separate Worksheet D, Part II, for the portion of the cost reporting period included in the PARHM demonstration.

Make no entries on this worksheet for any cost centers with a negative balance on Worksheet B, Part I, column 26.

Column 1--Enter on each line the capital-related costs for each cost center, as appropriate. Obtain this amount from Worksheet B, Part II, column 26. For the hospital component or subprovider, if applicable, enter on line 92 the amount from Worksheet D-1, Part IV, column 5, line 90.

Column 2--Enter on each line the total charges applicable to each cost center as shown on Worksheet C, Part I, column 8.

Column 3--Divide the capital cost of each cost center in column 1 by the charges in column 2 for each line to determine the cost-to-charge ratio. Round the ratios to six decimal places, e.g., round 0321514 to .032151. Enter the resultant departmental ratio in column 3.

Column 4--Enter on each line the appropriate title V; XVIII, Part A; or XIX, inpatient charges from Worksheet D-3, column 2. For title XVIII, enter on line 92, the observation bed charges applicable to title XVIII patients subsequently admitted after being treated in the observation area. Enter on line 96, the Medicare charges for medical equipment rented by an inpatient. The charges are reimbursed under the DRG. However, you are entitled to the capital-related cost pass-through applicable to this medical equipment.

NOTE: Program charges for PPS providers are reported in the cost reporting period in which the discharge is reported. TEFRA providers report charges in the cost reporting period in which they occur.

Do not include in Medicare charges any charges identified as MSP/LCC.

Column 5--Multiply the capital ratio in column 3 by the program charges in column 4 to determine the program's share of capital costs applicable to titles V; XVIII, Part A; or XIX, inpatient ancillary services, as appropriate.

4024.3 Part III - Apportionment of Inpatient Routine Service Other Pass-Through Costs.--This part computes the amount of pass-through costs other than capital applicable to hospital inpatient routine service costs. Complete only one Worksheet D, Part III, for each title (*). Report hospital, subprovider, hospital-based SNF and NF/ICF-IID (if applicable) information on the same worksheet, lines as appropriate.

* Hospitals that participated in the PARHM demonstration must complete Worksheet D, Part III, for the portion of the cost reporting period not included in the PARHM demonstration and a separate Worksheet D, Part III, for the portion of the cost reporting period included in the PARHM demonstration.

Column 1A--For each cost center, enter the amount of the applicable nursing program post step-down adjustments from Worksheet B-2. Apportion the post step-down adjustments using the respective program allocation statistics and unit cost multiplier reported on Worksheet B-1, column 20, or its subscripts. Do not complete this column if the response on Worksheet S-2, Part I, line 60, is no.

Column 1--For each applicable line, transfer the nursing program cost from Worksheet B, Part I, the sum of column 20, and its subscripts, minus post step-down adjustments reported in column 1A, if applicable, when Worksheet S-2, Part I, line 60, is yes, except do not transfer subscripts of line 60 with a criterion code of "4" in column 3. Do not transfer the costs if the response on Worksheet S-2, Part I, line 60, is no.

Column 2A--For each cost center, enter the amount of the applicable allied health/paramedical education program post step-down adjustments from Worksheet B-2. Apportion the post step-down adjustments using the respective program allocation statistics and unit cost multiplier reported on Worksheet B-1, column 23, or its subscripts. Do not complete this column if the response on Worksheet S-2, Part I, line 60, is no.

Column 2--For each applicable line, transfer the allied health/paramedical education program cost from Worksheet B, Part I, the sum of column 23, and its subscripts, minus post step-down adjustments reported in column 2A, if applicable, when Worksheet S-2, Part I, line 60, is yes, except do not transfer subscripts of line 60 with a criterion code of "4" in column 3. Do not transfer the costs if the response on Worksheet S-2, Part I, line 60, is no.

Column 3--For cost reporting periods beginning prior to December 27, 2020, transfer from Worksheet B, Part I, the sum of columns 21 and 22, for each applicable line, plus or minus post step-down adjustments (reported on Worksheet B-2), the applicable medical education costs for

interns and residents when Worksheet S-2, Part I, line 57, column 1, is yes, and column 2, is no. Otherwise, do not transfer the costs. For cost reporting periods beginning on or after December 27, 2020, do not transfer the costs.

NOTE: For cost reporting periods beginning prior to December 27, 2020, if you qualify for the exception in 42 CFR 413.77(e)(1), because this is the first cost reporting period in which you are training residents in approved programs and the residents were not on duty during the first month of this cost reporting period, then all direct GME costs are reimbursed as a pass-through based on reasonable cost. For cost reporting periods beginning on or after December 27, 2020, this exception for reasonable cost payment for direct GME no longer applies.

Column 4--Compute the amount of the swing-bed adjustment. If you have a swing-bed agreement, determine the amount for the cost center in which the swing-beds are located by multiplying the sum of the amounts in columns 1 through 3 by the ratio of the amount entered on Worksheet D-1, Part I, line 26, to the amount entered on Worksheet D-1, Part I, line 21.

Column 5--Enter the sum of columns 1, 2, and 3, minus column 4.

Column 6--Enter on each line the total patient days, excluding swing-bed days, for that cost center. Transfer these amounts from the appropriate Worksheet D, Part I, column 4. For SNFs enter total patient days from Worksheet S-3, Part I, column 8, line 19.

Column 7--Enter the per diem cost for each line by dividing the cost of each cost center in column 5 by the total patient days in column 6.

Column 8--Enter the program inpatient days for the applicable cost centers. Transfer these amounts from the appropriate Worksheet D, Part I, column 6. For SNF (line 44), enter the program days from Worksheet S-3, Part I, column 6, line 19.

For a provider that participated in the PARHM demonstration during this cost reporting period complete a separate Worksheet D, Part III, for the portion of the cost reporting period the provider participated in the PARHM demonstration. For the PARHM demonstration, transfer from the appropriate Worksheet D, Part I, column 6, lines 30 through 35, and line 43, respectively.

Column 9--Multiply the per diem cost in column 7 by the inpatient program days in column 8 to determine the program's share of pass-through costs applicable to inpatient routine services, as applicable. Transfer the sum of the amounts on lines 30 through 35 and 43 to Worksheet D-1, Part I, line 50, for the hospital or PARHM demonstration, as applicable. If you are a title XVIII hospital paid under the IPPS, also transfer this sum to Worksheet E, Part A, line 57, accordingly. Transfer the amounts on lines 40 through 42 to the appropriate Worksheet D-1, line 50, for the subprovider. Also transfer the amount on line 40 to Worksheet E-3, Part II, line 28, and the amount on line 41, to Worksheet E-3, Part III, line 29. For hospital-based SNF, NF or ICF/IID that follow Medicare principles, transfer the amount in column 9, line 44, to Worksheet E-3, Part VI, line 2, or for NF or ICF/IID to Worksheet E-3, Part VII, line 26, as applicable.

4024.4 Part IV - Apportionment of Inpatient/Outpatient Ancillary Service Other Pass-Through Costs.--This part computes the amount of pass-through costs other than capital applicable to hospitals, SNFs, NFs, ICF/IIDs, and effective for cost reporting periods beginning on or after April 1, 2019, CRNA pass-through costs for swing-bed SNFs. Hospitals and subprovider components subject to the IPPS and/or the OPPS must exclude direct medical education costs as these costs are reimbursed separately. TEFRA hospitals are subject to the TEFRA rate of increase limitation for inpatient operating costs. In order to determine inpatient operating costs, it is necessary to exclude capital-related and medical education costs as these costs are reimbursed separately.

This part also computes medical education costs for interns and residents for REHs effective for cost reporting periods beginning on or after October 1, 2023, when Worksheet S-2, Part I, line 107.01, is yes. (See 42 CFR 419.92(d).) Complete columns 4, 6, 7, 9, 12, and 13.

Complete a separate copy of this Worksheet D, Part IV, for the hospital (*), each subprovider, the SNF, NF and ICF/IID. For CRNA pass-through costs for IPPS hospital swing-bed SNFs complete columns 1, 7, 8, 10, and 11 only.

* Hospitals that participated in the PARHM demonstration must complete Worksheet D, Part IV, for the portion of the cost reporting period not included in the PARHM demonstration and a separate Worksheet D, Part IV, for the portion of the cost reporting period included in the PARHM demonstration.

Make no entries on this worksheet for any cost centers with a negative balance on Worksheet B, Part I, column 26.

Column 1--Transfer from Worksheet B, Part I, column 19, for each applicable line (plus or minus any adjustments reported on Worksheet B-2, if applicable) the nonphysician anesthetist's costs which qualify for a reasonable cost payment in accordance with 42 CFR 412.113(c). (See also §4013, line 19, description for more information.)

Column 2A--For each cost center, enter the amount of the applicable nursing program post step-down adjustments from Worksheet B-2. Apportion the post step-down adjustment using the respective program allocation statistics and unit cost multiplier reported on Worksheet B-1, column 20, or its subscripts. Do not complete this column if the response on Worksheet S-2, Part I, line 60, is no.

Column 2--For each applicable line, transfer the nursing program cost from Worksheet B, Part I, the sum of column 20, and its subscripts, minus post step-down adjustments reported in column 2A, if applicable, when Worksheet S-2, Part I, line 60, is yes, except do not transfer subscripts of line 60 with a criterion code of "4" in column 3. Do not transfer the costs if the response on Worksheet S-2, Part I, line 60, is no. For the hospital only, enter on line 92, observation beds, the amount from Worksheet D-1, Part IV, column 5, line 91.

Column 3A--For each cost center, enter the amount of the applicable allied health/paramedical education program post step-down adjustments from Worksheet B-2. Apportion the post step-down adjustments using the respective program allocation statistics and unit cost multiplier reported on Worksheet B-1, column 23, or its subscripts. Do not complete this column if the response on Worksheet S-2, Part I, line 60, is no.

Column 3--For each applicable line, transfer the allied health/paramedical education program cost from Worksheet B, Part I, the sum of column 23, and its subscripts, minus post step-down adjustments reported in column 3A, if applicable, when Worksheet S-2, Part I, line 60, is yes, except do not transfer subscripts of line 60 with a criterion code of "4" in column 3. Do not transfer the costs if the response on Worksheet S-2, Part I, line 60, is no. For the hospital component only, enter on line 92, the observation bed amount from Worksheet D-1, Part IV, column 5, line 92.

Column 4--For cost reporting periods beginning prior to December 27, 2020, transfer from Worksheet B, Part I, the sum of columns 21 and 22, for each applicable line, (plus or minus post step-down adjustments made on Worksheet B-2, if applicable), the applicable medical education costs for interns and residents when Worksheet S-2, Part I, line 57, column 1, is yes and column 2, is no, otherwise do not transfer the costs. For the hospital only, enter on line 92, observation beds, the amount from Worksheet D-1, Part IV, column 5, line 93. For cost reporting periods beginning on or after December 27, 2020, do not transfer the costs.

NOTE: For cost reporting periods beginning prior to December 27, 2020, if you qualify for the exception in 42 CFR 413.77(e)(1) because this is the first cost reporting period in which you are training residents in approved programs and the residents were not on duty during the first month of this cost reporting period, then all direct GME costs for interns and residents in approved programs are reimbursed as a pass-through based on reasonable cost. For cost reporting periods beginning on or after December 27, 2020, this exception for reasonable cost payment for direct GME no longer applies.

For REHs, effective for cost reporting periods beginning on or after October 1, 2023, transfer from Worksheet B, Part I, the sum of columns 21 and 22, for each applicable line, (plus or minus post step-down adjustments made on Worksheet B-2, if applicable), the applicable medical education costs for interns and residents when Worksheet S-2, Part I, line 107.01, is yes; otherwise, do not transfer the costs.

Column 5--This column represents total inpatient other pass-through costs. Enter on each appropriate line the sum of the amounts entered on the corresponding lines in columns 1, 2, 3, and 4.

Column 6--This column represents outpatient other pass-through costs. Enter on each appropriate line the sum of the amounts entered on the corresponding lines in columns 2, 3, and 4.

Column 7--Enter on each line the charges applicable to each cost center as shown on Worksheet C, Part I, column 8.

Column 8--Divide the cost of each cost center in column 5 by the charges in column 7, to determine the cost/charge ratio for each cost center. For CRNA IPPS hospital swing-bed SNF pass through costs, divide the cost of each cost center in column 1 by the charges in column 7, to determine the cost/charge ratio for each cost center. Round the ratios to six decimal places, e.g., round 0321514 to .032151.

Column 9--This column computes the outpatient ratio of cost to charges. Divide the cost of each cost center in column 6 by the charges in column 7, for each line, to determine the cost/charge ratio. Round the ratios to six decimal places, e.g., round .0321514 to .032151. Enter the resultant departmental ratio in column 9.

Column 10--Enter on each line titles V; XVIII, Part A; or XIX; inpatient charges from Worksheet D-3. For a hospital that participated in the PARHM demonstration during this cost reporting period complete a separate Worksheet D, Part IV. For the portion of the cost reporting period the provider participated in the PARHM demonstration enter the inpatient charges applicable to the PARHM demonstration period from Worksheet D-3.

Do not include in Medicare charges any charges identified as MSP/LCC.

Column 11--Multiply the ratio in column 8 by the charges in column 10 to determine the program's share of pass-through costs applicable to titles V; XVIII, Part A; or XIX; inpatient ancillary services, as appropriate.

For hospitals and subproviders, transfer column 11, line 200, to Worksheet D-1, Part II, column 1, line 51. If you are an IPPS hospital, also transfer this amount to Worksheet E, Part A, line 58. If you are an IPF or IPF subprovider, also transfer this amount to Worksheet E-3, Part II, line 28. If you are an IRF or IRF subprovider, also transfer this amount to Worksheet E-3, Part III, line 29. For SNFs, for title XVIII transfer the amount on line 200 to Worksheet E-3, Part VI, line 3; for SNFs, NFs and ICF/IIDs for titles V and XIX, transfer the amount on line 200 to E-3, Part VII, line 26, as applicable. If you are an IPPS hospital swing-bed SNF, for title XVIII transfer the amount on line 200 to Worksheet E-2, line 3.

Column 12--Enter on each line titles XVIII, Part B; V; or XIX (if applicable); outpatient charges from Worksheet D, Part V, column 2, and applicable subscripts. For a hospital that participated in the PARHM demonstration during this cost reporting period complete a separate Worksheet D, Part IV. For the portion of the cost reporting period the hospital participated in the PARHM demonstration, enter the outpatient charges applicable to the PARHM demonstration period from Worksheet D, Part V, column 2.

Do not include in Medicare charges any charges identified as MSP/LCC.

Column 13--Multiply the ratio in column 9 by the charges in column 12 to determine the program's share of pass-through costs applicable to titles XVIII, Part B; V; or XIX (if applicable); outpatient ancillary services, as appropriate.

For providers subject to the OPPS, transfer column 13, line 200, to Worksheet E, Part B, line 9.

4024.5 Part V - Apportionment of Medical and Other Health Services Costs.--This part provides for the apportionment of costs applicable to hospital and REH outpatient services reimbursable under titles V, XVIII, and XIX. Complete a separate copy of this Worksheet D, Part V, for the hospital (*), each subprovider, the SNF (including a distinct part SNF based in a REH), NF and ICF/IID, and the Swing-bed SNF (**) and Swing-bed NF.

* Hospitals, including CAHs, that (1) participated in the PARHM demonstration for the entire cost reporting period, select the "PARHM Demonstration" box only and complete Worksheet D, Part V; or (2) participated in the PARHM demonstration for a portion of the cost reporting period, select the "PARHM Demonstration" box and complete Worksheet D, Part V, for the portion of the cost reporting period included in the demonstration. Select the "Hospital" box and complete a separate Worksheet D, Part V, for the portion of the cost reporting period not included in the demonstration.

** CAH swing-bed SNFs that (1) participated in the PARHM demonstration for the entire cost reporting period, select the "PARHM Demonstration Swing-bed SNF" box only and complete Worksheet D, Part V; or (2) participated in the PARHM demonstration for a portion of the cost reporting period, select the "PARHM Demonstration Swing-bed SNF" box and complete Worksheet D, Part V, for the portion of the cost reporting period included in the demonstration. Select the "Swing-bed SNF" box and complete a separate Worksheet D, Part V, for the portion of the cost reporting period not included in the demonstration.

Enter in the appropriate cost center the program charges from the PS&R or from provider records.

Providers exempt from outpatient PPS (i.e., CAHs), complete columns 3, 4, 6, and 7. All other providers subscript columns 2 and 5 as necessary. Include charges for vaccine (i.e., pneumococcal, influenza, COVID-19, monoclonal antibody products for treatment of COVID-19, hepatitis B, and osteoporosis) as indicated on line 73 below.

Exclude charges for which costs were excluded on Worksheet A-8. For example, CRNA costs reimbursed on a fee schedule are excluded from total cost on Worksheet A-8. For titles V and XIX, enter the appropriate outpatient service charges.

NOTE: Do not enter CORF, OPT, OSP, OOT, or CMHC charges on Worksheet D, Part V. Report only charges for CMHCs on Worksheet J-2.

For title XVIII, complete a separate Worksheet D, Part V, for each provider component as applicable. Enter the applicable component number in addition to the hospital provider number. Make no entries in columns 5 through 7 of this worksheet for any cost centers with a negative balance on Worksheet B, Part I, column 26. However, complete columns 1 through 4 for such cost centers.

In accordance with ACA, section 3121, as amended by the Medicare and Medicaid Extenders Act (MMEA) of 2010, section 108; the Temporary Payroll Tax Cut Continuation Act of 2011, section 308; and, the Middle Class Tax Relief and Job Creation Act of 2012, section 3002; hold harmless payments are extended for rural hospitals with 100 or fewer beds through December 31, 2012; SCHs and EACHs regardless of bed size through February 29, 2012; and SCHs and EACHs with 100 or fewer beds through December 31, 2012. As such, rural hospitals and SCHs or EACHs that qualify and whose cost reporting period overlaps the effective date,

(Worksheet S-2, Part I, line 120, column 1 or 2, is yes), must subscript column 2 and enter the applicable charges that correspond to the respective portion of the cost reporting period.

In accordance with ACA 2010, section 3138, cancer hospitals must utilize a predetermined payment-to-cost ratio (PCR) to calculate the corresponding transitional outpatient payment effective for services rendered beginning January 1, 2012. The PCR may be revised each calendar year. Where the cost reporting period overlaps a PCR revision date, subscript column 2 and the corresponding column 5 to represent the portion of the cost reporting period that corresponds to each unique PCR. See section 4030.2 for further instruction/information.

Column 1--Enter on each line in column 1 the ratio from the corresponding line on Worksheet C, column 9.

Columns 2 through 4--Do not include in Medicare charges any charges identified as MSP/LCC.

Column 2--PPS Reimbursed Services--Enter the charges for services rendered which are subject to PPS. These charges should not include services paid under the fee schedule such as physical therapy, speech pathology or occupational therapy. Create separate subscripted column (e.g. 2.01, 2.02) when a cost reporting period overlaps the effective dates for the various transitional corridor payments and/or when a provider experiences a geographic reclassification from urban to rural. However, no subscripting is required when a provider geographically reclassifies from rural to urban. The subscripting of this column will directly correspond to the subscripts of Worksheet E, Part B, lines 2 through 8.

Do not include in any column services excluded from the OPPS because they are paid under another fee schedule, e.g., rehabilitation services and clinical diagnostic lab.

Column 3--Cost Reimbursed Services Subject to Deductibles and Coinsurance--Enter the charges for services rendered which are subject to cost reimbursement. This includes services rendered by CAHs.

Include the charges for drugs and supplies related to ESRD dialysis (excluding ESAs, and any drugs or supplies paid under the composite rate or ESRD PPS bundled payment rate), and corneal tissue on line 72.

Column 4--Cost Reimbursed Services Not Subject to Deductibles and Coinsurance--Vaccine Cost Apportionment--This column provides for the apportionment of costs which are not subject to deductible and coinsurance (i.e., pneumococcal, influenza, COVID-19, monoclonal antibody products for treatment of COVID-19, hepatitis B, and osteoporosis). Enter such charges for services which are not subject to deductible and coinsurance.

Column 5--Multiply the charges in column 2, and subscripts, if necessary, by the ratios in column 1, and enter the result. Line 200 equals the sum of lines 50 through 98.

Column 6--Multiply the charges in column 3 by the ratios in column 1 and enter the result. Line 200 equals the sum of lines 50 through 98.

Column 7--Multiply the charges in column 4 by the ratios in column 1 and enter the result. Line 200 equals the sum of lines 50 through 98.

Line Descriptions

Line 60--Generally, for title XVIII, Medicare outpatient covered clinical laboratory services are paid on a fee basis and should not be included on this line. Outpatient CAH clinical laboratory services will be paid on a reasonable cost basis not subject to deductibles and coinsurance. In addition, hospital outpatient laboratory testing by a hospital laboratory with fewer than 50 beds in a qualified rural area will also be paid on a reasonable cost basis not subject to deductibles and coinsurance, for cost reporting periods beginning on or after July 1, 2010, but before July 1, 2012

(Patient Protection and Affordable Care Act of 2010, §3122, amended by the MMEA, §109). For title V and XIX purposes, follow applicable State program instructions.

For CAHs, outpatient clinical laboratory diagnostic tests are paid at 101 percent of reasonable costs, and the beneficiary is not required to be physically present in the CAH at the time the specimen is collected. As such, enter the corresponding charges on this line. See MIPPA 2008, §148 and CR 6395, transmittal 1729, dated May 8, 2009.

Line 61--Enter the program charges for provider clinical laboratory tests for which the provider reimburses the pathologist. See §4013 for a more complete description on the use of this cost center. For title XVIII, do not include charges for outpatient clinical diagnostic laboratory services. For titles V and XIX purposes, follow applicable State program instructions.

NOTE: Since the charges on line 61 are also included on line 60, laboratory, reduce the total charges to prevent double counting. Make this adjustment on line 201.

Line 71--Enter in columns 2 and 3, the charges for medical supplies charged to patients which are not paid on a fee schedule. Do not report the charges for prosthetics and orthotics.

Line 72--Enter in columns 2 and 3, the charges for implantable devices charged to patients which are not paid on a fee schedule. Do not report the charges for prosthetics and orthotics.

Line 73--Enter the program charges for drugs charged to patients. Enter in column 2, charges for vaccines and drugs reimbursed at 100 percent under the OPPS. Include in column 3, charges for drugs paid at 80 percent of cost subject to deductibles and coinsurance, such as osteoporosis drugs and drugs paid under the OPPS such as hepatitis B vaccines. Include in column 4, vaccine charges for vaccines reimbursed at 100 percent of cost such as pneumococcal, influenza, and COVID-19 vaccines, and monoclonal antibody products for treatment of COVID-19, not subject to deductibles and coinsurance.

Line 74--The only renal dialysis services entered on this line are for inpatients that are not reimbursed under the composite rate regulations. (See 42 CFR 413.170.) Therefore, include only inpatient Part B charges on this line in column 3. Enter the related costs in column 6.

Line 75--Enter in column 3 the outpatient ASC facility charges and Part B charges for the hospital non-distinct part ASC. These charges represent the ASC facility charge only (i.e., in lieu of operating or recovery room charges), and do not include charges for the ancillary services provided to the patient.

Line 77--Enter the Medicare charges billed under revenue code 0815 (acquisition charges) for allogeneic HSCT. (Also report the detail for these charges on Worksheet D-6, Part I, lines 8 through 28, using your internal logs to report the charges by ancillary cost center.)

Line 78--For CAR T-cell immunotherapy, enter the Medicare charges billed under revenue codes 0871, 0872, 0873, 0874, and 0891, as described in CMS Pub. 100-04. chapter 32, §400.2.2.

Lines 88 through 93--Use these lines for outpatient service cost centers.

NOTE: For lines 88, 89, and 90, any ancillary service billed as clinic, RHC, or FQHC services must be reclassified to the appropriate ancillary cost center, e.g., radiology-diagnostic, PBP clinical lab services - program only. A similar adjustment must be made to program charges.

Line 92--Enter in column 2 the title XVIII Part B charges for observation beds. These are the charges for patients who were treated in the non-distinct observation beds and released. These patients were not admitted as inpatients.

Line 94--The only home program dialysis services which are cost reimbursed are those rendered to beneficiaries who have elected the option to deal directly with Medicare. Home program dialysis services reimbursed under the composite rate regulation (see 42 CFR 413.170) are not included on this line. This line includes costs applicable to equipment-related expenses only.

Line 95--Only CAHs eligible for cost reimbursement for ambulance services complete this line. Report charges for ambulance services from your records or the PS&R report type 85C in column 3. Multiply column 1 times column 3 and enter the result in column 6. All other hospital provider types are reimbursed under the ambulance fee schedule and do not complete this line

Lines 96 and 97--For title XVIII, DME is paid on a fee schedule through the contractor and, therefore, is not paid through the cost report.

Line 200--Enter the sum of lines 50 through 98.

Line 201--Enter in columns 3 and 4 program charges for provider clinical laboratory tests where the physician bills the provider for program patients only. Obtain this amount from line 61.

Line 202--Enter in columns 3, 4, 6, and 7, and subscripts, the amount on line 200 plus or minus the amounts on line 201, if applicable.

Transfer Referencing: For title XVIII, transfer the sum of the amounts in columns 3 and 4, and applicable subscripts, line 202 to Worksheet E, Part B, line 12 (ancillary services charges). Make no transfers of swing-bed charges to Worksheet E-2 since no LCC comparison is made. For titles V and XIX (other than IPPS), transfer the sum of the amounts in columns 2, 3, and /or 4, plus subscripts as applicable, line 202, plus the amount from Worksheet D-3, column 2, line 202, to the appropriate Worksheet E-3, Part VII, line 9.

For titles V and XIX (under IPPS), transfer the amount in columns 2, 3, and/or 4, plus subscripts as applicable, line 202, to the appropriate Worksheet E-3, Part VII, line 9.

NOTE: If the amount on line 202 includes charges for professional patient care services of provider-based physicians, eliminate the amount of the professional component charges from the total charges, and transfer the net amount as indicated. Submit a schedule showing these computations with the cost report.

	Transfer References		
From Wkst. D, Part V	Title XVIII, Part B Swing Bed	to	Titles V or XIX or Title XVIII, Part B
Column 6, line 202 and column 7, line 73, and subscripts	N/A		Wkst. E, Part B, col. 1 (and subscripts), line 1
Columns 5, line 202	N/A		Wkst. E, Part B, col. 1 (and subscripts), line 2
Sum of columns 2, 3, and 4, as applicable (SNF only), line 202	N/A		Wkst. E, Part B, line 12, or Wkst. E-3, Part VII, col. 1, line 9, for titles V or XIX
Sum of column 6 and 7 (SNF only), line 202	Wkst E-2, col. 2, line 3		Wkst. E, Part B, line 1, or Wkst. E-3, Part VII, col. 1, line 2, for titles V or XIX

This page is reserved for future use.

4025. WORKSHEET D-1 - COMPUTATION OF INPATIENT OPERATING COST

This worksheet provides for the computation of hospital inpatient operating cost in accordance with 42 CFR 413.53 (determination of cost of services to beneficiaries), 42 CFR 413.40 (ceiling on rate of hospital cost increases), and 42 CFR 412.1 through 412.125 (prospective payment). All providers must complete this worksheet.

Complete a separate copy of this worksheet for the hospital (*) (including CAH), each subprovider, hospital-based SNF, and hospital-based other nursing facility. Also, complete a separate copy of this worksheet for each health care program under which inpatient operating costs are computed. When this worksheet is completed for a component, show both the hospital and component numbers. REHs do not complete the Worksheet D-1 series.

At the top of each page, indicate by checking the appropriate line the health care program, provider component, and the payment system for which the page is prepared.

Worksheet D-1 consists of the following four parts:

Part I - All Provider Components
Part II - Hospital and Subproviders Only
Part III - Skilled Nursing Facility, Other Nursing Facility, and ICF/IID Only
Part IV - Computation of Observation Bed Pass-Through Cost

NOTE: If you have made a swing-bed election for your certified SNF, treat the SNF costs and patient days as though they were hospital swing-bed SNF-type costs and patient days on Parts I and II of this worksheet. Do not complete Part III for the SNF. (See CMS Pub. 15-1, chapter 22, §2230.9B.)

* Hospitals, including CAHs, that (1) participated in the PARHM demonstration for the entire cost reporting period, select the "PARHM Demonstration" box only and complete Worksheet D-1, Parts I and II; or (2) participated in the PARHM demonstration for a portion of the cost reporting period, select the "PARHM Demonstration" box and complete Worksheet D-1, Parts I and II, for the portion of the cost reporting period, included in the demonstration. Select the "Hospital" box and complete a separate Worksheet D-1, Parts I and II, for the portion of the cost reporting period not included in the demonstration.

Definitions

The following definitions apply to days used on this worksheet.

Inpatient Day--The number of days of care charged to a beneficiary for inpatient hospital services is always documented in units of full days. A day begins at midnight and ends 24 hours later. Use the midnight to midnight method in reporting the days of care for beneficiaries even if the hospital uses a different definition for statistical or other purposes.

A part of a day, including the day of admission, counts as a full day. However, do not count the day of discharge or death, or a day on which a patient begins a leave of absence, as a day. If both admission and discharge or death occur on the same day, consider the day a day of admission and count it as one inpatient day.

Include a maternity patient in the labor/delivery room ancillary area at midnight in the census of the inpatient routine (general or intensive) care area only if the patient has occupied an inpatient

routine bed at some time since admission. Count no days of inpatient routine care for a maternity inpatient who is discharged (or dies) without ever occupying an inpatient routine bed. However, once a maternity patient has occupied an inpatient routine bed, at each subsequent census include the patient in the census of the inpatient routine care area to which she is assigned, even if the patient is located in an ancillary area (labor/delivery room or another ancillary area) at midnight. In some cases, a maternity patient may occupy an inpatient bed only on the day of discharge if the day of discharge differs from the day of admission. For purposes of apportioning the cost of inpatient routine care, count this single day of routine care as the day of admission (to routine care) and discharge. This day is considered as one day of inpatient routine care. (See CMS Pub. 15-1, chapter 22, §2205.2.)

When an inpatient is occupying any other ancillary area (e.g., surgery or radiology) at the census taking hour prior to occupying an inpatient bed, do not record the patient's occupancy in the ancillary area as an inpatient day in the ancillary area. However, include the patient in the inpatient census of the routine care area. When the patient occupies a bed in more than one patient care area in one day, count the inpatient day only in the patient care area in which the patient was located at the census taking hour.

Newborn Inpatient Day--Newborn inpatient days are the days that an infant occupies a newborn bed in the nursery. Include an infant remaining in the hospital after the mother is discharged who does not occupy a newborn bed in the nursery, an infant delivered outside the hospital and later admitted to the hospital but not occupying a newborn bed in the nursery, or an infant admitted or transferred out of the nursery for an illness in inpatient days. Also, include an infant born in and remaining in the hospital and occupying a newborn bed in the nursery after the mother is discharged in newborn inpatient days.

Private Room Inpatient Day--Private room inpatient days are the days that an inpatient occupies a private room. If you have only private rooms, report your days statistic as general inpatient days. Inpatient private room days are used for computing any private room differential adjustment on Worksheet D-1, Part I, if you have a mixture of different type rooms to accommodate patients. Do not count swing-bed SNF or swing-bed NF-type services rendered in a private room as private room days.

Inpatient Swing-Bed Days--Inpatient swing-bed days are the days applicable to swing-bed SNF or swing-bed NF-type services. See 42 CFR 413.53(a)(2).

Intensive Care Type Inpatient Days--Intensive care type inpatient days are those days applicable to services rendered in intensive care type inpatient hospital units. These units must meet the requirements specified in CMS Pub. 15-1, chapter 22, §2202.7.II.A.

NOTE: When you place overflow general care patients temporarily in an intensive care type inpatient hospital unit because all beds available for general care patients are occupied, count the days as intensive care type inpatient hospital days for purposes of computing the intensive care type inpatient hospital unit per diem. However, count the program days as general routine days in computing program reimbursement. (See CMS Pub. 15-1, chapter 22, §2217.)

Observation Beds--Observation beds, for purposes of this worksheet, are those beds in general routine areas of the hospital which are not organized as a distinct, separately staffed observation area and which are used to house patients for observation. These beds need not be used full time for observation patients. These beds are not to be confused with a sub-intensive care unit (i.e., definitive observation unit, a stepdown from intensive care reported as an inpatient cost center following surgical intensive care (line 34)). If you have a distinct observation bed unit (an outpatient cost center), report the costs of this unit on the subscripted line 92.01 on Worksheet A.

4025.1 Part I - All Provider Components.--This part provides for the computation of the total general inpatient routine service cost net of swing-bed cost and private room cost differential for each separate provider component. When this worksheet is completed for a component, show both the hospital and component numbers.

Line Descriptions

Lines 1 through 16--Inpatient days reported, unless specifically stated, exclude days applicable to newborn and intensive care type patient stays. Report separately the required statistics for the hospital, each subprovider, hospital-based SNF, hospital-based other nursing facility and ICF/IID. Obtain the information from your records and/or Worksheet S-3, Part I, columns and lines as indicated.

Line 1--Enter the total general routine inpatient days, including private room days, swing-bed days, and observation bed days, as applicable. Do not include routine care days rendered in an intensive care type inpatient hospital unit. Enter the total days from Worksheet S-3, Part I, column 8, for the component and lines as indicated: hospitals from lines 7 and 28; subproviders from lines 16 through 18, as applicable, and 28, if applicable; SNFs from line 19; and NFs from line 20. If you answered yes to line 92 of Worksheet S-2, the NF days come from line 19 for the SNF level of care, and line 20 for the NF level of care, and you will need to prepare a separate Worksheet D-1 for each level of care for title XIX.

Line 2--Enter the total general routine inpatient days. Include private room days and exclude swing-bed and newborn days. Hospitals enter the sum of the days entered on Worksheet S-3, Part I, column 8, lines 1 and 28. Subproviders, SNFs, and NFs enter the days from line 1 of this worksheet.

Line 3--Enter the total private room days excluding swing-bed private room days and observation bed days. If you have only private room days, do not complete this line.

Line 4--Enter the result of line 2, minus line 3, minus total observation bed days from Worksheet S-3, Part I, column 8, line 28. The result will be semi-private room days exclusive of swing-bed semi-private room days and observation bed days. If you have only private room days, such days will be included in this line.

NOTE: For purposes of this computation, the program does not distinguish between semi-private and ward accommodations. (See CMS Pub. 15-1, chapter 22, §2207.3.)

Line 5--Enter the total swing-bed SNF-type inpatient days, including private room days, through December 31 of your cost reporting period. If you are on a calendar year end, report all swing-bed SNF-type inpatient days.

Line 6--Enter the total swing-bed SNF-type inpatient days, including private room days, after December 31 of your cost reporting period. If you are on a calendar year end, enter zero. The sum of lines 5 and 6 equals Worksheet S-3 Part I, line 5, column 8.

Line 7--Enter the total swing-bed NF-type inpatient days, including private room days, through December 31 of your cost reporting period. If you are on a calendar year end, report all swing-bed NF-type inpatient days. This line includes title V, title XIX, and all other payers.

Line 8--Enter the total swing-bed NF-type inpatient days, including private room days, after December 31 of your cost reporting period. If you are on a calendar year end, enter zero. This line includes title V, title XIX, and all other payers. The sum of lines 7 and 8 equals Worksheet S-3, Part I, line 6, column 8.

NOTE: Obtain the amounts entered on lines 5 and 7 from your records.

Line 9--Enter the total program general routine inpatient days as follows:

Type of Provider	From
Hospital	Wkst. S-3, Part I, cols. 5, 6, 6.01 (PARHM only), or 7, line 1
Subprovider	Wkst. S-3, Part I, cols. 5, 6, or 7, line 16, 17, or 18, as applicable
SNF	Wkst. S-3, Part I, cols. 5, 6, or 7, line 19
NF	Wkst. S-3, Part I, cols. 5, 6, or 7, for SNF only level of care; line 19. If line 92 of Wkst. S-2, Part I is a "Y", two D-1s must be completed for title XIX using line 19 for SNF level of care and line 20 for the NF level of care; or line 20 only for NF level of care.

Include private room days and exclude swing-bed and newborn days for each provider component. Add any program days for general care patients of the component who temporarily occupied beds in an intensive care or other special care unit. (See CMS Pub. 15-1, chapter 22, §2217.)

NOTE: If Worksheet S-2, line 92, columns 1 or 2, as applicable is "Y" for yes, then Worksheet D-1 for title XIX (for the SNF and NF component) must be completed. The results are to be combined and transferred to title XIX SNF, Worksheet E-3, Part VII, line 1.

Line 10--Enter the title XVIII swing-bed SNF-type inpatient days, including private room days, through December 31 of your cost reporting period. If you are on a calendar year end, report all program swing-bed SNF-type inpatient days. Combine titles V and XIX for all SNF lines if your State recognizes only SNF level of care.

Line 11--Enter the title XVIII swing-bed SNF-type inpatient days, including private room days, after December 31 of your cost reporting period. If you are on a calendar year end, enter zero.

Line 12--Enter the total titles V or XIX swing-bed NF-type inpatient days, including private room days, through December 31 of your cost reporting period. If you are on a calendar year end, report all program swing-bed NF-type inpatient days.

Line 13--Enter the total titles V or XIX swing-bed NF-type inpatient days, including private room days, after December 31 of your reporting period. If you are on a calendar year end, enter zero.

NOTE: If you are participating in both titles XVIII and XIX, complete, at a minimum, a separate Worksheet D-1, Part I, for title XIX, lines 9, 12, and 13. If these data are not supplied, the cost report is considered incomplete and is rejected.

Line 14--Enter the total medically necessary private room days applicable to the program, excluding swing-bed days, for each provider component.

Line 15--Enter, for titles V or XIX only, the total nursery inpatient days from Worksheet S-3, Part I, column 8, line 13.

Line 16--Enter, for titles V or XIX only, the total nursery inpatient days applicable to the program from Worksheet S-3, Part I, columns 5 and 7, respectively, line 13.

Lines 17 through 27--These lines provide for the carve-out of reasonable cost of extended care services furnished by a swing-bed hospital. Under the carve out method, the total costs attributable to SNF-type and NF-type routine services furnished to all classes of patients are subtracted from total general inpatient routine service costs before computing the average cost per diem for general routine hospital care. The rates on lines 17 through 20 are supplied by your contractor.

Line 17--Enter the Medicare swing-bed SNF rate applicable to the calendar year in which inpatient days on line 5 occurred. If the swing-bed SNF rate for the prior calendar year is higher, enter that rate instead. (See CMS Pub. 15-1, chapter 22, §2230ff.) CAHs do not complete this line.

Line 18--Enter the Medicare swing-bed SNF rate applicable to the calendar year in which inpatient days on line 6 occurred. If the swing-bed SNF rate for the prior calendar year is higher, enter that rate instead. (See CMS Pub. 15-1, chapter 22, §2230ff.) CAHs do not complete this line.

Line 19--Enter the average Statewide rate per patient day paid under the State Medicaid plan for routine services furnished by nursing facilities (other than NFs for individuals with intellectual disabilities) in that State. This rate is approximated by taking the average rate from the prior calendar year, (i.e., the calendar year preceding the year relating to inpatient days reported on line 7) updated to approximate the current year rate. Obtain the proper rate from your contractor.

Line 20--Enter the average Statewide rate per patient day paid under the State Medicaid plan for routine services furnished by nursing facilities (other than NFs for individuals with intellectual disabilities) in that State. This rate is approximated by taking the average rate from the prior calendar year (i.e., the calendar year preceding the year relating to inpatient days reported on line 8) updated to approximate the current year rate. Obtain the proper rate from your contractor.

Line 21--Enter the total general inpatient routine service costs for the applicable provider component.

For titles V, XVIII, and XIX, enter the amounts from Worksheet C, Part I, line 30, for adults and pediatrics or lines 40, 41, or 42, as applicable, for the subprovider, as appropriate:

COST or OTHER	Inpatient - Column 1 (includes CAHs)
TEFRA	Inpatient - Column 3 (includes cancer and children's hospitals)
PPS	Inpatient - Column 5 (includes acute, IPFs, IRFs, & LTCHs)

SNF/NF Inpatient Routine--For title XVIII, transfer this amount from Worksheet C, Part I, column 5, line 44 (SNF). For titles V and XIX, transfer this amount from Worksheet B, Part I, column 26, line 45 (NF) or 45.01 (ICF/IID).

Line 22--Enter the product of the days on line 5 multiplied by the amount on line 17.

Line 23--Enter the product of the days on line 6 multiplied by the amount on line 18.

Line 24--Enter the product of the days on line 7 multiplied by the amount on line 19.

Line 25--Enter the product of the days on line 8 multiplied by the amount on line 20.

Line 26--Enter the sum of the amounts on lines 22 through 25. This amount represents the total reasonable cost for swing-bed SNF-type and NF-type inpatient services.

For CAHs, subtract the sum of lines 24 and 25 from the amount reported on line 21. Divide that result by the patient days equal to lines 2, 5, and 6 above to arrive at a per diem (retain this amount for the calculation required on lines 38, 64, and 65). Multiply the per diem by the total days reported on lines 5 and 6. Add that result to the amounts reported on lines 24 and 25.

Line 27--Subtract the amount on line 26 from the amount on line 21. This amount represents the general inpatient routine service cost net of swing-bed SNF-type and NF-type inpatient costs.

Lines 28 through 36--All providers must complete lines 28 through 36. PPS providers complete these lines for data purposes only. However, if line 4 equals line 2 above or if line 3 above is zero, you are not to complete these lines.

Line 28--Enter the total charges for general inpatient routine services, excluding charges for swing-bed SNF-type and NF-type inpatient services and observation bed days (from your records).

Line 29--Enter the total charges for private room accommodations, excluding charges for private room accommodations for swing-bed SNF-type and NF-type inpatient services and observation bed days (from your records).

Line 30--Enter the total charges for semi-private room and ward accommodations, excluding semi-private room accommodation charges for swing-bed SNF-type and NF-type services (from your records).

Line 31--Enter the general inpatient routine cost-to-charge ratio (rounded to six decimal places) by dividing the total inpatient general routine service costs (line 27) by the total inpatient general routine service charges (line 28).

Line 32--Enter the average per diem charge (rounded to two decimal places) for private room accommodations by dividing the amount on line 29 by the days on line 3.

Line 33--Enter the average per diem charge (rounded to two decimal places) for semi-private accommodations by dividing the amount on line 30 by the days on line 4.

Line 34--Subtract the average per diem charge for all semi-private accommodations (line 33) from the average per diem charge for all private room accommodations (line 32) to determine the average per diem private room charge differential. If a negative amount results from this computation, enter zero on line 34.

Line 35--Multiply the average per diem private room charge differential (line 34) by the inpatient general routine cost-to-charge ratio (line 31) to determine the average per diem private room cost differential (rounded to two decimal places).

Line 36--Multiply the average per diem private room cost differential (line 35) by the private room accommodation days (excluding private room accommodation days applicable to swing-bed SNF-type and NF-type services) (line 3) to determine the total private room accommodation cost differential adjustment.

Line 37--Subtract the private room cost differential adjustment (line 36) from the general inpatient routine service cost net of swing-bed SNF-type and NF-type costs (line 27) to determine the adjusted general inpatient routine service cost net of swing-bed SNF-type service costs, NF-type service costs, and the private room accommodation cost differential adjustment. If line 4 equals line 2, enter the amount from line 27 above.

4025.2 Part II - Hospital and Subproviders Only.--This part provides for the apportionment of inpatient operating costs to titles V, XVIII, and XIX and the calculation of program excludable cost for all hospitals (*) and subproviders. CAHs are required to complete this worksheet. For hospitals reimbursed under TEFRA, it provides for the application of a ceiling on the rate of cost increase for the hospital and subproviders. When the worksheet is completed for a component, show both the hospital and component numbers.

* Hospitals, including CAHs, that (1) participated in the PARHM demonstration for the entire cost reporting period, select the "PARHM Demonstration" box only and complete Worksheet D-1, Parts I and II; or (2) participated in the PARHM demonstration for a portion of the cost reporting period, select the "PARHM Demonstration" box and complete Worksheet D-1, Parts I and II, for the portion of the cost reporting period included in the demonstration. Select the "Hospital" box and complete a separate Worksheet D-1, Parts I and II, for the portion of the cost reporting period not included in the demonstration.

Line Descriptions

Line 38--For non-IPPS providers, (includes CAHs), divide the adjusted general inpatient routine service cost (line 37) by the total general inpatient routine service days including private room (excluding swing-bed and newborn) days (line 2) to determine the general inpatient routine service average cost per diem (rounded to two decimal places).

For PPS providers (includes IRFs, IPFs, and LTCHs under 100 percent PPS), divide the sum of lines 36 and 37, by the inpatient days reported on line 2.

For CAHs the per diem, unless there is an adjustment for private room differential, should be equal to the per diem calculated in the formula on line 26. If this is a CAH and there is a private room differential, process as a non-PPS provider.

Line 39--Multiply the total program inpatient days including private room (excluding swing-bed and newborn) days (line 9) by the adjusted general inpatient routine service average cost per diem (line 38) to determine the general inpatient service cost applicable to the program.

Line 40--Multiply the medically necessary private room (excluding swing-bed) days applicable to the program (line 14) by the average per diem private room cost differential (line 35) to determine the reimbursable medically necessary private room cost applicable to the program. PPS providers including IRF, IPF, and LTCH, reimbursed at 100 percent Federal rate enter zero.

Line 41--Add lines 39 and 40 to determine the total general inpatient routine service cost applicable to the program.

Line 42--This line is for titles V and XIX only and provides for the apportionment of your inpatient routine service cost of the nursery, as appropriate.

Column 1--Enter the total inpatient cost applicable to the nursery from Worksheet C, Part I, line 43.

TEFRA, COST, or OTHER Inpatient	Column 3
PPS Inpatient, or IPF, IRF, and LTCH PPS	Column 5

Column 2--Enter the total inpatient days applicable to the nursery from line 15.

Column 3--Divide the total inpatient cost in column 1 by the total inpatient days in column 2 (rounded to two decimal places).

Column 4--Enter the program nursery days from line 16.

Column 5--Multiply the average per diem cost in column 3 by the program nursery days in column 4.

Lines 43 through 47--These lines provide for the apportionment of the hospital inpatient routine service cost of intensive care type inpatient hospital units (excluding nursery) to the program.

Column 1--Enter on the appropriate line the total inpatient routine cost applicable to each of the indicated intensive care type inpatient hospital units from Worksheet C, Part I, lines 31 through 35, as appropriate.

TEFRA, COST, or OTHER Inpatient	Column 3
PPS Inpatient, or IPF, IRF and LTCH PPS	Column 5

Column 2--Enter on the appropriate line the total inpatient days applicable to each of the indicated intensive care type inpatient units. Transfer these inpatient days from Worksheet S-3, Part I, column 8, lines 8 through 12, as appropriate.

Column 3--For each line, divide the total inpatient cost in column 1 by the total inpatient days in column 2 (rounded to two decimal places).

Column 4--Enter on the appropriate line the Program days applicable to each of the indicated intensive care type inpatient hospital units. Transfer these inpatient days from Worksheet S-3, Part I, columns 5, 6, 6.01 (PARHM only), or 7, as appropriate, lines 8 through 12.

NOTE: When you place overflow general care patients temporarily in an intensive care type inpatient hospital unit because all beds available for general care patients are occupied, count the days as intensive care type unit days for the purpose of computing the intensive care type unit per diem. The days are included in column 2. However, count the program days as general routine days in computing program reimbursement. Enter the program days on line 9 and not in column 4, lines 43 through 47, as applicable. (See CMS Pub. 15-1, chapter 22, §2217.)

Column 5--Multiply the average cost per diem in column 3 by the program days in column 4.

Line 48--Enter the total program inpatient ancillary service cost from the appropriate Worksheet D-3, column 3, line 200.

Line 48.01--TEFRA providers only: Transfer the Program inpatient cellular therapy acquisition cost from Worksheet D-6, Part III, line 10, column 1.

Line 49--Enter the sum of the amounts on lines 41 through 48.01. When this worksheet is completed for components, neither subject to prospective payment, nor subject to the target rate of increase ceiling (i.e., "Other" box is checked), transfer this amount to Worksheet E-3, Part V, line 1, or Part VII, line 1, as appropriate. Do not complete lines 50 through 63.

For all inclusive rate providers (Method E), apply the percentage to the sum of the aforementioned lines (lines 41 through 48.01) based on the provider type designated on Worksheet S-2, column 4, line 3 (see CMS Pub. 15-1, chapter 22, §2208).

Lines 50 through 53--These lines compute total program inpatient operating cost less program capital-related, nonphysician anesthetists, and approved medical education costs. Complete these lines for all provider components.

Line 50--Enter on the appropriate worksheet the total pass-through costs including capital-related costs applicable to program inpatient routine services. Transfer capital-related inpatient routine cost from Worksheet D, Part I, column 7, sum of lines 30 through 35 and line 43 for the hospital, and line 40, 41, or 42, as applicable, for the subprovider. Add that amount to the other pass-through costs from Worksheet D, Part III, column 9, sum of lines 30 through 35 and line 43, for the hospital, and line 40, 41, or 42, as applicable, for the subprovider.

Line 51--Enter the total pass-through costs including capital-related costs applicable to program inpatient ancillary services. Transfer capital-related inpatient ancillary costs from Worksheet D, Part II, column 5, line 200. Add that amount to the other pass-through costs from Worksheet D, Part IV, column 11, line 200.

Line 52--Enter the sum of lines 50 and 51.

Line 53--Enter total program inpatient operating cost (line 49) less program capital-related, nonphysician anesthetists (if appropriate), and approved medical education costs (line 52).

Lines 54 through 63--Except for those hospitals specified below, all hospitals (and distinct part hospital units) excluded from prospective payment and extended neoplastic disease care hospitals are reimbursed under cost reimbursement principles and are subject to the ceiling on the rate of hospital cost increases (TEFRA). (See 42 CFR 413.40.) CAHs do not complete these lines as CAH reimbursement is based on reasonable cost. The following hospitals are reimbursed under special provisions and, therefore, are not generally subject to TEFRA or prospective payment:

- Hospitals reimbursed under approved State cost control systems (see 42 CFR 403.300 through 403.322);
- Nonparticipating hospitals furnishing emergency services to Medicare beneficiaries.

For your components subject to the PPS or not otherwise subject to the rate of increase ceiling as specified above, make no entries on lines 54 through 63.

NOTE: A new non-PPS hospital or subprovider (lines 85 and/or 86 of Worksheet S-2 with a "Y" response) is cost reimbursed for all cost reporting periods through the end of its first 12-month cost reporting period. The 12-month cost reporting period also becomes the TEFRA base period unless an exemption under 42 CFR 413.40(f) is granted. If such an exemption is granted, cost reimbursement continues through the end of the exemption period. The last 12-month period of the exemption is the TEFRA base period.

NOTE: For lines 54 through 63: In the FFY 2018 IPPS final rule, (82 FR 38298 (August 14, 2017)), CMS created a new category of IPPS excluded hospitals named "extended neoplastic disease care hospitals" under subsection (d)(1)(B)(vi) of the Act, for hospitals that were formally classified as "subclause (II) LTCHs, effective for cost reporting periods beginning on or after January 1, 2015, (that is, calendar year 2015 and subsequent fiscal years). The payment adjustment is determined based on reasonable cost, as described at 42 CFR 412.526(c).

Line 54--Enter the number of program discharges including deaths (excluding newborn and DOAs) for the component from Worksheet S-3, Part I, columns 12 through 14 (as appropriate), lines 14 and 16 through 18 (as appropriate). A patient discharge, including death, is a formal release of a patient.

Line 55--Enter the target amount per discharge as obtained from your contractor. The target amount establishes a limitation on allowable rates of increase for hospital inpatient operating cost. The rate of increase ceiling limits the amount by which your inpatient operating cost may increase from one cost reporting period to the next. (See 42 CFR 413.40.) Ensure the amounts reported on lines 55.01 and 55.02 are not included on this line.

Line 55.01--If Worksheet S-2, Part I, line 88, column 1, is "Y", enter the amount of the permanent adjustment to the TEFRA target amount per discharge from Worksheet S-2, Part I, line 89, column 3, after applying the proper update factor (see 42 CFR 413.40) as obtained from your contractor. If the contractor approved more than one permanent adjustment to the TEFRA target amount per discharge (Worksheet S-2, Part I, line 88, column 2, is greater than 1), enter the sum of all permanent adjustments (i.e., the sum of the amounts entered on Worksheet S-2, Part I, line 89 and subscripts, column 3) after applying the proper update factors (see 42 CFR 413.40) as obtained from your contractor.

Line 55.02--This line is for contractor use only. Enter the contractor-approved amount of the adjustment to the TEFRA target amount per discharge. Do not use this line to report a permanent TEFRA target rate per discharge adjustment amount; report permanent adjustments on line 55.01.

Line 55.03--Enter the CAR T-cell amount paid to your facility that agrees with the interim payments made in advance of making a request for an adjustment to your TEFRA ceiling.

Line 56--Multiply the number of discharges on line 54 by the sum of the amounts on lines 55, 55.01, and 55.02; plus line 55.03, to determine the rate of increase ceiling.

Line 57--Subtract line 53 from line 56, to determine the difference between adjusted inpatient operating cost and the target amount.

Line 58 through 62--New providers and extended neoplastic disease care hospitals do not complete lines 58 through 62. This line provides incentive payments when your cost per discharge for the cost reporting period subject to the ceiling is less than the applicable target amount per discharge. In addition, bonus payments are provided for hospitals who have received PPS exempt payments for three or more previous cost reporting periods and whose operating costs are less than the target amount, expected costs (lesser of actual costs or the target amount for the previous year), or trended costs (lesser of actual operating costs or the target amount in 1996; or for hospitals where its third full cost reporting period was after 1996 the inpatient operating cost per discharge), updated and compounded by the market basket. It also provides for an adjustment when the cost per discharge exceeds the applicable target amount per discharge. If line 57 is zero, enter zero on lines 58 through 62.

Line 58--If line 57 is a positive amount (actual inpatient operating cost is less than the target amount), enter on line 58 the lesser of 15 percent of line 57 or 2 percent of line 56. If line 57 is negative, do not complete line 58 (leave blank); however, complete line 62 for calculation of any adjustments to the operating costs.

Line 59--Enter the hospital's trended cost:

- For a hospital for which its cost reporting period ending during FY 1996 was the third *or subsequent full cost reporting period, trended costs are the lesser of (line 53 divided by line 54), or the FY 1996 cost report Worksheet D-1, Part II, line 55 (target amount)* compounded forward for each succeeding fiscal year by the market basket.
- For all other hospitals, trended costs are the allowable inpatient operating costs per discharge (line 53 divided by line 54) from its third full cost reporting period compounded forward for each succeeding fiscal year by the market basket.

Line 60--Enter the hospital's expected cost, calculated as the lesser of the hospital's inpatient operating cost per discharge (line 53 divided by line 54) or the prior year cost report Worksheet D-1, Part II, sum of lines 55 and 55.01, updated by the market basket.

Line 61--Enter the continuous improvement bonus payment. If (line 53 divided by line 54) is less than the lowest of the sum of lines 55 and 55.01, or line 59, or line 60, enter the lesser of 50 percent of the amount by which operating costs (line 53) are less than expected costs (line 54 multiplied by line 60), or 1 percent of the target amount (line 56); otherwise enter zero. (See 42 CFR 413.40(d)(4)(i).)

Line 62--If line 57 is a negative amount (actual inpatient operating cost is greater than the target amount) and line 53 is greater than 110 percent of line 56, enter on this line the lesser of (1) or (2): (1) 50 percent of the result of (line 53 minus 110 percent of line 56) or (2) 10 percent of line 56; otherwise enter zero. (See 42 CFR 413.40(d)(3).)

Line 63--Allowable Cost Plus Incentive Payment--If line 57 is a positive amount, enter the sum of lines 52, 53, 58, and 61 (if applicable). If line 57 is a negative amount, enter the sum of lines 52, 56, and 62. If line 57 is zero, enter the sum of lines 52 and 56. New providers and extended neoplastic disease care hospitals enter the lesser of lines 53 or 56, plus line 52.

Line 64--Enter the amount of Medicare swing-bed SNF-type inpatient routine cost through December 31 of the cost reporting period. Determine this amount by multiplying the program swing-bed SNF-type inpatient days on line 10, by the rate used on line 17. For CAHs multiply line 10, times the per diem calculated on line 38.

Line 65--Enter the amount of Medicare swing-bed SNF-type inpatient routine cost for the period after December 31 of the cost reporting period. Determine this amount by multiplying the program swing-bed SNF-type inpatient days on line 11, by the rate used on line 18. For CAHs multiply line 11, times the per diem calculated on line 38.

Line 66--Enter the sum of lines 64 and 65. For CAHs only transfer this amount to Worksheet E-2, column 1, line 1.

Line 67--Enter the amount of titles V or XIX swing-bed NF-type inpatient routine cost through December 31 of the cost reporting period. Determine this amount by multiplying the program swing-bed NF-type inpatient days on line 12, by the rate used on line 19.

Line 68--Enter the amount of titles V or XIX swing-bed NF-type inpatient routine cost for the period after December 31 of the cost reporting period. Determine this amount by multiplying the program swing-bed NF-type inpatient days on line 13, by the rate used on line 20.

Line 69--Enter the sum of lines 67 and 68. Transfer this amount to the appropriate Worksheet E-2, column 1, line 2. If your state recognizes only one level of care obtain the amount from line 66.

4025.3 Part III - SNF, NF, and ICF/IID Only.--This part provides for the apportionment of inpatient operating costs to titles V, XVIII, and XIX. Hospital-based SNFs complete lines 70 through 74 and lines 83 through 86 for data purposes only as SNFs are reimbursed under SNF PPS for title XVIII. Complete lines 70 through 89 for titles V and XIX. When this worksheet is completed for a component, show both the hospital and component numbers. Any reference to the nursing facility will also apply to the ICF/IID unit.

Line Descriptions

Line 70--Enter the hospital-based SNF or other nursing facility routine service cost from Part I, line 37.

Line 71--Calculate the adjusted general inpatient routine service cost per diem by dividing the amount on line 70, by inpatient days, including private room days, shown on Part I, line 2.

Line 72--Calculate the routine service cost by multiplying the program inpatient days, including the private room days in Part I, line 9, by the per diem amount on line 71.

Line 73--Calculate the medically necessary private room cost applicable to the program by multiplying the days shown in Part I, line 14, by the per diem in Part I, line 35.

Line 74--Add lines 72 and 73 to determine the total reasonable program general inpatient routine service cost.

Lines 75 through 82--Apportionment of Inpatient Operating Costs for Other Nursing Facilities (NF)--These lines are used for titles V and/or XIX only. For title XVIII Medicare, skip lines 75 through 82, and continue with line 83.

Line 75--Enter the capital-related cost allocated to the general inpatient routine service cost center. For titles V and XIX, transfer this amount from Worksheet B, Part II, column 26, line 45 (NF).

Line 76--Calculate the per diem capital-related cost by dividing the amount on line 75 by the days in Part I, line 2.

Line 77--Calculate the program capital-related cost by multiplying line 76 by the days in Part I, line 9.

Line 78--Calculate the inpatient routine service cost by subtracting line 77 from line 74.

Line 79--Enter the aggregate charges to beneficiaries for excess costs obtained from your records.

Line 80--Enter the total program routine service cost for comparison to the cost limitation. Obtain this amount by subtracting line 79 from line 78.

Line 81--Enter the inpatient routine service cost per diem limitation. This amount is provided by your state contractor.

Line 82--Enter the inpatient routine service cost limitation. Obtain this amount by multiplying the number of inpatient days shown on Part I, line 9, by the cost per diem limitation on line 81.

Line 83--For titles V and XIX, enter the amount of reimbursable inpatient routine service cost determined by adding line 77 to the lesser of line 80 or line 82. If you are a provider not subject to the inpatient routine service cost limit, enter the sum of lines 77 and 80. For title XVIII, enter the amount from line 74.

Line 84-- Enter the program ancillary service amount from Worksheet D-3, column 3, line 200.

Line 85--Enter (only when Worksheet D-1 is used for a hospital-based SNF and NF) the applicable program's share of the reasonable compensation paid to physicians for services on utilization review committees to an SNF and/or NF. Include the amount eliminated from total costs on Worksheet A-8, line 25. If the utilization review costs are for more than one program, the sum of all the Worksheet D-1 amounts reported on this line must equal the amount adjusted on Worksheet A-8, line 25.

Line 86--Calculate the total program inpatient operating cost by adding the amounts on lines 83 through 85. Transfer this amount to the appropriate Worksheet E-3, Part VII, line 1, except for SNFs subject to SNF PPS. For NF and ICF/IID, transfer this amount to Worksheet E-3, Part VII, line 1, for titles V and XIX.

4025.4 Part IV - Computation of Observation Bed Pass-Through Cost.--This part provides for the computation of the total observation bed costs and the portion of costs subject to reimbursement as a pass-through cost for observation beds that are only in the general acute care routine area of the hospital. CAHs are required to complete this worksheet. For title XIX, insert the amount calculated for title XVIII for the hospital, if applicable. To avoid duplication of reporting observation bed costs, do not transfer the title XIX amount to Worksheet C.

Line 87--Transfer the total observation bed days from Worksheet S-3, Part I, column 8, line 28. NOTE: Observation days are only recognized and reported in the inpatient routine area of the hospital.

Line 88--Calculate the result of general inpatient routine cost on line 27 divided by line 2.

Line 89--Multiply the number of days on line 87 by the cost per diem on line 88 and enter the result. Transfer this amount to Worksheet C, Parts I and II, column 1, line 92.

Lines 90 through 93--These lines compute the observation bed costs used to apportion the routine pass-through costs and capital-related costs associated with observation beds for PPS, TEFRA, and new children's and new cancer providers. Lines 90 through 93 correspond to specific medical education programs reported on Worksheet D, Part III, columns 1, 2, and 3, respectively.

Column 1--For line 90, transfer the amount from Worksheet D, Part I, column 1, line 30, for the hospital. For line 91 through 93, enter the cost from Worksheet D, Part III, columns 1, 2 and 3, line 30.

Column 2--Enter on each line the general inpatient routine cost from line 21. Enter the same amount on each line.

Column 3--Divide column 1 by column 2, for each line, and enter the result. If there are no costs in column 1, enter 0 in column 3.

Column 4--Enter the total observation cost from line 89. Enter the same amount on each line.

Column 5--Multiply the ratio in column 3 by the amount in column 4. Use this cost to apportion routine pass-through costs associated with observation beds on Worksheet D, Parts II and IV.

Transfer the amount in column 5:

From	To	To
Wkst. D-1, Part IV	Wkst. D, Part II	Wkst D, Part IV
Col. 5, line 90	Col. 1, line 92	
Col. 5, line 91		Col. 2, line 92
Col. 5, line 92		Col. 3, line 92
Col. 5, line 93		Col. 4, line 92

4026. WORKSHEET D-2 - APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS

4026.1 Part I - Not in Approved Teaching Program.--Use this part only if you have interns and residents who are not in an approved teaching program. (See CMS Pub. 15-1, chapter 4.) If you have more than one hospital-based outpatient rehabilitation provider, subscript line 17 to accommodate reporting data for each.

Column 1--Enter the percentage of time that interns and residents, not in an approved teaching program, are assigned to each of the indicated patient care areas on lines 1 through 19 and 21 through 26 (from your records).

Column 2--Enter on line 1 the total cost of residents' services rendered in all patient care areas from Worksheet B, Part I, column 26, line 100. Multiply the amount in column 1 by the total cost in column 2, line 1. Enter the resulting amounts on the appropriate lines in column 2.

Inpatient

Column 3--Enter the total inpatient days applicable to the various patient care areas of the complex.

Description	Enter in Col. 3	Inpatient Days From Worksheet D-1
Adults & Pediatrics	line 2	Part I, col. 1, line 1
Intensive Care Unit	line 3	Part II, col. 2, line 43
Coronary Care Unit	line 4	Part II, col. 2, line 44
Burn Intensive Care Unit	line 5	Part II, col. 2, line 45
Surgical Intensive Care Unit	line 6	Part II, col. 2, line 46
Other Intensive Care Type Unit	line 7	Part II, col. 2, line 47
Nursery	line 8	S-3, Part I, col. 8, line 13
IPF - Inpatient Routine	line 10	Part I, col. 1, line 1
IPF - Inpatient Routine	line 11	Part I, col. 1, line 1
Subprovider	line 12	Part I, col. 1, line 1
SNF	line 13	Part I, col. 1, line 1
NF	line 14	Part I, col. 1, line 1

Column 4--Divide the allocated expenses in column 2 by the inpatient days in column 3 to arrive at the average per diem cost for each cost center.

For swing-bed SNF or swing-bed NF facilities, transfer the per diem amount in column 4, line 2, to Worksheet E-2, column 1 (for titles V and XIX) or column 2 (for title XVIII), line 4.

Columns 5, 6, and 7--Enter in the appropriate column the health care program inpatient days for each patient care area.

Titles V and XIX

Description	Enter in column 5 for title V or column 7 for title XIX	From Worksheet D-1
Adults & Pediatrics	line 2	Part I, col. 1, line 9
Intensive Care Unit	line 3	Part II, col. 4, line 43
Coronary Care Unit	line 4	Part II, col. 4, line 44
Burn Intensive Care Unit	line 5	Part II, col. 4, line 45
Surgical Intensive Care Type Unit	line 6	Part II, col. 4, line 46
Other Intensive Care Type Unit	line 7	Part II, col. 4, line 47
Nursery	line 8	Part II, col. 4, line 42
IPF - Inpatient Routine	line 10	Part I, col. 1, line 1
IRF - Inpatient Routine	line 11	Part I, col. 1, line 1
Subprovider	line 12	Part I, col. 1, line 1
SNF	line 13	Part I, col. 1, line 1
NF	line 14	Part I, col. 1, line 1

Title XVIII--Enter in column 6, lines 2 through 13, as appropriate, the total number of days in which beneficiaries were inpatients of the provider and had Medicare Part B coverage. Such days are determined without regard to whether Part A benefits were available. Submit a reconciliation with the cost report demonstrating the computation of Medicare Part B inpatient days. The following reconciliation format is recommended:

Cost Center	Part A Inpatient Days	plus	Part B Only Days	minus	Part A Coverage But No Part B Days Coverage	=	Medicare Part B Days

Part A Inpatient Days--Enter the Medicare Part A inpatient days from Worksheet D-1.

Cost Center	From Worksheet D-1
Adults & Pediatrics	Part I, column 1, line 9
Intensive Care Unit	Part II, column 4, line 43
Coronary Care Unit	Part II, column 4, line 44
Burn Intensive Care Type Unit	Part II, column 4, line 45
Surgical Intensive Care Type Unit	Part II, column 4, line 46
Other Intensive Care Type Unit	Part II, column 4, line 47
IPF - Inpatient Routine	Part I, column 1, line 9
IRF - Inpatient Routine	Part I, column 1, line 9
Subprovider	Part I, column 1, line 9
Skilled Nursing Facility	Part I, column 1, line 9

Part B Only Days--Enter the total number of days from your records in which inpatients were covered under Medicare Part B but did not have Part A benefits available.

No Part B Days--Enter the total number of days from your records in which inpatients were covered under Medicare Part A but did not have Part B benefits available.

Columns 8, 9, and 10--Multiply the average cost per day in column 4 by the health care program days in columns 5, 6, and 7, respectively. Enter the resulting amounts in columns 8, 9, and 10, as appropriate, for each cost center.

Outpatient

Column 3--Enter the total charges applicable to each outpatient service area. Obtain the total charges from Worksheet C, column 8, lines 88 through 93.

Column 4--Compute the total outpatient cost-to-charge ratio by dividing costs in column 2 by charges in column 3, for each cost center.

Columns 5, 6, and 7--Enter in these columns program charges for outpatient services. Do not include in Medicare charges any charges identified as MSP/LCC.

Titles V and XIX:

		Sum of	
Description	Enter in col. 5 for title V or col. 7 for title XIX	Worksheet D-3, col. 2	Worksheet D, Part V, sum of cols. 2 through 4 (and applicable subscripts)
RHC	line 21	line 88	line 88
FQHC	line 22	line 89	line 89
Clinic	line 23	line 90	line 90
Emergency	line 24	line 91	line 91
Observation Beds	line 25	line 92	line 92
Other Outpatient	line 26	line 93	line 93

Title XVIII:

		From				
Description	Enter in. col. 6 for title XVIII	Worksheet D-3, col. 2	Worksheet D, Part V, cols. 2 through 4 (& applicable subscripts)			Less Part A Only Charges
RHC	line 21	line 88	plus	line 88	minus	
FQHC	line 22	line 89	plus	line 89	minus	From
Clinic	line 23	line 90	plus	line 90	minus	Provider
Emergency	line 24	line 91	plus	line 91	minus	Records
Observation Beds	line 25	line 92	plus	line 92	minus	
Other Outpatient	line 26	line 93	plus	line 93	minus	

NOTE: Submit a reconciliation worksheet with the cost report showing the computations used for the charges for column 6.

If you have subproviders, the amounts entered in these columns are the sum of the hospital and subprovider Worksheets D-3 and D, Part V.

Columns 8, 9, and 10, lines 21 through 26--Compute program outpatient costs for titles V; XIX; and XVIII, Part B; cost by multiplying the cost-to-charge ratio in column 4 by the program outpatient charges in columns 5, 6, and 7. Enter the resulting amounts in columns 8, 9, and 10, as appropriate, for each cost center.

Transfer program expenses.

From Title V (column 8)/Title XIX (column 10)

Hospital: Sum of lines 9 and 27	TO	Worksheet E-3, Part VII, line 19
Subprovider: lines 10-12, as applicable	TO	Worksheet E-3, Part VII, line 19
Other Nursing Facility: line 14	TO	Worksheet E-3, Part VII, line 19

From Title XVIII (column 9) (only if Part II is not utilized)

Hospital: Sum of lines 9 and 27	TO	Worksheet E, Part B, line 22
Subprovider: line 10-12, as applicable	TO	Worksheet E, Part B, line 22
Skilled Nursing Facility: line 13	TO	Worksheet E, Part B, line 22

4026.2 Part II - In An Approved Teaching Program (Title XVIII, Part B Inpatient Routine Costs Only).--This part provides for reimbursement for inpatient routine services rendered by interns and residents in approved teaching programs to Medicare beneficiaries who have Part B coverage and are not entitled to benefits under Part A. (See CMS Pub. 15-1, chapter 4; and chapter 21, §2120.) Do not complete this section unless you qualify for the new teaching hospital exception for GME payments in 42 CFR 413.77(e)(1). This exception regarding payment of direct GME on a reasonable cost basis at 42 CFR 413.77(e)(1) applies for cost reporting periods beginning prior to December 27, 2020; therefore, do not complete this worksheet part for cost reporting periods beginning on or after December 27, 2020.

Column 1--Enter the amounts allocated in the cost finding process to the indicated cost centers. Obtain these amounts from Worksheet B, Part I, sum of the amounts in columns 21 and 22, as adjusted for any post step-down adjustments applicable to interns and residents in approved teaching programs.

Column 2--Enter the adjustment for intern and resident costs applicable to swing-bed services but allocated to hospital routine cost. Compute these amounts as follows:

Swing Inpatient Bed Amount	=	I&R Costs Allocated to Adults & Pediatrics	times	Total Swing-Bed Days	divided by	Total Days
For line 30 (SNF)		Wkst. D-2, col. 1, line 29		Wkst. D-1, sum of lines 5 and 6		Wkst. D-1, line 1
For line 31 (NF)		Wkst. D-2, col. 1, line 29		Wkst. D-1, sum of lines 7 and 8		Wkst. D-1, line 1

The amount subtracted from line 29 must equal the sum of the amounts computed for lines 30 and 31.

If you have swing-beds in your IPF subprovider, complete line 38 to adjust for swing-bed costs. Compute the swing-bed amounts as explained above except that the interns and residents costs allocated to adults and pediatrics (line 38) comes from Worksheet D-2, column 1, line 38. The amount subtracted from line 38 must equal the sum of subscripts of line 38, as applicable. If you have swing-beds in your IRF subprovider, complete line 39 to adjust for swing-bed costs. Compute the swing-bed amounts as explained above except that the interns and residents costs allocated to adults and pediatrics (line 39) comes from Worksheet D-2, column 1, line 39. The amount subtracted from line 39 must equal the sum of subscripts of line 39, as applicable.

Column 3--Enter on lines 29, and 38 through 40, as applicable, the amounts in column 1 minus the amount in column 2. Enter on line 30 the amount from column 2. Enter on lines 32 through 36, and 41, the amounts from column 1.

Column 4--Enter the total inpatient days applicable to the various patient care areas of the complex. (See instructions for Part I, column 3. For line 30, this is from Worksheet D-1, sum of lines 5 and 6.)

Column 5--Divide the allocated expense in column 3 by the inpatient days in column 4 to arrive at the average per diem cost for each cost center.

Column 6--Enter on lines 29, 30, 32 through 36, and 38 through 41, as applicable, the total number of days in which inpatients were covered under Medicare Part B but did not have Part A benefits available.

Column 7--Multiply the average per diem cost in column 5 by the number of inpatient days in column 6 to arrive at the expense applicable to title XVIII for each cost center. Transfer the amount on line 30, or lines 38 through 40, if you are a subprovider with a swing-bed, to Worksheet E-2, column 2, line 6.

For columns 1, 3, and 7, enter on line 37, the sum of the amounts on line 29 plus the sum of the amounts on lines 32 through 36.

Transfer the expenses on lines 37 through 41, to the appropriate lines on Part III, column 4, whenever you complete both Parts I and II.

However, when only Part II is completed, transfer the amount entered in column 7, lines 37 through 41, to Worksheet E, Part B, line 22, as appropriate.

4026.3 Part III - Summary for Title XVIII (To be completed only if both Parts I and II are completed).--This part is completed only if both Parts I and II are completed; do not complete this section unless you qualify for the exception for GME payments in 42 CFR 413.77(e)(1). This exception regarding payment of direct GME on a reasonable cost basis at 42 CFR 413.77(e)(1) only applies for cost reporting periods beginning prior to December 27, 2020. This part is applicable to Medicare only and is provided to summarize the amounts apportioned to the program in Parts I and II.

Transfer title XVIII expenses.

Description	From Column 6		
Hospital	Line 45	TO	Worksheet E, Part B, line 22
Subprovider	Lines 46 through 48	TO	Worksheet E, Part B, line 22
SNF	Line 49	TO	Worksheet E, Part B, line 22

4027. WORKSHEET D-3 - INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

This worksheet provides for the apportionment of cost applicable to hospital inpatient services reimbursable under titles V, XVIII and XIX as indicated in 42 CFR 413.53. All hospitals (*) filing a full cost report, including CAHs (Worksheet S-2, line 105, is "Y") must complete this worksheet. Complete a separate copy of this worksheet for each subprovider, distinct part SNF and NF, swing-bed SNF and NF, or any other component. Identify the health care program, provider component, and the payment system by checking the appropriate boxes at the top of the worksheet.

The cost centers on this worksheet have the same line numbers as the respective cost centers on Worksheets A, B, B-1, and C. This design facilitates referencing throughout the cost report.

* Hospitals that participated in the PARHM demonstration must complete Worksheet D-3, for the portion of the cost reporting period not included in the PARHM demonstration and a separate Worksheet D-3, for the portion of the cost reporting period included in the PARHM demonstration.

Column 1--Effective for cost reporting periods ending before September 30, 2018, enter the ratio of cost to charges developed for each cost center from Worksheet C, lines 50 through 94, and 96 through 98. The ratios in columns 10 and 11 of Worksheet C are used only for hospital or subprovider components for titles V, XVIII, and XIX inpatient services subject to the TEFRA rate of increase ceiling (see 42 CFR 413.40) or PPS (see 42 CFR 412, Subpart N, O, or P), respectively. Use the ratios in column 9 in all other cases.

Effective for cost reporting periods ending on or after September 30, 2018, enter the ratio of cost to charges developed for each cost center from Worksheet C, lines 50 through 94, and 96 through 98. The ratios in column 10 of Worksheet C are used for TEFRA providers (see 42 CFR 413.40). TEFRA providers include LTCHs classified as extended neoplastic disease care hospitals; children's hospitals; cancer hospitals; RNHCIs; and hospitals located outside the 50 States, the District of Columbia, and Puerto Rico (i.e., hospitals located in the U.S. Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa). The ratios in column 11 of Worksheet C are used for all PPS providers (see 42 CFR 412, Subpart N, O, or P; 42 CFR 413.114(a)(2) for other than CAHs; and 42 CFR 413, Subpart J). Use the ratios in column 9 for cost reimbursed providers such as CAHs, new TEFRA hospitals exempt from the rate of increase limits, and post-hospital SNF care furnished in a swing-bed CAH (see 42 CFR 413.114(a)(2)).

Column 2--Enter from the PS&R or your records the inpatient program charges applicable to the provider component services only (not professional component) in the appropriate cost centers as detailed below. Also include charges for cost centers with a negative balance on Worksheet B, Part I, column 26. Do not include Program charges for swing-bed services and Medicare charges identified as MSP/LCC. Hospitals that participated in the PARHM demonstration must report PS&R charges for the portion of the cost reporting period included in the PARHM demonstration and complete a separate worksheet and report PS&R charges for the portion of the cost reporting period not included in the demonstration.

Lines 30 through 35--Enter the program charges from the PS&R or your records (hospital only).

Lines 40 through 42--Enter inpatient program charges for the subproviders' component only. For subprovider components do not complete lines 30 through 35 and 43. For a hospital complex, do not complete lines 40 through 42.

Line 43--Enter the charges for your nursery department for which you were reimbursed. Complete this for Medicaid services only.

Line 61--Enter the program charges for your clinical laboratory tests for which you reimburse the pathologist. See the instructions for Worksheet A (see §4013) for a more complete discussion on the use of this cost center.

NOTE FOR LINE 61: Since the charges on line 61 are also included on line 60, laboratory, you must reduce total charges to prevent double counting. Make this adjustment on line 201.

Line 73--Enter only the program charges for drugs charged to patients that are not paid a predetermined amount.

Line 77--For cost reporting period beginning prior to October 1, 2020, enter the HSCT charges billed under revenue code 0815. For cost reporting periods beginning on or after October 1, 2020, do not report charges billed under revenue code 0815 on this line; and report those charges in accordance with §4029.6.

Line 78--For CAR T-cell immunotherapy cost, enter the charges for services for all patients (for Medicare, these are billed under revenue codes 0871, 0872, 0873, 0874, and 0891).

Lines 88 through 90 and 93--Do not enter on these lines program charges related to any inpatient ancillary services (e.g., radiology- diagnostic, laboratory) provided in a clinic, RHC, or FQHC and billed as inpatient services. Instead, reclassify such program charges to the related ancillary cost centers.

Lines 92 and 92.01--Enter on these lines, as applicable, the program charges for observation bed services if the patient was subsequently admitted as an inpatient. However, these program charges can only be reported on the main hospital's (e.g., acute care hospital, freestanding psychiatric hospital, freestanding rehabilitation hospital) Worksheet D-3 or PARHM Demonstration Worksheet D-3. (That is, program charges for observation bed services provided to patients subsequently admitted as inpatients to an acute hospital's excluded psychiatric or rehabilitation unit must be reported on Worksheet D-3 of the acute hospital.)

Lines 96 and 97--Do not enter program charges for oxygen rented or sold as the fee schedule applies for these services.

Line 200--Enter the total of the amounts in columns 2 and 3, lines 50 through 94, and lines 96 through 98.

Line 201--Enter in column 2, program charges for your clinical laboratory tests when the physician bills you for program patients only. Obtain this amount from line 61.

Line 202--Enter in column 2, the amount on line 200 less the amount on line 201.

Transfer the amount in column 2, line 202, as follows:

For title XVIII, Part A (other reimbursement), transfer the amount to Worksheet E-3, Part V, line 8. Do not transfer this amount if you are reimbursed under PPS or TEFRA. No transfers of swing-bed charges are made to Worksheet E-2 since no LCC comparison is made. For titles V and XIX (if not a PPS provider), transfer the amount plus the amount from Worksheet D, Part V, sum of columns 3 and 4, line 202, to Worksheet E-3, Part VII, column 1, line 9.

Column 3--Multiply the indicated program charges in column 2, by the ratio in column 1, to determine the program inpatient expenses.

Transfer column 3, line 200, as follows:

Type of Provider	TO
Hospital	Wkst. D-1, Part II, col. 1, line 48
Subprovider	Wkst. D-1, Part II, col. 1, line 48
SNF	Wkst. D-1, Part III, col. 1, line 84
NF	Wkst. D-1, Part III, col. 1, line 84
Swing-Bed SNF	Wkst. E-2, col. 1, line 3
Swing-Bed NF	Wkst. E-2, col. 1, line 3

4028. WORKSHEET D-4 - COMPUTATION OF ORGAN ACQUISITION COSTS AND CHARGES FOR A TRANSPLANT HOSPITAL WITH A MEDICARE-CERTIFIED TRANSPLANT PROGRAM

This worksheet computes organ acquisition costs for a transplant hospital that is a Medicare-certified transplant center (CTC) with a Medicare-approved transplant program (transplant program) as defined in 42 CFR 482.70. Hospitals that do not have a Medicare-approved transplant program do not complete this worksheet. (See CMS Pub. 15-1, chapter 31, §3107.)

Complete a separate worksheet for each transplant program (heart, liver, lung, pancreas, intestine, kidney, or islet) with a certification date on Worksheet S-2, Part I, lines 126 through 132. Check the applicable box to identify the transplant program for which the worksheet computes acquisition costs. When a CTC procures multiple organs from a single donor, the CTC must equitably and reasonably allocate the days and charges related to that procurement among the organ types procured, and report the days and charges for each organ type on the appropriate transplant program worksheet (see CMS Pub. 15-1, chapter 31, §3102).

Hospitals that participated in the PARHM demonstration for a portion of the cost reporting period or the entire cost reporting period DO NOT complete a separate Worksheet D-4. Hospitals participating in the PARHM demonstration for a portion of the cost reporting period, or the entire cost reporting period, complete this worksheet for the hospital for the entire cost reporting period and see specific instructions on line 69.

An OPO is either a hospital-based OPO or an independent OPO. OPO references throughout this chapter include both hospital-based and independent OPOs unless differentiation is required for context.

NOTE: For cost allocation purposes, count organs procured en bloc (two organs procured as one unit) and transplanted into the same recipient as one organ. En bloc organs include en bloc kidneys and en bloc lungs. Count organs procured en bloc and subsequently separated for transplant as two organs.

Worksheet D-4 consists of the following four parts:

- Part I - Computation of Organ Acquisition Cost (Inpatient Routine and Ancillary Services)
- Part II - Computation of Organ Acquisition Cost (Other than Inpatient Routine and Ancillary Service Costs)
- Part III - Summary of Costs and Charges
- Part IV - Statistics

4028.1 Part I - Computation of Organ Acquisition Costs (Inpatient Routine and Ancillary Services).--This worksheet computes the routine and ancillary costs for organ acquisitions, allocating routine costs based on the per diem cost for each routine cost center and allocating ancillary costs based on the cost-to-charge ratio for each ancillary cost center.

Lines 1 through 7--These lines provide for the computation of inpatient routine service costs applicable to organ acquisition and for the accumulation of inpatient routine service charges for organ acquisition.

Column 1--Enter on lines 1 through 6, as appropriate, the inpatient routine charges applicable to organ acquisition. Enter on line 7, the sum of the amounts reported on lines 1 through 6.

Column 2--Enter on lines 1 through 6, as appropriate, the average per diem cost from Worksheet D-1:

Description	To Worksheet D-4, Part I, col. 2	From Worksheet D-1, Part II
Adults & Pediatrics	line 1	col. 1, line 38
Intensive Care	line 2	col. 3, line 43
Coronary Care	line 3	col. 3, line 44
Burn Intensive Care Type Unit	line 4	col. 3, line 45
Surgical Intensive Care Type Unit	line 5	col. 3, line 46
Other Intensive Care Type Unit	line 6	col. 3, line 47

Column 3--For each cost center, enter total organ acquisition days (Medicare and non-Medicare). An organ acquisition day is an inpatient day of care rendered to a potential recipient/donor (before admission for the actual transplant) solely for a medical evaluation for an anticipated organ transplant; or an organ donor patient who is hospitalized for the surgical removal of an organ; or a day of care rendered to a cadaver in an inpatient routine service area for the surgical removal of its organs for transplant. Pro-rate these days proportionally to the number of organs excised. For example, if a cadaveric donor spent 1 day in the hospital following the declaration of death and consent to donate, and five organs were excised from the cadaveric donor (e.g., two kidneys, two lungs, and one liver), the number of organ acquisition days reported as a ratio is computed:

- on Worksheet D-4 (kidney) as 2 kidneys divided by 5 organs total = 0.40 days for kidney;
- on Worksheet D-4 (lung) as 2 lungs divided by 5 organs total = 0.40 days for lung; and
- on Worksheet D-4 (liver) as 1 liver divided by 5 organs total = 0.20 days for liver.

On line 7, enter the sum of lines 1 through 6. (See CMS Pub. 100-02, chapter 11, §§140.4-140.8.)

Column 4--For each cost center, enter the amount in column 2 multiplied by the amount in column 3. On line 7, enter the sum of lines 1 through 6.

Lines 8 through 40--These lines provide for the computation of ancillary service cost applicable to organ acquisition. These lines also provide for the accumulation of inpatient and outpatient organ acquisition ancillary charges.

Column 1--For each cost center, transfer the "cost or other" cost-to-charge ratio from Worksheet C, column 9.

Column 2--For each cost center, enter inpatient and outpatient organ acquisition ancillary charges from your records. On line 41, enter the sum of lines 8 through 40. When a CTC procures multiple organs from a single donor, equitably attribute the ancillary charges to each organ procured. For example, if the CTC's operating room charge is $12,000 to procure two kidneys, procured and transplanted en bloc, and one heart, the CTC reports a $6,000 operating room charge for the en bloc kidneys on the kidney Worksheet D-4 and a $6,000 operating room charge for the heart on the heart Worksheet D-4. However, if the CTC's operating room charge is $12,000 to procure two kidneys (not en bloc) and one heart, the CTC reports a $4,000 operating room charge for each kidney on the kidney Worksheet D-4 and a $4,000 operating room charge for the heart on the heart Worksheet D-4. When attributing the ancillary charges, the CTC may use an alternate basis for allocation (e.g., number of operating room minutes) if the contractor can verify the alternate basis results in a more accurate cost per organ.

Column 3--For each cost center, compute the organ acquisition costs by multiplying the ratio in column 1 by the amount in column 2. On line 41, enter the sum of lines 8 through 40.

4028.2 Part II - Computation of Organ Acquisition Costs (Other Than Inpatient Routine and Ancillary Service Costs).-- This worksheet apportions the cost of I&R not in an approved teaching program attributable to organ acquisitions.

Lines 42 through 47--These lines apportion the cost of I&R not in an approved teaching program for inpatient services attributable to organ acquisitions.

Column 1--For each applicable line, transfer the average cost per day of I&R not in an approved teaching program from Worksheet D-2, Part I, column 4, lines as indicated.

Column 2--Transfer the number of organ acquisition days in each inpatient routine service area from Part I, column 3, lines 1 through 6, as applicable.

Column 3--For each cost center multiply the average cost per day amount in column 1 by the number of days in column 2.

Line 48--For columns 2 and 3, enter the sum of lines 42 through 47.

Lines 49 through 54--These lines apportion the cost of I&R not in an approved teaching program for outpatient services attributable to organ acquisitions.

Column 1--For each applicable line, transfer the organ acquisition charges from the outpatient service areas on Part I, column 2, lines 35 through 40, as applicable.

Column 2--Transfer the ratio of cost to charges for outpatient costs of I&R not in an approved teaching program for each outpatient service area from Worksheet D-2, Part I, column 4, lines 21 through 26, as applicable.

Column 3--For each cost center, compute organ acquisition costs by multiplying the charges in column 1 by the ratios in column 2.

Line 55--For columns 1 and 3, enter the sum of lines 49 through 54.

4028.3 Part III - Summary of Costs and Charges.--

Line 56--In column 1, enter the sum of the costs in Part I, column 4, line 7, and column 3, line 41. In column 3, enter the sum of the charges in Part I, column 1, line 7, and column 2, line 41.

Line 57--In column 1, enter the cost of inpatient services of I&R not in an approved teaching program from Part II, column 3, line 48. In column 3, enter the charges for the services for which the cost is entered in column 1. If you do not charge separately for the services of I&R, enter zero in column 3.

Line 58--In column 1, enter the cost of outpatient services of I&R not in an approved teaching program from Part II, column 3, line 55. In column 3, enter the charges for the services for which the cost is entered in column 1. If you do not charge separately for the services of interns and residents, enter zero in column 3.

Line 59--In column 1, enter the direct organ acquisition costs and allocated general service costs from Worksheet B, Part I, column 26, lines 105, 106, 107, 108, 109, 110, or 111, whichever is applicable. In accordance with 42 CFR 413.402(b), direct costs include, but are not limited to, the cost of services purchased under arrangements or billed directly to you for:

- Fees for physician services (preadmission donor and recipient tissue typing),
- Costs for organs acquired from other providers or organ procurement organizations,
- Transportation costs excluding costs for transporting organs outside of the United States,
- Organ recipient registration fees,
- Surgeon's fees for excising cadaveric organs, and
- Tissue typing services furnished by independent laboratories.

In column 3, enter the applicable charges from your schedule of charges. If your facility has no schedule of charges for the services, enter the cost from column 1.

Line 60--If Worksheet S-2, Part I, line 58, is "Y," enter the cost of physicians in column 1. For cost reporting periods ending before June 30, 2014, transfer the amount from Worksheet D-5, Part II, column 3, lines 24 through 30, as applicable. For cost reporting periods ending on or after June 30, 2014, transfer the amount from Worksheet D-5, Part IV, lines 24 through 30, as applicable. In column 3, enter the applicable charges from your schedule of charges. If your facility has no schedule of charges for the services, enter the cost from column 1.

Line 61--Enter in columns 1 and 3 the sum of lines 56 through 60. This amount must be equal to or greater than the amount reported on line 66 (revenues for organs sold). For cost reporting periods beginning on or after January 1, 2023, reduce the amount in column 1 by the amount reported on line 82, column 3, calculated as the sum of lines 56 through 60, column 1, minus line 82, column 3.

Line 62--Enter the number of total usable organs excised and purchased (Worksheet D-4, Part IV, line 74, sum of columns 1 and 2), minus all unusable organs that could not be transplanted (Worksheet D-4, Part IV, line 83, sum of columns 1 and 2), and for cost reporting periods beginning on or after January 1, 2023, minus research organs, including organs intended for transplant but subsequently determined unsuitable and furnished for research (Worksheet D-4, Part IV, line 82, sum of columns 1 and 2). For islets, enter the number of patients who received islets injections. (See CMS Pub. 100-04, chapter 32, section 70.4.)

Line 63--In column 2, enter the number of Medicare usable organs that are included on line 62. Medicare usable organs include:

- organs transplanted into Medicare beneficiaries (line 75.01);
- kidneys (not including non-renal organs) transplanted into MA beneficiaries effective for transplants occurring on or after January 1, 2021 (line 75.02);
- organs transplanted into Medicare beneficiaries with partial payments by a primary insurer in addition to Medicare (line 75.03);
- organs sent to other transplant hospitals and OPOs; (sum of lines 77 and 78); and,
- kidneys sent to military renal transplant centers (MRTCs) that have a reciprocal sharing agreement with the hospital-based OPO in effect prior to March 3, 1988, and approved by the contractor (line 79.01).

NOTE FOR LINE 63: Do not include:

- organs used for research (line 82);
- kidneys sent to MRTCs without a reciprocal sharing agreement with the hospital-based OPO in effect prior to March 3, 1988, and approved by the contractor and organs sent to veterans' hospitals (line 79);
- organs sent or sold outside of the United States (lines 80 and 81); and
- organs transplanted into non-Medicare beneficiaries; organs that were totally paid by primary insurance other than Medicare; organs that were paid by a MA plan (except for kidneys transplanted into MA beneficiaries for transplants occurring on or after January 1, 2021) or a PACE (program of all-inclusive care for the elderly) organization; and organs procured from a non-certified OPO.

Line 64--Enter the ratio of Medicare usable organs (line 63) to total usable organs (line 62).

Line 65--In column 1, calculate the Medicare costs by multiplying the ratio on line 64 by the total costs on line 61, column 1. In column 3, calculate the Medicare charges by multiplying the ratio on line 64, column 2, by the total charges on line 61, column 3.

Line 66--Enter in column 1 (and transfer to column 3), the total revenue applicable to organs reported on line 63, i.e.:

- Revenue amounts for organs sent to other providers, organs sent to OPOs, and kidneys sent to MRTCs with a reciprocal sharing agreement with the hospital-based OPO in effect prior to March 3, 1988, and approved by the contractor; and

- For cost reporting periods beginning prior to October 1, 2022, also include on this line the primary insurer payment amounts applicable to organ acquisition for organs that were partially reimbursed by primary insurers when Medicare is the secondary payer. When the primary insurer does not pay in full for the services, that is for the transplant and the organ acquisition costs, Medicare may have a secondary payer liability for the organ acquisition costs (see 42 CFR 413.414(c)). When Medicare is the secondary payer and the primary insurer makes a payment for both the transplant and the organ acquisition costs, the portion of the payment applicable to organ acquisition costs must be used to reduce the Medicare organ acquisition cost. Enter in column 1 (and transfer to column 3) the amount applicable to the organ acquisition costs by prorating the primary payer payment amount between the organ acquisition and transplant based on the charges submitted to the primary insurer. (The amount reported on this line must not be included on Worksheet E, Part A, line 60.) For cost reporting periods beginning on or after October 1, 2022, do not include the primary insurer payment amounts applicable to organ acquisition on this line; instead, report the amounts on line 66.01.

Line 66.01-- For cost reporting periods beginning on or after October 1, 2022, enter the primary insurer payment amounts applicable to organ acquisition for organs included on line 63 and line 75.03 that were partially reimbursed by primary insurers when Medicare is the secondary payer. When the primary insurer does not pay in full for the services, that is for the transplant and the organ acquisition costs, Medicare may have a secondary payer liability for the organ acquisition costs (see 42 CFR 413.414(c)). When Medicare is the secondary payer and the primary insurer makes a payment for both the transplant and the organ acquisition costs, the portion of the payment applicable to organ acquisition costs must be used to reduce the Medicare organ acquisition cost. Enter in column 1 (and transfer to column 3) the amount applicable to the organ acquisition costs by prorating the primary payer payment amount between the organ acquisition and transplant based on the charges submitted to the primary insurer. (The amount reported on this line must not be included on Worksheet E, Part A, line 60.)

Line 66.02--For cost reporting periods beginning on or after October 1, 2022, enter the primary insurer payment amounts applicable to the organ transplant for organs included on line 63 and line 75.03 that were partially reimbursed by primary insurers when Medicare is the secondary payer. When the primary insurer does not pay in full for the services, that is for the transplant and the organ acquisition costs, Medicare may have a secondary payer liability for the organ acquisition costs (see 42 CFR 413.414(c)). When Medicare is the secondary payer and the primary insurer makes a single payment for both the transplant and the organ acquisition costs, the portion of the payment applicable to organ acquisition costs must be reported on line 66.01 and the amount applicable to the transplant must be reported on this line. Enter in column 1 (and transfer to column 3) the amount applicable to the transplant by prorating the amount received between the organ acquisition and the transplant based on the charges submitted to the primary insurer. This line is informational to reconcile primary insurer payment amounts reported on line 75.03 and captured on the provider's PS&R report. (The amount reported on this line must remain on Worksheet E, Part A, line 60.)

Line 67--For cost reporting periods beginning prior to October 1, 2022, enter the result of line 65 minus line 66. For cost reporting periods beginning on or after October 1, 2022, enter the result of line 65 minus the sum of lines 66 and 66.01.

Line 68--Enter in all columns the total amount of organ acquisition charges billed to Medicare under Part B. This occurs when organs are transplanted into Medicare beneficiaries who, on the day of transplantation, are not entitled to Part A benefits. This computation reflects an adjustment between Medicare Part A and Part B costs and charges so that the amount added under Part B is the same amount subtracted under Part A.

Line 69--For columns 1 and 3 subtract line 68 from line 67. For columns 2 and 4, transfer that amount from line 68. Hospitals participating in the PARHM demonstration for a portion of the cost reporting period, or the entire cost reporting period, must prorate the amount on line 69 using Medicare patient days and transfer to the appropriate Worksheet E, Part A, line 55. For example, a hospital with a June 30, 2019, year-end that began participation in the PARHM demonstration on January 29, 2019, reported Medicare inpatient days on Worksheet S-3, Part I, column 6, line 14, for the period of July 1, 2018, through January 28, 2019, and reported Medicare inpatient days on Worksheet S-3, Part I, column 6.01, line 14, for the period of January 29, 2019, through June 30, 2019. Multiply the amount on line 69 by the ratio of Medicare inpatient days reported on Worksheet S-3, Part I, column 6, line 14, divided by total Medicare inpatient days (sum of Worksheet S-3, Part I, columns 6 plus 6.01, line 14) and enter on the "Hospital" Worksheet E, Part A, line 55. To compute the portion of line 69 applicable to the PARHM demonstration, multiply the amount on line 69 by the ratio of Medicare inpatient days reported on Worksheet S-3, Part I, column 6.01, line 14, divided by total Medicare inpatient days (sum of Worksheet S-3, Part I, columns 6 plus 6.01, line 14) and enter on the "PARHM Demonstration" Worksheet E, Part A, line 55.

4028.4 Part IV - Statistics.--For each organ type, report the statistics applicable to living donors in column 1, cadaveric donors in column 2, and revenues in column 3. Report in column 1 the statistics applicable to living donors for kidneys, partial livers, or partial lungs. Do not report in column 1 any statistics for hearts, pancreata, intestines, whole livers, whole lungs, or islets; report these statistics in column 2. Count organs as one organ when:

- procured en bloc (two organs procured as one unit) and transplanted into the same recipient, and
- procured en bloc with the intention of transplanting en bloc as one organ, including en bloc kidneys and en bloc lungs.

Line 70--For columns 1 and 2, enter the number of organs excised in the CTC. Do not include organs excised outside of the CTC, even if a procurement team from your CTC excised the organs.

Line 71--For columns 1 and 2, enter the number of organs purchased from other transplant hospitals. Include organs excised outside of the CTC by a procurement team from your CTC.

Line 72--For columns 1 and 2, enter the number of organs purchased from non-transplant hospitals.

Line 73--Enter in column 2 the number of organs purchased from OPOs.

Line 74--For each column, enter the sum of lines 70 through 73.

Line 75--For cost reporting periods beginning prior to October 1, 2022, enter in columns 1 and 2, the total number of organs transplanted by the CTC. For cost reporting periods beginning on or after October 1, 2022, line 75 is the sum of lines 75.01, 75.02, 75.03, and 75.04.

NOTE FOR LINES 75.01, 75.02, and 75.03: The number of organs reported on lines 75.01, 75.02, and 75.03 must also be reported on line 63 (Medicare usable organs).

Line 75.01--For cost reporting periods beginning on or after October 1, 2022, enter in columns 1 and 2, the number of organs transplanted by the CTC into Medicare beneficiaries.

Line 75.02--For cost reporting periods beginning on or after October 1, 2022, enter in columns 1 and 2, the number of kidneys transplanted into MA beneficiaries on or after January 1, 2021, by the CTC.

Line 75.03--For cost reporting periods beginning on or after October 1, 2022, enter in columns 1 and 2, the number of organs transplanted by the CTC into patients with Medicare as a secondary payer where Medicare had a financial responsibility as the secondary payer. In column 3, enter the amount of revenue received from the primary payer for organs reported in columns 1 and 2. Where the amount reported in column 3 includes the cost of acquiring and transplanting the organ, the amount must be split on lines 66.01 and 66.02, accordingly. The amount reported on this line in column 3 must equal the sum of line 66.01, column 1, and line 66.02, column 1.

Line 75.04--For cost reporting periods beginning on or after October 1, 2022, enter in columns 1 and 2, the number of organs transplanted by the CTC into non-Medicare patients, MA beneficiaries who received non-renal (heart, liver, pancreas, islet, lung, intestine) organ transplants, and Medicare beneficiaries where Medicare was secondary payer but had no financial responsibility as the secondary payer.

Line 76--In columns 1 and 2, enter the number of organs sold to other hospitals. Enter in column 3 the amount of revenue received for organs reported in columns 1 and 2.. Effective for cost reporting periods beginning on or after October 1, 2022, do not use this line and report organs sold to other transplant hospitals on line 78.

Line 77--In columns 1 and 2, enter the number of organs sold to OPOs. In column 3, enter the revenue received for organs reported in columns 1 and 2.

Line 78--In columns 1 and 2, enter the number of organs sold to transplant hospitals. In column 3, enter the revenue received for organs reported in columns 1 and 2.

Line 79--In columns 1 and 2, enter the number of:

- kidneys sold to MRTCs without a reciprocal sharing agreement with the hospital-based OPO in effect prior to March 3, 1988, and approved by the contractor; and
- organs sold to VA hospitals.

Effective for cost reporting periods beginning on or after October 1, 2022, leave column 3 blank.

Line 79.01--In columns 1 and 2, enter the number of kidneys sold to MRTCs that have a reciprocal sharing agreement with the hospital-based OPO in effect prior to March 3, 1988, and approved by the contractor. In column 3, enter the revenue received for kidneys reported in columns 1 and 2.

Line 80--In columns 1 and 2, enter the number of organs sold outside of the U.S. Effective for cost reporting periods beginning on or after October 1, 2022, leave column 3 blank.

Line 81--In columns 1 and 2, enter the number of organs sent outside of the U.S. with no revenue received.

Line 82--In columns 1 and 2, enter the number of organs intended for research. For cost reporting periods beginning on or after January 1, 2023, also include on this line organs intended for transplant but subsequently determined unusable and furnished for research. In column 3, enter the amount used to offset these costs in accordance with 42 CFR 413.412(a)(4), for organs reported in columns 1 and 2. The amount reported in column 3 may be the costs to furnish the organs for research or the revenue received for these organs but in no event should the amount exceed organ acquisition costs.

Line 83--In columns 1 and 2, enter the number of unusable organs. For cost reporting periods beginning on or after January 1, 2023, do not include on this line organs intended for transplant but subsequently determined unusable and furnished for research, but instead report these organs on line 82.

Line 84--In columns 1 and 2, enter the sum of line 75 and lines 76 through 83. In column 3, enter the sum of lines 77, 78, and line 79.01. The totals for columns 1 and 2 must equal the totals on line 74, columns 1 and 2, respectively. For cost reporting periods beginning prior to October 1, 2022, do not complete column 3. For cost reporting periods beginning on or after October 1, 2022, the total for column 3 must equal the amount on line 66, column 1.

This page is reserved for future use.

4029. WORKSHEET D-5 - APPORTIONMENT OF COST FOR PHYSICIANS' SERVICES IN A TEACHING HOSPITAL

A teaching hospital engaged in an approved GME residency program in accordance with 42 CFR 415.152, may elect to receive payment on a reasonable cost basis for the direct medical and surgical services of its physicians in lieu of fee schedule payments that might otherwise be made for these services. These services, and the supervision of interns and residents furnishing care to individual beneficiaries, are covered as hospital services for which Medicare pays the hospital on a reasonable cost basis. Teaching hospitals that have elected to be paid for these services on a reasonable cost basis in accordance with 42 CFR 415.160, are subject to RCEs. This worksheet provides for the computation of the RCE limits by medical specialty and the apportionment of reimbursable adjusted cost to titles V, XVIII, and XIX, in accordance with 4 CFR 415.162 and CMS Pub. 15-1, chapter 21, §2148.

NOTE: CAHs do not complete this worksheet.

If such election is made, direct medical and surgical services to program patients, including supervision of interns and residents, rendered in a teaching hospital by physicians on the hospital staff are reimbursable as provider services on a reasonable cost basis. In addition, certain medical school costs may be reimbursed. Payments for services donated by volunteer physicians to program patients are made to a fund designated by the organized medical staff the teaching hospital or medical school.

Limits on the amount of physician compensation which may be recognized as a reasonable provider cost are imposed in accordance with 42 CFR 415.70.

Worksheet D-5 consists of four parts:

- Part I - Reasonable Compensation Equivalent Computation for Cost Reporting Periods Ending Before June 30, 2014
- Part II - Apportionment of Cost for Physicians' Services in a Teaching Hospital for Cost Reporting Periods Ending Before June 30, 2014
- Part III - Reasonable Compensation Equivalent Computation for Cost Reporting Periods Ending On or After June 30, 2014
- Part IV - Apportionment of Cost for Physicians' Services in a Teaching Hospital for Cost Reporting Periods Ending On or After June 30, 2014

Effective for cost reporting periods ending on or after June 30, 2014, do not complete Worksheet D-5, Parts I and II, but complete Worksheet D-5, Parts III and IV.

4029.1 Part I - Reasonable Compensation Equivalent Computation for Cost Reporting Periods Ending Before June 30, 2014.--This part provides for the computation of the RCE limit by medical specialty of the physician on the hospital staff or physician on the medical school faculty. Complete separate parts for the hospital staff physicians and for physicians on the medical staff faculty. This part must be completed by applicable hospitals for cost reporting periods ending before June 30, 2014.

Where several physicians work in the same specialty, see CMS Pub. 15-1, chapter 21, §2182.6C, for a discussion of applying the RCE limit in the aggregate for the specialty versus on an individual basis to each of the physicians in the specialty.

When RCE limits are applied on an individual basis to each physician in a medical specialty, prepare a supporting worksheet identical in columnar format to Worksheet D-5, Part I, for each medical specialty. Enter on the first line under columns 1 and 9, the line number applicable to the medical specialty (as displayed on Worksheet D-5, Part I). Enter the name of the medical specialty on the first line in columns 2 and 10. Following the first line, use a separate line to compute the adjusted cost of physician's direct medical and surgical services (column 16) for each physician.

Enter the total amount from column 16 of the supporting worksheet in column 16 of the line on Worksheet D-5, Part I, corresponding to the medical specialty for which the supporting worksheet is prepared. If the individual physician method is used, list each physician using an individual identifier that is not the name or social security number of the physician (e.g., Dr. A, Dr. B). However, the identity of the physician must be made available to your contractor.

NOTE: The method used on Worksheet D-5 (i.e., aggregate or individual physician) must be the same as the method used on Worksheet A-8-2.

Column Descriptions

Column 3--Enter for each medical specialty the amount of the total cost included in Worksheet A-8-2, column 3. When the individual physician method is used, enter in column 3 of the supporting worksheet the amount included on Worksheet A-8-2, column 3, for that physician.

Column 4--Enter for each medical specialty the amount of the cost included in Worksheet A-8-2, column 4, for the direct medical and surgical services, including the supervision of interns and residents by physicians on the hospital staff or by physicians on the faculty of a medical school, as appropriate.

If the individual physician method is used, enter in column 4 of the supporting worksheet the amount included on Worksheet A-8-2, column 4, for the indicated physician.

Column 5--Enter for each line of data the reasonable compensation equivalent (RCE) limit applicable to the physician's compensation. The amount entered is the limit applicable to the physician specialty. Obtain the RCE applicable to the specialty from the table listed in the 68 FR 45488 (August 1, 2003). If the physician specialty is not identified in the table, use the RCE for the total category in the table. The beginning date of the cost reporting period determines which calendar year (CY) RCE is used. Your location governs which of the three geographical categories are applicable: non-metropolitan areas, metropolitan areas less than one million, or metropolitan areas greater than one million.

Column 6--Enter the physician's hours allocated to professional services (i.e., professional component hours) in all components (e.g., hospitals, subproviders) of the health care complex. If the physician is paid for unused vacation, unused sick leave, etc., exclude the hours so paid from the hours entered in this column. Time records or other documentation that supports this allocation must be available for verification by your contractor upon request. (See CMS Pub. 15-1, chapter 21, §2182.3E.)

Column 7--Enter the unadjusted RCE limit for each line of data. This amount is the product of the RCE amount entered in column 5 and the ratio of the physician's professional component hours entered in column 6 to 2080 hours.

Column 8--Enter, for each line of data, five percent of the amounts entered in column 7.

Column 11--You may adjust upward, up to five percent of the computed limit (column 8), the computed RCE limit in column 7 to take into consideration the actual costs of membership for physicians in professional societies and continuing education paid by the provider or medical school.

Enter for each line of data the actual amounts of these expenses paid by the provider or medical school.

Column 12--Enter for each line of data, the result of multiplying column 4 by column 11 and dividing by column 3.

Column 13--You may also adjust upward the computed RCE limit in column 7 to reflect the actual malpractice expense incurred by the provider or by the medical school, as appropriate, for the services of a physician or group of physicians to provider patients.

Enter for each line of data the actual amounts of these malpractice expenses paid by the provider (or medical school, if applicable).

Column 14--Enter for each line of data, the result of multiplying column 4 by column 13, and dividing by column 3.

Column 15--Enter for each line of data, the sum of columns 7 and 14, plus the lesser of columns 8 or 12.

Column 16--Enter for each line of data, the adjusted cost of direct medical and surgical services, including the supervision of interns and residents (i.e., the lesser of column 4 or column 15).

Line Descriptions

Line 11--Total the amounts in columns 3 through 8, and 11 through 16.

4029.2 Part II - Apportionment of Cost for Physicians' Services in a Teaching Hospital for Cost Reporting Periods Ending Before June 30, 2014.--This part provides for the accumulation and apportionment of reimbursable cost for titles V, XVIII, and XIX using the aggregate per diem method of apportionment (see CMS Pub. 15-1, chapter 22, §2218) for the adjusted direct medical and surgical services, including the supervision of interns and residents, rendered by physicians to patients in a teaching hospital which makes the election described in CMS Pub. 15-1, chapter 21, §2148. Complete a separate Part II for the hospital and for each subprovider for cost reporting periods ending before June 30, 2014.

Line Descriptions

Line 1--Enter in the appropriate column, the adjusted cost of direct medical and surgical services, including the supervision of interns and residents, rendered to all patients by physicians on the hospital staff (column 1) and by physicians on the medical school faculty (column 2), as determined in accordance with CMS Pub. 15-1, chapter 21, §2148. Transfer these amounts from Part I, column 16, line 11. Enter the same amount on each component's Part II.

Line 2--Enter in column 1, the sum of the hospital inpatient days and the hospital outpatient visit days for all patients in the hospital and each hospital subprovider. Compute these days in the manner described in CMS Pub. 15-1, chapter 22, §2218.C. Enter in column 2, the same number of days as entered in column 1. Make the same entries on each component's Part II.

Line 3--Enter the result obtained by dividing the cost of services on line 1 by the sum of the days on line 2 for each category of physicians.

Lines 4 through 16--Enter in column 1, on the appropriate line, the reimbursable days and outpatient visit days for titles V, XVIII, and XIX for the hospital and each hospital subprovider, as applicable. Lines 10 through 16 contain the total of the title XVIII organ acquisition days and outpatient visit days. Enter in column 2 the same number of days as entered in column 1. Compute these days from your records in the manner described in CMS Pub. 15-1, chapter 22, §2218.C. Do not complete lines 10 through 16 for an IRF, IPF or hospital subprovider(s).

Line 17--Do not use.

Lines 18 through 31--Enter on the appropriate line the result of multiplying the days entered on lines 4 through 16 by the average cost per diem from line 3. Enter the total of columns 1 and 2 in column 3 for each line. The total becomes a part of the reimbursement settlement through the transfers denoted on this worksheet.

4029.3 Part III - Reasonable Compensation Equivalent Computation for Cost Reporting Periods Ending On or After June 30, 2014.--This part provides for the computation of the RCE limit of the physician on the hospital staff or physician on the medical school faculty. This part must be completed by applicable hospitals for cost reporting periods ending on or after June 30, 2014.

Column Descriptions

Columns 1 through 5, 9 through 11, and 13--For each line in columns 1 through 4, transfer the information from the corresponding columns on Worksheet A-8-2. For each line in column 5, transfer the amount from Worksheet A-8-2, column 6. For each line in columns 9 and 10, transfer the information from Worksheet A-8-2, columns 10 and 11, respectively. For each line in columns 11 and 13, transfer the amounts from Worksheet A-8-2, columns 12 and 14, respectively.

Column 6--For each line, enter the physician's hours allocated to professional services (i.e., professional component hours) in all components, e.g., hospitals, subproviders, of the health care complex. If the physician is paid for unused vacation, unused sick leave, etc., exclude the hours so paid from the hours entered in this column. Time records or other documentation supporting this allocation must be available for verification by your contractor upon request. (See CMS Pub. 15-1, chapter 21, §2182.3E.)

Column 7--For each line, enter the unadjusted RCE limit calculated by multiplying the RCE amount in column 5, by the ratio of the physician's professional component hours entered in column 6 to 2080 hours (column 5 x (column 6 ÷ 2080)).

Column 8--For each line, enter five percent of the amount entered in column 7.

Column 12--For each line, enter the professional component share of column 11 by multiplying column 4 by column 11 and dividing by column 3.

Column 14--Enter for each line of data the result of multiplying column 4 by column 13 and dividing by column 3.

Column 15--For each line, enter the sum of column 7 plus column 14, plus the lesser of column 8 or 12.

Column 16--For each line, enter the lesser of column 4 or column 15.

Line Descriptions

Line 200--Total the amounts in columns 3 through 8, and columns 11 through 16.

4029.4 Part IV - Apportionment of Cost for Physicians' Services in a Teaching Hospital for Cost Reporting Periods Ending On or After June 30, 2014.--This part provides for the accumulation and apportionment of reimbursable cost for titles V, XVIII, and XIX using the aggregate per diem method of apportionment (see CMS Pub. 15-1, chapter 22, §2218) for the adjusted direct medical and surgical services, including the supervision of interns and residents, rendered by physicians to patients in a teaching hospital which makes the election described in CMS Pub. 15-1, chapter 21, §2148. Complete a separate Part IV for the hospital and each hospital subprovider for cost reporting periods ending on or after June 30, 2014.

Line Descriptions

Line 1--Enter the adjusted cost of direct medical and surgical services, including the supervision of interns and residents, rendered to all patients by physicians, determined in accordance with CMS Pub. 15-1, chapter 21, §2148. Transfer these amounts from Part III, column 16, line 200. When completing this worksheet for multiple components of a health care complex, enter the same amount on each component's Part IV worksheet.

Line 2--Enter the sum of the hospital inpatient days and the hospital outpatient visit days for all patients in the hospital and each hospital subprovider. Compute these days in the manner described in CMS Pub. 15-1, chapter 22, §2218.C. When completing this worksheet for the hospital or hospital subprovider(s), enter the same amount on each component's Part IV.

Line 3--Enter the result obtained by dividing the cost of services on line 1 by the sum of the days on line 2.

Lines 4 through 16--For each line, enter the reimbursable days and outpatient visit days for titles V, XVIII, and XIX for the hospital and each subprovider. Lines 10 through 16 contain the total of the title XVIII organ acquisition days and outpatient visit days. Compute these days from your records in the manner described in CMS Pub. 15-1, chapter 22, §2218.C.

Line 17.01--Transfer the reimbursable inpatient allogeneic HSCT acquisition days for title XVIII for the hospital for cost reporting periods beginning on or after October 1, 2020, from Worksheet D-6, Part I, line 7, column 3.

Line 17.02--Enter the reimbursable outpatient allogeneic HSCT acquisition days for title XVIII for the hospital for cost reporting periods beginning on or after October 1, 2020. Compute these days from your records in the manner described in CMS Pub. 15-1, chapter 22, §2218.C.

Lines 18 through 31.02--For each line, enter the result of multiplying the days entered on lines 4 through 17.02 by the average cost per diem from line 3. The total becomes a part of the reimbursement settlement through the transfers denoted on this worksheet. Transfer the amounts as follows:

From Worksheet D-5, Part IV	To Worksheet
Sum of line 18 and line 19	E-3, Part VII, line 20 (title V hospital or component)
Line 20	E, Part A, line 56 (Medicare IPPS hospital)
	E-3, Part I, line 3 (TEFRA hospital)
	E-3, Part II, line 15 (IPF)
	E-3, Part III, line 16 (IRF)
	E-3, Part IV, line 6 (LTCH)
	E-3, Part V, line 17 (Cost reimbursement)
Line 21	E, Part B, line 23 (Medicare hospital Part B)
Sum of line 22 and line 23	E-3, Part VII, line 20 (title XIX hospital or component)
Sum of line 24 through 30	D-4 (for each organ type), Part III, line 60 (see note)
Line 31.01	D-6, Part III, line 5 (see note)

NOTE FOR LINES 24 THROUGH 30: Transfer the cost on each line to the Worksheet D-4 for the organ type as specified (e.g., transfer the cost for physicians' services in a teaching hospital applicable to kidney acquisition on Worksheet D-5, Part IV, line 24, to the kidney acquisition Worksheet D-4, Part III, line 60).

NOTE FOR LINES 31.01 AND 31.02: Transfer the cost on each line to Worksheet D-6 as follows:

- from Worksheet D-5, Part IV, line 31.01, to Worksheet D-6, Part III, line 5, col. 1.
- from Worksheet D-5, Part IV, line 31.02, to Worksheet D-6, Part III, line 5, col. 2.

4029.5 WORKSHEET D-6 - COMPUTATION OF CELLULAR THERAPY ACQUISITION COSTS

On the Worksheet D-6, the hospital reports the acquisition costs for allogeneic HSCT. The worksheet, effective for cost reporting periods beginning on or after October 1, 2020, calculates the inpatient routine, ancillary, and other costs associated with acquiring allogeneic hematopoietic stem cells for transplantation, including acquisition costs in cases that do not result in transplant due to death of the intended recipient or other causes, and reimbursed under reasonable cost as required under §1886(d)(5)(M) of the Act. Costs for allogeneic hematopoietic stem cell transplants are paid under the IPPS and not included on this worksheet.

See CMS Pub. 100-04, chapter 3, §90.3.1, and CMS Pub. 100-04, chapter 4, §231.11, for costs that may be included as allogeneic HSCT acquisition costs.

The Worksheet D-6 consists of the following parts:

- Part I - Inpatient Routine and Ancillary Services Cellular Therapy Acquisition Costs
- Part II - Interns and Residents Not In An Approved Teaching Program Cellular Therapy Acquisition Costs
- Part III - Summary of Cellular Therapy Acquisition Costs and Charges
- Part IV - Statistics

4029.6 Part I - Inpatient Routine and Ancillary Services Cellular Therapy Acquisition Costs.--On this part, the hospital calculates the routine and ancillary services costs for allogeneic HSCT acquisition, allocating routine services costs based on the per diem cost for each routine service cost center and allocating ancillary services costs based on the cost-to-charge ratio for each ancillary service cost center.

Lines 1 through 6--These lines calculate inpatient routine services costs applicable to allogeneic HSCT acquisition days, and provide for reporting the associated inpatient routine services charges.

Line 7--Enter the sum of the amounts reported on lines 1 through 6.

Column 1--For each cost center, enter the inpatient routine services charges applicable to allogeneic HSCT acquisition days.

Column 2--For each cost center, transfer the average per diem cost from Worksheet D-1:

Description	From Worksheet D-1, Part II	To Worksheet D-6, Part I, column 2
Adults & Pediatrics	col. 1, line 38	line 1
Intensive Care	col. 3., line 43	line 2
Surgical Intensive Care Type Unit	col. 3., line 46	line 5
Other Intensive Care Type Unit	col. 3., line 47	line 6

Column 3--For each cost center, enter the inpatient allogeneic HSCT acquisition days (Medicare and non-Medicare) for services rendered to:

- an allogeneic HSCT donor or potential donor, solely for a medical evaluation in anticipation of the collection of stem cells for transplant; and
- an allogeneic HSCT donor in an inpatient routine service area for the collection of stem cells for transplant.

Column 4--For each cost center, calculate the allogeneic HSCT acquisition costs for routine services by multiplying the per diem in column 2 by the days in column 3.

Lines 8 through 28--These lines provide for the computation of the inpatient and outpatient ancillary services acquisition cost.

Column 1--For each cost center, transfer the corresponding "cost or other" cost-to-charge ratio from Worksheet C, Part I, column 9.

Column 2--For each cost center, using your internal logs, enter the sum of:

- itemized charges for services furnished to allogeneic HSCT donors or potential donors and billed under the transplant recipient (for Medicare, billed using revenue code 0815) (i.e., enter the acquisition charges for inpatient ancillary services for all patients)
- charges for recipient tissue typing as described in 42 CFR 412.113(e)(2)
- acquisition charges for cases that do not result in transplant due to death of the intended recipient or other causes

Column 3--For each cost center, using your internal logs, enter the sum of:

- itemized charges for services furnished to allogeneic HSCT donors or potential donors and billed under the transplant recipient (for Medicare, billed using revenue code 0815) (i.e., enter the acquisition charges for outpatient ancillary services for all patients)
- charges for recipient tissue typing as described in 42 CFR 412.113(e)(2)
- acquisition charges for cases that do not result in transplant due to death of the intended recipient or other causes

Column 4--For each cost center, calculate the inpatient ancillary services acquisition costs by multiplying the ratio in column 1 by the inpatient ancillary charges in column 2.

Column 5--For each cost center, calculate the outpatient ancillary services acquisition costs by multiplying the ratio in column 1 by the outpatient ancillary services charges in column 3.

Line 30--For each column (2 through 5), enter the sum of lines 8 through 28.

4029.7 Part II - Interns and Residents not in an Approved Program Cellular Therapy Acquisition Costs.--On this part, the hospital calculates the Part B cost of interns and residents not in an approved teaching program attributable to allogeneic HSCT acquisition.

Lines 1 through 6--These lines apportion the cost of interns and residents not in an approved teaching program for inpatient routine services attributable to allogeneic HSCT acquisition.

Line 7--Enter the sum of lines 1 through 6 in columns 2 and 3.

Column 1--For each cost center, transfer the corresponding average cost per day of I&R not in an approved teaching program from Worksheet D-2, Part I, column 4.

Column 2--For each cost center, transfer the number of allogeneic HSCT acquisition days in each inpatient routine service area from Part I, column 3, lines 1 through 6.

Column 3--For each cost center, calculate the allogeneic HSCT I&R not in an approved program acquisition costs by multiplying the average cost per day in column 1 by the number of days in column 2. Transfer the total cost from line 7 to Part III, line 3, column 2.

4029.8 Part III - Summary of Cellular Therapy Acquisition Costs and Charges.--On this part, the hospital summarizes the costs and charges for allogeneic HSCT acquisition.

Line 1--Transfer the direct acquisition costs and allocated general service costs from Worksheet B, Part I, line 77, column 26. The direct costs include, but are not limited to, the cost of services purchased under arrangements or billed directly to you for:

- National Marrow Donor Program fees, if applicable, for stem cells from an unrelated donor;
- Tissue typing of donor and recipient;
- Donor evaluation;
- Physician pre-admission/pre-procedure donor evaluation services;
- Costs associated with harvesting procedure (e.g., general routine and special care services, procedure/operating room and other ancillary services, apheresis services, etc.);
- Post-operative/post-procedure evaluation of donor; and
- Preparation and processing of stem cells.

Line 2--In column 1, enter the sum of the costs from Part I, line 7, column 4, and Part I, line 30, column 4. In column 2, enter the cost from Part I, line 30, column 5.

Line 3--In column 2, enter the cost of services of interns and residents not in an approved teaching program from Part II, line 7, column 3.

Line 4--Apportion the acquisition cost from line 1 between inpatient and outpatient using the ratio of inpatient transplants (line 7, column 1) to total transplants (line 7, column 3) and outpatient transplants (line 7, column 2) to total transplants (line 7, column 3).

Line 5--If Worksheet S-2, Part I, line 58, is "Y," transfer the cost of physicians from Worksheet D-5, Part IV, line 31.01 and 31.02, to columns 1 and 2, respectively.

Line 6--For each column, enter the sum of lines 2 through 5.

Line 7--Enter the number of inpatient and outpatient allogeneic HSCTs in columns 1 and 2, respectively. In column 3, enter the sum of columns 1 and 2.

Line 8--Enter the number of Medicare inpatient and outpatient allogeneic HSCTs in columns 1 and 2, respectively.

Line 9--Calculate the Medicare ratio by dividing line 8 by line 7.

Line 10--Calculate the Medicare acquisition cost for allogeneic HSCTs by multiplying line 6 by line 9 for each column. Transfer the HSCT acquisition costs from line 10, column 1, as follows:

IPPS hospital - Inpatient	to Worksheet E, Part A, line 55.01
TEFRA hospital - Inpatient	to Worksheet D-1, Part II, line 48.01
CAH - Inpatient	to Worksheet E-3, Part V, line 3.01

Do not transfer total outpatient acquisition costs for allogeneic HSCTs from column 2 as these costs are paid under OPPS and not reimbursed under reasonable cost.

4029.9 Part IV - Statistics.--

Line 1--Enter the number of recipients intended to receive an allogeneic hematopoietic stem cell transplant for whom the acquisition cost was incurred and reported on Worksheet D-6, Part I, but the transplant did not occur due to death of the intended recipient or other causes.

This page is reserved for future use.

4030. WORKSHEET E - CALCULATION OF REIMBURSEMENT SETTLEMENT

Worksheet E, Parts A and B, calculate title XVIII settlement for inpatient hospital services under the IPPS (including IPPS hospitals participating in the PARHM demonstration), title XVIII (Part B) settlement for medical and other health services. Worksheet E-3 computes title XVIII, Part A settlement for non-IPPS hospitals, settlements under titles V and XIX, and settlements for title XVIII SNFs reimbursed under a PPS.

Worksheet E consists of the following two parts:

Part A - Inpatient Hospital Services Under the IPPS
Part B - Medical and Other Health Services

Application of Lesser of Reasonable Cost or Customary Charges--Worksheet E, Part B, allows for the computation of the lesser of reasonable costs or customary charges (LCC), where applicable, for services covered under Part B. Make a separate computation on each of these worksheets. In addition, make separate computations to determine whether the services on any or all of these worksheets are exempt from LCC. For example, the provider may meet the nominal charge criteria for the services on Worksheet E, Part B, and, therefore, be exempt from LCC only for these services.

For those provider Part B services exempt from LCC for this reason, reimbursement for the affected services is based on 80 percent of reasonable cost net of the Part B deductible amounts.

4030.1 Part A - Inpatient Hospital Services Under the IPPS.--

For SCH/MDH status change and/or geographical reclassification (see 42 CFR 412.102 and 103), subscript column 1 for lines 1 through 3, 22, 28, 29, 33, 34, 41, 45, 47, and 48. For SCH/MDH status changes see additional instructions at line 35.03. If you responded "1" and "2", or "2" and "1", to Worksheet S-2, Part I, questions 26 and 27, respectively, which indicated your facility experienced a change in geographic classification status during the year, subscript column 1, and report the payments before the reclassification, and on or after the reclassification in the applicable column. Effective for cost reporting periods ending on or after June 30, 2018, if a SCH experienced a change in geographic reclassification (Worksheet S-2, Part I, questions 26 and 27, answered "1" and "2", or "2" and "1", respectively) and the hospital maintained the SCH status for the entire cost reporting period, do not subscript column 1; report all payments, both before and after the geographic reclassification, in column 1.

For cost reporting periods that overlap or begin on or after October 1, 2014, if you responded "Y", to Worksheet S-2, Part I, line 22.03, column 1 or 2, which indicated your facility experienced a change in geographic redesignation as a result of the OMB standards for delineating statistical areas adopted by CMS in FY 2015, subscript column 1, for lines 33 and 34.

For SCH or MDH status change, enter on lines 1 through 3, in column 1, the applicable payment data for the period applicable to SCH or MDH status. Enter on lines 1 through 3, in column 1.01, the payment data for the period in which the provider did not retain SCH or MDH status. The data for lines 1 through 3 must be obtained from the provider's records or the PS&R.

For IPPS hospitals participating in Model 4 of the Bundled Payments for Care Improvement (BPCI) initiative, IME and disproportionate share hospital (DSH) payments will be calculated based on the non-discounted base DRG payment that would have been made in the absence of the model, as will outlier payments and hospital capital payments (see CR 8196, dated February 15, 2013). Enter on lines 1.03 and 2.02, in column 1, the applicable payment data for the cost reporting period.

For IPPS hospitals participating in the PARHM demonstration during this cost reporting period and (1) the hospital participated in the PARHM demonstration for the entire cost reporting period, select the "PARHM Demonstration" box only and complete this worksheet; or (2) the hospital participated in the PARHM demonstration for a portion of the cost reporting period, select the "PARHM Demonstration" box and complete Worksheet E, Part A, for the portion of the cost reporting period included in the demonstration. Select the "Hospital" box and complete a separate Worksheet E, Part A, for the portion of the cost reporting period not included in the demonstration.

For hospitals participating in the PARHM demonstration for a portion of this cost reporting period, enter the applicable data on Worksheet E, Part A, for the PARHM demonstration, lines 1.01, 1.02, 1.03, 1.04, 2, 2.02, 2.03, 2.04, 3, 35.03, 35.04, 35.05, 41.01, 48, 52, 53, 54, 54.01, 55, 56, 60, 62, 63, 64, 66, 68, 70, 70.87, 70.88, 70.89, 70.92, 70.93, 70.94, 70.95, 71.01, 71.02, 72.01, 73.01, 74.01, and lines 92 through 96. The data input in all other applicable lines are the same for the PARHM participation portion and non-participation portion of the cost reporting period.

Line Descriptions

Line 1--The amount entered on this line is the sum of the federal specific operating portion (DRG payments) paid for PPS discharges during the cost reporting period and the DRG payments made for PPS transfers during the cost reporting period. For cost reporting periods overlapping October 1, 2013, and subsequent years, do not complete line 1, but complete lines 1.01 and 1.02.

Line 1.01--For cost reporting periods that overlap October 1, 2013, and subsequent years, enter the amount of the federal specific operating portion (DRG payments) paid for PPS discharges and transfers occurring prior to October 1. For example, a calendar year provider would include DRG payments for discharges occurring during the period of January 1 through September 30.

Line 1.02--For cost reporting periods that begin or overlap October 1, 2013, and subsequent years, enter the amount of the federal specific operating portion (DRG payments) paid for PPS discharges and transfers occurring on or after October 1. For example, a calendar year provider would include DRG payments for discharges occurring during the period of October 1 through December 31.

Line 1.03--Enter the amount of the federal specific operating portion (DRG payments) for Model 4 bundled payments for care improvement (BPCI) initiative, effective for discharges occurring on or after October 1, 2013. Effective for cost reporting periods that overlap October 1, 2014, and subsequent years, enter the amount of the federal specific operating portion (DRG payments) paid for Model 4 BPCI discharges and transfers occurring prior to October 1.

Line 1.04--Effective for cost reporting periods that begin or overlap October 1, 2014, and subsequent years, enter the amount of the federal specific operating portion (DRG payments) paid for Model 4 BPCI discharges and transfers occurring on or after October 1.

Line 2--Enter the amount of outlier payments made for PPS discharges during the cost reporting period. See 42 CFR 412, Subpart F, for a discussion of these items. For cost reporting periods that begin on or after October 1, 2018, do not complete line 2, but complete lines 2.03 and 2.04.

Line 2.01--For inpatient PPS services rendered during the cost reporting period, enter the operating outlier reconciliation amount for operating expenses from line 92.

Line 2.02--Effective for discharges occurring on or after October 1, 2013, enter the amount of outlier payments made for Model 4 BPCI discharges during the cost reporting period.

Line 2.03--For cost reporting periods that begin on or after October 1, 2018, enter the amount of the outlier payments made for PPS discharges occurring prior to October 1 of the cost reporting period. For example, a calendar year provider would include outlier payments for discharges occurring during the period of January 1, through September 30.

Line 2.04--For cost reporting periods that begin on or after October 1, 2018, enter the amount of the outlier payments made for PPS discharges occurring on or after October 1 of the cost reporting period. For example, a calendar year provider would include outlier payments for discharges occurring during the period of October 1, through December 31.

Line 3--Hospitals receive payments for IME for managed care patients based on the DRG payment that would have been made if the service had not been a managed care service. The PS&R will capture in conjunction with the PPS PRICER the simulated payments. Enter the total managed care "simulated payments" from the PS&R.

Line 4--Enter the result of dividing the number of bed days available (Worksheet S-3, Part I, column 3, line 14) by the number of days in the cost reporting period (365, or 366 in case of leap year). Effective for cost reporting periods beginning on or after October 1, 2012, enter the result of dividing the number of bed days available (Worksheet S-3, Part I, column 3, line 14, plus line 32) by the number of days in the cost reporting period (365, or 366 in case of leap year).

NOTE: Reduce the bed days available by: (1) swing-bed days (Worksheet S-3, Part I, column 8, sum of lines 5 and 6): (2) the number of observation days (Worksheet S-3, Part I, column 8, line 28); (3) effective for cost reporting periods beginning on or after October 1, 2011, the number of non-distinct part hospice days (Worksheet S-3, Part I, column 8, line 24.10); (4) effective for cost reporting periods beginning on or after October 1, 2012, the number of outpatient ancillary labor and delivery days (Worksheet S-3, Part I, column 8, line 32.01); and (5) the number of temporary expansion COVID-19 PHE acute care bed days (Worksheet S-3, Part I, column 3, line 34).

Indirect Medical Educational Adjustment Calculation for Hospitals--Calculate the IME adjustment only if you answered "yes" to line 56 on Worksheet S-2, and complete lines 5 through 29.01, as applicable. In addition, a hospital may be entitled to the IME adjustment if Worksheet S-2, line 56, is "no" and lines 13 and/or 14 are greater than zero. (See 42 CFR 412.105.) Hospitals that incur indirect costs for GME programs are eligible for an additional payment as defined in 42 CFR 412.105(d). This section calculates the additional payment by applying the applicable multiplier of the adjustment factor for such hospitals.

Calculation of the IME adjusted FTE Resident cap in accordance with 42 CFR 412.105(f):

Line 5--Enter the FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before December 31, 1996, (see 42 CFR 412.105(f)(1)(iv)). Adjust this count for the 30 percent increase for qualified rural hospitals and also adjust for any increases due to primary care residents that were on approved leaves of absence (see 42 CFR 412.105(f)(1)(iv) and (xi) respectively). Temporarily reduce the FTE count of a hospital that closed a program(s), if the regulations at 42 CFR 412.105(f)(1)(ix) are applicable. (Effective October 1, 2001, see 42 CFR 413.79(h)(3)(ii)).

Line 5.01--Enter the FTE cap adjustment if your hospital qualifies under section 131 of the CAA 2021 for a reset to your FTE cap, and this cost report is after the cap-building window has closed for the qualifying new program(s). During the new program cap-building window, report the FTEs on line 16 (see 86 FR 73418 and 73465 (December 27, 2021)).

Line 6--Enter the FTE count for allopathic and osteopathic programs that meet the criteria for an adjustment to the cap for new programs in accordance with 42 CFR 413.79(e).

For hospitals qualifying for a cap adjustment under 42 CFR 413.79(e)(1) or (e)(3), the cap is effective beginning with the fourth program year of the first new program accredited or begun on or after January 1, 1995, but before October 1, 2012. For urban hospitals that participate in training residents in a new program for the first time on or after October 1, 2012, under 42 CFR 413.79(e)(1), the cap is effective beginning with the hospital's cost reporting period that coincides with or follows the start of the sixth program year of the first new program started (see 79 FR 50110 (August 22, 2014)). For rural hospitals that participate in training residents in a new program on or after October 1, 2012, under 413.79(e)(3), each new program in which the rural hospital participates has its own initial years before the rural hospital's FTE resident cap is adjusted based on each new program. Therefore, the rural hospital's FTE resident cap is adjusted for each new program effective with the hospital's cost reporting period that coincides with or follows the start of the sixth program year of each new program started (see 79 FR 50110 (August 22, 2014)).

For hospitals qualifying for a cap adjustment under 42 CFR 413.79(e)(2), the cap for each new program accredited or begun on or after January 1, 1995, and before August 6, 1997, is reported on this line and is effective in the fourth program year of each of those new programs (see 66 FR 39881 (August 1, 2001)). The cap adjustment reported on this line should not include any resident FTEs that were already included in the cap on line 5. Do not report new program FTEs during the time frame prior to the effective date of the hospital's FTE cap adjustment on this line. Report new program FTEs during the time frame prior to the effective date of the hospital's FTE cap adjustment on line 16.

Rural track programs in effect prior to section 127 of the CAA 2021: For urban hospitals that already have an FTE cap adjustment on line 5 but start a rural track program in accordance with 42 CFR 413.79(k), enter here the allopathic or osteopathic FTE count for residents in all years of a rural track program that meet the criteria for an add-on to the cap under 42 CFR 412.105(f)(1)(x). (If the rural track program is a new program under 42 CFR 413.79(l) and the hospital qualifies for a cap adjustment under 42 CFR 413.79(e)(1) or (3), do not report FTE residents in the rural track program on this line during the time frame prior to the effective date of the hospital's FTE cap). Only enter rural track cap adjustments in effect in a cost reporting period beginning prior to October 1, 2022.

Line 6.26--Rural track programs in effect under section 127 of the CAA 2021: For rural track program FTE cap limitation adjustments effective in a cost reporting period beginning on or after October 1, 2022, for both urban and rural hospitals that participate in a rural track program (defined at 42 CFR 413.75(b), see 86 FR 73418 (December 27, 2021); under section 127 of the CAA 2021, enter the rural track program FTE cap limitation adjustment after the cap-building window has closed for the particular rural track program. During the cap-building window, report the FTEs on line 16. Further subscript this line through line 6.49 for each additional rural track program FTE limitation at either the urban hospital or rural hospital.

Line 7--Enter the section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1).

Line 7.01--Enter the section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2). If this cost report straddles July 1, 2011, calculate the prorated section 5503 reduction amount off the cost report and enter the result on this line. (Prorate the cap reduction amount by multiplying it by the ratio of the number of days from July 1, 2011, to the end of the cost reporting period to the total number of days in the cost reporting period.) Otherwise enter the full cap reduction amount.

Line 7.02--Enter the adjustment (increase or decrease) to the hospital's rural track FTE limitation(s) from line 6, for rural track programs with a rural track Medicare GME affiliation agreement, in accordance with 87 FR 49075 (August 10, 2022).

Line 8--Enter the adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002). Note: Affiliation adjustments on this line must not include FTEs from rural track programs on lines 6 through 6.49.

Line 8.01--Enter, as applicable, all of or a portion of the amount of the FTE cap slots the hospital was awarded under section 5503 of the ACA. The amount of the section 5503 award that is reported on this line is the amount of the section 5503 award that is being "used" in this cost reporting period. In the 5-year evaluation period following implementation of section 5503 (that is, July 1, 2011, through June 30, 2016), at least 75 percent of the slots are to be "used" for additional primary care and/or general surgery residents, while 25 percent of the amount that is reported may be (but need not be) "used" for other purposes. During the 5-year evaluation period, failure to meet the requirements at 42 CFR 413.79(n)(2) of the regulations means loss of a hospital's section 5503 slots. Therefore, for portions of cost reporting periods occurring during the 5-year evaluation period (July 1, 2011, and before July 1, 2016), do not automatically report the full amount of the section 5503 award; only enter the amount of the section 5503 award that equates to at least 75 percent of the FTEs being "used" for additional primary care and/or general surgery FTEs, and no more than 25 percent being used for other FTEs. If, during the 5-year evaluation period, your hospital has not added any primary care or general surgery residents in accordance with receipt of the section 5503 award, leave this line blank and do not report any of the section 5503 award on this line in this cost reporting period.

For portions of cost reporting periods occurring during the 5-year evaluation period, if the amount reported on Worksheet S-2, Part I, line 61.02, column 2, is less than the amount on line 61.01, column 2, then report zero (0) on this line.

Line 8.02--Enter the amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. Further subscript this line (lines 8.03 through 8.20) as necessary if the hospital receives FTE cap slot awards on more than one occasion under section 5506. Refer to the letter from CMS awarding this hospital the slots under section 5506 to determine the effective date of the cap increase. If the section 5506 award is phased in over more than one effective date, only report the portions of the section 5506 award as they become effective. If the effective date of the cap increase is not the same as your fiscal year beginning date, then prorate the cap increase accordingly. (Prorate the cap increase amount by multiplying it by the ratio of the number of days from the effective date of the cap increase to the end of the cost reporting period to the total number of days in the cost reporting period).

Line 8.21--Enter the amount of increase if the hospital was awarded FTE cap slots from section 126 of the CAA 2021, effective beginning July 1, 2023. If this cost report straddles July 1, calculate a prorated cap increase by multiplying the increase by the ratio of the number of days from July 1 to the end of the cost reporting period, to the total number of days in the cost reporting period. Use subscripted lines 8.22 through 8.27 if the hospital receives FTE cap slot awards on more than one occasion under section 126 of the CAA 2021, effective July 1 of a year.

Line 8.28--Enter the amount of increase if the hospital was awarded FTE cap slots from section 4122 of the CAA 2023, effective beginning July 1, 2026. If this cost report straddles July 1, 2026, calculate a prorated cap increase by multiplying the increase by the ratio of the number of days from July 1, 2026, to the end of the cost reporting period, to the total number of days in the cost reporting period.

Line 9--Adjusted IME FTE Resident Cap--Enter the result of line 5 plus 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus or minus line 8, plus lines 8.01 through 8.28. However, if the resulting IME cap is less than zero (0), enter zero (0) on this line.

Calculation of the allowable current year FTEs:

Line 10--Enter the FTE count for allopathic and osteopathic programs in the current year from your records. Do not include residents in the initial years of the new program, which, for urban or rural hospitals that participate in training residents in a new program under 42 CFR 413.79(e)(1) or (e)(3), prior to October 1, 2012, means that the program has not yet completed one cycle of the program (i.e., "period of years,") or the minimum accredited length of the program. (See 42 CFR 412.105(f)(1)(iv) and/or (f)(1)(v).) For new programs started prior to October 1, 2012, contact your contractor for instructions on how to complete this line if you have a new program for which the period of years is less than or more than three years. For urban hospitals that began participating in training residents in a new program for the first time on or after October 1, 2012, under 42 CFR 413.79(e)(1), do not include FTE residents in a new program on this line if this cost reporting period is prior to the cost reporting period that coincides with or follows the start of the sixth program year of the first new program started (i.e., the initial years) (see 79 FR 50110 (August 22, 2014)). For rural hospitals participating in a new program(s) on or after October 1, 2012, under 42 CFR 413.79(e)(3), each new program in which the rural hospital participates has its own initial years before the rural hospital's FTE resident cap is adjusted based on that new program. Therefore, for rural hospitals, do not include FTE residents in a particular new program on this line if this cost reporting period is prior to the cost reporting period that coincides with or follows the start of the sixth program year of that specific new program started (see 79 FR 50110 (August 22, 2014)). For both urban and rural hospitals, report FTE residents in the initial years of the new program and/or the new rural track program on line 16. Exclude FTE residents displaced by hospital or program closure that are in excess of the cap for which a temporary cap adjustment is needed (see 42 CFR 412.105(f)(1)(v)).

Line 11--Enter the FTE count for residents in dental and podiatric programs.

Line 12--Enter the result of the lesser of line 9, or line 10 added to line 11.

Line 13--Enter the total allowable FTE count for the prior year, either from Form CMS-2552-96 line 3.14 or from Form CMS-2552-10 line 12, as applicable. Do not include residents in the initial years of the program that are exempt from the rolling average under 42 FR 412.105(f)(1)(v). However, if the period of years during which the FTE residents in any of your new training programs were exempted from the rolling average has expired (see 42 CFR 412.105(f)(1)(v)), enter on this line the allowable FTE count from line 12 plus the count of previously new FTE residents in that specific program that were added to line 16 of the prior year's cost report (line 3.17 if the prior year cost report was the Form CMS-2552-96). If you were not training any residents in approved teaching programs in the prior year, make no entry.

Line 14--Enter the total allowable FTE count for the penultimate year, either from Form CMS-2552-96 line 3.14, or Form CMS-2552-10 line 12, as applicable. If you were not training any residents in approved programs in the penultimate year, make no entry. Do not include residents in the initial years of the program that are exempt from the rolling average under 42 CFR 412.105(f)(1)(v). However, if the period of years during which the FTE residents in any of your new training programs were exempted from the rolling average has expired (see 42 CFR 412.105(f)(1)(v)), enter on this line the allowable FTE count from line 12 plus the count of previously new FTE residents in that specific program that were added to line 16 of the penultimate year's cost report (line 3.17 if the prior year cost report was the Form CMS-2552-96).

Line 15--Enter the sum of lines 12 through 14 divided by three.

Line 16--Enter the number of FTE residents in the initial years of the program (see 42 CFR 412.105(f)(1)(v).) This line is reserved for use only by urban hospitals that do not have a previous FTE cap established on line 5 or line 6, and are first establishing an FTE cap by participating in training residents in a new allopathic or osteopathic residency program(s) for the first time in accordance with 42 CFR 413.79(e)(1). (Rural hospitals participating in training residents in new programs in accordance with 42 CFR 413.79(e)(3) would also report FTE

residents in the initial years of the new program on this line). For a new program started prior to October 1, 2012, contact your contractor for instructions on how to complete this line if you have a new program for which the period of years is less than or more than three years. For urban hospitals that began participating in training residents in a new program for the first time on or after October 1, 2012, under 42 CFR 413.79(e)(1), include FTE residents in a new program on this line if this cost reporting period is prior to the cost reporting period that coincides with or follows the start of the sixth program year of the first new program started (see 79 FR 50110 (August 22, 2014)). For rural hospitals participating in a new program(s) on or after October 1, 2012, under 42 CFR 413.79(e)(3), include FTE residents in a particular new program on this line if this cost reporting period is prior to the cost reporting period that coincides with or follows the start of the sixth program year of that new program (see 79 FR 50110 (August 22, 2014)).

For hospitals receiving an adjusted FTE cap for new program(s) under section 131 of the CAA 2021, enter the FTEs prior to the cost reporting period that coincides with or follows the start of the sixth program year of the new program(s) (see 86 FR 73418 (December 27, 2021)).

For cost reports beginning on or after October 1, 2022, for urban and rural hospitals participating in a rural track program(s), enter the FTEs prior to the cost reporting period that coincides with or follows the start of the sixth program year of that rural track program (see 86 FR 73418 (December 27, 2021)).

Line 17--Enter the additional FTEs for residents that were displaced by program or hospital closure, which you would not be able to count without a temporary cap adjustment (see 42 CFR 412.105(f)(1)(v)).

Line 18--Enter the sum of lines 15, 16 and 17.

Line 19--Enter the current year resident to bed ratio by dividing line 18 by line 4.

Line 20--In general, enter from the prior year cost report the intern and resident to bed ratio by dividing line 12 by line 4 (divide line 3.14 by line 3 if the prior year cost report was the Form CMS-2552-96). However, if the provider is participating in training residents in a new medical residency training program(s) under 42 CFR 413.79(e) for a new program started prior to October 1, 2012, add to the numerator of the prior year intern and resident to bed ratio (i.e., line 12 of the prior cost report, which might be zero), if applicable, the number of FTE residents in the current cost reporting period that are in the initial period of years of a new program (line 16) (i.e., the period of years is the minimum accredited length of the program). For a new program started prior to October 1, 2012, contact your contractor for instructions on how to complete this line if you have a new program for which the period of years is less than or more than three years. For urban hospitals that began participating in training residents in a new program for the first time on or after October 1, 2012, under 42 CFR 413.79(e)(1), if this cost reporting period is prior to the cost reporting period that coincides with or follows the start of the sixth program year of the first new program started, then divide line 16 of this cost report by line 4 of the prior year cost report (see 79 FR 50110 (August 22, 2014)). For rural hospitals participating in a new program on or after October 1, 2012, under 42 CFR 413.79(e)(3), for each new program started, if this cost reporting period is prior to the cost reporting period that coincides with or follows the start of the sixth program year of each particular new program, then add the amount from line 12 of the prior year (if greater than zero) and line 16 of this cost report, and divide the sum by line 4 of the prior year cost report (see 79 FR 50110 (August 22, 2014)). If the provider is participating in a Medicare GME affiliation agreement or rural track Medicare GME affiliation agreement under 42 CFR 413.79(f), and the provider increased its current year FTE cap (difference of the sum of current year line 8 and line 7.02, and sum of prior year line 8 and line 7.02 is positive) and increased its current year allowable FTE count (difference of current year line 12 (excluding current year dental and podiatry from line 11) and prior year line 12 (excluding prior year dental and podiatry from line 11) is positive) due to this affiliation agreement, identify the lower of: a) the difference between the current year numerator line 15 and the prior year numerator line 12 of the prior year cost report, and b) the number by which the FTE cap increased per the affiliation agreement (difference of sum of current year line 8 and line 7.02, and sum of prior year line 8 and

line 7.02), and add the lower of these two numbers to the prior year's numerator line 12 of the prior year cost report. If the lower of these two numbers is a negative number, do not adjust the prior year numerator line 12 (see 42 CFR 412.105(a)(1)(i) and FY 2024 IPPS final rule, 88 FR 59047 (August 28, 2023)). If the hospital is participating in a valid emergency Medicare GME affiliation agreement under a §1135 waiver, and a portion of this cost report falls within the time frame covered by that emergency affiliation agreement, then, effective on and after October 1, 2008, enter the current year resident-to-bed ratio from line 19 (see 73 FR 48649 (August 19, 2008) and 42 CFR 412.105(f)(1)(vi)). Effective for cost reporting periods beginning on or after October 1, 2002, if the hospital is training FTE residents in the current year that were displaced by the closure of another hospital or program, also adjust the numerator of the prior year ratio for the number of current year FTE residents that were displaced by hospital or program closure (see 42 CFR 412.105(a)(1)(iii)). The amount added to the prior year's numerator is the displaced resident FTE amount that you would not be able to count without a temporary cap adjustment. This is the same amount of displaced resident FTEs entered on line 17. For cost reporting periods beginning on or after October 1, 2022, for urban and rural hospitals participating in a rural track program(s), adjust the numerator by adding to the amount on Worksheet E, Part A, line 12, of the prior year cost report (if greater than zero) the FTEs in the rural track program(s) on line 16 of this worksheet, if this cost report is still prior to the cost reporting period that coincides with or follows the start of the sixth program year of that rural track program.

Line 21--Enter the lesser of line 19 or 20.

IME Add-on Payment for SCHs--Effective for cost reporting periods beginning on or after October 1, 2014, all SCHs that are subsection (d) teaching hospitals will receive an IME add-on payment for discharges of Medicare Part C (managed care) patients in accordance with the 79 FR 50004 (August 22, 2014), regardless of whether the SCH is paid based on the federal rate or the hospital specific rate. For purposes of the comparison of payments based on the federal rate and the hospital specific rate, Medicare Part C patients will no longer be included as part of the federal rate payment.

Line 22--For cost reporting periods beginning before October 1, 2014, calculate the IME payment adjustment as follows: Multiply the appropriate multiplier of the adjustment factor (currently 1.35) times {((1 + line 21) to the .405 power) - 1} times {the sum of lines 1, 1.01, 1.02, 1.03, 1.04, and 3}.

Effective for cost reporting periods beginning on or after October 1, 2014, calculate the IME payment adjustment as follows: Multiply the appropriate multiplier of the adjustment factor (currently 1.35) times {((1 + line 21) to the .405 power) - 1} times {the sum of lines 1.01, 1.02, 1.03, and 1.04}.

Line 22.01--Effective for cost reporting periods beginning on or after October 1, 2014, calculate the IME payment adjustment for managed care, as follows: Multiply the appropriate multiplier of the adjustment factor (currently 1.35) times {((1 + line 21) to the .405 power) - 1} times line 3.

IME Adjustment Calculation for the Add-on--Computation of IME payments for additional allopathic and osteopathic resident cap slots received under 42 CFR 412.105(f)(1)(iv)(C)(1)--Complete lines 23 through 28 only where the amount on line 23 is greater than zero (0).

Line 23--Section 422 IME FTE Cap--Enter the number of allopathic and osteopathic IME FTE residents cap slots the hospital received under 42 CFR 412.105(f)(1)(iv)(C)(1), section 422, of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA).

Line 24--IME FTE Resident Count Over the Cap--Subtract line 9 from line 10, and enter the result. If the result is zero or negative, the hospital does not need to use the 422 IME cap. Therefore, do not complete lines 25 through 28.

Line 25--Section 422 Allowable IME FTE Resident Count--If the count on line 24 is greater than zero, enter the lesser of line 23 or line 24.

Line 26--Resident to Bed Ratio for Section 422--Divide line 25 by line 4.

Line 27--IME Adjustment Factor for Section 422 IME Residents--Enter the result of the following: .66 times [({1 + line 26} to the .405 power) - 1].

Line 28--IME Add-On Adjustment--For cost reporting periods beginning before October 1, 2014, enter the sum of lines 1, 1.01, 1.02, 1.03, 1.04, and 3, multiplied by the factor on line 27. For cost reporting periods beginning on or after October 1, 2014, calculate the IME add-on adjustment as follows: Enter the sum of lines 1.01, 1.02, 1.03, and 1.04, multiplied by the factor on line 27.

Line 28.01--IME Add-On Adjustment - Managed Care--Effective for cost reporting periods beginning on or after October 1, 2014, enter the result of line 3, multiplied by the factor on line 27.

Line 29--Total IME Payment--Enter the sum of lines 22 and 28.

Line 29.01--Total IME Payment - Managed Care--Effective for cost reporting periods beginning on or after October 1, 2014, enter the sum of lines 22.01 and 28.01.

Disproportionate Share Adjustment--Section 1886(d)(5)(F) of the Act, as implemented by 42 CFR 412.106, requires additional Medicare payments to hospitals with a disproportionate share of low income patients. Calculate the amount of the Medicare disproportionate share adjustment on lines 30 through 34. Complete line 34 only if you are an IPPS hospital and answered yes to line 22, column 1, of Worksheet S-2, Part I.

Line 30--Enter the percentage of SSI recipient patient days to Medicare Part A patient days. (Obtain the percentage from your contractor.)

Line 31--Enter the percentage resulting from the calculation of Medicaid patient days (Worksheet S-2, Part I, columns 1 through 6, line 24) to total days reported on Worksheet S-3, Part I, column 8, line 14, plus line 32, minus the sum of lines 5 and 6, plus employee discount days reported on line 30.

Line 32--Add lines 30 and 31, to equal the hospital's DSH patient percentage.

Line 33--Compare the percentage on line 32 with the criteria described in 42 CFR 412.106(c) and (d). Enter the payment adjustment factor calculated in accordance with 42 CFR 412.106(d). Hospitals qualifying for DSH in accordance with 42 CFR 412.106(c)(2) (Pickle Amendment hospitals), if Worksheet S-2, Part I, line 22, column 2, is "Y" for yes, enter 35.00 percent on line 33.

NOTE: For cost reporting periods ending on or after October 1, 2014, and before October 1, 2016, 42 CFR 412.102 provides for a 2-year transition to a rural DSH payment amount from an urban DSH payment amount, for hospitals that received a geographic redesignation from urban to rural under the OMB standards for delineating statistical areas adopted by CMS in FY 2015. Impacted hospitals whose DSH payment adjustment exceeds 12 percent will receive 2/3 of the difference between the urban and rural operating DSH for FY 2015 and 1/3 of the difference between the urban and rural operating DSH for FY 2016. This affects providers that responded yes in column 1 or column 2, and yes in column 3 of Worksheet S-2, Part I, line 22.03. See 79 FR 49963 (August 22, 2014).

NOTE: For cost reporting periods ending on or after October 1, 2020, and before October 1, 2022, 42 CFR 412.102 provides for a 2-year transition to a rural DSH payment amount from an urban DSH payment amount, for hospitals that received a geographic redesignation from urban to rural under the OMB standards for delineating statistical areas adopted by CMS in FY 2021. Impacted hospitals whose DSH payment adjustment exceeds 12 percent will receive 2/3 of the difference between the urban and rural operating DSH for FY 2021 and 1/3 of the difference between the urban and rural operating DSH for FY 2022. This affects providers that responded "Y" for yes in column 1 or column 2, and "Y" yes in column 3 of Worksheet S-2, Part I, line 22.04. See 85 FR 58746 (September 18, 2020).

Line 34--Multiply line 33 by line 1 for cost reporting periods ending on or before September 30, 2013. Effective for cost reporting periods that overlap October 1, 2013, enter the sum of {(line 33 times line 1.01), plus ((line 33 times the sum of lines 1.02 and 1.03) times 25 percent)}. For cost reporting periods beginning on or after October 1, 2013, multiply (line 33 times the sum of lines 1.01 through 1.03) times 25 percent. For cost reporting periods that overlap or begin on or after October 1, 2014, enter the sum of {((line 33 times the sum of lines 1.01 and 1.03) times 25 percent), plus ((line 33 times the sum of lines 1.02 and 1.04) times 25 percent)}.

Section 3133 of the ACA provides that, for services occurring on or after October 1, 2013, a subsection (d) hospital (i.e., IPPS hospital) which is entitled to receive a DSH payment will receive two separately calculated payments. The "empirically justified Medicare DSH payment," which represents 25 percent of the amount the hospital would have received under 42 CFR 412.106(d), is calculated on line 34. The "additional payment for uncompensated care" payment is calculated on lines 35 through 36.

Uncompensated Care Payment Adjustment--Section 3133 of the ACA: (1) provides that for discharges occurring on or after October 1, 2013, subsection (d) hospitals' Medicare DSH payments are reduced by 75 percent (to the empirically justified Medicare DSH payment); and (2) established an UCP, which represents the remaining 75 percent of the DSH payments, and distributes a portion of this amount to each qualifying DSH hospital based on its share of uncompensated care. Effective for cost reporting periods overlapping or beginning on or after October 1, 2013, complete lines 35 through 36, columns 1 and 2, as applicable, only if you are a subsection (d) hospital and answered yes to Worksheet S-2, Part I, line 22, column 1.

If Worksheet S-2, Part I, line 22, column 1, is "Y" and Worksheet S-2, Part I, line 22.01, columns 1 and 2, are "Y", do not complete lines 35 and 35.01. If Worksheet S-2, Part I, line 22.01, either column 1 or 2, is "N", complete only the column with the "N" response for lines 35 and 35.01. A response of "Y" for both questions indicates that a hospital UCP has been pre-determined for your hospital for the applicable FFY. For SCHs, if Worksheet S-2, Part I, line 22, column 1, is "Y" and Worksheet S-2, Part I, line 35, column 1, is greater than or equal to 1, complete lines 35 through 35.03, columns 1 and 2, as applicable.

NOTE: For cost reporting periods that overlap October 1, 2013, leave column 1 blank and complete only column 2. For cost reporting periods that begin on October 1, complete only column 2; however, when the cost reporting period begins on October 1, and overlaps October 1, of the subsequent year, complete column 1 for the first period (October 1, through September 30) and complete column 2 for the remainder of the cost reporting period.

Line 35--If Worksheet S-2, Part I, line 22, column 1, is "Y" and Worksheet S-2, Part I, line 22.01, column 1 or 2, is "N", or Worksheet S-2, Part I, line 22, column 1, is "Y" and this is a newly merged DSH eligible hospital (Worksheet S-2, Part I, line 22.02, column 1 or 2, is "Y"), enter in the corresponding column the full amount (for all eligible IPPS hospitals) available for UCPs for the appropriate FFY. For example, for a cost reporting period ending December 31, 2013, enter zero in column 1 for the portion of the cost reporting period that began prior to October 1, 2013, and enter the FFY 14 UCP in column 2. The total UCP for FFY 14 is $9,046,380,143 and for FFY 15 is $7,647,644,885. Subsequent total uncompensated care amounts should be obtained from the corresponding federal year IPPS final rule or correction notice, as applicable. If this is a SCH and Worksheet S-2, Part I, line 22, column 1, is "Y", but an amount for line 35.02 was not determined by CMS for a FFY, complete this line accordingly.

Line 35.01--If Worksheet S-2, Part I, line 22.01, column 1 or 2, is "N", enter the applicable Factor 3 value determined by CMS for UCPs for the appropriate FFY in columns 1 and 2. If this is a SCH and Worksheet S-2, Part I, line 22, column 1, is "Y", but an amount for line 35.02 was not determined by CMS for a FFY, enter the applicable Factor 3 value determined by CMS for the appropriate FFY in column 1 and/or 2. If you are a new hospital (Worksheet S-2, Part I, line 47, column 2, is "Y"), or a newly merged DSH eligible hospital (Worksheet S-2, Part I, line 22.02, column 1 or 2, is "Y"), Factor 3 must be calculated. Refer to the applicable FFY IPPS final rule for further information. In determining Factor 3, the numerator is the applicable year cost report Medicaid days (Worksheet S-2, Part I, line 24, sum of columns 1 through 6) plus the SSI days published for the applicable FFY, divided by the denominator which is a fixed amount obtained from the applicable FFY IPPS rule. For FFY 14 the denominator is 36,429,747, for FFY 15 the denominator is 36,484,622, and for FFY 16 the denominator is 36,755,805 (the denominator represents the total IPPS hospitals' Medicaid days and SSI days for the applicable FFY).

For FFY 2017, a hospital's Factor 3 is the average of three individual Factor 3s calculated based on cost reporting periods beginning in FY 2011, FY 2012, and FY 2013. The denominator for FY 2011 Factor 3 is 36,930,764; FY 2012 Factor 3 is 37,123,932, and FY 2013 Factor 3 is 37,302,359. If the hospital does not have data for one or more of the three cost reporting periods, compute Factor 3 for the periods available and average those by dividing the sum of the individual Factor 3s by the number of cost reporting periods for which there are data. Round Factor 3 to 9 decimal places.

For FFY 2018, a hospital's Factor 3 is the average of three individual Factor 3s calculated based on cost reporting periods beginning in FY 2012, FY 2013, and FY 2014. The denominator for FY 2012 Factor 3 is 37,065,316; FY 2013 Factor 3 is 37,311,194; and FY 2014 Factor 3 is based on uncompensated care costs of $25,199,302,174. If the hospital does not have data for one or more of the three cost reporting periods, compute Factor 3 for the periods available and average those by dividing the sum of the individual Factor 3s by the number of cost reporting periods for which there are data. Round Factor 3 to 9 decimal places. For FFY 2018, the Medicaid days and uncompensated care costs are annualized.

For FFY 2019, a hospital's Factor 3 is the average of three individual Factor 3s calculated based on cost reporting periods beginning in FY 2013, FY 2014, and FY 2015. The denominator for FY 2013 Factor 3 is 37,539,919; FY 2014 Factor 3 is $31,598,052,056; and FY 2015 Factor 3 is $30,210,112,106. FY 2014 and FY 2015 are based on uncompensated care cost. If the hospital does not have data for one or more of the three cost reporting periods, compute Factor 3 for the periods available and average those by dividing the sum of the individual Factor 3s by the number of cost reporting periods for which there are data. Round Factor 3 to 9 decimal places. For FFY 2019, the Medicaid days and uncompensated care costs are annualized.

For FFY 2020, a hospital's Factor 3, is calculated based on data from cost reporting periods beginning in FY 2015. If you are a new hospital eligible for DSH and the date certified (Worksheet S-2, Part I, line 3, column 5) is on or after October 1, 2015, (see 84 FR 42371, August 19, 2019)), in determining Factor 3, the numerator is the uncompensated care costs

reported on Worksheet S-10, line 30, of the hospital's FY 2020 cost report, and the denominator is $29,616,638,717. For new hospitals located in Puerto Rico (that is, no Factor 3 calculated), refer to the FY 2020 IPPS final rule for calculating a Factor 3, from Worksheet S-10 data from the hospital's FY 2020 cost report (84 FR 42370-42371 (August 16, 2019)).

For FFY 2021, a hospital's Factor 3, is calculated based on data from cost reporting periods beginning in FY 2017. If you are a new hospital eligible for DSH and the date certified (Worksheet S-2, Part I, line 3, column 5) is on or after October 1, 2017, (see 85 FR 58829, September 18, 2020)), in determining Factor 3, the numerator is the uncompensated care costs reported on Worksheet S-10, line 30, of the hospital's FY 2021 cost report, and the denominator is $31,966,377,083. For new hospitals located in Puerto Rico (that is, no Factor 3 calculated), refer to the FY 2021 IPPS final rule for calculating a Factor 3 from Worksheet S-10 data from the hospital's FY 2021 cost report.

For FFY 2022, a hospital's Factor 3, is calculated based on data from cost reporting periods beginning in FY 2018. If you are a new hospital eligible for DSH and the date certified (Worksheet S-2, Part I, line 3, column 5) is on or after October 1, 2018, (see 86 FR 45244 (August 13, 2021)), in determining Factor 3, the numerator is the uncompensated care costs reported on Worksheet S-10, line 30, of the hospital's FY 2022 cost report, and the denominator is $33,208,266,108. For new hospitals located in Puerto Rico (that is, no prospective Factor 3), refer to the FY 2022 IPPS final rule for calculating a Factor 3 from Worksheet S-10 data from the hospital's FY 2022 cost report.

For FFY 2023, a hospital's Factor 3 is calculated based on data from cost reporting periods beginning in FY 2018 and beginning in FY 2019. If you are a new hospital eligible for DSH and the date certified (Worksheet S-2, Part I, line 3, column 5) is on or after October 1, 2019, in determining unscaled Factor 3, the numerator is the uncompensated care costs reported on Worksheet S-10, Part I (formerly Worksheet S-10), line 30, of the hospital's FY 2023 cost report, and the denominator is $34,463,223,233. The unscaled Factor 3 for new hospitals, newly merged hospitals, and hospitals treated as new hospitals, is adjusted by a scaling adjustment factor as described in the FY 2023 IPPS final rule (87 FR 49042 (August 10, 2022)).

For FFY 2024 and subsequent fiscal years, a hospital's Factor 3 is calculated based on data from the three most recent cost reporting years for which audits have been conducted (e.g., for hospital's FY 2024 Factor 3 that is FY 2018, FY 2019, and FY 2020 cost reports). If you are a new hospital eligible for DSH and the date certified (Worksheet S-2, Part I, line 3, column 5) is after the most recent cost reporting period for which audits have been conducted (e.g., for FFY 2024, the most recent audited cost reporting begin date is October 1, 2020), in determining unscaled Factor 3, the numerator is the uncompensated care costs reported on Worksheet S-10, Part I (formerly Worksheet S-10), line 30, of the hospital's applicable cost report, and the denominator will be available on the applicable CMS IPPS final rule webpage in the applicable DSH Supplemental Data File. The unscaled Factor 3 for new hospitals, newly merged hospitals, and hospitals treated as new hospitals, is adjusted by a scaling adjustment factor as described in the FY 2023 IPPS final rule (87 FR 49042 (August 10, 2022)).

Line 35.02--If Worksheet S-2, Part I, line 22, column 1, is *"N" or line 32 is less than 15 percent, enter zero on this line. If Worksheet S-2, Part I, line 22, column 1, is "Y" and:*

- *the provider is an SCH, but an amount for line 35.02 was not determined by CMS for a FFY, compute the amount by multiplying line 35 by line 35.01, for column 1 and column 2.*
- *Worksheet S-2, Part I, line 22.01, column 1 or 2, is "Y", enter the hospital UCP determined by CMS for the appropriate FFY in columns 1 and 2.*
- *If Worksheet S-2, Part I, line 22.01, column 1, is "N" or if WS S-2, Part I, line 22.02, column 1, is "Y", calculate the hospital UCP for column 1 by multiplying line 35, column 1, by line 35.01, column 1.*
- *If Worksheet S-2, Part I, line 22.01, column 2, is "N" or if WS S-2, Part I, line 22.02, column 2, is "Y", calculate the hospital UCP for column 2 by multiplying line 35, column 2, by line 35.01, column 2.*

In addition, beginning in FY 2023, if Worksheet S-2, Part I, line 22, column 1, is "Y", for Puerto Rico hospitals and Indian Health Service and Tribal hospitals, include the hospital's supplemental UCP (42 CFR 412.106(h)) determined by CMS for the appropriate FFY in columns 1 and 2. The hospital-specific supplemental UCP is published in the applicable IPPS final rule and posted on the CMS website.

Line 35.03--Enter the pro rata share of the hospital's UCP in columns 1 and 2. Enter in column 1, line 35.02, times the number of days in the cost reporting period prior to October 1, divided by the total days in the FFY. Enter in column 2, line 35.02, times the number of days in the cost reporting period on or after October 1, divided by the total days in the FFY.

In addition, effective beginning on or after October 1, 2022, for IHS/Tribal hospitals and hospitals located in Puerto Rico that are determined DSH eligible, include the pro rata share of the hospital's supplemental UCP (42 CFR 412.106(h)) in columns 1 and 2.

For example, for a calendar year cost reporting period January 1, 2013, through December 31, 2013, enter zero in column 1, for the period of January 1, 2013, through September 30, 2013, because this period is prior to FFY 14 (the UCC payment is effective beginning FFY 14); enter in column 2, for the period of October 1, 2013, through December 31, 2013 (FFY 14), the result of 92 days divided by 365 days in FFY 14, multiplied by line 35.02, column 2.

As another example, for a calendar year cost reporting period of January 1, 2014, through December 31, 2014, enter in column 1, for the period of January 1, 2014, through September 30, 2014 (FFY 14), the result of 273 days divided by 365 days in FFY 14, multiplied by line 35.02, column 1; enter in column 2, for the period of October 1, 2014, through December 31, 2014 (FFY 15), the result of 92 days divided by 365 days in FFY 15, multiplied by line 35.02, column 2.

For SCH/MDH status changes, use subscripted lines 35.04 and 35.05. For SCH or MDH status changes, subscript column 1, for any portion of the cost reporting period under IPPS status.

Lines 35.04--For portions of the cost reporting period under MDH status, enter in columns 1 and 2, the pro rata share of the hospital's UCPs, including supplemental UCPs, reported on line 35.03, columns 1 and 2. For any portion of the cost reporting period under IPPS, enter the pro rata share of the hospital's UCPs, including supplemental UCPs, reported on line 35.03, columns 1 and 2, in subscripted column 1.01.

Lines 35.05--For portions of the cost reporting period under SCH status, enter in columns 1 and 2, the pro rata share of the hospital's UCPs, including supplemental UCPs, reported on line 35.03, columns 1 and 2. For any portion of the cost reporting period under IPPS, enter the pro rata share of the hospital's UCPs, including supplemental UCPs, reported on line 35.03, columns 1 and 2, in subscripted column 1.01.

For example, a hospital with a 2015 calendar year cost reporting period loses its MDH status on October 15, 2015. Enter on line 35.04, column 1, for the period of January 1, 2015, through September 30, 2015, the UCP from line 35.03, column 1. Enter on line 35.04, column 1.01, the pro rata share of the UCP from line 35.03, column 2 (IPPS status for the period of October 15, 2015, through December 31, 2015), ((78 days/365 days) times line 35.03, column 2). Enter on line 35.04, column 2, the pro rata share of the UCP from line 35.03, column 2, (MDH status for the period of October 1, 2015, through October 14, 2015), ((14 days/365 days) times line 35.03, column 2).

Line 36--Enter the hospital's total UCP adjustment (the sum of columns 1 and 2, line 35.03).

Lines 37 through 39--Reserved for future use.

Additional Payment for High Percentage of ESRD Beneficiary Discharges--Calculate the additional payment amount allowable for a high percentage of ESRD beneficiary discharges pursuant to 42 CFR 412.104. When the average weekly cost per dialysis treatment changes within a cost reporting period, create an additional column (column 1.01) for lines 41 and 45.

Line 40--Enter total Medicare discharges excluding discharges for MS-DRGs 652, 682, 683, 684, and 685 (see 73 FR 48447 and 48520 (August 19, 2008)). Effective for cost reporting periods beginning on or after October 1, 2011, enter total Medicare discharges (see 76 FR 51693 (August 18, 2011)) for all Medicare beneficiaries entitled to Medicare Part A. Individuals entitled to Medicare Part A include individuals receiving benefits under original Medicare, individuals whose inpatient benefits are exhausted or whose stay was not covered by Medicare, and individuals enrolled in Medicare Advantage Plans, cost contracts under §1876 of the Act (HMOs), and competitive medical plans (CMPs). These discharges, excluding discharges for MS-DRGs 652, 682, 683, 684, and 685, must be included in the denominator of the calculation for the purpose of determining eligibility for the ESRD additional payment to hospitals. Effective for discharges occurring on or after October 1, 2020, exclude discharges for MS-DRGs 019, 650, 651, 682, 683, and 684, from the denominator (see 85 FR 58844 (September 18, 2020)).

Line 41--Enter total Medicare discharges for ESRD beneficiaries who received dialysis treatment during an inpatient stay (see 69 FR 49087 (August 11, 2004)) excluding MS-DRGs 652, 682, 683, 684, and 685 (see 73 FR 48520 and 48447 (August 19, 2008)). Effective for cost reporting periods beginning on or after October 1, 2011, enter total Medicare discharges (see 76 FR 51693 (August 18, 2011)) for all ESRD Medicare beneficiaries entitled to Medicare Part A who receive inpatient dialysis. Individuals entitled to Medicare Part A include individuals receiving benefits under original Medicare, individuals whose inpatient benefits are exhausted or whose stay was not covered by Medicare, and individuals enrolled in Medicare Advantage Plans, cost contracts under §1876 of the Act (HMOs), and CMPs. These discharges, excluding discharges for MS-DRGs 652, 682, 683, 684, and 685, must be included in the numerator of the calculation for the purpose of determining eligibility for the ESRD additional payment to hospitals. Effective for discharges occurring on or after October 1, 2020, exclude discharges for MS-DRGs 019, 650, 651, 682, 683, and 684, from the numerator (see 85 FR 58844 (September 18, 2020)).

Line 41.01--Enter total Medicare discharges for ESRD beneficiaries who received dialysis treatment during an inpatient stay (see 69 FR 49087 (August 11, 2004)) excluding MS-DRGs 652, 682, 683, 684, and 685 (see 73 FR 48520 and 48447 (August 19, 2008)). The discharges on this line are associated with Medicare covered and paid hospital stays, and are included in the discharges in Worksheet S-3, Part I, column 13, line 14. These discharges are a subset of the discharges on line 41. The discharges on this line are only used to determine the ESRD add-on payment, not eligibility for the add-on payment. Effective for discharges occurring on or after October 1, 2020, exclude discharges for MS-DRGs 019, 650, 651, 682, 683, and 684, from this line (see 85 FR 58844 (September 18, 2020)).

Line 42--Divide line 41, sum of columns 1 and 1.01 by line 40. If the result is less than 10 percent, you do not qualify for the ESRD adjustment.

Line 43--Enter the total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684, and 685, as applicable. The Medicare ESRD inpatient days must be included in the Medicare inpatient days reported in Worksheet S-3, Part I, column 6, line 14, and are part of a Medicare covered stay. Effective for discharges occurring on or after October 1, 2020, exclude days for discharges for MS-DRGs 019, 650, 651, 682, 683, and 684, from this line (see 85 FR 58844 (September 18, 2020)).

Line 44--Enter the average length of stay expressed as a ratio to 7 days. For cost reporting periods ending before June 30, 2014, divide line 43 by line 41, sum of columns 1 and 1.01, and divide that result by 7 days. For cost reporting periods ending on or after June 30, 2014, divide line 43 by line 41.01, sum of columns 1 and 1.01, and divide that result by 7 days.

Line 45--Enter the average weekly cost per dialysis treatment calculated by multiplying the unadjusted composite rate per treatment by 3. For example, the average weekly cost per dialysis treatment for CY 2013 is $435.60 ($145.20 times the average weekly number of treatments of 3).

In the FY 2025 IPPS/LTCH PPS final rule (89 FR 69386), effective for cost reporting periods beginning on or after October 1, 2024, the estimated weekly cost of dialysis is calculated as the applicable ESRD PPS base rate (as defined in 42 CFR 413.171) multiplied by three, which represents the typical number of dialysis sessions per week. The ESRD PPS base rate is applicable for renal dialysis services furnished during the calendar year (CY) (that is, effective January 1 through December 31 each year) and updated annually (see §413.196). Use the annual CY ESRD PPS base rate (as published in the applicable CY ESRD PPS final rule or subsequent corrections, as applicable) multiplied by three to calculate the ESRD add-on payment for hospital cost reporting periods that begin during the FFY for the same year. The following table illustrates the applicable CY ESRD PPS base rate used to determine the add-on amount for eligible discharges during cost reporting periods beginning on or after October 1, 2024 (FY 2025) and on or after October 1, 2025 (FY 2026) under this methodology.

FY IPPS Hospital Cost Report Period	**Applicable ESRD PPS Base Rate**
Cost reports beginning on or after October 1, 2024, through September 30, 2025 (FY 2025)	CY 2025 (January 1, 2025, through December 31, 2025) CY 2025 ESRD final rule (89 FR 89085) $273.82 times 3=$821.46
Cost reports beginning on or after October 1, 2025, through September 30, 2026 (FY 2026)	CY 2026 (January 1, 2026, through December 31, 2026)

Line 46--For cost reporting periods ending before June 30, 2014, enter the ESRD payment adjustment (line 44, column 1, times line 45, column 1, times line 41, column 1, plus, if applicable, line 44, column 1, times line 45, column 1.01, times line 41, column 1.01). For cost reporting periods ending on or after June 30, 2014, enter the ESRD payment adjustment (line 44, column 1, times line 45, column 1, times line 41.01, column 1, plus, if applicable, line 44, column 1, times line 45, column 1.01, times line 41.01, column 1.01).

Line 47--Enter the sum of lines 1, 1.01, 1.02, 2, 2.01, 2.02, 2.03, 2.04, 29, 34, 36, and 46.

Line 48--SCHs are paid the highest of the federal payment rate, the hospital-specific rate (HSR) determined based on a FFY 1982 base period (see 42 CFR 412.73), the hospital-specific rate determined based on a FFY 1987 base period (see 42 CFR 412.75), for cost reporting periods beginning on or after October 1, 2000, the hospital-specific rate determined based on a FFY 1996 base period (see 42 CFR 412.77), or for cost reporting periods beginning on or after January 1, 2009, the hospital-specific rate determined based on a FFY 2006 base period (see 42 CFR 412.78). MDHs are paid the highest of the federal payment rate, or the federal rate plus 75 percent of the amount of the excess over the federal rate of the highest rate for the 1982, 1987, or 2002 (see 42 CFR 412.79), base period hospital specific rate. Effective January 1, 2016, former MDHs that lost their MDH status because they are no longer in a rural area due to the new OMB delineations in FY 2015 (Worksheet S-2, Part I, line 37.01, is yes) will transition from payments based, in part, on the hospital-specific rate to payments based entirely on the Federal rate. For discharges occurring on or after January 1, 2016, and before October 1, 2016, these former MDHs will receive the Federal rate plus two-thirds of 75 percent of the amount by which the Federal rate payment is exceeded by the hospital's hospital-specific rate payment. For FY 2017, that is, for discharges occurring on or after October 1, 2016, and before October 1, 2017, these former MDHs will receive the Federal rate plus one-third of 75 percent of the amount by which the Federal rate payment is exceeded by the hospital's hospital-specific rate. For FY 2018, that is, for discharges occurring on or after October 1, 2017, these former MDHs will be paid based solely on the Federal rate. For SCHs, MDHs and former MDHs, enter the applicable hospital-specific payments.

For SCHs only, the hospital-specific payment amount entered on this line is supplied by your contractor. Calculate it by multiplying the sum of the DRG weights for the period (per the PS&R) by the final per discharge hospital-specific rate for the period. Use the hospital specific rate based on the higher of the cost reporting periods beginning in FFY 1982, 1987, or 1996.

Additionally, for SCHs only (effective for cost reporting periods beginning on or after January 1, 2009), use the highest of the determined hospital specific rate based on FFY 1982, 1987, 1996, or 2006.

For MDH discharges occurring on or after October 1, 2006, and before October 1, 2025, an MDH can use a FFY 2002 hospital specific rate. The MDH program ends on September 30, 2025.

Line 49--For SCHs, enter the greater of line 47 or 48, plus the amount from line 29.01. For MDH discharges occurring on or after October 1, 2006, and before October 1, 2024, if line 47 is greater than line 48, enter the amount on line 47, plus the amount from line 29.01. For MDHs, if line 48 is greater than line 47, enter the amount on line 47, plus 75 percent of the amount that line 48 exceeds line 47, plus the amount from line 29.01. Hospitals not qualifying as SCH or MDH providers will enter the amount from line 47, plus the amount from line 29.01.

For former MDHs (Worksheet S-2, Part I, line 37.01, is yes), effective for cost reporting periods that begin or overlap January 1, 2016, if line 48 is greater than line 47, enter the amount on line 47, plus two-thirds of (75 percent of the amount that line 48 exceeds line 47, times (the number of days in the cost reporting period between January 1, 2016, and September 30, 2016, divided by the total number of days in the cost reporting period)), plus the amount from line 29.01. For cost reporting periods that begin or overlap October 1, 2016, if line 48 is greater than line 47, enter the amount on line 47, plus two-thirds of (75 percent of the amount that line 48 exceeds line 47, times (the number of days in the cost reporting period prior to October 1, 2016, divided by the total number of days in the cost reporting period)), plus one-third of (75 percent of the amount that line 48 exceeds line 47, times (the number of days in the cost reporting period beginning on or after October 1, 2016, and before October 1, 2017, divided by the total number of days in the cost reporting period)), plus the amount from line 29.01.

For hospitals subscripting column 1 of line 47 due to a change in geographic location, this computation will be computed separately for each column, and the sum of the calculations will be entered in column 1 of this line.

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Line 50--Enter the payment for inpatient program capital costs from Worksheet L, Part I, line 12, or Part II, line 5, as applicable.

Line 51--Enter the special exceptions payment for inpatient program capital, if applicable pursuant to 42 CFR 412.348(f) by entering the result of Worksheet L, Part III, line 13, less Worksheet L, Part III, line 17. If this amount is negative, enter zero on this line.

Line 52--Enter the amount from Worksheet E-4, line 49. Complete this line only for the hospital component.

Obtain the payment amounts for lines 53 and 54 from your contractor.

Line 53-- Enter the amount of NAHE managed care payments, if applicable. When a healthcare complex includes an IPF and/or IRF subprovider (excluded unit), enter the NAHE managed care payments for the entire healthcare complex (i.e., the NAHE managed care payments for the hospital plus NAHE managed care payments for any subproviders) on this line.

Line 54--Enter the special add-on payment for new technologies (see 42 CFR 412.87 and 412.88). Include in the add-on payment for new technologies payments associated with Model 4 BPCI.

Line 54.01--Enter the special add-on payment for islet isolation cell transplantation from the PS&R (see CR 9570).

Line 55--Enter the net organ acquisition cost from Worksheet(s) D-4, Part III, column 1, line 69.

Line 55.01--Transfer the Medicare inpatient cellular therapy acquisition cost from Worksheet D-6, Part III, line 10, column 1.

Line 56--Teaching hospitals or subproviders electing to be reimbursed for services of physicians on the basis of reasonable cost (see 42 CFR 415.160 and CMS Pub. 15-1, chapter 21, §2148), enter the cost of physicians. For cost reporting periods ending before June 30, 2014, transfer the amount from Worksheet D-5, Part II, column 3, line 20. For cost reporting periods ending on or after June 30, 2014, transfer the amount from Worksheet D-5, Part IV, line 20.

Line 57--Enter the routine service other pass-through costs from Worksheet D, Part III, column 9, lines 30 through 35 for the hospital.

Line 58--Enter the ancillary service other pass-through costs from Worksheet D, Part IV, column 11, line 200.

Line 59--Enter the sum of lines 49 through 58.

Line 60--Enter the amounts paid or payable by primary payers (when program liability is secondary to that of a primary payer) such as:

- Workers' compensation,
- No fault coverage,
- General liability coverage,
- Working aged provisions,
- Disability provisions, and
- Working ESRD provisions.

Generally, when payment by the primary payer satisfies the total liability of the program beneficiary, for cost reporting purposes only, treat the services as if they were non-program services. (The primary payment satisfies the beneficiary's liability when you accept that payment as payment in full. This is noted on no-pay bills submitted by you in these situations.) Include the patient days and charges in total patient days and charges but do not include them in program patient days and charges. In this situation, enter no primary payer payment on line 60. In addition, exclude amounts paid by other primary payers for outpatient dialysis services reimbursed under the composite rate system.

However, when the payment by the primary payer does not satisfy the beneficiary's obligation, the program pays the lesser of (a) the amount it otherwise pays (without regard to the primary payer payment or deductible and coinsurance) less the primary payer payment, or (b) the amount it otherwise pays (without regard to the primary payer payment or deductible and coinsurance) less applicable deductible and coinsurance. Credit primary payer payment toward the beneficiary's deductible and coinsurance obligation.

When the primary payment does not satisfy the beneficiary's liability, include the covered days and charges in program days and charges and include the total days and charges in total days and charges for cost apportionment purposes. Enter the primary payer payment on line 60 to the extent that primary payer payment is not credited toward the beneficiary's deductible and coinsurance. Do not enter primary payer payments credited toward the beneficiary's deductible and coinsurance on line 60.

Enter the primary payer amounts applicable to organ transplants. However, do not enter the primary payer amounts applicable to organ acquisitions. Report these amounts on Worksheet D-4, Part III, line 66.

If you are subject to PPS, include the covered days and charges in the program days and charges, and include the total days and charges in the total days and charges for inpatient and pass-through cost apportionment. Furthermore, include the DRG amounts applicable to the patient stay on line 1. Enter the primary payer payment on line 60 to the extent that the primary payer payment is not credited toward the beneficiary's deductible and coinsurance. Do not enter primary payer payments credited toward the beneficiary's deductibles.

Line 61--Enter the result of line 59 minus line 60.

Line 62--Enter, from the PS&R or your records, the deductibles billed to program patients excluding deductibles and coinsurance associated with Model 4 BPCI payments.

Line 63--Enter, from the PS&R or your records, the coinsurance billed to program patients excluding deductibles and coinsurance associated with Model 4 BPCI payments.

Line 64--Enter the program allowable bad debts, reduced by the bad debt recoveries. If recoveries exceed the current year's bad debts, line 64 and 65 will be negative. (See 42 CFR 413.89.)

Line 65--Enter the result of line 64 (including negative amounts) times 70 percent for cost reporting periods that begin prior to October 1, 2012. For cost reporting periods that begin on or after October 1, 2012, enter the result of line 64 times 65 percent.

Line 66--Enter the gross allowable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. These amounts must also be reported on line 64.

Line 67--Enter the sum of lines 61 and 65, minus the sum of lines 62 and 63.

Line 68--Enter, from the PS&R, the partial or full credits received from manufacturers for replaced devices applicable to MS-DRGs listed in the IPPS final rule for the applicable cost reporting period. (See CMS Pub. 100-04, chapter 3, §100.8.)

Line 69--Enter the time value of money for operating expenses, the capital outlier reconciliation amount and time value of money for capital related expenses by entering the sum of lines 93, 95, and 96.

For SCHs, if the hospital specific payment amount on line 48, is greater than the federal specific payment amount on line 47, do not complete this line.

Line 70--Enter any other adjustments. Specify the adjustment in the space provided. Hardcoded subscripts of this line are identified as such.

Line 70.50--Enter the §410A rural community hospital demonstration project payment adjustment amount from line 218, column 1.

Line 70.75--Transfer the payment adjustment amount for domestic NIOSH-approved surgical N95 respirators from Worksheet E-95, Part III, line 4, column 1.

Line 70.76--Transfer the payment adjustment amount for essential medicines from Worksheet E-90, Part II, line 7.

Line 70.87--Enter any demonstration payment adjustment amounts for demonstration projects in which the provider participated where the demonstration adjustment amounts are subject to the sequestration adjustment. Obtain this amount from the PS&R. Do not include demonstration payment adjustment amounts reported on lines 70.50 and 70.89.

Line 70.88--Contractor use only: Enter the volume decrease adjustment for SCH or MDH hospitals in accordance with 42 CFR 412.92(e) or 412.108(d), respectively.

Line 70.89--Enter the Pioneer Accountable Care Organization (ACO) demonstration payment adjustment amount. Obtain this amount from the PS&R. Do not use this line for services rendered on or after January 1, 2017. Report any ACO demonstration payment adjustments for services on or after January 1, 2017, on line 70.87 or line 71.02, accordingly.

Line 70.90--For MDH use only. Enter the hospital value-based purchasing (HVBP) adjustment amount relative to the HSP bonus payment from line 102, sum of columns 1 and 2.

Line 70.91--For MDH use only. Enter the hospital readmission reduction (HRR) adjustment amount relative to the HSP bonus payment from line 104, columns 1 and 2.

Line 70.92--Enter the discount amount for the bundled payments for care improvement initiative (also referred to as Model 1) in accordance with ACA 2010, §3023, effective for discharges occurring on or after October 1, 2013. This demonstration actually began April 1, 2013; however, the discounted payments begin October 1, 2013. Obtain this amount from the PS&R. Do not change the sign of the amount displayed on the PS&R.

Line 70.93--Enter the payment adjustment amount for the HVBP program in accordance with ACA 2010, §3001, effective for discharges occurring on or after October 1, 2012. Obtain this amount from the PS&R.

Line 70.94--Enter the adjustment amount resulting from the HRR program in accordance with ACA 2010, §3025, effective for discharges occurring on or after October 1, 2012. Obtain this amount from the PS&R.

Line 70.95--Enter the program share of any recovery of accelerated depreciation applicable to prior periods resulting from your termination or a decrease in Medicare utilization. (See CMS Pub. 15-1, chapter 1, §§136-136.16, and 42 CFR 413.134(d)(3)(i).)

Line 70.96 through 70.98 (lines 70.96 and 70.97 are hardcoded)--Effective for discharges occurring during FFYs 2011 through 2018, the low volume payment adjustment is determined in accordance with 42 CFR 412.101(c)(2). Effective for discharges occurring during FFYs 2019 through 2022, the low volume payment adjustment is determined in accordance with 42 CFR 412.101(c)(3). Effective for discharges occurring during FFY 2023 and subsequent years the low volume payment adjustment is determined in accordance with 42 CFR 412.101(c)(1).

For cost reporting periods that are concurrent with the FFY (October 1, through September 30), use line 70.97 only. For cost reporting periods that overlap October 1, enter on lines 70.96 (low- volume adjustment (enter the corresponding federal year for the period prior to October 1)) and line 70.97 (low-volume adjustment (enter the corresponding federal year for the period ending on or after October 1)), and, if necessary, line 70.98 (low-volume adjustments for additional portions of the cost reporting period, if necessary), the Medicare inpatient payment adjustment for low-volume hospitals as applicable in accordance with Exhibit 4 (low-volume adjustment calculation schedule and corresponding instructions).

Line 70.99--Enter the HAC program payment reduction adjustment amount effective for discharges occurring on or after October 1, 2014. Use Exhibit 5 or similar worksheet to reconcile the HAC payment adjustment amount.

Line 71--Enter the result of line 67 plus the sum of lines 69, 70 through 70.86, 70.88, 70.90, 70.91, 70.92, 70.93, 70.94, and lines 70.96 through 70.98; minus the sum of lines 68, 70.87, 70.89, 70.95, and 70.99.

Line 71.01--For cost reporting periods that overlap or begin on or after April 1, 2013, calculate the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur during the sequestration period, divided by total days in the entire cost reporting period, rounded to six decimal places), rounded to four decimal places) times line 71]. Do not apply the sequestration calculation when gross reimbursement is less than zero. In accordance with §3709 of the Coronavirus Aid, Relief, and Economic Security (CARES) Act, as amended by §102 of the CAA 2021, §1 of Public Law 117-7, and §2 of the Protecting Medicare and American Farmers from Sequester Cuts Act of 2021 (PAMA) , do not apply the sequestration adjustment to the period of May 1, 2020, through March 31, 2022. In accordance with §2 of the PAMA 2021, for cost reporting periods that overlap or begin on or after April 1, 2022, calculate the sequestration adjustment amount for the period of April 1, 2022, through June 30, 2022, as follows: [(1 percent times (total days in the cost reporting period that occur from April 1, 2022, through June 30, 2022, divided by total days in the entire cost reporting period, rounded to six decimal places), rounded to four decimal places), times line 71]; and for cost reporting periods that overlap or begin on or after July 1, 2022, calculate the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur on or after July 1, 2022, through the end of the cost reporting period, divided by total days in the entire cost reporting period, rounded to six decimal places), rounded to four decimal places) times line 71].

Line 71.02--Enter any demonstration payment adjustment amounts for demonstration projects in which the provider participated where the demonstration adjustment amounts are not subject to the sequestration adjustment. Obtain this amount from the PS&R.

Line 71.03--This line is a subset of line 71.01. Enter the sequestration adjustment amount for the portion of the cost reporting period that the hospital participated in the PARHM demonstration. Calculate the sequestration adjustment amount as [(2 percent times (total days in the cost reporting period that occur during the sequestration period, divided by total days in the entire cost reporting period, rounded to six decimal places), rounded to four decimal places) times the sum of lines 52, 53, 55, 57, 58, and 65]. In accordance with §3709 of the CARES Act, as amended by §102 of the CAA 2021, §1 of Public Law 117-7, and §2 of the PAMA 2021 do not apply the sequestration adjustment to the period of May 1, 2020, through March 31, 2022. In accordance with §2 of the PAMA 2021, for cost reporting periods that overlap or begin on or after April 1, 2022, calculate the sequestration adjustment amount for the period of April 1, 2022, through June 30, 2022, as follows: [(1 percent times (total days in the cost reporting period that occur from April 1, 2022, through June 30, 2022, divided by total days in the entire cost reporting period, rounded to six decimal places), rounded to four decimal places), times the sum of (lines 52, 53, 55, 57, 58, and 65)]; and for cost reporting periods that overlap or begin on or after July 1, 2022, calculate the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur on or after July 1, 2022, through the end of the cost reporting period, divided by total days in the entire cost reporting period, rounded to six decimal places), rounded to four decimal places) times the sum of (lines 52, 53, 55, 57, 58, and 65)].

Line 72--Enter the total interim payments (received or receivable) from Worksheet E-1, column 2, line 4. For contractor final settlements, enter the amount reported on Worksheet E-1, column 2, line 5.99, on line 73. Included in the interim payments are the amounts received as the estimated nursing and allied health managed care payments and capital, IME, DSH, and outlier payments associated with Model 4 BPCI.

Line 72.01--This line is a subset of line 72. Enter the interim pass-through payments received (or receivable) for the portion of the cost reporting period that the hospital participated in the PARHM demonstration. These payments should include bi-weekly pass-through payments as well as any lump sum adjustments received for bad debts, organ acquisition costs, and medical education (DGME and NAHE).

Line 73--Tentative settlement amount (transfer this amount from Worksheet E-1, Part I, column 2, line 5.99).

Line 73.01--Tentative settlement amount PARHM demonstration (enter the tentative settlement amount from the PARHM demonstration Worksheet E-1, Part I, column 2, line 5.99).

Line 74--Enter line 71 minus the sum of lines 71.01, 71.02, 72, and 73. Transfer to Worksheet S, Part III, column 2, line 1. For providers participating in the PARHM demonstration, do not transfer amounts from this line. See line 74.01 for instruction.

Line 74.01--For providers participating in the PARHM demonstration complete this line for the settlement of pass-through payments paid outside of the PARHM demonstration. The amount reported on this line is a subset of the amount reported on line 74. Enter the sum of lines 52, 53, 55, 57, 58, and 65, minus lines 71.03, 72.01 and 73.01. Transfer to Worksheet S, Part III, column 2, line 1.01.

Line 75--Enter the program reimbursement effect of protested items. Estimate the reimbursement effect of the non-allowable items by applying a reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See CMS Pub. 15-2, chapter 1, §115.2.) Attach a schedule showing the details and computations for this line.

Lines 76 through 89 were intentionally skipped to accommodate future revisions to this worksheet.

LINES 90 THROUGH 96 ARE FOR CONTRACTOR USE ONLY.

NOTE FOR LINES 90 THROUGH 96: CONTRACTOR USE ONLY. Complete lines 90 through 96 at cost report final settlement if the hospital meets the criteria at CMS Pub. 100-04, chapter 3, §20.1.2.5.

Line 90--For cost reporting periods beginning prior to October 1, 2018, enter the operating outlier amount from the provider's submitted Worksheet E, Part A, line 2, sum of all columns. For cost reporting periods beginning on or after October 1, 2018, enter the operating outlier amounts from the provider's submitted Worksheet E, Part A, sum of lines 2.03 and 2.04, sum of all columns.

Line 91--Enter the capital outlier amount from the provider's submitted Worksheet L, Part I, line 2.

Line 92--Enter the operating outlier reconciliation adjustment amount in accordance with CMS Pub. 100-4, chapter 3, §§20.1.2.5 - 20.1.2.7.

Line 93--Enter the capital outlier reconciliation adjustment amount in accordance with CMS Pub. 100-4, chapter 3, §§20.1.2.5 - 20.1.2.7.

Line 94--Enter the interest rate used to calculate the time value of money. (See CMS Pub. 100-04, chapter 3, §§20.1.2.5 - 20.1.2.7.)

Line 95--Enter the operating time value of money for operating related expenses.

Line 96--Enter the capital time value of money for capital related expenses.

Hospital Specific Payment (HSP) Bonus Payment HVBP Adjustment and HRR Adjustment--The ACA 2010 §§3001 and 3025 implemented HVBP and HRR and applied special rules for MDHs through FFY 13. Effective for discharges occurring on or after October 1, 2013, MDHs that receive a HSP bonus payment on the cost report are subject to a HVBP and HRR adjustment for that bonus payment amount. The HSP bonus payment amount is 75 percent of the amount that line 48 exceeds line 47. Complete lines 100 through 104 only when line 48 exceeds line 47.

For a former MDH (Worksheet S-2, Part I, line 37.01, is yes), for FY 2016 the HSP bonus payment amount determined for the period of January1, 2016, through September 30, 2016, is two-thirds of 75 percent of the amount by which line 48 exceeds line 47. For FY 2017, the HSP bonus payment amount determined for the period of October 1, 2016, through September 30, 2017, is one-third of 75 percent of the amount by which line 48 is exceeds line 47.

NOTE FOR LINE 100: For cost reporting periods that overlap October 1, 2013, leave column 1 blank and complete only column 2. For cost reporting periods that begin on October 1, complete only column 2.

Line 100--If line 48 is greater than line 47, enter the pro rata share of the HSP bonus payment amount in columns 1 and 2. Enter in column 1, {((line 48 minus line 47) times 75 percent) times (the number of days in the cost reporting period prior to October 1, divided by the total days in the cost reporting period)}. Enter in column 2, {((line 48 minus line 47) times 75 percent) times (the number of days in the cost reporting period on or after October 1, divided by the total days in the cost reporting period)}. If the hospital does not have MDH status for the entire cost reporting period, prorate accordingly.

For former MDHs for FY 2016, for cost reporting periods that begin on or after January 1, 2016, enter in column 1, two-thirds of {((line 48 minus line 47) times 75 percent) times (the number of days in the cost reporting period on or after January 1, 2016, through September 30, 2016, divided by the total days in the cost reporting period)}. Enter in column 2, one-third of {((line 48 minus line 47) times 75 percent) times (the number of days in the cost reporting period on or after October 1, 2016, through September 30, 2017, divided by the total days in the cost reporting period)}. For cost reporting periods that overlap January 1, 2016, and end on or before

September 30, 2016, enter zero in column 1, and enter in column 2, two-thirds of {((line 48 minus line 47) times 75 percent) times (the number of days in the cost reporting period on or after January 1, 2016, through September 30, 2016, divided by the total days in the cost reporting period)}. For cost reporting periods that overlap January 1, 2016, and October 1, 2016, enter in column 1, two-thirds of {((line 48 minus line 47) times 75 percent) times (the number of days in the cost reporting period on or after January 1, 2016, through September 30, 2016, divided by the total days in the cost reporting period)}. Enter in column 2, one-third of {((line 48 minus line 47) times 75 percent) times (the number of days in the cost reporting period on or after October 1, 2016, through September 30, 2017, divided by the total days in the cost reporting period)}.

For former MDHs for FY 2017, for cost reporting periods that begin October 1, 2016, enter in column 2, one-third of {((line 48 minus line 47) times 75 percent) times (the number of days in the cost reporting period on or after October 1, 2016, through September 30, 2017, divided by the total days in the cost reporting period)}. For cost reporting periods that overlap October 1, 2016, enter in column 1, two-thirds of {((line 48 minus line 47) times 75 percent) times (the number of days in the cost reporting period prior to October 1, 2016, divided by the total days in the cost reporting period)}. Enter in column 2, one-third of {((line 48 minus line 47) times 75 percent) times (the number of days in the cost reporting period on or after October 1, 2016, through September 30, 2017, divided by the total days in the cost reporting period)}. For cost reporting periods that overlap September 30, 2017, enter in column 1, one-third of {((line 48 minus line 47) times 75 percent) times (the number of days in the cost reporting period between October 1, 2016, through September 30, 2017, divided by the total days in the cost reporting period)} and zero in column 2.

Line 101--Enter the HVBP adjustment factor that corresponds to the portion of the cost reporting period prior to October 1, in column 1 and the HVBP adjustment factor that corresponds to the portion of the cost reporting period on or after October 1, in column 2. The HVBP adjustment factors are published annually in the IPPS final rule and posted on the CMS website. Enter "1" if the provider is not subject to the HVBP adjustment.

Line 102--The HVBP adjustment amount is computed as ((HSP Bonus x HVBP adjustment factor)-HSP Bonus). Enter in column 1, the HVBP adjustment amount for the portion of the cost reporting period prior to October 1, by multiplying (column 1, line 100, times column 1, line 101), minus column 1, line 100. Enter in column 2, the HVBP adjustment amount for the portion of the cost reporting period on or after October 1, by multiplying (column 2, line 100, times column 2, line 101) minus column 2, line 100.

Line 103--Enter the HRR adjustment factor that corresponds to the portion of the cost reporting period prior to October 1, in column 1, and HRR adjustment factor that corresponds to the portion of the cost reporting period on or after October 1, in column 2. The HRR adjustment factors are published annually in the IPPS final rule and posted on the CMS website. Enter "1" if the provider is not subject to the HRR adjustment.

Line 104--The HRR adjustment amount is computed as ((HSP Bonus x HRR adjustment factor)-HSP Bonus). Enter in column 1, the HRR adjustment amount for the portion of the cost reporting period prior to October 1, by multiplying (column 1, line 100, times column 1, line 103) minus column 1, line 100. Enter in column 2, the HRR adjustment amount for the portion of the cost reporting period on or after October 1, by multiplying (column 2, line 100, times column 2, line 103) minus column 2, line 100.

Rural Community Health Demonstration Project (§410A Demonstration) Adjustment--For cost reporting periods ending on or after September 30, 2017, lines 200 through 218 provide for the calculation of the §410 Demonstration project adjustment in accordance with the MMA of 2003, §410A, and extended under §§3123 and 10313 of the ACA 2010, and §15003 of the 21st Century Cures Act of 2016. Complete the applicable lines if Worksheet S-2, Part I, line 110, is "Y," and calculate line 201 based on reasonable cost at 100 percent (not 101 percent).

A hospital participating in the §410A Demonstration receives payment for inpatient hospital services furnished to Medicare beneficiaries, with the exclusion of services furnished in a psychiatric or rehabilitation unit that is a distinct part of the hospital, using the following rules: a) For discharges occurring in the first cost reporting period on or after the implementation of the extension, their reasonable costs of providing covered inpatient hospital services; b) For discharges occurring during the second and subsequent cost reporting periods, the lesser of their reasonable costs or a target amount. The target amount for the second cost reporting period is defined as the reasonable costs of providing covered inpatient hospital services in the first cost reporting period, increased by the IPPS update factor (as defined in section 1886(b)(3)(B)) for that particular cost reporting period. The target amount for each subsequent cost reporting period is defined as the preceding cost reporting period's target amount increased by the IPPS update factor for that particular cost reporting period.

Line 200--Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.

Line 201--Enter the Medicare inpatient service costs from Worksheet D-1, Part II, line 49.

Line 202--Enter the Medicare discharges from Worksheet S-3, column 13, line 1.

Line 203--Enter the case-mix adjustment factor (four-decimal places) used to update the target amount for years 2 through 5. Obtain the update factor from the contractor.

Line 204--Enter the Medicare target amount per discharge. Obtain the target amount per discharge from the contractor.

Line 205--Enter the case-mix adjusted target amount for years 2 through 5, determined by multiplying line 203 by line 204.

Line 206--Enter the Medicare inpatient routine cost cap determined by multiplying line 202 by line 205.

Line 207--Enter the Program reimbursement as determined under the §410A Demonstration as follows: For the first year of the current 5-year demonstration period, enter the amount from line 201. For the subsequent years of the current 5-year demonstration period, enter the lesser of line 201 or line 206.

Line 208--Enter the Medicare Part A inpatient service costs for Medicare beneficiaries from Worksheet E, Part A, line 59.

Line 209--Enter the adjustment to Medicare IPPS payments (the difference between reimbursement under IPPS and cost reimbursement under the §410A Demonstration). Enter the result of line 207 minus line 208.

Line 210--This line is reserved for future use.

Line 211--Enter the total adjustment to the Medicare IPPS payment. Enter the total amount from line 209.

Line 212--Enter the total adjustment to the Medicare Part A IPPS payment from line 211.

Line 213--Enter the low volume adjustment payments from Worksheet E, Part A, lines 70.96, 70.97, and 70.98, as applicable.

Lines 214 through 217--Reserved for future use.

Line 218--Enter the net adjustment to the Medicare Part A IPPS payment, the difference between the IPPS payment and the cost reimbursement under the rural community hospital demonstration project, by subtracting the amount on line 213 from the amount on line 212. Transfer the amount in column 1 to line 70.50.

Instructions for Completing Exhibit 4--

Low-Volume Adjustment Calculation Schedule:

42 CFR 412.101 provides for a low-volume adjustment for Medicare discharges in qualifying hospitals. The amount of any adjustment depends on the FFY in which the discharges occur.

42 CFR 412.101(c)(1) provides for the low-volume adjustment for Medicare discharges in FFYs 2005 through 2010 (discharges on and after October 1, 2004, and before October 1, 2010), and FFY 2026 and subsequent FFYs (discharges on and after October 1, 2025). Qualifying hospitals, those hospitals more than 25 road miles from the nearest subsection (d) hospital and with fewer than 200 discharges, receive a payment adjustment of an additional 25 percent for each Medicare discharge.

42 CFR 412.101(c)(2) provides for a temporary change in the low-volume adjustment for qualifying hospitals for FFYs 2011 through 2018 (discharges on and after October 1, 2010, and before October 1, 2018). Qualifying hospitals, those hospitals more than 15 road miles from the nearest subsection (d) hospital and with fewer than 1,600 Medicare discharges based on the latest available Medicare Provider Analysis and Review (MedPAR) data, receive a payment adjustment as follows:

- Those hospitals with 200 or fewer Medicare discharges will receive an adjustment of an additional 25 percent for each discharge; and
- Those with more than 200 and fewer than 1,600 Medicare discharges will receive an adjustment of an additional percentage for each discharge. This adjustment is calculated using the formula [(4/14) - (Medicare discharges/5,600)].

42 CFR 412.101(c)(3) provides for a temporary change in the low-volume adjustment for qualifying hospitals for FFYs 2019 through 2025 (discharges on and after October 1, 2018, and before October 1, 2025). Qualifying hospitals, those hospitals more than 15 road miles from the nearest subsection (d) hospital and with fewer than 3,800 total discharges based on the hospital's most recently submitted cost report, receive a payment adjustment as follows:

- Those hospitals with 500 or fewer total discharges will receive an adjustment of an additional 25 percent for each Medicare discharge; and,
- Those with more than 500 and fewer than 3,800 total discharges will receive an adjustment of an additional percentage for each Medicare discharge. This adjustment is calculated using the formula [(95/330) - (total discharges/13,200)].

CMS provided a table listing the IPPS hospitals with fewer than 1,600 Medicare discharges and their low-volume percentage add-on, if applicable, for FFYs 2011 through 2018 (discharges before October 1, 2018). However, this list is not a list of all hospitals that qualify for the low-volume adjustment since it does not reflect whether or not the hospital meets the mileage criteria. Hospitals were required to request low-volume status in writing to their contractor and provide documentation that they met the mileage criteria.

The low-volume payment adjustment for eligible hospitals is based on their total per discharge payments made under §1886 of the Act, including the capital IPPS payments, DSH payments, IME payments, and outlier payments. For SCHs and MDHs, the low-volume payment adjustment for eligible hospitals is based on either the federal rate or the hospital-specific payment (HSP) rate, whichever results in a greater operating IPPS payment. The low-volume payment amount calculated by the IPPS Pricer is an interim payment amount and is subject to adjustment during year end cost report settlement if any of the payment amounts upon which the low-volume payment amount is based are also recalculated at cost report settlement (for example, payments for DSH and IME or federal rate versus HSP rate payments for SCHs and MDHs).

NOTE: Because a hospital's eligibility for the low-volume payment adjustment and/or a hospital's applicable low-volume adjustment percentage can change during its cost reporting period (for example, a hospital with a cost report that spans the start of the FFY), it is necessary to determine the low-volume payment amount using the applicable low-volume adjustment percentage for the FFY and payment amounts listed above for a hospital's discharges that occur during the FFY for each FFY included by the hospital's cost reporting period.

After the cost report is calculated for settlement, the low-volume payment adjustment must be calculated. The low-volume payment amount must be calculated by FFY. Therefore, if the cost report overlaps a FFY, the information computed on Worksheet E, Part A, must be recomputed by FFY accordingly. The amounts may not be prorated, but must be calculated using the appropriate information. The following payment amounts are multiplied by the low-volume payment adjustment percentage by FFY:

- Operating Federal IPPS payments;
- Operating HSR payments;
- Operating outlier payments including any Operating Outlier Reconciliation amounts;
- Operating IME payments;
- Operating IME payments for Medicare Advantage patients;
- Operating DSH payments;
- Uncompensated care payments;
- ESRD adjustment payments;
- Total Capital IPPS payment;
- New technology payments;
- Credits for replaced devices; and
- Capital outlier reconciliation amounts (if applicable, see instructions)

Complete Exhibit 4 to compute the low-volume adjustment payment applicable to this cost reporting period. **The Exhibit 4 is designed to simulate the Medicare cost report and must be completed after the cost report is calculated.**

If the provider participated in the PARHM demonstration (Worksheet S-2, Part I, line 112, column 1, is "Y") for only a portion of the cost reporting period complete Exhibit 4 only for the non-participation portion of the cost reporting period.

Column 0--Line references are comparable to the actual line references on Worksheet E, Part A, and Worksheet L, Part I.

Column 1--Enter from Worksheet E, Part A, and Worksheet L, Part I, the amounts reported on the corresponding lines of the Medicare cost report.

Column 2--Enter amounts related to discharges occurring in the cost reporting period either pre-entitlement (discharges occurring in the cost reporting period prior to October 1) or post-entitlement (discharges occurring in the cost reporting period on or after October 1). Discharges occurring in these periods are not eligible for the low-volume adjustment.

In addition, if there are discharges occurring during this cost reporting period and the provider was not eligible for the low-volume adjustment for the entire eligibility period, report the information relative to those discharges in this column, for example, where a provider has a cost reporting period ending June 30, 2011, which began prior to the October 1, 2010, effective date of the provision. Or where the low-volume adjustment for discharges occurring in this cost reporting period is effective for discharges on or after October 1, 2010; however, the provider did not request the low-volume adjustment until November 15, 2010, and the low-volume adjustment was implemented within 30 days of the request. The period of time from October 1, 2010, until the contractor notified the provider of eligibility, which should be no later than December 15, 2010, is considered a period of ineligibility.

Column 3--Enter amounts related to discharges occurring during the provider's low-volume eligibility period and prior to October 1. If the cost reporting period is not concurrent with a federal year of October 1, through September 30, do not include discharges occurring on or after October 1, in this column.

If the provider goes in and out of eligibility for discharges occurring prior to October 1, add all discharges for the eligibility periods prior to October 1, and include in this column. If the provider's classification (i.e., SCH to small rural) changes during the eligibility period, use subscripted column 3.01 to accommodate the change for discharges occurring prior to October 1.

Column 4--Enter amounts related to discharges occurring during the provider's low-volume eligibility period and on or after October 1. If the cost reporting period is concurrent with a federal year of October 1, through September 30, report all discharges occurring on or after October 1, in this column. If the provider goes in and out of eligibility for discharges occurring on or after October 1, add all discharges for the eligibility periods on or after October 1, and include in this column. If the provider's classification (i.e., SCH to small rural) changes during the eligibility period, use subscripted column 4.01 to accommodate the change for discharges occurring on or after October 1.

Columns 3, 3.01, 4, and 4.01--Use the beginning and ending dates of the applicable portion of the cost reporting period as the respective column headings.

Column 5--Subtotal columns 2 through 4, and applicable subscripts. Column 5 must equal column 1, and any resulting rounding difference must be applied to the highest value in columns 2 through 4, and applicable subscripts.

Line Descriptions

Line 1--The amount entered on this line is computed as the sum of the federal operating portion (DRG payment) paid for PPS discharges during the cost reporting period and the DRG payments made for PPS transfers during the cost reporting period. The PS&R information must be split and reported in columns 2 through 4, and must concur with the PS&R paid-through date used to calculate the cost report.

Line 1.01 (Corresponds to Worksheet E, Part A, line 1.01)--Enter the DRG amounts other than outlier payments for discharges occurring prior to October 1, in column 3.

Line 1.02 (Corresponds to Worksheet E, Part A, line 1.02)--Enter the DRG amounts other than outlier payments for discharges occurring on or after October 1, in column 4.

Line 1.03 (Corresponds to Worksheet E, Part A, line 1.03)--Enter the DRG for federal specific operating payments for Model 4 BPCI on this line. The PS&R information must be split and

reported in columns 2 through 4, and must concur with the PS&R paid-through date used to calculate the cost report. Effective for cost reporting periods that overlap October 1, 2014, and subsequent years, enter the amount of the federal specific operating portion (DRG payments) paid for Model 4 BPCI discharges and transfers occurring prior to October 1, in columns 2 and 3 accordingly.

Line 1.04 (Corresponds to Worksheet E, Part A, line 1.04)--Enter the DRG for federal specific operating payments for Model 4 BPCI occurring on or after October 1, on this line. The PS&R information must be split and reported in columns 2 and 4 accordingly, and must concur with the PS&R paid-through date used to calculate the cost report.

Line 2--Enter the amount of outlier payments made for PPS discharges occurring during the cost reporting period. The PS&R information must be split and reported in columns 2 through 4, and must concur with the PS&R paid-through date used to calculate the cost report. For cost reporting periods beginning on or after October 1, 2018, do not complete this line, but complete lines 2.02 and 2.03.

Line 2.01 (Corresponds to Worksheet E, Part A, line 2.02)--Enter the outlier payment for discharges for Model 4 BPCI on this line. The PS&R information must be split and reported in columns 2 through 4, and must concur with the PS&R paid-through date used to calculate the cost report.

Line 2.02 (Corresponds to Worksheet E, Part A, line 2.03)--For cost reporting periods beginning on or after October 1, 2018, enter the amount of the outlier payments made for PPS discharges occurring prior to October 1, in column 3.

Line 2.03 (Corresponds to Worksheet E, Part A, line 2.04)--For cost reporting periods beginning on or after October 1, 2018, enter the amount of the outlier payments made for PPS discharges occurring on or after October 1, in column 4.

Line 3 (Corresponds to Worksheet E, Part A, line 2.01)--For inpatient PPS services rendered during the cost reporting period, enter the operating outlier reconciliation amount for operating expenses from line Worksheet E, Part A, line 92, for each respective period. The lump sum utility produces a claim-by-claim output. If the provider has two different low-volume hospital adjustment percentages during its cost reporting period, the contractor must report the operating and capital outlier reconciliation adjustment amounts for the discharges occurring in each of the FFYs spanned by the cost report separately. The sum of columns 2 through 4 must equal the amount reported on Worksheet E, Part A, line 2.01.

Line 4 (Corresponds to Worksheet E, Part A, line 3)--Enter the IME for managed care patients based on the DRG payment that would have been made if the service had not been a managed care service. The PS&R will capture, in conjunction with the PPS PRICER, the simulated payments. Enter the total managed care "simulated payments" from the PS&R. The PS&R information must be split and reported in columns 2 through 4, and must concur with the PS&R paid-through date used to calculate the cost report.

Line 5 (Corresponds to Worksheet E, Part A, line 21)--Enter the ratio calculated from Worksheet E, Part A, line 21, in columns 2 through 4.

Line 6 (Corresponds to Worksheet E, Part A, line 22)--For cost reporting periods beginning before October 1, 2014, calculate the IME payment adjustment as follows: Multiply the appropriate multiplier of the adjustment factor (currently 1.35) times {((1 + line 5) to the .405 power) - 1} times {the sum of lines 1, 1.01, 1.02, 1.03, 1.04, and line 4}. The sum of columns 2 through 4 must equal the amount reported on Worksheet E, Part A, line 22.

Effective for cost reporting periods beginning on or after October 1, 2014, calculate the IME payment adjustment as follows: Multiply the appropriate multiplier of the adjustment factor (currently 1.35) times {((1 + line 5) to the .405 power) - 1} times {the sum of lines 1.01, 1.02, 1.03 and line 1.04}.

Line 6.01 (Corresponds to Worksheet E, Part A, line 22.01)--Effective for cost reporting periods beginning on or after October 1, 2014, calculate the IME payment adjustment for managed care, as follows: Multiply the appropriate multiplier of the adjustment factor (currently 1.35) times {((1 + line 5) to the .405 power) - 1} times line 4.

Line 7 (Corresponds to Worksheet E, Part A, line 27)--Enter the ratio calculated from Worksheet E, Part A, line 27, in columns 2 through 4.

Line 8 (Corresponds to Worksheet E, Part A, line 28)--IME Add-On Adjustment--For cost reporting periods beginning before October 1, 2014, enter the sum of lines 1, 1.01, 1.02, 1.03, 1.04, and line 4, multiplied by the factor on line 7.

Effective for cost reporting periods beginning on or after October 1, 2014, calculate the IME add-on adjustment as follows: Enter the sum of lines 1.01, 1.02, 1.03 and line 1.04, multiplied by the factor on line 7.

Line 8.01 (Corresponds to Worksheet E, Part A, line 28.01)--IME Add- On Adjustment - Managed Care--Effective for cost reporting periods beginning on or after October 1, 2014, enter the result of line 4, multiplied by the factor on line 7.

Line 9 (Corresponds to Worksheet E, Part A, line 29)--Total IME Payment--Enter the sum of lines 6 and 8. The sum of columns 2 through 4 must equal the amount reported on Worksheet E, Part A, line 29.

Line 9.01 (Corresponds to Worksheet E, Part A, line 29.01)--Total IME Payment - Managed Care--Effective for cost reporting periods beginning on or after October 1, 2014, enter the sum of lines 6.01 and 8.01. The sum of columns 2 through 4 must equal the amount reported on Worksheet E, Part A, line 29.01.

Line 10 (Corresponds to Worksheet E, Part A, line 33)--Enter the DSH percentage calculated from Worksheet E, Part A, line 33, in columns 2 through 4.

Line 11 (Corresponds to Worksheet E, Part A, line 34)--Multiply line 10 by line 1 for cost reporting periods ending on or before September 30, 2013. Effective for cost reporting periods that overlap October 1, 2013, enter the sum of {(line 10 times line 1.01), plus ((line 10 times the sum of lines 1.02 and 1.03) times 25 percent)}. For cost reporting periods beginning on or after October 1, 2013, multiply (line 10 times the sum of lines 1.01, 1.02, and 1.03) times 25 percent. For cost reporting periods overlapping or beginning on or after October 1, 2014, multiply (line 10 times the sum of lines 1.01, 1.02, 1.03, and line 1.04) times 25 percent. The sum of columns 2 through 4 must equal the amount reported on Worksheet E, Part A, line 34.

Line 11.01 (Corresponds to Worksheet E, Part A, line 36)--Enter the UCPs. For cost reporting periods that overlap or begin on or after October 1, 2013, when you are eligible for the low-volume payment adjustment for the entire cost reporting period, enter in column 3, the UCP from Worksheet E, Part A, column 1, line 35.03, and enter in column 4, the UCP from Worksheet E, Part A, column 2, line 35.03.

For cost reporting periods that overlap or begin on or after October 1, 2013, when you are not eligible for the low-volume payment adjustment for any portion of the cost reporting period, enter the UCPs as follows:

- Enter in column 3, the UCP eligible for the low-volume payment adjustment for the portion of the cost reporting period prior to October 1, (calculated as the amount from Worksheet E, Part A, column 1, line 35.03, times the ratio of the number of days prior to October 1, in the cost reporting period eligible for the low-volume payment adjustment divided by the total days in the cost reporting period prior to October 1).

- Enter in column 4, the UCP eligible for the low-volume payment adjustment for the portion of the cost reporting period on and after October 1 (calculated as the amount from Worksheet E, Part A, column 2, line 35.03, times the ratio of the number of days on and after October 1, in the cost reporting period eligible for the low-volume payment adjustment divided by the total days in the cost reporting period on and after October 1).

- Enter in column 2, the UCP not eligible for the low-volume payment adjustment (calculated as the UCPs from Worksheet E, Part A, line 35.03, sum of columns 1 and 2, minus the sum of the UCPs reported in columns 3 and 4 of this exhibit). The sum of columns 2 through 4, must equal Worksheet E, Part A, line 36.

Line 12 (Corresponds to Worksheet E, Part A, line 46)--Prorate in columns 2 through 4, the amount reported on Worksheet E, Part A, line 46, based on the ratio of days in each applicable period to total days in the cost reporting period. The sum of columns 2 through 4 must equal the amount reported on Worksheet E, Part A, line 46.

Line 13 (Corresponds to Worksheet E, Part A, line 47)--Enter the sum of lines 1, 1.01, 1.02, 2, 2.01, 2.02, 2.03, 3, 9, 11, 11.01, and 12. The sum of columns 2 through 4 must equal the amount reported on Worksheet E, Part A, line 47.

Line 14 (Corresponds to Worksheet E, Part A, line 48)--For SCHs and MDHs, enter the applicable hospital-specific payments. The sum of columns 2 through 4 must equal the amount reported on Worksheet E, Part A, line 48. If Worksheet E, Part A, line 47, is greater than Worksheet E, Part A, line 48, do not complete this line.

Line 15 (Corresponds to Worksheet E, Part A, line 49)--Enter in column 1, the amount from Worksheet E, Part A, line 49. For SCHs, if line 13, column 1, is greater than line 14, column 1, enter in columns 2 through 4, the amount reported on line 13, plus the amount from line 9.01, for each applicable column. If line 14, column 1, is greater than line 13, column 1, enter in columns 2 through 4, the amount reported on line 14, plus the amount from line 9.01, for each applicable column. For MDH discharges occurring on or after October 1, 2006, and before October 1, 2025, if line 13, column 1, is greater than line 14, column 1, enter in columns 2 through 4, the amount reported on line 13, plus the amount from line 9.01, for each applicable column. If line 14, column 1, is greater than line 13, column 1, enter in columns 2 through 4, the amount on line 13, for each applicable column, plus 75 percent of the difference between line 14 minus line 13, plus the amount from line 9.01. Hospitals not qualifying as SCH or MDH providers will enter in columns 2 through 4, the amount from line 13, plus the amount from line 9.01, for each applicable column. The sum of columns 2 through 4 must equal the amount reported on Worksheet E, Part A, line 49.

For former MDHs, line 15 is calculated based on the amounts in column 1. For former MDHs (Worksheet S-2, Part I, line 37.01, is yes) for FY 2016, for cost reporting periods that begin on or after January 1, 2016, if line 14, column 1, is greater than line 13, column 1, enter in column 3, the amount on line 13, column 1, times (the number of days in the cost reporting period prior to October 1, divided by the total days in the cost reporting period), plus Worksheet E, Part A, line 100, column 1, plus the amount from line 9.01, column 3. Enter in column 4, the amount on line 13, column 1, times (the number of days in the cost reporting period on or after October 1, divided by the total days in the cost reporting period), plus Worksheet E, Part A, line 100, column 2, plus the amount from line 9.01, column 4. For cost reporting periods that overlap January 1, 2016, and end on or before September 30, 2016, enter in column 3, the amount on line 13, column 1, times (the number of days in the cost reporting period prior to October 1, divided by the total days in the cost reporting period), plus Worksheet E, Part A, line 100, column 1, plus the amount from line 9.01, column 3. Enter in column 4, the amount on line 13, column 1, times (the number of days in the cost reporting period on or after October 1, divided by the total days in the cost reporting period), plus Worksheet E, Part A, line 100, column 2, plus the amount from line 9.01, column 4. For cost reporting periods that overlap

January 1, 2016, and October 1, 2016, enter in column 3, the amount on line 13, column 1, times (the number of days in the cost reporting period prior to October 1, divided by the total days in the cost reporting period), plus Worksheet E, Part A, line 100, column 1, plus the amount from line 9.01, column 3. Enter in column 4, the amount on line 13, column 1, times (the number of days in the cost reporting period on or after October 1, divided by the total days in the cost reporting period), plus Worksheet E, Part A, line 100, column 2, plus the amount from line 9.01, column 4.

For former MDHs for FY 2017, for cost reporting periods that begin October 1, 2016, enter in column 4, the amount on line 13, column 1, times (the number of days in the cost reporting period on or after October 1, divided by the total days in the cost reporting period), plus Worksheet E, Part A, line 100, column 2, plus the amount from line 9.01, column 4. For cost reporting periods that overlap October 1, 2016, enter in column 3, the amount on line 13, column 1, times (the number of days in the cost reporting period prior to October 1, divided by the total days in the cost reporting period), plus Worksheet E, Part A, line 100, column 1, plus the amount from line 9.01, column 3. Enter in column 4, the amount on line 13, column 1, times (the number of days in the cost reporting period on or after October 1, divided by the total days in the cost reporting period), plus Worksheet E, Part A, line 100, column 2, plus the amount from line 9.01, column 4. For cost reporting periods that overlap September 30, 2017, enter in column 3, the amount on line 13, column 1, times (the number of days in the cost reporting period prior to October 1, divided by the total days in the cost reporting period), plus Worksheet E, Part A, line 100, column 1, plus the amount from line 9.01, column 3. Enter in column 4, the amount on line 13, column 1, times (the number of days in the cost reporting period on or after October 1, divided by the total days in the cost reporting period), plus Worksheet E, Part A, line 100, column 2, plus the amount from line 9.01, column 4.

Line 16 (Corresponds to Worksheet E, Part A, line 50)--Enter in columns 2 through 4, the amounts computed from line 26, columns 2 through 4. The sum of columns 2 through 4 must equal the amount reported on Worksheet E, Part A, line 50. If Worksheet S-2, Part I, line 47, column 2, is yes, and Worksheet S-2, Part I, line 48, column 2, is no, do not transfer the amount from Worksheet E, Part A, line 50.

Line 17 (Corresponds to Worksheet E, Part A, line 54)--Enter the add-on payment for new technologies. The PS&R information must be split and reported in columns 2 through 4 and must concur with the PS&R paid-through date used to calculate the cost report.

Line 17.01 (Corresponds to Worksheet E, Part A, line 55)--Do not complete this line. Organ acquisition costs are not included in the low volume adjustment calculation.

Line 17.02 (Corresponds to Worksheet E, Part A, line 68)--For discharges on or after October 1, 2014, enter the credits for replaced devices. The PS&R information must be split and reported in columns 2 through 4 and must concur with the PS&R paid-through date used to calculate the cost report.

Line 18 (Corresponds to Worksheet E, Part A, line 93)--Enter the capital outlier reconciliation adjustment amount in columns 2 through 4 accordingly. The sum of columns 2 through 4 must equal the amount reported on Worksheet E, Part A, line 93.

Line 19 (Subtotal)--Enter in columns 2 through 4, the sum of amounts on lines 15, 16, 17, and 18. For SCH, if the hospital specific payment amount on line 14, column 1, is greater than the federal specific payment amount on line 13, column 1, enter in columns 2 through 4, the sum of the amounts on lines 15, 16, 17, and 17.02.

Line 20 (Corresponds to Worksheet L, Part I, line 1)--Enter the amount of the federal rate portion of the capital DRG payments for other than outlier during this cost reporting period. The PS&R information must be split and reported in columns 2 through 4 and must concur with the PS&R paid-through date used to calculate the cost report for settlement. The sum of columns 2 through 4 must equal the amount reported on Worksheet L, Part I, line 1, column 1, and, if applicable, column 1.01.

Line 20.01 (Corresponds to Worksheet L, Part I, line 1.01)--Enter the Model 4 BPCI Capital DRG other than outlier payments. The PS&R information must be split and reported in columns 2 through 4 and must concur with the PS&R paid-through date used to calculate the cost report for settlement. The sum of columns 2 through 4 must equal the amount reported on Worksheet L, Part I, line 1.01, column 1, and, if applicable, column 1.01.

Line 21 (Corresponds to Worksheet L, Part I, line 2)--Enter the amount of the federal rate portion of the capital outlier payments made for PPS discharges during this cost reporting period. The PS&R information must be split and reported in columns 2 through 4 and must concur with the PS&R paid-through date used to calculate the cost report. The sum of columns 2 through 4 must equal the amount reported on Worksheet L, Part I, line 2.

Line 21.01 (Corresponds to Worksheet L, Part I, line 2.01)--Enter the Model 4 BPCI Capital DRG outlier payments. The PS&R information must be split and reported in columns 2 through 4 and must concur with the PS&R paid-through date used to calculate the cost report. The sum of columns 2 through 4 must equal the amount reported on Worksheet L, Part I, line 2.01.

Line 22 (Corresponds to Worksheet L, Part I, line 5)--Enter the ratio calculated from Worksheet L, Part I, line 5, in all applicable columns.

Line 23 (Corresponds to Worksheet L, Part I, line 6)--Multiply line 22 by the sum of lines 20 and 20.01. The sum of columns 2 through 4 must equal the amount reported on Worksheet L, Part I, line 6.

Line 24 (Corresponds to Worksheet L, Part I, line 10)--Enter the percentage calculated from Worksheet L, Part I, line 10, in all applicable columns.

Line 25 (Corresponds to Worksheet L, Part I, line 11)--Multiply line 24 by the sum of lines 20 and 20.01, and enter the result. The sum of columns 2 through 4 must equal the amount reported on Worksheet L, Part I, line 11.

Line 26 (Corresponds to Worksheet L, Part I, line 12)--Enter the sum of lines 20, 20.01, 21, 21.01, 23, and 25. If the amounts on lines 20 and/or 20.01, columns 3 and/or 4, or applicable subscripts of either column, pertain to rural status, enter zero. Transfer this amount to line 16. The sum of columns 2 through 4 must equal the amount reported on Worksheet L, Part I, line 12.

Low-volume payment adjustment--Effective for discharges occurring during FFYs 2011 and subsequent, compute the amount of the low-volume adjustment as follows:

Line 27--Low-volume adjustment factor--Enter the appropriate adjustment factor in columns 3 and 4. For FFYs 2011 through 2018, obtain the adjustment factor from the appropriate IPPS final rule. For FFYs 2019 through 2025, calculate the adjustment factor in accordance with 42 CFR412.101(c)(3), using the most recently submitted cost report. For FFY 2026 and forward (discharges on or after October 1, 2025), use an adjustment factor of 25 percent.

Line 28 (Corresponds to Worksheet E, Part A, line 70.96 discharges prior to October 1)--Multiply line 19 by line 27. Transfer this amount to the cost report, Worksheet E, Part A, line 70.96.

Line 29 (Corresponds to Worksheet E, Part A, line 70.97 discharges on or after October 1)--Multiply line 19 by line 27. Transfer this amount to the cost report, Worksheet E, Part A, line 70.97.

EXHIBIT 4
LOW-VOLUME ADJUSTMENT CALCULATION SCHEDULE

LOW-VOLUME CALCULATION EXHIBIT 4	PROVIDER CCN:	PERIOD: FROM: TO:

		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)	Pre/Post Entitlement	Prior to 10/1	On and after 10/1	Total (cols. 2 through 4)	
		(0)	(1)	(2)	(3)	(4)	(5)	
1	DRG Amounts Other than Outlier Payments	1						1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01						1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02						1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03						1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04						1.04
2	Outlier payments for discharges (see instructions)	2						2
2.01	Outlier payment for discharges for Model 4 BPCI	2.02						2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03						2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04						2.03
3	Operating outlier reconciliation	2.01						3
4	Managed Care Simulated Payments	3						4
	Indirect Medical Education Adjustment							
5	Amount from Worksheet E, Part A, line 21 (see instructions)	21						5
6	IME payment adjustment (see instructions)	22						6
6.01	IME payment adjustment for managed care (see instructions)	22.01						6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7	IME payment adjustment factor (see instructions)	27						7
8	IME add-on adjustment amount (see instructions)	28						8
8.01	IME payment adjustment add on for managed care (see instructions)	28.01						8.01
9	Total IME payment (sum of lines 6 and 8)	29						9
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01						9.01
	Disproportionate Share Adjustment							
10	Allowable disproportionate share percentage (see instructions)	33						10
11	Disproportionate share adjustment (see instructions)	34						11
11.01	Uncompensated care payments	36						11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12	Total ESRD additional payment (see instructions)	46						12
13	Subtotal (see instructions)	47						13
14	Hospital specific payments (completed by SCH and MDH, small rural hospitals only) (see instructions)	48						14
15	Total payment for inpatient operating costs (see instructions)	49						15
16	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50						16
17	Special add-on payments for new technologies	54						17
17.01	Net organ acquisition cost	55						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68						17.02
18	Capital outlier reconciliation adjustment amount (see instructions)	93						18
19	**SUBTOTAL**							19
		Wkst. L, line	(Amt. from Wkst. L)					
		(0)	(1)	(2)	(3)	(4)	(5)	
20	Capital DRG other than outlier	1						20
20.01	Model 4 BPCI Capital DRG other than outlier	1.01						20.01
21	Capital DRG outlier payments	2						21
21.01	Model 4 BPCI Capital DRG outlier payments	2.01						21.01
22	Indirect medical education percentage (see instructions)	5						22
23	Indirect medical education adjustment (see instructions)	6						23
24	Allowable disproportionate share percentage (see instructions)	10						24
25	Disproportionate share adjustment (see instructions)	11						25
26	Total prospective capital payments (see instructions)	12						26
		Wkst. E, Pt. A, line	(Amt. to Wkst. E, Pt. A)					
		(0)	(1)	(2)	(3)	(4)	(5)	
27	**Low-volume adjustment factor**							27
28	Low-volume adjustment (transfer amount to Wkst. E, Pt. A, line 70.96) (prior to 10/1)							28
29	Low-volume adjustment (transfer amount to Wkst. E, Pt. A, line 70.97) (on and after 10/1)							29

Instructions for Completing Exhibit 5--

Adjustment to Hospital Payments for Hospital Acquired Conditions (HAC) Calculation Schedule:

Section 3008 of ACA 2010 establishes the HAC Reduction Program, beginning in FFY 2015 (discharges occurring on or after October 1, 2014), for IPPS hospitals to improve patient safety. HACs are medical errors or serious infections that patients contract while in the hospital. Under the HAC Reduction Program, a 1 percent payment reduction applies to a hospital whose ranking is in the top quartile (25 percent) of all applicable hospitals, relative to the national average, of HACs acquired during the applicable period, and applies to all of the hospital's discharges for the specific fiscal year. For SCHs and MDHs, the HAC reduction percentage applies to either the federal payment rate or the HSP rate, whichever results in a greater operating IPPS payment. See 2015 IPPS final rule (79 FR 50087-50104 (August 22, 2014)).

Applicable IPPS hospitals subject to the HAC reduction adjustment for discharges occurring during FFY 2015 (i.e., discharges occurring on or after October 1, 2014, through September 30, 2015) are listed in Table 17 of the FY 2015 IPPS final rule. Consult the appropriate CMS final rule for the table listing IPPS hospitals subject to the HAC reduction adjustment. The HAC reduction adjustment amount is calculated after all IPPS per discharge payments, which includes adjustment for DSH (including the UCP), IME payments, outliers, new technology, net organ acquisition costs, credits for replace devices, readmissions, HVBP, and capital payments. The HAC reduction adjustment calculated by the IPPS Pricer is an interim payment amount and is subject to adjustment during cost report settlement if any of the payment amounts upon which the HAC reduction adjustment is based are also recalculated at cost report settlement (for example, payments for DSH, IME, Low-volume adjustment, or federal rate versus HSP rate payments for SCHs and MDHs).

After the cost report is calculated for settlement, the HAC reduction adjustment must be calculated by FFY. If the cost report overlaps a FFY, the information computed on Worksheet E, Part A, must be recomputed by FFY accordingly. The amounts are not prorated (except where noted), but must be calculated using the appropriate information. The following payment amounts are required to calculate the HAC reduction adjustment by FFY:

- Operating Federal IPPS payments;
- Operating HSR payments;
- Operating Outlier payments including any Operating Outlier Reconciliation amounts;
- Operating IME payments;
- Operating IME payments for Medicare Advantage patients;
- Operating DSH payments;
- Uncompensated care payments;
- ESRD adjustment payments;
- Total capital IPPS payment;
- New technology payments;
- Credits for replaced devices;
- Low-volume adjustment;
- HVBP payment adjustment;
- HRR adjustment; and
- Capital outlier reconciliation amounts (if applicable, see instructions)

Complete Exhibit 5 to compute the HAC reduction adjustment applicable to this cost reporting period. **The following Exhibit 5 is designed to simulate the Medicare cost report and must be completed after the cost report is calculated.**

If the provider participated in the PARHM demonstration (Worksheet S-2, Part I, line 112, column 1, is "Y") for only a portion of the cost reporting period, complete Exhibit 5 only for the non-participation portion of the cost reporting period.

Column 0--Line references are comparable to the actual line references on Worksheet E, Part A, and Worksheet L, Part I.

Column 1--Enter from Worksheet E, Part A, and Worksheet L, Part I, the amounts reported on the corresponding lines of the Medicare cost report.

Column 2--Enter amounts related to discharges occurring during the applicable provider's HAC reduction period prior to October 1. If the cost reporting period is not concurrent with a federal year (October 1, through September 30), do not include discharges occurring on or after October 1, in this column. If the provider's classification (i.e., SCH to small rural) changes during the HAC reduction period, use subscripted column 2.01 to accommodate the change for discharges occurring prior to October 1.

Column 3--Enter amounts related to discharges occurring during the applicable provider's HAC reduction period on or after October 1. If the cost reporting period is concurrent with a federal year (October 1, through September 30), report all discharges occurring on or after October 1, in this column. If the provider's classification (i.e., SCH to small rural) changes during the HAC reduction period, use subscripted column 3.01 to accommodate the change for discharges occurring prior to October 1.

When a hospital with a cost reporting period that is not concurrent with a FFY is subject to the HAC reduction adjustment for only part of the cost reporting period, complete both columns 2 and 3. If Worksheet S-2, Part I, line 40, column 1, is "N" do not complete the HAC reduction program adjustment amount in column 2, line 32. If Worksheet S-2, Part I, line 40, column 2, is "N" do not complete the HAC reduction program adjustment amount in column 3, line 32.

Columns 2 and 3--Use the beginning and ending dates of the applicable portion of the cost reporting period as the respective column headings.

Column 4--Sum of columns 2 and 3. Column 4 must equal column 1 and any resulting rounding difference must be applied to the highest value in column 2 or column 3.

Line Descriptions

Line 1--Do not use this line.

Line 1.01 (Corresponds to Worksheet E, Part A, line 1.01)--Enter the DRG amounts other than outlier payments for discharges occurring prior to October 1, in column 2.

Line 1.02 (Corresponds to Worksheet E, Part A, line 1.02)--Enter the DRG amounts other than outlier payments for discharges occurring on or after October 1 in column 3.

Line 1.03 (Corresponds to Worksheet E, Part A, line 1.03)--Enter the DRG for federal specific operating payments for Model 4 BPCI on this line. The PS&R information must be split and reported in columns 2 and 3, and must concur with the PS&R paid-through date used to calculate the cost report. Effective for cost reporting periods that overlap October 1, 2014, and subsequent years, enter the amount of the federal specific operating portion (DRG payments) paid for Model 4 BPCI discharges and transfers occurring prior to October 1, in column 2.

Line 1.04 (Corresponds to Worksheet E, Part A, line 1.04)--Enter the DRG for federal specific operating payments for Model 4 BPCI on this line. The PS&R information must be split and reported in columns 2 and 3, and must concur with the PS&R paid-through date used to calculate the cost report.

Line 2--Enter the amount of outlier payments made for PPS discharges occurring during the cost reporting period. The PS&R information must be split and reported in columns 2 and 3, and must concur with the PS&R paid-through date used to calculate the cost report. For cost reporting periods beginning on or after October 1, 2018, do not complete this line, but complete lines 2.02 and 2.03.

Line 2.01 (Corresponds to Worksheet E, Part A, line 2.02)--Enter the outlier payment for discharges for Model 4 BPCI on this line. The PS&R information must be split and reported in columns 2 and 3, and must concur with the PS&R paid-through date used to calculate the cost report.

Line 2.02 (Corresponds to Worksheet E, Part A, line 2.03)--For cost reporting periods beginning on or after October 1, 2018, enter the amount of the outlier payments made for PPS discharges occurring prior to October 1, in column 2.

Line 2.03 (Corresponds to Worksheet E, Part A, line 2.04)--For cost reporting periods beginning on or after October 1, 2018, enter the amount of the outlier payments made for PPS discharges occurring on or after October 1, in column 3.

Line 3 (Corresponds to Worksheet E, Part A, line 2.01)--For inpatient PPS services rendered during the cost reporting period, enter the operating outlier reconciliation amount for operating expenses from line Worksheet E, Part A, line 92, for each respective period. The lump sum utility produces a claim-by-claim output. If the provider has two different low-volume hospital adjustment percentages during its cost reporting period, the contractor must report the operating and capital outlier reconciliation adjustment amounts for the discharges occurring in each of the FFYs spanned by the cost report separately. The sum of columns 2 and 3 must equal the amount reported on Worksheet E, Part A, line 2.01.

Line 4 (Corresponds to Worksheet E, Part A, line 3)--Enter the IME for managed care patients based on the DRG payment that would have been made if the service had not been a managed care service. The PS&R will capture, in conjunction with the PPS PRICER, the simulated payments. Enter the total managed care simulated payments from the PS&R. The PS&R information must be split and reported in columns 2 and 3, and must concur with the PS&R paid-through date used to calculate the cost report.

Line 5 (Corresponds to Worksheet E, Part A, line 21)--Enter the ratio calculated from Worksheet E, Part A, line 21, in columns 2 and 3.

Line 6 (Corresponds to Worksheet E, Part A, line 22)--For cost reporting periods that overlap October 1, 2014, calculate the IME payment adjustment as follows: Multiply the appropriate multiplier of the adjustment factor (currently 1.35) times {((1 + line 5) to the .405 power) - 1} times {the sum of lines 1.01, 1.02, 1.03, 1.04 and line 4}. The sum of columns 2 and 3 must equal the amount reported on Worksheet E, Part A, line 22.

Effective for cost reporting periods beginning on or after October 1, 2014, calculate the IME payment adjustment as follows: Multiply the appropriate multiplier of the adjustment factor (currently 1.35) times {((1 + line 5) to the .405 power) - 1} times {the sum of lines 1.01, 1.02, 1.03 and 1.04}. The sum of columns 2 and 3 must equal the amount reported on Worksheet E, Part A, line 22.

Line 6.01 (Corresponding to Worksheet E, Part A, line 22.01)--Effective for cost reporting periods beginning on or after October 1, 2014, calculate the IME payment adjustment for managed care, as follows: Multiply the appropriate multiplier of the adjustment factor (currently 1.35) times {((1 + line) to the .405 power) - 1} times line 4.

Line 7 (Corresponds to Worksheet E, Part A, line 27)--Enter the ratio calculated from Worksheet E, Part A, line 27, in columns 2 and 3.

Line 8 (Corresponds to Worksheet E, Part A, line 28)--IME Add-On Adjustment--For cost reporting periods that overlap October 1, 2014, enter the sum of lines 1.01, 1.02, 1.03, 1.04, and line 4, multiplied by the factor on line 7.

Effective for cost reporting periods beginning on or after October 1, 2014, calculate the IME add-on adjustment as follows: Enter the sum of lines 1.01, 1.02, 1.03, and 1.04, multiplied by the factor on line 7.

Line 8.01 (Corresponding to Worksheet E, Part A, line 28.01)--Total IME Add-On Adjustment for Managed Care--Effective for cost reporting periods beginning on or after October 1, 2014, enter the result of line 4, multiplied by the factor on line 7.

Line 9 (Corresponds to Worksheet E, Part A, line 29)--Total IME Payment--Enter the sum of lines 6 and 8. The sum of columns 2 and 3 must equal the amount reported on Worksheet E, Part A, line 29.

Line 9.01 (Corresponds to Worksheet E, Part A, line 29.01)--Total IME Payment - Managed Care--Effective for cost reporting periods beginning on or after October 1, 2014, enter the sum of lines 6.01 and 8.01. The sum of columns 2 and 3 must equal the amount reported on Worksheet E, Part A, line 29.01.

Line 10 (Corresponds to Worksheet E, Part A, line 33)--Enter the DSH percentage calculated from Worksheet E, Part A, line 33, in columns 2 and 3.

Line 11 (Corresponds to Worksheet E, Part A, line 34)--Multiply (line 10 times the sum of lines 1.01, 1.02 1.03, and 1.04) times 25 percent. The sum of columns 2 and 3 must equal the amount reported on Worksheet E, Part A, line 34.

Line 11.01 (Corresponds to Worksheet E, Part A, line 36)--Enter the UCPs. For cost reporting periods that overlap October 1, enter in column 2, the UCP from Worksheet E, Part A, column 1, line 35.03, and enter in column 3, the UCP from Worksheet E, Part A, column 2, line 35.03.

Line 12 (Corresponds to Worksheet E, Part A, line 46)--Prorate, in columns 2 and 3, the amount reported on Worksheet E, Part A, line 46, based on the ratio of days in each applicable period to total days in the cost reporting period. The sum of columns 2 and 3 must equal the amount reported on Worksheet E, Part A, line 46.

Line 13 (Corresponds to Worksheet E, Part A, line 47)--Enter the sum of lines 1.01, 1.02, 2, 2.01, 2.02, 2.03, 3, 9, 11, 11.01, and 12. The sum of columns 2 and 3 must equal the amount reported on Worksheet E, Part A, line 47.

Line 14 (Corresponds to Worksheet E, Part A, line 48)--For SCHs and MDHs, enter the applicable hospital-specific payments. The sum of columns 2 and 3 must equal the amount reported on Worksheet E, Part A, line 48. If Worksheet E, Part A, line 47, is greater than Worksheet E, Part A, line 48, do not complete this line.

Line 15 (Corresponds to Worksheet E, Part A, line 49)--Enter in column 1, the amount from Worksheet E, Part A, line 49. For SCHs, if line 13, column 1 is greater than line 14, column 1, enter in columns 2 and 3, the amount reported on line 13, plus the amount from line 9.01, for each applicable column. If line 14, column 1, is greater than line 13, column 1, enter in columns 2 and 3, the amount reported on line 14, plus the amount from line 9.01, for each applicable column. For MDH discharges occurring on or before October 1, 2022, if line 13, column 1, is greater than line 14, column 1, enter in columns 2 and 3, the amount reported on line 13, plus the amount from line 9.01, for each applicable column. If line 14, column 1, is greater than line 13, column 1, enter in columns 2 and 3, the amount on line 13, for each column, plus 75 percent of the difference between line 14 minus line 13, plus the amount from line 9.01. Hospitals not qualifying as SCH or MDH providers will enter in columns 2 and 3, the amount from line 13, plus the amount from line 9.01, for each column. The sum of columns 2 and 3 must equal the amount reported on Worksheet E, Part A, line 49.

For former MDH's, line 15 is calculated based on the amounts in column 1. For former MDHs (Worksheet S-2, Part I, line 37.01 is yes) for FY 2016, for cost reporting periods that begin on or after January 1, 2016, if line 14, column 1 is greater than line 13, column 1, enter in column 2, the amount on line 13, column 1, times (the number of days in the cost reporting prior to October 1, divided by the total days in the cost reporting period), plus Worksheet E, Part A, line 100, column 1, plus the amount from line 9.01, column 2. Enter in column 3, the amount on line 13, column 1, times (the number of days in the cost reporting period on or after October 1, divided by the total days in the cost reporting period), plus Worksheet E, Part A, line 100, column 2, plus the amount from line 9.01, column 3. For cost reporting periods that overlap January 1, 2016, and end on or before September 30, 2016, enter in column 2, the amount on line 13, column 1, times (the number of days in the cost reporting period prior to October 1, divided by the total days in the cost reporting period), plus Worksheet E, Part A, line 100, column 1, plus the amount from line 9.01, column 2. Enter in column 3, the amount on line 13, column 1, times (the number of days in the cost reporting period on or after October 1, divided by the total days in the cost reporting period), plus Worksheet E, Part A, line 100, column 2, plus the amount from line 9.01, column 3. For cost reporting periods that overlap January 1, 2016, and October 1, 2016, enter in column 2, the amount on line 13, column 1, times (the number of days in the cost reporting period prior to October 1, divided by the total days in the cost reporting period), plus Worksheet E, Part A, line 100, column 1, plus the amount from line 9.01, column 2. Enter in column 3, the amount on line 13, column 1, times (the number of days in the cost reporting period on or after October 1, divided by the total days in the cost reporting period), plus Worksheet E, Part A, line 100, column 2, plus the amount from line 9.01, column 3.

For former MDHs for FY 2017, for cost reporting periods that begin October 1, 2016, enter in column 3, the amount on line 13, column 1, times (the number of days in the cost reporting period on or after October 1, divided by the total days in the cost reporting period), plus Worksheet E, Part A, line 100, column 2, plus the amount from line 9.01, column 3. For cost reporting periods that overlap October 1, 2016, enter in column 2, the amount on line 13, column 1, times (the number of days in the cost reporting period prior to October 1, divided by the total days in the cost reporting period), plus Worksheet E, Part A, line 100, column 1, plus the amount from line 9.01, column 2. Enter in column 3, the amount on line 13, column 1, times (the number of days in the cost reporting period on or after October 1, divided by the total days in the cost reporting period), plus Worksheet E, Part A, line 100, column 2, plus the amount from line 9.01, column 3. For cost reporting periods that overlap September 30, 2017, enter in column 2, the amount on line 13, column 1, times (the number of days in the cost reporting period prior to October 1, divided by the total days in the cost reporting period), plus Worksheet E, Part A, line 100, column 1, plus the amount from line 9.01, column 2. Enter in column 3, the amount on line 13, column 1, times (the number of days in the cost reporting period on or after October 1, divided by the total days in the cost reporting period), plus Worksheet E, Part A, line 100, column 2, plus the amount from line 9.01, column 3.

Line 16 (Corresponds to Worksheet E, Part A, line 50)--Enter in columns 2 and 3, the amounts computed from line 26, columns 2 and 3. The sum of columns 2 and 3 must equal the amount reported on Worksheet E, Part A, line 50. If Worksheet S-2, Part I, line 47, column 2, is yes, and Worksheet S-2, Part I, line 48, column 2 is no, do not transfer the amount from Worksheet E, Part A, line 50.

Line 17 (Corresponds to Worksheet E, Part A, line 54)--Enter the add-on payment for new technologies. The PS&R information must be split and reported in columns 2 and 3 and must concur with the PS&R paid-through date used to calculate the cost report.

Line 17.01 (Corresponds to Worksheet E, Part A, line 55)--Do not complete this line. Organ acquisition costs are not included in the HAC reduction calculation.

Line 17.02 (Corresponds to Worksheet E, Part A, line 68)--Enter the credits for replaced devices. The PS&R information must be split and reported in columns 2 and 3 and must concur with the PS&R paid-through date used to calculate the cost report.

Line 18 (Corresponds to Worksheet E, Part A, line 93)--Enter the capital outlier reconciliation adjustment amount in columns 2 and 3. The sum of columns 2 and 3 must equal the amount reported on Worksheet E, Part A, line 93.

Line 19 Subtotal--Enter in columns 2 and 3, the sum of amounts on lines 15, 16, 17, 17.02, and 18. For SCH, if the hospital specific payment amount on line 14, column 1, is greater than the federal specific payment amount on line 13, column 1, enter in columns 2 and 3, the sum of the amounts on lines 15, 16, 17, and 17.02.

Line 20 (Corresponds to Worksheet L, Part I, line 1)--Enter the amount of the federal rate portion of the capital DRG payments other than outlier during this cost reporting period. The PS&R information must be split and reported in columns 2 and 3, and must concur with the PS&R paid-through date used to calculate the cost report. The sum of columns 2 and 3 must equal the amount reported on Worksheet L, Part I, line 1, column 1, and, if applicable, column 1.01.

Line 20.01 (Corresponds to Worksheet L, Part I, line 1.01)--Enter the Model 4 BPCI Capital DRG other than outlier payments. The PS&R information must be split and reported in columns 2 and 3, and must concur with the PS&R paid-through date used to calculate the cost report. The sum of columns 2 and 3 must equal the amount reported on Worksheet L, Part I, line 1.01, column 1, and, if applicable, column 1.01.

Line 21 (Corresponds to Worksheet L, Part I, line 2)--Enter the amount of the federal rate portion of the capital outlier payments made for PPS discharges during this cost reporting period. The PS&R information must be split and reported in columns 2 and 3, and must concur with the PS&R paid-through date used to calculate the cost report. The sum of columns 2 and 3 must equal the amount reported on Worksheet L, Part I, line 2.

Line 21.01 (Corresponds to Worksheet L, Part I, line 2.01)--Enter the Model 4 BPCI Capital DRG outlier payments. The PS&R information must be split and reported in columns 2 and 3, and must concur with the PS&R paid-through date used to calculate the cost report. The sum of columns 2 and 3 must equal the amount reported on Worksheet L, Part I, line 2.01.

Line 22 (Corresponds to Worksheet L, Part I, line 5)--Enter the ratio calculated from Worksheet L, Part I, line 5, in all applicable columns.

Line 23 (Corresponds to Worksheet L, Part I, line 6)--Multiply line 22 by the sum of lines 20 and 20.01. The sum of columns 2 and 3 must equal the amount reported on Worksheet L, Part I, line 6.

Line 24 (Corresponds to Worksheet L, Part I, line 10)--Enter the percentage calculated from Worksheet L, Part I, line 10, in applicable columns.

Line 25 (Corresponds to Worksheet L, Part I, line 11)--Multiply line 24 by the sum of lines 20 and 20.01, and enter the result. The sum of columns 2 and 3 must equal the amount reported on Worksheet L, Part I, line 11.

Line 26 (Corresponds to Worksheet L, Part I, line 12)--Enter the sum of lines 20, 20.01, 21, 21.01, 23, and 25. If the amounts on lines 20 and/or 20.01, columns 2 and/or 3, or applicable subscripts of either column, pertain to rural status, enter zero. Transfer this amount to line 16 of this exhibit. The sum of columns 2 and 3 must equal the amount reported on Worksheet L, Part I, line 12.

Line 27--Do not use. This line was left blank to maintain line number consistency between the low-volume and HAC adjustment worksheets.

Line 28 (Corresponds to Worksheet E, Part A, line 70.96 discharges prior to October 1)--Enter the amount from Worksheet E, Part A, line 70.96, in column 2.

Line 29 (Corresponds to Worksheet E, Part A, line 70.97 discharges on or after October 1)-- Enter the amount from Worksheet E, Part A, line 70.97, in column 3.

Line 30 (Corresponds to Worksheet E, Part A, line 70.93)--Enter the HVBP payment adjustment amount. The PS&R information for Worksheet E, Part A, line 70.93, must be split and reported in columns 2 and 3, and must concur with the PS&R paid-through date used to calculate the cost report. The sum of columns 2 and 3 must equal the amount reported on Worksheet E, Part A, line 70.93.

Line 30.01 (Corresponds to Worksheet E, Part A, line 70.90)--Enter in columns 2 and 3, the HVBP payment adjustment amounts from Worksheet E, Part A, line 102, columns 1 and 2, respectively. The sum of columns 2 and 3 must equal the amount reported on Worksheet E, Part A, line 70.90.

Line 31 (Corresponds to Worksheet E, Part A, line 70.94)--Enter the HRR adjustment amount. The PS&R information for Worksheet E, Part A, line 70.94, must be split and reported in columns 2 and 3, and must concur with the PS&R paid-through date used to calculate the cost report. The sum of columns 2 and 3 must equal the amount reported on Worksheet E, Part A, line 70.94.

Line 31.01 (Corresponds to Worksheet E, Part A, line 70.91)--Enter in columns 2 and 3, the HRR adjustment amounts from Worksheet E, Part A, line 104, columns 1 and 2, respectively. The sum of columns 2 and 3 must equal the amount reported on Worksheet E, Part A, line 70.91.

Line 32 (Corresponds to Worksheet E, Part A, line 70.99)--Enter the HAC reduction adjustment amount. If you responded "N" on Worksheet S-2, Part I, line 40, column 1, do not complete the HAC reduction adjustment in column 2. If you responded "N" on Worksheet S-2, Part I, line 40, column 2, do not complete the HAC reduction adjustment in column 3. Enter in column 2, the sum of lines 19, 28, 30, 30.01, 31, and 31.01, times 1 percent. For cost reporting periods that overlap October 1, 2014, enter zero in column 2. Enter in column 3, the sum of lines 19, 29, 30, 30.01, 31, and 31.01, times 1 percent. Enter in column 4, the sum of columns 2 and 3. Transfer the amount in column 4 to the cost report calculated settlement, Worksheet E, Part A, line 70.99.

EXHIBIT 5
HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION SCHEDULE

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5	PROVIDER CCN:	PERIOD: FROM:_____ TO:

		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)	Prior to 10/1	On or after 10/1	Total (cols. 2 and 3)	
		(0)	(1)	(2)	(3)	(4)	
1	DRG Amounts Other than Outlier Payments	1					1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01					1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02					1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03					1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04					1.04
2	Outlier payments for discharges (see instructions)	2					2
2.01	Outlier payment for discharges for Model 4 BPCI	2.02					2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03					2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04					2.03
3	Operating outlier reconciliation	2.01					3
4	Managed Care Simulated Payments	3					4
	Indirect Medical Education Adjustment						
5	Amount from Worksheet E, Part A, line 21 (see instructions)	21					5
6	IME payment adjustment (see instructions)	22					6
6.01	IME payment adjustment for managed care (see instructions)	22.01					6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7	IME payments adjustment factor (see instructions)	27					7
8	IME add-on adjustment amount (see instructions)	28					8
8.01	IME payment adjustment add-on for managed care (see instructions)	28.01					8.01
9	Total IME payment (sum of lines 6 and 8)	29					9
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01					9.01
	Disproportionate Share Adjustment						
10	Allowable disproportionate share percentage (see instructions)	33					10
11	Disproportionate share adjustment (see instructions)	34					11
11.01	Uncompensated care payments	36					11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12	Total ESRD additional payment (see instructions)	46					12
13	Subtotal (see instructions)	47					13
14	Hospital specific payments (completed by SCH and MDH, small rural hospitals only) (see instructions)	48					14
15	Total payment for inpatient operating costs (see instructions)	49					15
16	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50					16
17	Special add-on payments for new technologies	54					17
17.01	Net organ acquisition cost	55					17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68					17.02
18	Capital outlier reconciliation adjustment amount (see instructions)	93					18
19	SUBTOTAL						19
		Wkst. L, line	(Amt. from Wkst. L)				
		(0)	(1)	(2)	(3)	(4)	
20	Capital DRG other than outlier	1					20
20.01	Model 4 BPCI Capital DRG other than outlier	1.01					20.01
21	Capital DRG outlier payments	2					21
21.01	Model 4 BPCI Capital DRG outlier payments	2.01					21.01
22	Indirect medical education percentage (see instructions)	5					22
23	Indirect medical education adjustment (see instructions)	6					23
24	Allowable disproportionate share percentage (see instructions)	10					24
25	Disproportionate share adjustment (see instructions)	11					25
26	Total prospective capital payments (see instructions)	12					26
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		(0)	(1)	(2)	(3)	(4)	
27							27
28	Low-volume adjustment prior to October 1	70.96					28
29	Low-volume adjustment on or after October 1	70.97					29
30	HVBP payment adjustment (see instructions)	70.93					30
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90					30.01
31	HRR adjustment (see instructions)	70.94					31
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91					31.01
32	HAC Reduction Program adjustment (see instructions) (amount in col. 4 to Wkst. E, Pt. A)	70.99					32

4030.2 Part B - Medical and Other Health Services.--Use Worksheet E, Part B, to calculate reimbursement settlement for hospitals (including REHs), subproviders, SNFs and providers participating in the PARHM demonstration.

For IPPS hospitals participating in the PARHM demonstration during this cost reporting period and (1) the hospital participated in the PARHM demonstration for the entire cost reporting period, select the "PARHM Demonstration" box only and complete this worksheet; or (2) the hospital participated in the PARHM demonstration for a portion of the cost reporting period, select the "PARHM Demonstration" box and complete Worksheet E, Part B, for the portion of the cost reporting period included in the demonstration. Select the "Hospital" box and complete a separate Worksheet E, Part B, for the portion of the cost reporting period not included in the demonstration.

For hospitals participating in the PARHM demonstration for a portion of this cost reporting period, enter the applicable data on Worksheet E, Part B, for the PARHM demonstration. The data input for line 5 must be the same for the PARHM participation portion and non-participation portion of the cost reporting period.

Use a separate copy of Worksheet E, Part B, for each of these reporting situations. If you have more than one hospital-based subprovider or are a hospital participating in the PARHM demonstration, complete a separate worksheet for each facility and PARHM demonstration. Enter check marks in the appropriate spaces at the top of each page of Worksheet E to indicate the component program for which it is used. When the worksheet is completed for a component, show both the hospital and component numbers. For purposes of prospective payment for outpatient services when the PCR transition date (applicable to cancer hospitals) (see the following paragraph), transitional outpatient payment calculation date, or geographic reclassification date (urban to rural only) (42 CFR 412.103 and 412.230), occurs at other than the cost report period beginning date, complete subscripted column 1.01 in addition to column 1, for lines 2 through 8 only. Order the subscripted columns chronologically as the transition dates or geographic reclassification dates correspond to your fiscal year. The dates should also agree with the format on Worksheet D, Part V, columns 2, 2.01, 2.02, 2.03, etc., if applicable.

In accordance with ACA 2010, §3138, cancer hospitals (as defined in 42 CFR 412.23(f)) must utilize a predetermined target PCR to calculate the corresponding transitional outpatient payment effective for services rendered beginning January 1, 2012. Where the cost reporting period overlaps a target PCR revision date, subscript column 1 as indicated in the preceding paragraph to correspond to each target PCR period.

NOTE: If you are not a cancer or children's hospital or covered by ACA §3121, do not complete lines 2 and 5 through 8.

Line Descriptions

Line 1--Enter the cost of medical and other health services for title XVIII, Part B. This amount also includes the cost of ancillary services furnished to inpatients under the medical and other health services benefit of Medicare Part B. These services are covered in this manner for Medicare beneficiaries with Part B coverage only when Part A benefits are not available. Obtain this amount from Worksheet D, Part V, line 202, columns 6 and 7, for hospitals and enter in column 1. For SNFs transfer the amount from Worksheet D, Part V, columns 6 and 7.

The following providers are temporarily eligible for hold harmless payments and must use columns 1 and 1.01 to correspond to the respective portion of the cost reporting period for lines 2

through 8. Rural hospitals with 100 or fewer beds whose reporting period overlaps December 31, 2012, are eligible through December 31, 2012; SCHs and EACHs regardless of bed size whose reporting period overlaps February 29, 2012, are eligible through February 29, 2012; and SCHs and EACHs with 100 or fewer beds whose reporting period overlaps December 31, 2012, are eligible through December 31, 2012, (Worksheet S-2, Part I, line 120, column 1 or 2 is "Y" for yes).

CAHs are not subject to transitional corridor payments, therefore, lines 2 through 9 do not apply to CAHs. Transfer Worksheet D, Part V, columns 6 and 7, line 202.

Line 2--Enter the cost of medical and other health services reimbursed under OPPS from Worksheet D, Part V, column 5, and applicable subscripts, line 202. Subtract from this amount outpatient pass through costs reported on Worksheet D, Part IV, line 200, column 13.

Line 3--Enter the gross OPPS payments received including payment for drugs and device pass through payments.

REHs enter the gross OPPS payments (which are based on OPPS payment amounts plus 5 percent). See §1834(x)(1) of the Act.

Line 4--Enter the amount of outlier payments made for OPPS services rendered during the cost reporting period.

Contractors only, add or subtract, as applicable, to the gross OPPS payments the total outlier reconciliation amount from line 94. Effective for cost reporting periods ending on or after September 30, 2017, do not include the outlier reconciliation amount on this line, but rather enter the amount on line 4.01.

Line 4.01--Contractor use only: Effective for cost reporting periods ending on or after September 30, 2017, for OPPS services rendered during the cost reporting period, enter the operating outlier reconciliation amount for operating expenses from line 94.

Line 5--Enter the hospital specific payment to cost ratio provided by your contractor. If a new provider does not file a full cost report for a cost reporting period that ends prior to January 1, 2001, the provider is not eligible for transitional corridor payments and should enter zero (0) on this line. (See PM A-01-51.)

For a cancer hospital, enter the target PCR as published in the applicable OPPS final rule (or correction notice), and subscript column 1 for each PCR period when the cost reporting period overlaps a PCR revision date. See §4090, Table VI, for the PCRs beginning with CY 2012.

Line 6--Enter the result of line 2 times line 5.

If the sum of lines 3, 4, and 4.01, is less than line 6, complete lines 7 and 8; otherwise, do not complete lines 7 and 8.

Line 7--Enter the result of the sum of lines 3, 4, and 4.01, divided by line 6.

Line 8--Enter the transitional corridor payment amount calculated based on the following:

a. If the sum of lines 3, 4, and 4.01, is less than the amount on line 6, and Worksheet S-2, Part I, line 3, column 4, response is 3 or 7 (cancer or children's hospital, respectively), enter the result of line 6 minus the sum of lines 3, 4, and 4.01.

In accordance with ACA 2010, section 3121, and MMEA of 2010, section 108, as amended by the Temporary Payroll Tax Cut Continuation Act of 2011, section 308, and the Middle Class Tax Relief and Job Creation Act of 2012, section 3002, the outpatient hold harmless provision is effective for services rendered from January 1, 2010, through February 29, 2012, to all SCHs and

EACHs regardless of bed size; and from March 1, 2012, through December 31, 2012, to all SCHs and EACHs with 100 or fewer beds; and from January 1, 2010, through December 31, 2012, for rural hospitals with 100 or fewer beds.

a. For services rendered January 1, 2010, through December 31, 2012, if Worksheet S-2, Part I, line 120, column 1 or 2, is "Y", enter 85 percent of the result of line 6 minus the sum of lines 3 and 4.

Line 9--Enter the outpatient ancillary pass through amount from Worksheet D, Part IV, column 13, line 200. For cost reporting periods beginning on or after October 1, 2023, a REH that incurs costs of training full-time equivalent (FTE) residents that rotate to the REH may receive direct graduate medical education payments for those costs.

Line 10--If you are a CTC with an approved transplant program, enter the cost of organ acquisition from Worksheet D-4, Part III, column 2, line 69, when this worksheet is completed for the hospital. Do not complete this line for a hospital distinct part unit or subprovider. The Medicare program only reimburses CTCs for organ acquisition costs.

Line 11--Enter the sum of lines 1 and 10.

Computation of Lesser of Reasonable Cost or Customary Charges--You are paid the lesser of the reasonable cost of services furnished to beneficiaries or the customary charges made by you for the same services. This part provides for the computation of the lesser of reasonable cost or customary charges as defined in 42 CFR 413.13(a).

NOTE: CAHs and REHs are not subject to the computation of the lesser of reasonable costs or customary charges (42 CFR 413.13(c)(2)(vii)), and do not complete lines 12 through 20. Instead, enter on line 21 the amount computed on line 11.

Line Descriptions

NOTE: If the medical and other health services reported here qualify for exemption from the application of LCC (see 42 CFR 413.13(c)), also enter the total reasonable cost from line 11 directly on line 21. Still complete lines 6 through 16 to ensure that you meet one of the criteria for this exemption.

Lines 12 through 20--These lines provide for the accumulation of charges which relate to the reasonable cost on line 11.

Do not include on these lines: (1) the portion of charges applicable to the excess cost of luxury items or services (see CMS Pub. 15-1, chapter 21, §2104.3) and (2) charges to beneficiaries for excess costs. (See CMS Pub. 15-1, chapter 25, §§2570-2577.)

Line 12--For total charges for medical and other services, enter the sum of Worksheet D, Part V, columns 3 and 4, line 202.

Line 13--If you are an approved CTC, enter the organ acquisition charges from Worksheet D-4, Part III, column 4, line 69, for the hospital.

Line 14--Enter the sum of lines 12 and 13.

Lines 15 through 18--These lines provide for the reduction of program charges when you do not actually impose such charges on most of the patients liable for payment for services on a charge basis or fail to make reasonable efforts to collect such charges from those patients. If line 17 is greater than zero, multiply line 14 by line 17, and enter the result on line 18. If you impose these charges and make reasonable efforts to collect the charges from patients liable for payment for services on a charge basis, you are not required to complete lines 15 through 17. Enter on line 18 the amount from line 14. In no instance may the customary charges on line 18 exceed the actual charges on line 14. (See 42 CFR 413.13(e).)

Line 19--Enter the excess of the customary charges over the reasonable cost. If line 18 exceeds line 11, enter the difference.

Line 20--Enter the excess of reasonable cost over the customary charges. If line 11 exceeds line 18, enter the difference.

Line 21--Enter the amount from line 11, less any amount reported on line 20 for hospital/services subject to LCC.

For hospital/services that are not subject to LCC in accordance with 42 CFR 413.13 (e.g., nominal charge public or private hospitals identified on Worksheet S-2, Part I, lines 155 through 161), enter the reasonable costs from line 11.

For CAHs enter on this line 101 percent of line 11.

Line 22--Enter the cost of services rendered by interns and residents as follows from Worksheet D-2.

Provider/Component	Title XVIII Hospital	Title XVIII Subprovider	Title XVIII SNF
Hospital	Part I, col. 9, line 9, plus line 27; or Part II, col. 7, line 37; or Part III, col. 6, line 45	Part I, col. 9, lines 10, 11, or 12; or Part II, col. 7, lines 38, 39, or 40; or Part III, col. 6, line 46, 47, or 48	Part I, col. 9, line 13; or Part II, col. 7, line 41; or Part III, col. 6, line 49

Line 23--Teaching hospitals or subproviders participating in an approved GME program, electing to be reimbursed for services of physicians on the basis of reasonable cost (see 42 CFR 415.160 and CMS Pub. 15-1, chapter 21, §2148), enter the cost of physicians. For cost reporting periods ending before June 30, 2014, transfer the amount from Worksheet D-5, Part II, line 21, column 3. For cost reporting periods ending on or after June 30, 2014, transfer the amount from Worksheet D-5, Part IV, line 21.

Line 24--Enter the sum of lines 3, 4, 4.01, 8, and 9, all columns.

Computation of reimbursement Settlement

Line 25--Enter the Part B deductible and the Part B coinsurance amounts billed to Medicare beneficiaries. DO NOT INCLUDE deductible or coinsurance amounts billed to program patients for physicians' professional services. If a hospital bills beneficiaries a discounted amount for coinsurance, enter on this line the full coinsurance amount, not the discounted amount. For provider Part B services exempt from LCC, enter only the Part B deductible amounts billed to the program beneficiaries, as reimbursement for those services is based on 80 percent of reasonable cost net of the Part B deductible amounts. Do not enter any Part B coinsurance amounts for those provider Part B services exempt from LCC.

Line 26--Enter the deductible and coinsurance amounts relating to the amounts reported on line 24.

NOTE: If these services are exempt from LCC as a result of charges being equal to or less than 60 percent of cost (refer to Worksheet S-2, Part I, lines 155 through 161, columns 1 through 5, as applicable), enter the Part B deductible amounts billed to program beneficiaries only. Do not enter any Part B coinsurance. For CAHs, enter the deductible amounts on line 25, and the coinsurance amounts on line 26.

Line 27--Subtract lines 25 and 26 from lines 21 and 24, respectively. Add to that result the sum of lines 22 and 23.

NOTE: If these services are exempt from LCC, (line 21 minus line 25 minus Worksheet D, Part V, line 202, column 7) times 80 percent, then add back Worksheet D, Part V, line 202, column 7, plus lines 22 and 23. Add to that result line 24 minus line 26.

CAHs enter the lesser of (line 21 minus the sum of lines 25 and 26) or 80 percent times the result of (line 21 minus line 25 minus 101 percent of lab cost (Worksheet D, Part V, column 6, lines 60, 61, and subscripts) minus 101 percent of costs not subject to deductible and coinsurance (Worksheet D, Part V, column 7, line 202). Add back the aforementioned 101 percent of lab cost and 101 percent of cost not subject to deductibles and coinsurance. Add to that result the sum of lines 22 and 23.

Line 28--Enter in column 1, the amount from Worksheet E-4, line 50. Complete this line for the hospital component only.

Line 28.50--Enter the total REH facility payment amount determined prior to the application of the sequestration adjustment. See §1834(x)(2) of the Act, as implemented by §125 of the CAA 2021.

Line 29--Enter in column 1, the amount from Worksheet E-4, line 36. Complete this line for the hospital component only.

Line 30--Enter in column 1, the sum of columns 1 and 1.01, lines 27, 28, 28.50, and 29.

Line 31--Enter the amounts paid or payable by workers' 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:

- Workers' compensation,
- No fault coverage,
- General liability coverage,
- Working aged provisions,
- Disability provisions, and
- Working ESRD provisions.

Generally, when payment by the primary payer satisfies the total liability of the program beneficiary, the services are treated as if they were non-program services for cost reporting purposes only. (The primary payment satisfies the beneficiary's liability when you accept that payment as payment in full. This is noted on no-pay bills submitted in these situations.) Include the patient charges in total charges but not in program charges. In this situation, enter no primary payer payment on line 31. In addition, exclude amounts paid by other primary payers for outpatient dialysis services reimbursed under the composite rate system.

However, when the payment by the primary payer does not satisfy the beneficiary's obligation, the program pays the lesser of (a) the amount it otherwise pays (without regard to the primary payer payment or deductible and coinsurance) less the primary payer payment, or (b) the amount it otherwise pays (without regard to the primary payer payment or deductible and coinsurance) less applicable deductible and coinsurance. Credit primary payer payment toward the beneficiary's deductible and coinsurance obligation.

When the primary payment does not satisfy the beneficiary's liability, include the covered charges in program charges, and include the charges in charges for cost apportionment purposes. Enter the primary payer payment on line 31 to the extent that primary payer payment is not credited toward the beneficiary's deductible and coinsurance. Primary payer payments credited toward the beneficiary's deductible and coinsurance are not entered on line 31.

Line 32--Enter line 30 minus line 31.

Line 33--Enter the amount of allowable bad debts for deductibles and coinsurance for ESRD services reimbursed under the composite rate system from Worksheet I-5, line 11.

Allowable bad debts (Exclude bad debts for professional services)

Line 34--Enter, from your records, allowable bad debts for deductibles and coinsurance net of recoveries for other services, excluding professional services. Do not include ESRD bad debts. These are reported on line 33. Bad debts associated with ambulance services rendered (since these costs are reimbursed on a fee basis) are not allowable. If recoveries exceed the current year's bad debts, lines 34 and 35 will be negative. (See 42 CFR 413.89.)

Line 35--Multiply the amount (including negative amounts) on line 34 times 70 percent (hospitals and subproviders only). The reduction does not apply to CAHs. For cost reporting periods that begin on or after October 1, 2012, multiply the amount (including negative amounts) on line 34 by 65 percent (hospitals and subproviders only). For CAHs with cost reporting periods beginning on or after October 1, 2012, multiply the amount on line 34 (including negative amounts) by 88 percent. For cost reporting periods beginning on or after October 1, 2013, multiply the amount on line 34 by 76 percent. For cost reporting periods beginning on or after October 1, 2014, multiply the amount on line 34 by 65 percent.

For SNFs with cost reporting periods beginning prior to October 1, 2012, enter the amount on line 34. For cost reporting periods beginning on or after October 1, 2012, calculate this line as follows: [((line 34 - line 36) * 65 percent) + (line 36 * 88 percent)]. For cost reporting periods beginning on or after October 1, 2013, calculate this line as follows: [((line 34 - line 36) * 65 percent) + (line 36 * 76 percent)]. For cost reporting periods beginning on or after October 1, 2014, multiply the amount on line 34 by 65 percent.

Line 36--Enter the gross allowable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only except for the calculation of dual eligible bad debts for SNFs cost reporting periods beginning on or after October 1, 2012. This amount must also be reported on line 34.

Line 37--Enter the sum of lines 32, 33 and 34 or 35 (hospitals and subproviders only). For cost reporting periods beginning on or after October 1, 2012, enter the sum of lines 32, 33, and 35 (hospital, CAH, subproviders and SNFs).

Line 38--Enter the MSP-LCC reconciliation amount. Obtain this amount from the PS&R.

Line 39--Enter any other adjustments. Specify the adjustment in the space provided.

Line 39.50--Enter the Pioneer ACO demonstration payment adjustment amount. Obtain this amount from the PS&R. Do not use this line for services rendered on or after January 1, 2017. Report any ACO demonstration payment adjustments for services on or after January 1, 2017, on line 39.97 or line 40.02, accordingly.

Line 39.75--Transfer the N95 respirator payment adjustment amount for the hospital, IPF subprovider, or IRF subprovider, from Worksheet E-95, Part III, line 4, column 2, 3, or 4, respectively.

Line 39.97--Enter any demonstration payment adjustment amounts for all demonstration projects in which the provider participated where the demonstration adjustment amounts are subject to the sequestration adjustment. Obtain this amount from the PS&R. Do not include payment demonstration adjustment amounts included on line 39.50.

Line 39.98--Enter from the PS&R, the partial or full credits received from manufacturers for replaced devices. See CMS Pub. 100-04, chapter 4, §61.3. This is captured for informational purposes only.

Line 39.99--Enter the program share of any recovery of accelerated depreciation applicable to prior periods resulting from your termination or a decrease in Medicare utilization. (See CMS Pub. 15-1, chapter 1, §§136-136.16, and 42 CFR 413.134(d)(3)(i).)

Line 40--Enter the result of line 37, plus line 39 and its subscripts not previously identified (excluding line 39.98 that is for informational purposes only) plus line 39.75, minus lines 38, 39.50, 39.97, and 39.99.

Line 40.01--For cost reporting periods that overlap or begin on or after April 1, 2013, calculate the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur during the sequestration period, divided by total days in the entire cost reporting period, rounded to six decimal places), rounded to four decimal places) times line 40]. Do not apply the sequestration calculation when gross reimbursement (line 40) is less than zero. In accordance with §3709 of the CARES Act, as amended by §102 of the CAA 2021, §1 of Public Law 117-7, and §2 of the PAMA 2021, do not apply the sequestration adjustment to the period of May 1, 2020, through March 31, 2022. In accordance with §2 of the PAMA 2021, for cost reporting periods that overlap or begin on or after April 1, 2022, calculate the sequestration adjustment amount for the period of April 1, 2022, through June 30, 2022, as follows: [(1 percent times (total days in the cost reporting period that occur from April 1, 2022, through June 30, 2022, divided by total days in the entire cost reporting period, rounded to six decimal places), rounded to four decimal places), times line 40]; and for cost reporting periods that overlap or begin on or after July 1, 2022, calculate the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur on or after July 1, 2022, through the end of the cost reporting period, divided by total days in the entire cost reporting period, rounded to six decimal places), rounded to four decimal places) times line 40].

Line 40.02--Enter any demonstration payment adjustment amounts for demonstration projects in which the provider participated where the demonstration adjustment amounts are not subject to the sequestration adjustment. Obtain this amount from the PS&R.

Line 40.03--This line is a subset of line 40.01. Calculate the sequestration adjustment amount for the portion of the cost reporting period that the hospital participated in the PARHM demonstration. Calculate the sequestration adjustment amount as [(2 percent times (total days in the cost reporting period that occur during the sequestration period, divided by total days in the entire cost reporting period, rounded to six decimal places), rounded to four decimal places) times the sum of lines 9, 10, 22, 28, 29, and 35]. In accordance with §3709 of the CARES Act, as amended by §102 of the CAA 2021, §1 of Public Law 117-7, and §2 of the PAMA 2021, do not apply the sequestration adjustment to the period of May 1, 2020, through March 31, 2022. In accordance with §2 of the PAMA 2021, for cost reporting periods that overlap or begin on or after April 1, 2022, calculate the sequestration adjustment amount for the period of April 1, 2022, through June 30, 2022, as follows: [(1 percent times (total days in the cost reporting period that occur from April 1, 2022, through June 30, 2022, divided by total days in the entire cost reporting period, rounded to six decimal places), rounded to four decimal places), times the sum of (lines 9, 10, 22, 28, 29, and 35)]; and for cost reporting periods that overlap or begin on or after July 1, 2022, calculate the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur on or after July 1, 2022, through the end of the cost reporting period, divided by total days in the entire cost reporting period, rounded to six decimal places), rounded to four decimal places) times the sum of (lines 9, 10, 22, 28, 29, and 35)].

Line 41--Enter interim payments from Worksheet E-1, column 4, line 4. For contractor final settlements, enter the amount reported on line 5.99 on line 42. For contractor purposes, it will be necessary to make a reclassification of the bi-weekly pass through payments from Part A to Part B, and report that Part B portion on line 42. Maintain the necessary documentation to support the amount of the reclassification.

Line 41.01--This line is a subset of line 41. Enter the interim pass-through payments received (or receivable) for the portion of the cost reporting period that the hospital participated in the PARHM demonstration. These payments should include bi-weekly pass through payments as well as any lump sum adjustments received for bad debts, organ acquisition costs, and medical education (DGME and NAHE).

Line 42--Tentative settlement amount (transfer this amount from Worksheet E-1, Part I, column 4, line 5.99).

Line 42.01--Tentative settlement amount PARHM demonstration (enter the tentative settlement amount from the PARHM demonstration Worksheet E-1, Part I, column 4, line 5.99).

Line 43--Enter line 40 minus the sum of lines 40.01, 40.02, 41 and 42. Transfer this amount to Worksheet S, Part III, column 3, line as appropriate. For providers participating in the PARHM demonstration, do not transfer amounts from this line. See line 43.01 for instruction.

Line 43.01--For providers participating in the PARHM demonstration complete this line for the settlement of pass-through payments paid outside of the PARHM demonstration. The amount reported on this line is a subset of the amount reported on line 43. Enter the sum of lines 9, 10, 22, 28, 29, and 35, minus lines 40.03, 41.01 and 42.01. Transfer to Worksheet S, Part III, column 3, line 1.01.

Line 44--Enter the program reimbursement effect of protested items. Estimate the reimbursement effect of the nonallowable items by applying a reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See CMS Pub. 15-2, chapter 1, §115.2.) Attach a schedule showing the details and computations for this line.

Lines 45 through 89 were intentionally skipped to accommodate future revisions to this worksheet.

DO NOT COMPLETE THE REMAINDER OF WORKSHEET E, PART B. LINES 90 THROUGH 94 ARE FOR CONTRACTOR USE ONLY.

Line 90--Enter the original outlier amount from line 4 (sum of all columns) prior to the inclusion of line 94 of Worksheet E, Part B.

Line 91--Enter the outlier reconciliation adjustment amount in accordance with CMS Pub. 100-04, chapter 4, §§10.7.2.2-10.7.2.4.

Line 92--Enter the rate used to calculate the time value of money. (See CMS Pub. 100-04, chapter 4, §§10.7.2.2-10.7.2.4.)

Line 93--Enter the time value of money.

Line 94--Enter sum of lines 91 and 93.

4031. WORKSHEET E-1 - ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

4031.1 Part I - Analysis of Payments to Providers for Services Rendered.--

Complete this worksheet for each component of the health care complex which has a separate provider or subprovider number as shown on Worksheet S-2, Part I. Hospitals that participated in the PARHM demonstration must complete a separate Worksheet E-1 for each PARHM demonstration E series worksheet (i.e., Worksheets E, Part A; E, Part B; E-2; and E-3, Part V). If you have more than one hospital-based subprovider, complete a separate worksheet for each facility. When the worksheet is completed for a component, show both the hospital provider number and the component number. Complete this worksheet only for Medicare interim payments paid by the contractor. Do not complete it for purposes of reporting interim payments for titles V or XIX or for reporting payments made under the composite rate for ESRD services. Providers paid on an interim basis on periodic interim payment (PIP) adjust the interim payments for MSP/LCC claims.

For IPPS hospitals participating in the PARHM demonstration during this cost reporting period and (1) the hospital participated in the PARHM demonstration for the entire cost reporting period, select the "PARHM Demonstration" box only and complete this worksheet; or (2) the hospital participated in the PARHM demonstration for a portion of the cost reporting period, select the "PARHM Demonstration" box and complete Worksheet E-1, for the portion of the cost reporting period included in the demonstration. Select the "Hospital" box and complete a separate Worksheet E-1, for the portion of the cost reporting period not included in the demonstration.

The following components use the indicated worksheet instead of Worksheet E-1:

- Hospital-based HHAs use Worksheet H-5.
- Hospital-based outpatient rehabilitation facilities use Worksheet J-4.
- Hospital-based RHCs/FQHCs use Worksheet M-5.
- Hospital-based FQHCs under FQHC PPS use Worksheet N-5.

The column headings designate two categories of payments:

Columns 1 and 2 - Inpatient Part A
Columns 3 and 4 - Part B

Complete lines 1 through 4. The remainder of the worksheet is completed by your contractor. All amounts reported on this worksheet must be for services, the costs of which are included in this cost report.

NOTE: When completing the heading, enter the provider number and the component number which corresponds to the provider, subprovider, SNF, or swing-bed SNF which you indicated.

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

DO NOT include fee-schedule payments for ambulance services rendered.

* For the PARHM demonstration Worksheet E-1, only complete information related to non-claims-based payments (pass through payments for DGME, organ acquisition costs, bad debt and NAHE costs)

Line Descriptions

Line 1--Enter the total Medicare interim payments paid to you (excluding payments made under the composite rate for ESRD services), including amounts paid under PPS, pass through payments, payments from the supplemental PS&R associated with the Model 4 BPCI, OPPS payments for IOP services, REH outpatient services, and REH facility payment amounts paid, in accordance with §1834(x) of the Act, and volume decrease adjustment payments received for SCHs and MDHs as reported on Worksheet E, Part A, line 70.88. The amount entered must reflect 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 must also include amounts withheld from your interim payments due to an offset against overpayments applicable to the prior cost reporting periods. Do not include (1) any retroactive lump sum adjustment amounts based on a subsequent revision of the interim rate, (2) tentative or net settlement amounts, or (3) interim payments payable. If you are reimbursed under the periodic interim payment method of reimbursement, enter the periodic interim payments received for this cost reporting period. For the PARHM demonstration worksheet do not include PPS payment amounts. Include pass-through payments for DGME, organ acquisition, bad debt, and NAHE only.

Line 2--Enter the total Medicare interim payments (excluding payments made under the ESRD composite rate) 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. Also, include in column 4 the total Medicare payments payable for servicing home program renal dialysis equipment when the provider elected 100 percent cost reimbursement. For the PARHM demonstration model worksheet do not complete this line.

Line 3--Enter the amount of each retroactive lump sum adjustment and the applicable date. For the PARHM demonstration worksheet only include lump sum payment adjustments to pass through payments for the applicable period.

Line 4--Enter the total amount of the interim payments (sum of lines 1, 2, and 3.99). Transfer as follows (* use these lines on the applicable PARHM worksheet):

Reimbursement Method	From Column	Transfer To
Part B Payments	4	Wkst. E, Part B, line 41 (*41.01)
Part A Payments		
IPPS	2	Wkst. E, Part A, line 72 (*72.01)
TEFRA	2	Wkst. E-3, Part I, line 19
IPF PPS	2	Wkst. E-3, Part II, line 32
IRF PPS	2	Wkst. E-3, Part III, line 33
LTC PPS	2	Wkst. E-3, Part IV, line 23
Cost	2	Wkst. E-3, Part V, line 31 (*31.01)
SNF PPS Title XVIII	2	Wkst. E-3, Part VI, line 16

NOTE: For a swing-bed SNF, transfer the column 2, line 4, and column 4, line 4, amounts to Worksheet E-2, columns 1 and 2, line 20 (*20.01), respectively.

PROVIDERS DO NOT COMPLETE THE REMAINDER OF WORKSHEET E-1. LINES 5 THROUGH 8 ARE FOR CONTRACTOR USE ONLY. (EXCEPTION: IF WORKSHEET S, PART I, LINE 5, IS "5" (AMENDED COST REPORT), THE PROVIDER MAY COMPLETE THIS SECTION.)

Line 5--List separately each settlement payment after the cost report is received together with the date of payment. If the cost report is reopened after the NPR has been issued, continue to report all settlement payments after the cost report is received separately on this line. For the PARHM demonstration worksheet only include tentative settlement payment amounts applicable to the PARHM demonstration payment (global payment adjustments, pass through payment amounts and bad debts for the applicable period).

Line 6--Enter the net settlement amount (balance due the provider or balance due the program). Obtain the amounts as follows:

Worksheet E-1, Column as Indicated	From Settlement Worksheet
2	Wkst. E, Part A, line 74 (*74.01)
4	Wkst. E, Part B, line 43 (*43.01)
2	Wkst. E-3, Part I, line 21
2	Wkst. E-3, Part II, line 34
2	Wkst. E-3, Part III, line 35
2	Wkst. E-3, Part IV, line 25
2	Wkst. E-3, Part V, line 33 (*33.01)
2	Wkst. E-3, Part VI, line 18

For swing-bed SNF services, column 2 must equal Worksheet E-2, column 1, line 22. Column 4 must equal Worksheet E-2, column 2, line 22 (*22.01).

* Line references for PARHM demonstration worksheet.

NOTE: On lines 3, 5, and 6, when a provider to program amount is due, 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 in columns 2 and 4, the sum of lines 4 through 6. Enter amounts due the program as a negative number. These amounts must agree with amount due provider reported on Worksheet E, Part A, line 71, less the amounts on lines 71.01 and 71.02 (for PARHM demonstration Worksheet E, Part A, sum of lines 52, 53, 55, 57, 58 and 65, minus line 71.03); Worksheet E, Part B, line 40, less the amounts on lines 40.01 and 40.02 (for PARHM demonstration Worksheet E, Part B, sum of lines 11, 22, 23, 28, 29, and 35, minus line 40.03); Worksheet E-2, line 19, less the amounts on lines 19.01, 19.02, and 19.25 (for PARHM demonstration Worksheet E-2, sum of lines 3.01 and 17.01, minus line 19.03); Worksheet E-3, Part I, line 18, less the amounts on lines 18.01 and 18.02; Worksheet E-3, Part II, line 31, less the amounts on lines 31.01 and 31.02; Worksheet E-3, Part III, line 32, less the amounts on lines 32.01 and 32.02; Worksheet E-3, Part IV, line 22, less the amounts on lines 22.01 and 22.02; Worksheet E-3, Part V, line 30, less the amounts on lines 30.01 and 30.02 (for PARHM demonstration Worksheet E-3, Part V, sum of lines 2, 3, 18, and 26, minus line 30.03); and Worksheet E-3, Part VI, line 15, less the amounts on lines 15.01, 15.02, and 15.75.

Line 8--Enter the contractor name, the contractor number and NPR date in columns 0, 1, and 2, respectively.

4031.2 Part II - Calculation of Reimbursement Settlement for Health Information Technology.--

THIS PART IS COMPLETED BY THE CONTRACTOR FOR STANDARD COST REPORTING PERIODS AND BY THE CONTRACTOR FOR NONSTANDARD COST REPORTING PERIODS. Hospitals that qualify for the HIT incentive payment under ARRA 2009, §4120, complete this worksheet for cost reporting periods ending on or before September 30, 2016; do not complete this worksheet for cost reporting periods beginning on or after October 1, 2016. Hospitals that qualify for the HIT incentive payment under CAA 2016, §602, complete this worksheet for cost reporting periods ending on or before September 30, 2021; do not complete this worksheet for cost reporting periods beginning on or after October 1, 2021.

In accordance with the ARRA of 2009, §4102, inpatient acute care services under IPPS for providers subject to §1886(d) of the Act, and CAHs are eligible for HIT payments. The CAA 2016, §602, added subsection (d) hospitals in Puerto Rico as hospitals eligible for HIT payments. Puerto Rico hospitals may begin participation for EHR reporting periods in 2016.

This part captures relevant data used to compute the HIT payment and records the single HIT initial payment paid by the contractor to the provider and any corresponding adjustments to this initial payment.

Data Collection Required for the Health Information Technology Calculation--

NOTE: Lines 1 through 7 must transfer data as indicated below for reporting periods which cover exactly 12 months (referred to as standard cost reporting periods and covers a range of 360 through 371 days). For cost reporting periods which cover other than exactly 12 months (less than or greater than 12 months) (referred to as non-standard cost reporting periods and covers a range of less than 360 days or greater than 371 days), lines 1 through 8 must be directly input by the contractor.

NOTE: For standard cost reporting periods, the provider will complete lines 30 and 31 in the "as filed" cost report, and the amount computed on line 32 will be transferred to Worksheet S, Part III, column 4. For non-standard cost reporting periods, the "as filed" cost report will display zeroes on all lines, and a zero will be transferred from line 32 to Worksheet S, Part III, column 4. The contractor must complete this worksheet for non-standard cost reporting periods at cost report settlement.

Line 1--As defined in ARRA, §4102, transfer the total hospital discharges from Worksheet S-3, Part I, column 15, line 14.

Line 2--Transfer the Medicare days from Worksheet S-3, Part I, column 6, sum of lines 1, 8 through 12, and, for cost reporting periods beginning on or after October 1, 2013, line 32.

Line 3--Transfer the Medicare HMO days from Worksheet S-3, Part I, column 6, line 2.

Line 4--Transfer the total inpatient days from Worksheet S-3, Part I, column 8, sum of lines 1, 8 through 12, and, for cost reporting periods beginning on or after October 1, 2013, line 32.

Line 5--Transfer the hospital charges from Worksheet C, Part I, column 8, line 200.

Line 6--Transfer the hospital charity care charges from Worksheet S-10, column 3, line 20.

Line 7--CAHs only, transfer the reasonable costs to purchase certified HIT technology from Worksheet S-2, Part I, line 168.

Line 8--Calculate and enter the HIT payment in accordance with ARRA, §4102, as indicated below. This line can be overridden by the contractor in instances where the provider's circumstances require a customized HIT calculation. The HIT payment calculation uses a Medicare share calculation defined as follows:

> EHR Medicare share: (Part A days + Part C days) ÷ [(total inpatient days) × ((total hospital charges - charity care charges) ÷ total hospital charges)].

The EHR Medicare share is expressed as {(H1/(line 4 × H2)} in the CAH HIT calculation (see following paragraphs), and as {(H2/(line 4 × H3)} for the IPPS hospital HIT calculation (see following paragraphs). The EHR Medicare share calculation is rounded to four decimal places, with no rounding of the imbedded calculations.

For CAHs, if Worksheet S-2, lines 105 and 167, are both "Y" for yes, enter the result of {(H1)/(line 4 x H2)} rounded to four decimal places + .20 times the amount on Worksheet S-2, Part I, line 168. (Note: the result of {(H1)/(line 4 x H2)} + .20 cannot exceed 100 percent.) The resulting amount must be fully expensed in the current reporting period. H1 = line 2 plus line 3. H2 = total charges from Worksheet C, Part I, column 8, line 200, minus charity care charges from Worksheet S-10, column 3, line 20, divided by Worksheet C, Part I, column 8, line 200.

OR

For an acute care IPPS hospital (§1886(d) of the Act), or a subsection (d) hospital in Puerto Rico (eligible for the HIT payment under §602 of the CAA 2016), if Worksheet S-2, line 105, is "N" for no and line 167 is "Y" for yes, enter the result of {($2,000,000.00 + H1) x {(H2)/(line 4 x H3)} rounded to four decimal places x H4}. If line 1 is less than 1,150 discharges, then H1 equals 0 (zero). If line 1 equals 1,150 through 23,000 discharges, then H1 equals the result of line 1 minus 1,149 times $200. If line 1 is greater than or equal to 23,000 discharges, then H1 = $4,370,200 [that is: 23,000 minus 1,149 times $200]. H2 = line 2 plus line 3. H3 = total charges from Worksheet C, Part I, column 8, line 200, minus charity care charges from Worksheet S-10, column 3, line 20, divided by Worksheet C, Part I, column 8, line 200. H4 = the transition factor from Worksheet S-2, Part I, line 169.

Line 9--If the EHR reporting period ending date on Worksheet S-2, line 170, column 2, is on or after April 1, 2013, enter the sequestration adjustment amount as follows: [2 percent times line 8].

If the EHR reporting period ending date on Worksheet S-2, line 170, column 2, is on or after April 1, 2013, calculate the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur during the sequestration period, divided by total days in the entire cost reporting period, rounded to six decimal places), rounded to four decimal places) times line 8]. In accordance with §3709 of the CARES Act, as amended by §102 of the CAA of 2021, §1 of Public Law 117-7, and §2 of the PAMA 2021, do not apply the sequestration adjustment to the period of May 1, 2020, through March 31, 2022. In accordance with §2 of the PAMA 2021, for cost reporting periods that overlap or begin on or after April 1, 2022, calculate the sequestration adjustment amount for the period of April 1, 2022, through June 30, 2022, as follows: [(1 percent times (total days in the cost reporting period that occur from April 1, 2022, through June 30, 2022, divided by total days in the entire cost reporting period, rounded to six decimal places), rounded to four decimal places), times line 8]; and for cost reporting periods that overlap or begin on or after July 1, 2022, calculate the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur on or after July 1, 2022, through the end of the cost reporting period, divided by total days in the entire cost reporting period, rounded to six decimal places), rounded to four decimal places) times line 8].

Line 10--Calculate and enter the HIT payment after application of the sequestration adjustment by entering the result of line 8 minus line 9.

Lines 11 through 29--Reserved for future use.

Inpatient Hospital Services Under the IPPS & CAH--

Line 30--Enter the initial (first) payment received for HIT assets for this cost reporting period. This initial payment is a single payment for the cost reporting period rather than a series of periodic interim payments during the period. This line must be completed by the providers for standard cost reporting periods and by the contractors for nonstandard cost reporting periods.

Line 31--Enter the sum of all additional initial payment adjustments, as applicable for this cost reporting period. Enter a positive amount on this line if the sum of the initial payment adjustments represents an increase to the initial payment. Enter a negative amount on this line if the sum of the initial payment adjustments represents a decrease to the initial payment.

Line 32--Balance Due Provider/(Program)--Calculate and enter the result of line 8 minus the sum of lines 30 and 31. Effective for cost reporting periods that overlap or begin on or after April 1, 2013, calculate and enter the result of line 10 minus the sum of lines 30 and 31. Transfer this amount to Worksheet S, Part III, column 4, line 1.

4032. WORKSHEET E-2 - CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING-BEDS

This worksheet provides for the reimbursement calculation for swing-bed services rendered to program patients under titles V, XVIII, and XIX. It provides for an accumulation of reimbursable costs determined on various worksheets within the cost report package. It also provides (under Part B) for the computation of the lesser of 80 percent of reasonable cost after deductibles or reasonable cost minus coinsurance and deductibles. These worksheets have been designed so that components must prepare a separate worksheet for swing-bed SNF title XVIII, Parts A and B, and separate worksheets for swing-bed NF for title V and title XIX. Use column 1 only on the worksheets for title V and title XIX. Indicate the use of each worksheet by checking the appropriate boxes.

For IPPS hospitals participating in the PARHM demonstration during this cost reporting period and (1) the hospital participated in the PARHM demonstration for the entire cost reporting period, select the "PARHM CAH Swing-Bed SNF" box and complete this worksheet; or (2) the hospital participated in the PARHM demonstration for a portion of the cost reporting period, select the "PARHM CAH Swing-Bed SNF" box and complete Worksheet E-2, for the portion of the cost reporting period included in the demonstration. Select the "Swing-Bed SNF" box and complete a separate Worksheet E-2, for the portion of the cost reporting period not included in the demonstration.

Lines 1 through 9--Enter in the appropriate column on lines 1 through 7, the indicated costs for each component of the health care complex.

Line 1--Post-hospital swing-beds in rural hospitals (other than CAHs) are paid in accordance with SNF PPS. Enter the total SNF PPS payments in column 1 or 2, as applicable, from the provider's books and records or the PS&R. (See 42 CFR 413.114(a)(2).) For CAHs, transfer 101 percent of the cost of swing-bed SNF inpatient routine services from Worksheet D-1, Part II, line 66.

Do not use lines 2 and 3, column 1, for swing-bed SNF PPS providers.

Line 2--Enter the cost of swing-bed NF inpatient routine services from Worksheet D-1, Part II, line 69 (titles V and XIX only). Make no entry on line 2 when Worksheet E-2 is used for swing-bed SNF.

Line 3--Enter the amount of ancillary services provided by swing-bed-SNFs for vaccines (pneumococcal, influenza, COVID-19, and monoclonal antibody products for treatment of COVID-19) that are cost reimbursed in column 2. For CAH title XVIII services, transfer 101 percent of the amounts from the applicable worksheets and, for swing-bed SNF services that are cost reimbursed, transfer 100 percent of the amount from the applicable worksheet:

Title V	from	Worksheet D-3, col. 3, line 200
Title XVIII, Part A	from	Worksheet D-3, col. 3, line 200
Title XVIII, Part B	from	The sum of Worksheet D, Part V, columns 6 and 7, line 202
Title XIX	from	Worksheet D-3, col. 3, line 200

Enter title XVIII, Part B amounts only in column 2. Enter all other amounts in column 1.

For swing-bed pass through costs, transfer the title XVIII, Part A amounts from Worksheet D, Part IV, column 11, line 200.

Line 3.01--This line is a subset of line 3. Amounts included are from Worksheet D, Part IV, column 11, line 200. Only those participating in the PARHM demonstration complete this line.

Line 4--Enter (in column 1 for titles V and XIX and in column 2 for title XVIII) the per diem cost for interns and residents not in an approved teaching program transferred from Worksheet D-2, Part I, column 4, line 2.

Line 5--For title XVIII, enter in column 1 the total number of days in which program swing-bed SNF patients were inpatients. Transfer these days from Worksheet D-1, Part I, sum of lines 10 and 11. For titles V or XIX, enter in column 1 the total number of days in which program swing-bed NF patients were inpatients. Transfer these days from Worksheet D-1, Part I, sum of lines 12 and 13. For title XVIII, enter in column 2, the total number of days in which Medicare swing-bed beneficiaries were inpatients and had Medicare Part B coverage. Determine such days without regard to whether Part A benefits were available. Submit a reconciliation with the cost report demonstrating the computation of Medicare Part B inpatient days.

The following reconciliation format is recommended:

Part A Inpatient Days	Plus	Part B Only Days	Minus	Part A Coverage But No Part B Days Coverage	Equals	Medicare Part B Days

NOTE: See §4026.1.

Line 6--Enter the amount on line 4 multiplied by the number of days recorded on line 5, plus, if the hospital qualifies for the exception for GME payments in 42 CFR 413.77(e)(1), the amount from Worksheet D-2, Part II, column 7, line 30. Effective for cost reporting periods beginning on or after December 27, 2020, do not include the amount from Worksheet D-2, Part II, column 7, line 30, as the exception for direct GME payments no longer applies.

Line 7--If Worksheet E-2 is completed for a certified SNF, enter the applicable program's share of the reasonable compensation paid to physicians for services on utilization review committees applicable to the SNF.

Line 8--Enter the sum of lines 1 through 3, plus lines 6 and 7, for each column.

Line 9--Enter any amounts paid and/or payable by workers' compensation and other primary payers. (See instructions for Worksheet E, Part A, line 60, in §4030.1 for further clarification.)

Line 10--Line 8 minus line 9.

Line 11--Enter the deductible billed to program patients. DO NOT INCLUDE deductible applicable to physician professional services. Obtain this amount from your records.

Line 12--Enter line 10 minus line 11.

Line 13--Enter from your records the amounts billed to program patients for coinsurance. DO NOT INCLUDE coinsurance billed to program patients for physician professional services.

Line 14--For cost reporting periods beginning before September 30, 2019, in column 2, enter 80 percent of the amount on line 12. For cost reporting periods ending on or after September 30, 2019, do not complete this line.

Line 15--For cost reporting periods beginning before September 30, 2019, enter the lesser of line 12, less line 13, or line 14. For cost reporting periods ending on or after September 30, 2019, enter the amount of line 12, less line 13.

Line 16--Enter any other adjustments.

Line 16.50--Enter the Pioneer ACO demonstration payment adjustment amount. Obtain this amount from the PS&R. Do not use this line for services rendered on or after January 1, 2017. Report any ACO demonstration payment adjustments for services on or after January 1, 2017, on line 16.99 or line 19.02, accordingly.

Line 16.55--Enter the §410A rural community hospital demonstration project payment adjustment amount.

Line 16.99--Enter any demonstration payment adjustment amounts for demonstration projects in which the provider participated where the demonstration adjustment amounts are subject to the sequestration adjustment. Obtain this amount from the PS&R. Do not include demonstration payment adjustment amounts reported on lines 16.50 and 16.55.

Line 17--When Worksheet E-2 is completed for Medicare, enter the amount of bad debts (net of bad debt recoveries) for billed deductibles and coinsurance (excluding bad debts for physician professional services and bad debts arising from covered services paid under a reasonable charge-based methodology or a fee-schedule) for Part A services in column 1, and for Part B services in column 2. If recoveries exceed the current year's bad debts, line 17 will be negative. (See 42 CFR 413.89.)

Line 17.01--For cost reporting periods that begin prior to October 1, 2012, enter the amount on line 17. For cost reporting periods that begin on or after October 1, 2012, calculate this line as follows: [((line 17 - line 18) * 65 percent) + (line 18 * 88 percent)]. For cost reporting periods that begin on or after October 1, 2013, calculate this line as follows: [((line 17 - line 18) * 65 percent) + (line 18 * 76 percent)]. For cost reporting periods that begin on or after October 1, 2014, multiply the amount on line 17 by 65 percent.

Line 18--Enter the gross allowable bad debts for dual eligible beneficiaries. For cost reporting periods that begin prior to October 1, 2012, this amount is reported for statistical purposes only. This amount must also be reported on line 17.

Line 19--For title XVIII, Part A, enter in column 1, the sum of lines 15, 16.55, and 17.01, plus or minus line 16, and minus lines 16.50, and 16.99. For title XVIII, Part B, enter in column 2, the sum of lines 15 and 17.01, plus or minus line 16, and minus lines 16.50, and 16.99. For titles V and XIX, enter in column 1, the sum of line 15, plus or minus line 16.

Line 19.01--For cost reporting periods that overlap or begin on or after April 1, 2013, calculate the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur during the sequestration period, divided by total days in the entire cost reporting period, rounded to six decimal places), rounded to four decimal places) times line 19]. Do not apply the sequestration calculation when gross reimbursement (line 19) is less than zero. In accordance with §3709 of the CARES Act, as amended by §102 of the CAA 2021, §1 of Public Law 117-7, and §2 of the PAMA 2021,do not apply the sequestration adjustment to the period of May 1, 2020, through March 31, 2022. In accordance with §2 of the PAMA 2021, for cost reporting periods that overlap or begin on or after April 1, 2022, calculate the sequestration adjustment amount for the period of April 1, 2022, through June 30, 2022, as follows: [(1 percent times (total days in the cost reporting period that occur from April 1, 2022, through June 30, 2022, divided by total days in the entire cost reporting period, rounded to six decimal places), rounded to four decimal places), times line 19]; and for cost reporting periods that overlap or begin on or after July 1, 2022, calculate the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur on or after July 1, 2022, through the end of the cost reporting period, divided by total days in the entire cost reporting period, rounded to six decimal places), rounded to four decimal places) times line 19].

For non-CAHs' for cost reporting periods that overlap or begin on or after May 1, 2020, enter the sequestration adjustment amount from the PS&R (claims based amounts). In accordance with §3709 of the CARES Act, as amended by §102 of the CAA 2021, §1 of Public Law 117-7, and §2 of the PAMA 2021, do not apply the sequestration adjustment to the period of May 1, 2020, through March 31, 2022. In accordance with §2 of the PAMA 2021, the sequestration adjustment is 1 percent for the portion of the cost reporting period from April 1, 2022, through June 30, 2022; and 2 percent for the portion of the cost reporting period on or after July 1, 2022.

Line 19.02--Enter any demonstration payment adjustment amounts for demonstration projects in which the provider participated where the demonstration adjustment amounts are not subject to the sequestration adjustment. Obtain this amount from the PS&R.

Line 19.03--This line is a subset of line 19.01. Enter the sequestration adjustment amount for the portion of the cost reporting period that the hospital participated in the PARHM demonstration. Enter the sequestration adjustment amount as [2 percent times the sum of lines 3.01 and 17.01].

For cost reporting periods that overlap or begin on or after May 1, 2020, this line is a subset of line 19.25. Calculate the sequestration adjustment amount for the portion of the cost reporting period that the hospital participated in the PARHM demonstration. Calculate the sequestration adjustment amount as [(2 percent times (total days in the cost reporting period that occur during the sequestration period, divided by total days in the entire cost reporting period, rounded to six decimal places), rounded to four decimal places) times the sum of lines 3.01 and 17.01]. In accordance with §3709 of the CARES Act, as amended by §102 of the CAA 2021, §1 of Public Law 117-7, and §2 of the PAMA 2021, do not apply the sequestration adjustment to the period of May 1, 2020, through March 31, 2022.) In accordance with §2 of the PAMA 2021, for cost reporting periods that overlap or begin on or after April 1, 2022, calculate the sequestration adjustment amount for the period of April 1, 2022, through June 30, 2022, as follows: [(1 percent times (total days in the cost reporting period that occur from April 1, 2022, through June 30, 2022, divided by total days in the entire cost reporting period, rounded to six decimal places), rounded to four decimal places), times the sum of (lines 3.01 and 17.01)]; and for cost reporting periods that overlap or begin on or after July 1, 2022, calculate the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur on or after July 1, 2022, through the end of the cost reporting period, divided by total days in the entire cost reporting period, rounded to six decimal places), rounded to four decimal places) times the sum of (lines 3.01 and 17.01)].

Line 19.25--For non-CAHs for cost reporting periods that overlap or begin on or after May 1, 2020, calculate the sequestration adjustment for non-claims based amounts as [(2 percent times (total days in the cost reporting period that occur during the sequestration period, divided by total days in the entire cost reporting period, rounded to six decimal places), rounded to four decimal places) times the sum of (lines 3, 6, 7, 16 and its subscripts, 16.55 (do not use lines 16.50 or 16.99 in this calculation), and line 17.01)]. If the sum is less than zero, do not calculate the sequestration adjustment. In accordance with §3709 of the CARES Act, as amended by §102 of the CAA 2021, §1 of Public Law 117-7, and §2 of the PAMA 2021, do not apply the sequestration adjustment to the period of May 1, 2020, through March 31, 2022.) In accordance with §2 of the PAMA 2021, for cost reporting periods that overlap or begin on or after April 1, 2022, calculate the sequestration adjustment amount for the period of April 1, 2022, through June 30, 2022, as follows: [(1 percent times (total days in the cost reporting period that occur from April 1, 2022, through June 30, 2022, divided by total days in the entire cost reporting period, rounded to six decimal places), rounded to four decimal places), times the sum of (lines 3, 6, 7, 16 and its subscripts, 16.55 (do not use lines 16.50 or 16.99 in this calculation), and line 17.01)]; and for cost reporting periods that overlap or begin on or after July 1, 2022, calculate the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur on or after July 1, 2022, through the end of the cost reporting period, divided by total days in the entire cost reporting period, rounded to six decimal places), rounded to four decimal places) times the sum of (lines 3, 6, 7, 16 and its subscripts, 16.55 (do not use lines 16.50 or 16.99 in this calculation), and line 17.01)].

Line 20--For title XVIII, enter in column 1, the amount from the appropriate Worksheet E-1, column 2, line 4, and enter in column 2, the amount from the appropriate Worksheet E-1, column 4,line 4. For contractor final settlement, report on line 21 the amount from line 5.99 for columns 2 and 4. For titles V and XIX, enter interim payments from your records.

Line 20.01--This line is a subset of line 20. Enter the interim pass-through payments received (or receivable) for the portion of the cost reporting period that the hospital participated in the PARHM demonstration. These payments should include bi-weekly pass-through payments as well as any lump sum adjustments received for bad debts and NAHE.

Line 21--Tentative settlement amount (transfer this amount from Worksheet E-1, Part I, columns 2 and 4, as applicable, line 5.99).

Line 21.01--Tentative settlement amount PARHM demonstration (enter the tentative settlement amount from the PARHM demonstration Worksheet E-1, Part I, columns 2 and 4, as applicable, line 5.99).

Line 22--Enter line 19 minus the sum of lines 19.01, 19.02, 19.25, 20, and 21. Transfer this amount to Worksheet S, Part III, columns as appropriate, lines 5 or 6, for the swing-bed SNF or the swing-bed NF, respectively. For providers participating in the PARHM demonstration, do not transfer amounts from this line. See line 22.01 for instruction.

Line 22.01--For providers participating in the PARHM demonstration complete this line for the settlement of pass-through payments paid outside of the PARHM demonstration. The amount reported on this line is a subset of the amount reported on line 22. Enter the sum of lines 3.01 and 17.01, minus lines 19.03, 20.01, and 21.01. Transfer to Worksheet S, Part III, columns as appropriate, line 5.01 for the swing-bed PARHM-CAH only.

Line 23--Enter the Medicare reimbursement effect of protested items. Estimate the reimbursement effect of the non-allowable 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 CMS Pub. 15-2, chapter 1, §115.2.) Attach a schedule showing the supporting details and computations for this line.

Rural Community Health Demonstration Project (§410A Demonstration) Adjustment--For cost reporting periods ending on or after September 30, 2017, lines 200 through 215 provide for the calculation of the §410A Demonstration project adjustment in accordance with the MMA of 2003, §410A, and extended under §§3123 and 10313 of the ACA 2010, and §15003 of the 21st Century Cures Act of 2016. Complete the applicable lines if Worksheet S-2, Part I, line 110, is "Y," and calculate lines 201 and 202 based on reimbursement cost at 100 percent (not 101 percent).

A hospital participating in the §410A Demonstration receives payment for inpatient swing-bed SNF services, furnished to Medicare beneficiaries, with the exclusion of services furnished in a psychiatric or rehabilitation unit that is a distinct part of the hospital, using the following rules:

a) For discharges occurring in the first cost reporting period on or after the implementation of the extension, their reasonable costs of providing covered inpatient swing-bed services;
b) For discharges occurring during the second and subsequent cost reporting periods, the lesser of their reasonable costs or a target amount.
c) The target amount for each of the remaining cost reporting periods of the 5-year extension period is defined as the reasonable costs of providing covered inpatient swing-bed services in the first cost reporting period, increased by the applicable percentage increase (under clause (i) of §1886(b)(3)(B) of the Act) in the market basket percentage increase for each particular cost reporting period.

Line 200--Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.

Line 201--Enter in column 1, the Medicare swing-bed SNF inpatient routine service costs from the hospital Worksheet D-1, Part II, line 66.

Line 202--Enter in column 1, the Medicare swing-bed SNF inpatient ancillary service costs from the Swing-bed SNF Worksheet D-3, column 3, line 200.

Line 203--Enter in column 1, the sum of lines 201 and 202.

Line 204--Enter in column 1, the Medicare swing-bed SNF discharges. Obtain this amount from the PS&R.

Line 205--Enter in column 1, the Medicare swing-bed target amount per discharge. Obtain the target amount from the contractor.

Line 206--Enter in column 1, the Medicare swing-bed inpatient routine cost cap determined by multiplying line 205 times line 204.

Line 207--Enter in column 1, the Program reimbursement as determined under the §410A Demonstration as follows: For the first year of the current 5-year demonstration period, enter the amount from line 203. For the subsequent years of the current 5-year demonstration period, enter the lesser of line 203 or line 206.

Line 208--Enter in column 1, the Medicare swing-bed SNF inpatient service costs for Medicare beneficiaries from Worksheet E-2, column 1, line 1 (inpatient routine service costs), and line 3 (inpatient ancillary service costs).

Line 209--Enter in column 1, the adjustment to the Medicare swing-bed PPS payments by subtracting line 208 (reimbursement under IPPS) from line 207 (cost reimbursement under the §410A Demonstration).

Line 210--This line is reserved for future use.

Line 215--Enter in column 1, the total adjustment to the Medicare swing-bed PPS payment, the amount from line 209. Transfer the amount to column 1, line 16.55.

4033. WORKSHEET E-3 - CALCULATION OF REIMBURSEMENT SETTLEMENT

The five parts of Worksheet E-3 are used to calculate reimbursement settlement:

Part I - Calculation of Medicare Reimbursement Settlement Under TEFRA
Part II - Calculation of Medicare Reimbursement Settlement Under IPF PPS
Part III - Calculation of Medicare Reimbursement Settlement Under IRF PPS
Part IV - Calculation of Medicare Reimbursement Settlement Under LTCH PPS
Part V - Calculation of Reimbursement Settlement for Medicare Part A Services - Cost Reimbursement
Part VI - Calculation of Reimbursement Settlement - Title XVIII Part A PPS SNF Services
Part VII - Calculation of Reimbursement Settlement - All Other Health Services for Titles V or XIX Services

4033.1 Part I - Calculation of Medicare Reimbursement Settlement Under TEFRA.--Use Worksheet E-3, Part I, to calculate Medicare reimbursement settlement under TEFRA for cancer hospitals, children's hospitals, and extended neoplastic disease care hospitals.

The "TEFRA" payment system includes long term care hospitals (LTCH) classified as extended neoplastic disease care hospitals (previously referred to as "subclause (II)" LTCHs), children's hospitals, cancer hospitals, Religious Non-Medical Health Care Institutions (RNHCIs), and hospitals located outside the 50 States, the District of Columbia, and Puerto Rico (i.e., hospitals located in the U.S. Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa).

Line Descriptions

Line 1--Enter the amount from Worksheet D-1, Part II, line 63.

Line 1.01--Enter the amount of Nursing and Allied Health Managed Care payments if applicable. Only complete this line if your facility is a freestanding/ independent non-PPS provider that does not complete Worksheet E, Part A.

Line 2--If you are an approved CTC, enter the cost of organ acquisition from Worksheet(s) D-4, Part III, column 1, line 69. If you are not an approved CTC do not complete line 2.

Line 3--Teaching hospitals participating in an approved GME program, electing to be reimbursed for services of physicians on the basis of reasonable cost (see 42 CFR 415.160 and CMS Pub. 15-1, chapter 21, §2148), enter the cost of physicians. For cost reporting periods ending before June 30, 2014, transfer the amount from Worksheet D-5, Part II, column 3, line 20. For cost reporting periods ending on or after June 30, 2014, transfer the amount from Worksheet D-5, Part IV, line 20.

Line 4--Enter the sum of lines 1 through 3.

Line 5--Enter the amounts paid or payable by workers' 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:

- Workers' compensation,
- No fault coverage,
- General liability coverage,
- Working aged provisions,
- Disability provisions, and
- Working ESRD provisions.

Generally, when payment by the primary payer satisfies the total liability of the program beneficiary, for cost reporting purposes only, the services are treated as if they were non-program

services. (The primary payment satisfies the beneficiary's liability when you accept that payment as payment in full. This is noted on no-pay bills submitted in these situations.)

Include the patient days and charges in total patient days and charges but do not include them in program patient days and charges. In this situation, enter no primary payer payment on line 5. In addition, exclude amounts paid by other primary payers for outpatient dialysis services reimbursed under the composite rate system.

However, when the payment by the primary payer does not satisfy the beneficiary's obligation, the program pays the lesser of (a) the amount it otherwise pays (without regard to the primary payer payment or deductible 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. Primary payer payment is credited toward the beneficiary's deductible and coinsurance obligation.

When the primary payment does not satisfy the beneficiary's liability, include the covered days and charges in program days and charges, and include the total days and charges in total days and charges for cost apportionment purposes. Enter the primary payer payment on line 5 to the extent that primary payer payment is not credited toward the beneficiary's deductible and coinsurance.

Do not enter on line 5 primary payer payments credited toward the beneficiary's deductible and coinsurance.

Line 6--Enter line 4 minus line 5.

Line 7--Enter the Part A deductibles.

Line 8--Enter line 6 less line 7.

Line 9--Enter the Part A coinsurance.

Line 10--Enter the result of subtracting line 9 from line 8.

Line 11--Enter program allowable bad debts reduced by recoveries. If recoveries exceed the current year's bad debts, lines 11 and 12 will be negative. (See 42 CFR 413.89.)

Line 12--Multiply the amount (including negative amounts) from line 11 by 70 percent for cost reporting periods beginning prior to October 1, 2012, and 65 percent for cost reporting periods that begin on or after October 1, 2012.

Line 13--Enter the gross allowable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. This amount must also be reported on line 11.

Line 14--Enter the sum of lines 10 and 12.

Line 15--Enter the amount from Worksheet E-4, line 49, for the hospital component only.

Line 16--DO NOT USE THIS LINE.

Line 17--Enter any other adjustments. Specify the adjustment in the space provided. See line 17.98 to report the recovery of accelerated depreciation. Do not report adjustments resulting from permanent or other adjustments to the TEFRA target amount per discharge on this line.

Line 17.50--Enter the Pioneer ACO demonstration payment adjustment amount. Obtain this amount from the PS&R. Do not use this line for services rendered on or after January 1, 2017. Report any ACO demonstration payment adjustments for services on or after January 1, 2017, on line 17.99 or line 18.02, accordingly.

Line 17.98--Enter the program share of any recovery of accelerated depreciation applicable to prior periods resulting from your termination or a decrease in Medicare utilization. (See CMS Pub. 15-1, chapter 1, §§136-136.16 and 42 CFR 413.134(d)(3)(i).) This line is identified as "Recovery of accelerated depreciation."

Line 17.99--Enter any demonstration payment adjustment amounts for demonstration projects in which the provider participated where the demonstration adjustment amounts are subject to the sequestration adjustment. Obtain this amount from the PS&R.

Line 18--Enter the sum of lines 14, 15, and 16, plus or minus line 17, and minus lines 17.50, 17.98, and 17.99.

Line 18.01--For cost reporting periods that overlap or begin on or after April 1, 2013, calculate the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur during the sequestration period, divided by total days in the entire cost reporting period, rounded to six decimal places), rounded to four decimal places) times line 18]. Do not apply the sequestration calculation when gross reimbursement (line 18) is less than zero. In accordance with §3709 of the CARES Act, as amended by §102 of the CAA 2021, §1 of Public Law 117-7, and §2 of the PAMA 2021, do not apply the sequestration adjustment to the period of May 1, 2020, through March 31, 2022. In accordance with §2 of the PAMA 2021, for cost reporting periods that overlap or begin on or after April 1, 2022, calculate the sequestration adjustment amount for the period of April 1, 2022, through June 30, 2022, as follows: [(1 percent times (total days in the cost reporting period that occur from April 1, 2022, through June 30, 2022, divided by total days in the entire cost reporting period, rounded to six decimal places), rounded to four decimal places), times lines 18]; and for cost reporting periods that overlap or begin on or after July 1, 2022, calculate the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur on or after July 1 2022, through the end of the cost reporting period, divided by total days in the entire cost reporting period, rounded to six decimal places), rounded to four decimal places) times line 18].

Line 18.02--Enter any demonstration payment adjustment amounts for demonstration projects in which the provider participated where the demonstration adjustment amounts are not subject to the sequestration adjustment. Obtain this amount from the PS&R.

Line 19--Enter the amount of interim payments from Worksheet E-1, column 2, line 4. For contractor final settlements, report on line 20 the amount on line 5.99.

Line 20--Contractor use only: Report the amount from Worksheet E-1, column 2, line 5.99.

Line 21--Enter line 18 minus the sum of lines 18.01, 18.02, 19, and 20. Transfer this amount to Worksheet S, Part III, line 1.

Line 22--Enter the program reimbursement effect of protested items. Estimate the reimbursement effect of the nonallowable items by applying a reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See CMS Pub. 15-2, chapter 1, §115.2.) Attach a schedule showing the details and computations.

4033.2 Part II - Calculation of Medicare Reimbursement Settlement Under IPF PPS.--Use Worksheet E-3, Part II, to calculate Medicare reimbursement settlement under IPF PPS for hospitals and subproviders. (See 42 CFR 412, Subpart N.)

Use a separate copy of Worksheet E-3, Part II, for each of these reporting situations. Enter check marks in the appropriate spaces at the top of each page of Worksheet E-3, Part II, to indicate the component for which it is used. When the worksheet is completed for a component, show both the hospital and component numbers.

Line Descriptions

Line 1--Enter the net Federal IPF PPS payment. This amount excludes payments for outliers, electroconvulsive therapy (ECT), and the teaching adjustment. Obtain this information from the PS&R and/or your records.

Line 2--Enter the net IPF outlier payment. Obtain this from the PS&R and/or your accounting books records.

Line 3--Enter the net IPF payments for ECT. Obtain this from the PS&R and/or your accounting books and records.

NOTE: Complete only line 4 or line 5, but not both.

Line 4--For providers that trained residents in the most recent **cost reporting period filed on or before November 15, 2004** (response on Worksheet S-2, Part I, line 71, column 1, is "Y" for yes), enter the unweighted FTE resident count for the most recent cost reporting period filed on or before November 15, 2004. See 69 FR 66922 (November 4, 2004) for a detailed explanation.

Line 4.01--For IPFs that qualify to receive a temporary adjustment to the FTE cap, enter the additional unweighted FTE count for residents that were displaced by program or hospital closure, which you would not be able to count without a temporary cap adjustment under 42 CFR 412.424(d)(1)(iii)(F)(1) or (2).

Line 5--If the response to Worksheet S-2, Part I, line 71, column 2, is "Y" and your facility did not train residents in the most recent cost report filed before November 15, 2004, but qualifies to receive a cap adjustment under 42 CFR 412.424(d)(1)(iii)(D), enter the new program cap adjustment on this line. Do not complete this line until the new program growth period has ended using the method described in 42 CFR 413.79(e)(1)(i) and (ii). For new programs started prior to October 1, 2012, if your fiscal year end does not correspond to the program year end, and this cost reporting period includes the beginning of the fourth program year following the new program growth period of the first new program, then prorate the cap adjustment accordingly. For facilities that participate in training residents in a new program for the first time on or after October 1, 2012, consistent with the regulations at 42 CFR 413.79(e)(1), complete this line effective beginning with the facility's cost reporting period that coincides with or follows the start of the sixth program year of the first new program started (see 79 FR 50110 (August 22, 2014)).

Line 6--Enter the current year unweighted FTE resident count excluding FTEs in the new program growth period as determined using the method described in 42 CFR 413.79(e)(1)(i) and (ii). FTEs in the new program growth period are reported on line 7. For new programs started prior to October 1, 2012, if your fiscal year end does not correspond to the program year end, and this cost reporting period includes the beginning of the fourth program year following the new program growth period of the first new program, then prorate the FTE count accordingly. For facilities that began participating in training residents in a new program for the first time on or after October 1, 2012, consistent with the regulations at 42 CFR 413.79(e)(1), include FTE residents in a new program on this line if this cost reporting period is the cost reporting period that coincides with or follows the start of the sixth program year of the first new program started (i.e., the initial years) (see 79 FR 50110 (August 22, 2014)). Continue to report FTE residents on this line in subsequent cost reporting periods.

Line 7--Enter the current year unweighted FTE count for residents in the new program growth period. Complete this line only during the new program growth period of the first new program's existence. For new programs started prior to October 1, 2012, if your fiscal year end does not correspond to the program year end, and this cost reporting period includes the beginning of the fourth program year following the new program growth period of the first new program, then prorate the FTE count accordingly. For facilities that began participating in training residents in a new program for the first time on or after October 1, 2012, if your fiscal year end does not correspond to the program year end, and this cost reporting period includes the beginning of the

sixth program year following the new program growth period of the first new program, then prorate the FTE count accordingly. (See 42 CFR 413.79(e)(1).)

Line 8--For providers that completed line 4, enter the lower of the FTE count on line 6 or the sum of the cap amounts on lines 4 and 4.01.

For providers that qualify to receive a cap adjustment under 42 CFR 412.424(d)(1)(iii)(D) during the new program growth period of the first new program's existence, enter the FTE count from line 7.

For new programs started prior to October 1, 2012, beginning with the program year following the new program growth period of the first new program's existence, enter the lower of the FTE count on line 6 or the FTE count on line 5. Add to this count the FTEs on line 7 if your fiscal year end does not correspond with the program year end, and this cost reporting period includes the beginning of the fourth program year following the new program growth period of the first new program. For new programs started on or after October 1, 2012, effective beginning with the facility's cost reporting period that coincides with or follows the start of the sixth program year of the first new program started, enter the lower of the FTE count on line 6 or the FTE count on line 5. Add to this count the FTEs on line 7 if your fiscal year end does not correspond with the program year end, and this cost reporting period includes the beginning of the sixth program year following the new program growth period of the first new program.

Beginning with the program year that does not coincide with but follows the new program growth period of the first new program's existence, enter the lower of the FTE count on line 6 or the FTE count on line 5.

Line 9--Enter the total IPF patient days divided by the number of days in the cost reporting period (Worksheet S-3, Part I, column 8, line 1 (independent/freestanding), or 16, and applicable subscripts (subprovider/provider based), divided by the total number of days in cost reporting period). This is the average daily census.

Line 10--Enter the teaching adjustment factor by adding 1 to the ratio of line 8 to line 9. Raise that result to the power of .5150. Subtract 1 from this amount to calculate the teaching adjustment factor. This is expressed mathematically as {(1 + (line 8 / line 9)) to the .5150 power - 1}. In accordance with 85 FR 27567-27568 (May 8, 2020), for cost reporting periods ending after February 29, 2020, and beginning on or before May 11, 2023 (the end of the COVID-19 Public Health Emergency), enter the higher of the calculated teaching adjustment factor or the teaching adjustment factor for the cost reporting period immediately preceding February 29, 2020.

Line 11--Enter the teaching adjustment by multiplying line 1 by line 10.

Line 12--Enter the adjusted net IPF PPS payments by entering the sum of lines 1, 2, 3, and 11.

Line 13--Enter the amount of NAHE managed care payments, if applicable. Only complete this line if your facility is a freestanding/independent IPF PPS hospital or a freestanding/independent IPF PPS hospital with an IRF PPS subprovider (i.e., enter the NAHE managed care payment for the IPF PPS hospital plus the NAHE managed care payments for the IRF PPS subprovider).

Line 14--DO NOT USE THIS LINE.

Line 15--Teaching IPFs or IPF subproviders participating in an approved GME program, electing to be reimbursed for services of physicians on the basis of reasonable cost (see 42 CFR 415.160 and CMS Pub. 15-1, chapter 21, §2148), enter the cost of physicians. For cost reporting periods ending before June 30, 2014, transfer the amount from Worksheet D-5, Part II, column 3, line 20. For cost reporting periods ending on or after June 30, 2014, transfer the amount from Worksheet D-5, Part IV, line 20.

Line 16--Enter the sum of lines 12, 13, 14, and 15.

Line 17--Enter the amounts paid or payable by primary payers (when program liability is secondary to that of a primary payer) such as:

- Workers' compensation,
- No fault coverage,
- General liability coverage,
- Working aged provisions,
- Disability provisions, and
- Working ESRD provisions.

Generally, when payment by the primary payer satisfies the total liability of the program beneficiary, for cost reporting purposes only, the services are treated as if they were non-program services. (The primary payment satisfies the beneficiary's liability when you accept that payment as payment in full. This is noted on no-pay bills submitted in these situations.) Include the patient days and charges in total patient days and charges but do not include them in program patient days and charges. In this situation, enter no primary payer payment on line 17. In addition, exclude amounts paid by other primary payers for outpatient dialysis services reimbursed under the composite rate system.

However, when the payment by the primary payer does not satisfy the beneficiary's obligation, the program pays the lesser of (a) the amount it otherwise pays (without regard to the primary payer payment or deductible 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. Primary payer payment is credited toward the beneficiary's deductible and coinsurance obligation.

When the primary payment does not satisfy the beneficiary's liability, include the covered days and charges in program days and charges, and include the total days and charges in total days and charges for cost apportionment purposes. Enter the primary payer payment on line 17 to the extent that primary payer payment is not credited toward the beneficiary's deductible and coinsurance.

Do not enter on line 17 primary payer payments credited toward the beneficiary's deductible and coinsurance.

Line 18--Enter line 16 minus line 17.

Line 19--Enter the Part A deductibles.

Line 20--Enter line 18 minus line 19.

Line 21--Enter the Part A coinsurance.

Line 22--Enter the result of subtracting line 21 from line 20.

Line 23--Enter program allowable bad debts reduced by recoveries. If recoveries exceed the current year's bad debts, lines 23 and 24 will be negative. (See 42 CFR 413.89.)

Line 24--Multiply the amount (including negative amounts) from line 23 by 70 percent for cost reporting periods beginning prior to October 1, 2012, and 65 percent for cost reporting periods that begin on or after October 1, 2012.

Line 25--Enter the gross allowable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. This amount must also be reported on line 23.

Line 26--Enter the sum of lines 22 and 24.

Line 27--Enter the amount from the applicable Worksheet E-4, line 49, for the freestanding IPF hospital or the CAH-based IPF excluded unit. Do not complete this line for a hospital-based IPF excluded unit.

Line 28--Enter the routine service other pass through costs from Worksheet D, Part III, column 9, line 30, for a freestanding facility or line 40 for the IPF subprovider. Add to this amount the ancillary service other pass through costs from Worksheet D, Part IV, column 11, line 200.

Line 29--Enter the outlier reconciliation amount by entering the sum of lines 51 and 53.

Line 30--Enter any other adjustments. For example, if you change the recording of vacation pay from the cash basis to accrual basis, etc., enter the adjustment. (See CMS Pub. 15-1, chapter 21, §2146.4.) Specify the adjustment in the space provided. See line 30.98 to report the recovery of accelerated depreciation.

Line 30.50--Enter the Pioneer ACO demonstration payment adjustment amount. Obtain this amount from the PS&R. Do not use this line for services rendered on or after January 1, 2017. Report any ACO demonstration payment adjustments for services on or after January 1, 2017, on line 30.99 or line 31.02, accordingly.

Line 30.98--Enter the program share of any recovery of accelerated depreciation applicable to prior periods resulting from your termination or a decrease in Medicare utilization. (See CMS Pub. 15-1, chapter 1, §§136 through 136.16 and 42 CFR 413.134(d)(3)(i).) This line is identified as "Recovery of accelerated depreciation."

Line 30.99--Enter any demonstration payment adjustment amounts for demonstration projects in which the provider participated where the demonstration adjustment amounts are subject to the sequestration adjustment. Obtain this amount from the PS&R.

Line 31--Enter the sum of lines 26 through 28 plus or minus lines 29 and 30, and minus lines 30.50, 30.98 and 30.99.

Line 31.01--For cost reporting periods that overlap or begin on or after April 1, 2013, calculate the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur during the sequestration period, divided by total days in the entire cost reporting period, rounded to six decimal places), rounded to four decimal places) times line 31]. Do not apply the sequestration calculation when gross reimbursement (line 31) is less than zero. In accordance with §3709 of the CARES Act, as amended by §102 of the CAA 2021, §1 of Public Law 117-7, and §2 of the PAMA 2021, do not apply the sequestration adjustment to the period of May 1, 2020, through December 31, 2021. In accordance with §2 of the PAMA 2021, for cost reporting periods that overlap or begin on or after April 1, 2022, calculate the sequestration adjustment amount for the period of April 1, 2022, through June 30, 2022, as follows: [(1 percent times (total days in the cost reporting period that occur from April 1, 2022, through June 30, 2022, divided by total days in the entire cost reporting period, rounded to six decimal places), rounded to four decimal places), times line 31]; and for cost reporting periods that overlap or begin on or after July 1, 2022, calculate the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur on or after July 1, 2022, through the end of the cost reporting period, divided by total days in the entire cost reporting period, rounded to six decimal places), rounded to four decimal places) times line 31].

Line 31.02--Enter any demonstration payment adjustment amounts for demonstration projects in which the provider participated where the demonstration adjustment amounts are not subject to the sequestration adjustment. Obtain this amount from the PS&R.

Line 32--Enter the amount of interim payments from Worksheet E-1, column 2, line 4. For contractor final settlements, report on line 33 the amount on line 5.99.

Line 34--Enter line 31 minus the sum of lines 31.01, 31.02, 32 and 33. Transfer this amount to Worksheet S, Part III, line 1, or line 2, as appropriate.

Line 35--Enter the program reimbursement effect of protested items. Estimate the reimbursement effect of the nonallowable items by applying a reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See CMS Pub. 15-1, chapter 1, §115.2.) Attach a schedule showing the details and computations.

DO NOT COMPLETE THE REMAINDER OF WORKSHEET E-3, PART II. LINES 50 THROUGH 53, ARE FOR CONTRACTOR USE ONLY.

Line 50--Enter the original outlier amount from Worksheet E-3, Part II, line 2.

Line 51--Enter the outlier reconciliation adjustment amount in accordance with CMS Pub. 100-04, chapter 3, §§190.7.2.3-190.7.2.5.

Line 52--Enter the interest rate used to calculate the time value of money. (See CMS Pub. 100-04, chapter 3, §§190.7.2.3-190.7.2.5.)

Line 53--Enter the time value of money.

4033.3 Part III - Calculation of Medicare Reimbursement Settlement Under IRF PPS.--Use Worksheet E-3, Part III, to calculate Medicare reimbursement settlement under IRF PPS for hospitals and subproviders. (See 42 CFR 412, Subpart P.)

Use a separate copy of Worksheet E-3, Part III, for each of these reporting situations. Enter check marks in the appropriate spaces at the top of each page of Worksheet E-3, Part III, to indicate the component for which it is used. When the worksheet is completed for a component, show both the hospital and component numbers.

Line Descriptions

Line 1--Enter the net federal IRF PPS payment. The federal payment includes short stay outlier amounts. Exclude low income patient (LIP) and outlier payments. Obtain this information from the PS&R and/or your records.

In accordance with the 78 FR 47869 (August 6, 2013), effective for IRF discharges rendered on or after October 1, 2013, the IRF LIP adjustment factor is updated. Subscript column 1 for lines 1 and 3 for cost reporting periods that overlap October 1, 2013. Enter the net federal IRF PPS payments associated with IRF PPS discharges prior to October 1, 2013, in column 1 and the net federal IRF PPS payments associated with IRF PPS discharges on or after October 1, 2013, in column 1.01 to facilitate the calculation of the LIP adjustment on line 3, columns 1 and 1.01, respectively. Do not subscript column 1 for cost reporting periods beginning on or after October 1, 2013.

Line 2--Enter the Medicare SSI ratio from your contractor as applicable for a freestanding IRF (IRF hospital or facility) or a hospital based IRF (subprovider or subunit).

Line 3--Effective for cost reporting periods ending prior to October 1, 2013, enter the IRF LIP payment as the result of {(1 + (line 2) + (L1/L2)) to the .4613 power - 1} times (line 1). L1 = IRF Medicaid Days from Worksheet S-2, Part I, columns 1 through 6, line 25. L2 = IRF total days from Worksheet S-3, Part I, column 8, lines 1 or 17 as applicable plus employee discount days (Worksheet S-3, Part I, column 8, line 30 (line 31 for IRF subproviders)).

For cost reporting periods that overlap October 1, 2013, subscript column 1. To calculate the IRF LIP payment for discharges prior to October 1, 2013, enter in column 1 the result of {(1 + (line 2) + (L1/L2)) to the .4613 power - 1} times (line 1, column 1). To calculate the IRF LIP payment for discharges on or after October 1, 2013, enter in column 1.01 the result of {(1 + (line 2) + L1/L2)) to the .3177 power - 1} times (line 1, column 1.01). Do not subscript column 1 for cost reporting periods beginning on or after October 1, 2013. To calculate the IRF LIP payment for

(cost reporting periods beginning on or after October 1, 2013, enter in column 1 the result of {(1 + (line 2) +(L1/L2)) to the .3177 power - 1} times line 1.

Line 4--Enter the IRF outlier payment. Obtain this from the PS&R and/or your records.

NOTE: Complete only line 5 or line 6, but not both.

Line 5--For providers that trained residents in the most recent **cost reporting period ending on or before November 15, 2004** (response to Worksheet S-2, Part I, line 76, column 1 is "Y" for yes), enter the unweighted FTE resident count for the most recent cost reporting period ending on or before November 15, 2004.

Line 5.01--For IRFs that qualify to receive a temporary adjustment to the FTE cap, enter the additional unweighted FTE count for residents that were displaced by program or hospital closure, which you would not be able to count without a temporary cap adjustment in accordance with 76 FR 47846 (August 5, 2011).

Line 6--If the response to Worksheet S-2, Part I, line 76, column 2, is "Y" and your facility did not train residents in the most recent cost reporting period ending on or before November 15, 2004, and qualifies to receive a cap adjustment (see 70 FR 47929 (August 15, 2005) enter the new cap adjustment on this line. Do not complete this line until the new program growth period has ended using the method described in 42 CFR 413.79(e)(1)(i) and (ii). For new programs started prior to October 1, 2012, if your fiscal year end does not correspond to the program year end, and this cost reporting period includes the beginning of the fourth program year following the new program growth period of the first new program, then prorate the cap adjustment accordingly. For facilities that participate in training residents in a new program for the first time on or after October 1, 2012, consistent with the regulations at 42 CFR 413.79(e)(1), complete this line effective beginning with the facility's cost reporting period that coincides with or follows the start of the sixth program year of the first new program started (see 79 FR 50110 (August 22, 2014)).

Line 7--Enter the current year unweighted FTE resident count excluding FTEs in the new program growth period as determined using the method described in 42 CFR 413.79(e)(1)(i) and (ii). FTEs in the new program growth period are reported on line 8. If your fiscal year end does not correspond to the program year end and this cost reporting period includes the beginning of the fourth program year following the new program growth period of the first new program, then prorate the FTE count accordingly. For facilities that began participating in training residents in a new program for the first time on or after October 1, 2012, consistent with the regulations at 42 CFR 413.79(e)(1), include FTE residents in a new program on this line if this cost reporting period is the cost reporting period that coincides with or follows the start of the sixth program year of the first new program started (i.e., the initial years) (see 79 FR 50110 (August 22, 2014)). Continue to report FTE residents on this line in subsequent cost reporting periods.

Line 8--Enter the current year unweighted FTE count for residents in the new program growth period. Complete this line only during the new program growth period of the first new program's existence. For new programs started prior to October 1, 2012, if your fiscal year end does not correspond with the program year end, and this cost reporting period includes the beginning of the fourth program year following the new program growth period of the first new program, then prorate the FTE count accordingly. For facilities that began participating in training residents in a new program for the first time on or after October 1, 2012, if your fiscal year end does not correspond to the program year end, and this cost reporting period includes the beginning of the sixth program year following the new program growth period of the first new program, then prorate the FTE count accordingly.

Line 9--For providers that completed line 5, enter the lower of the FTE count on line 7 or the sum of the cap amounts on lines 5 and 5.01.

For providers that qualify to receive a cap adjustment (see 70 FR 47929 (August 15, 2005)), during the new program growth period of the first new program's existence enter the FTE count from line 8.

For new programs started prior to October 1, 2012, beginning with the program year following the new program growth period of the first new program's existence, enter the lower of the FTE count on line 7 or the FTE count on line 6. Add to this count the FTEs on line 8 if your fiscal year end does not correspond with the program year end, and this cost reporting period includes the beginning of the fourth program year following the new program growth period of the first new program. For new programs started on or after October 1, 2012, effective beginning with the facility's cost reporting period that coincides with or follows the start of the sixth program year of the first new program started, enter the lower of the FTE count on line 7 or the FTE count on line 6. Add to this count the FTEs on line 8 if your fiscal year end does not correspond with the program year end, and this cost reporting period includes the beginning of the sixth program year following the new program growth period of the first new program.

Beginning with the program year that does not coincide with but follows the new program growth period of the first new program's existence, enter the lower of the FTE count on line 7 or the FTE count on line 6.

Line 10--Enter the total IRF patient days divided by the number of days in the cost reporting period (Worksheet S-3, column 8, line 1 (independent/freestanding), or 17, and applicable subscripts (subprovider/provider based), divided by the total number of days in cost reporting period). This is the average daily census.

NOTE: For cost reporting periods overlapping October 1, 2013, subscript column 1 (add column 1.01) for lines 11 and 12. For cost reporting periods beginning on or after October 1, 2013, do not script column 1.

Line 11--For cost reporting periods ending prior to October 1, 2013, calculate in column 1, the teaching adjustment factor by adding 1 to the ratio of line 9 divided by line 10. Raise that result to the power of .6876. Subtract 1 from this amount to calculate the teaching adjustment factor. This is expressed mathematically as {(1 + (line 9 / line 10)) to the .6876 power - 1}.

In accordance with the 78 FR 47869 (August 6, 2013), effective for IRF discharges rendered on or after October 1, 2013, the teaching adjustment factor is updated. For cost reporting periods that overlap October 1, 2013, subscript column 1.

To calculate the teaching adjustment factor for discharges prior to October 1, 2013, enter in column 1 the result of adding 1 to the ratio of line 9 divided by line 10. Raise that result to the power of .6876 and then subtract 1 from this amount. This is expressed mathematically as {(1 + (line 9 / line 10)) to the .6876 power - 1}. To calculate the teaching adjustment factor for discharges on or after October 1, 2013, enter in column 1.01, the result of adding 1 to the ratio of line 9 divided by line 10. Raise that result to the power of 1.0163 and then subtract 1 from this amount. This is expressed mathematically as {(1 + (line 9 / line 10)) to the 1.0163 power - 1}. Do not subscript column 1 for cost reporting periods beginning on or after October 1, 2013.

To calculate the teaching adjustment factor for cost reporting periods beginning on or after October 1, 2013, enter in column 1, the result of adding 1 to the ratio of line 9 divided by line 10. Raise that result to the power of 1.0163 and then subtract 1 from this amount. This is expressed mathematically as {(1 + (line 9 / line 10)) to the 1.0163 power - 1}. In accordance with 85 FR 27567 through 27568 (May 8, 2020), for cost reporting periods ending after February 29, 2020, and beginning on or before May 11, 2023 (the end of the COVID-19 Public Health Emergency), enter the higher of the calculated teaching adjustment factor or the teaching adjustment factor for the cost reporting period immediately preceding February 29, 2020.

Line 12--For cost reporting periods ending prior to October 1, 2013, calculate the teaching adjustment by multiplying line 1, by line 11. For cost reporting periods that overlap October 1, 2013, subscript column 1. Calculate the teaching adjustment for discharges prior to October 1, 2013, in column 1 by multiplying line 1, column 1 by line 11, column 1. Calculate the teaching adjustment for discharges on or after October 1, 2013, in column 1.01 by multiplying line 1, column 1.01 by line 11, column 1.01. Do not subscript column 1 for cost reporting periods

beginning on or after October 1, 2013. For cost reporting periods beginning on or after October 1, 2013, calculate the teaching adjustment by multiplying line 1, by line 11.

Line 13--Enter the sum of line 1, columns 1 and 1.01; line 3, columns 1 and 1.01; line 4 and line 12, columns 1 and 1.01.

Line 14--Enter the amount of NAHE managed care payments, if applicable. Only complete this line if your facility is a freestanding/independent IRF PPS hospital or a freestanding/independent IRF PPS hospital with an IPF PPS subprovider (i.e., enter the NAHE managed care payment for the IRF PPS hospital plus the NAHE managed care payments for the IPF PPS subprovider).

Line 15--DO NOT USE THIS LINE.

Line 16--Teaching IRFs or IRF subproviders participating in an approved GME program, electing to be reimbursed for services of physicians on the basis of reasonable cost (see 42 CFR 415.160 and CMS Pub. 15-1, chapter 21, §2148), enter the cost of physicians. For cost reporting periods ending before June 30, 2014, transfer the amount from Worksheet D-5, Part II, column 3, line 20. For cost reporting periods ending on or after June 30, 2014, transfer the amount from Worksheet D-5, Part IV, line 20.

Line 17--Enter the sum of lines 13, 14, 15, and 16.

Line 18--Enter the amounts paid or payable by workers' 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:

- Workers' compensation,
- No fault coverage,
- General liability coverage,
- Working aged provisions,
- Disability provisions, and
- Working ESRD provisions.

Generally, when payment by the primary payer satisfies the total liability of the program beneficiary, for cost reporting purposes only, the services are treated as if they were non-program services. (The primary payment satisfies the beneficiary's liability when you accept that payment as payment in full. This is noted on no-pay bills submitted in these situations.) Include the patient days and charges in total patient days and charges but do not include them in program patient days and charges. In this situation, enter no primary payer payment on line 18. In addition, exclude amounts paid by other primary payers for outpatient dialysis services reimbursed under the composite rate system.

However, when the payment by the primary payer does not satisfy the beneficiary's obligation, the program pays the lesser of (a) the amount it otherwise pays (without regard to the primary payer payment or deductible 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. Primary payer payment is credited toward the beneficiary's deductible and coinsurance obligation.

When the primary payment does not satisfy the beneficiary's liability, include the covered days and charges in program days and charges, and include the total days and charges in total days and charges for cost apportionment purposes. Enter the primary payer payment on line 18 to the extent that primary payer payment is not credited toward the beneficiary's deductible and coinsurance.

Do not enter on line 18 primary payer payments credited toward the beneficiary's deductible and coinsurance.

Line 19--Enter line 17 minus line 18.

Line 20--Enter the Part A deductibles.

Line 21--Enter line 19 less line 20.

Line 22--Enter the Part A coinsurance.

Line 23--Enter the result of subtracting line 22 from line 21.

Line 24--Enter program allowable bad debts reduced by recoveries. If recoveries exceed the current year's bad debts, lines 24 and 25 will be negative. (See 42 CFR 413.89.)

Line 25--Multiply the amount (including negative amounts) from line 24 by 70 percent for cost reporting periods beginning prior to October 1, 2012, and 65 percent for cost reporting periods that begin on or after October 1, 2012.

Line 26--Enter the gross allowable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. This amount must also be reported on line 24.

Line 27--Enter the sum of lines 23 and 25.

Line 28--Enter the amount from the applicable Worksheet E-4, line 49, for the freestanding IRF hospital or the CAH-based IRF excluded unit. Do not complete this line for a hospital-based IRF excluded unit.

Line 29--Enter the routine service other pass through costs from Worksheet D, Part III, column 9, line 30 for a freestanding facility or line 41 for IRF the subproviders. Add to this amount the ancillary service other pass through costs from Worksheet D, Part IV, column 11, line 200.

Line 30--Enter the outlier reconciliation amount by entering the sum of lines 51 and 53.

Line 31--Enter any other adjustments. For example, if you change the recording of vacation pay from the cash basis to accrual basis, etc., enter the adjustment. (See CMS Pub. 15-1, chapter 21, §2146.4.) Specify the adjustment in the space provided. See line 31.98 to report the recovery of accelerated depreciation.

Line 31.50--Enter the Pioneer ACO demonstration payment adjustment amount. Obtain this amount from the PS&R. Do not use this line for services rendered on or after January 1, 2017. Report any ACO demonstration payment adjustments for services on or after January 1, 2017, on line 31.99 or line 32.02, accordingly.

Line 31.98--Enter the program share of any recovery of accelerated depreciation applicable to prior periods resulting from your termination or a decrease in Medicare utilization. (See CMS Pub. 15-1, chapter 1, §§136 - 136.16, and 42 CFR 413.134(d)(3)(i).) This line is identified as "Recovery of accelerated depreciation."

Line 31.99--Enter any demonstration payment adjustment amounts for demonstration projects in which the provider participated where the demonstration adjustment amounts are is subject to the sequestration adjustment. Obtain this amount from the PS&R.

Line 32--Enter the sum of lines 27, 28, and 29 plus or minus lines 30, and 31, and minus lines 31.50, 31.98, and 31.99.

Line 32.01--For cost reporting periods that overlap or begin on or after April 1, 2013, calculate the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur during the sequestration period, divided by total days in the entire cost reporting period, rounded to six decimal places), rounded to four decimal places) times line 32]. Do not apply the sequestration calculation when gross reimbursement (line 32) is less than zero. In accordance with §3709 of the CARES Act, as amended by §102 of the CAA 2021, §1 of Public Law 117-7, and §2 of the PAMA 2021, do not apply the sequestration adjustment to the

period of May 1, 2020, through March 31, 2021. In accordance with §2 of the PAMA 2021, for cost reporting periods that overlap or begin on or after April 1, 2022, calculate the sequestration adjustment amount for the period of April 1, 2022, through June 30, 2022, as follows: [(1 percent times (total days in the cost reporting period that occur from April 1, 2022, through June 30, 2022, divided by total days in the entire cost reporting period, rounded to six decimal places), rounded to four decimal places), times line 32]; and for cost reporting periods that overlap or begin on or after July 1, 2022, calculate the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur on or after July 1, 2022, through the end of the cost reporting period, divided by total days in the entire cost reporting period, rounded to six decimal places), rounded to four decimal places) times line 32].

Line 32.02--Enter any demonstration payment adjustment amounts for demonstration projects in which the provider participated where the demonstration adjustment amounts are not subject to the sequestration adjustment. Obtain this amount from the PS&R.

Line 33--Enter the amount of interim payments from Worksheet E-1, column 2, line 4. For contractor final settlement, report on line 34 the amount on line 5.99.

Line 35--Enter line 32 minus the sum of lines 32.01, 32.02, 33 and 34. Transfer this amount to Worksheet S, Part III, line 1 or 3, as appropriate.

Line 36--Enter the program reimbursement effect of protested items. Estimate the reimbursement effect of the nonallowable items by applying a reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See CMS Pub. 15-2, chapter 1, §115.2.) Attach a schedule showing the details and computations.

DO NOT COMPLETE THE REMAINDER OF WORKSHEET E-3, PART III. LINES 50 THROUGH 53, ARE FOR CONTRACTOR USE ONLY.

Line 50--Enter the original outlier amount from Worksheet E-3, Part III, line 4.

Line 51--Enter the outlier reconciliation adjustment amount in accordance with CMS Pub. 100-04, chapter 3, §140.2.8 - §140.2.10.

Line 52--Enter the interest rate used to calculate the time value of money. (See CMS Pub. 100-04, chapter 3, §140.2.8 - §140.2.10)

Line 53--Enter the time value of money.

4033.4 Part IV - Calculation of Medicare Reimbursement Settlement under LTCH PPS.--Use Worksheet E-3, Part IV, to calculate Medicare reimbursement settlement under LTCH PPS for hospitals. (See 42 CFR 412, Subpart O.) Providers that qualify as an extended neoplastic disease care hospital do not complete this worksheet, but rather complete Worksheet E-3, Part I.

Line Descriptions

Line 1--Enter the net federal LTCH PPS payment including short stay outlier payments. Obtain this information from the PS&R and/or your records. Effective for cost reporting periods ending on or after September 30, 2017, enter the sum of the amounts on lines 1.01 through 1.04.

Complete lines 1.01 through 1.04 for discharges occurring in cost reporting periods beginning on or after October 1, 2015. See 42 CFR 412.522. These amounts may be obtained from the PS&R and/or your records.

NOTE: The amounts on lines 1.01 through 1.04 are for informational purposes only. The amount on line 1 above includes the amounts on lines 1.01 through 1.04, and must reconcile to line 1.

Line 1.01--Enter the full standard LTCH PPS payment.

Line 1.02--Enter the short stay outlier standard payment amount.

Line 1.03--Enter the cost-based site neutral payment amount.

Line 1.04--Enter the LTCH PPS comparable site neutral payment amount, which may include high cost outlier payments.

Line 2--Enter the high cost outlier payments. Obtain this from the PS&R and/or your records.

Line 3--Enter the sum of lines 1 and 2.

Line 4--Enter the amount of nursing and allied health managed care payments, if applicable.

Line 5--DO NOT USE THIS LINE.

Line 6--Teaching hospitals participating in an approved GME program, electing to be reimbursed for services of physicians on the basis of reasonable cost (see 42 CFR 415.160 and CMS Pub. 15-1, chapter 21, §2148), enter the cost of physicians. For cost reporting periods ending before June 30, 2014, transfer the amount from Worksheet D-5, Part II, column 3, line 20. For cost reporting periods ending on or after June 30, 2014, transfer the amount from Worksheet D-5, Part IV, line 20.

Line 7--Enter the sum of lines 3, 4, 5, and 6.

Line 8--Enter the amounts paid or payable by workers' 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:

- Workers' compensation,
- No fault coverage,
- General liability coverage,
- Working aged provisions,
- Disability provisions, and
- Working ESRD provisions.

Generally, when payment by the primary payer satisfies the total liability of the program beneficiary, for cost reporting purposes only, the services are treated as if they were non-program services. (The primary payment satisfies the beneficiary's liability when you accept that payment as payment in full. This is noted on no-pay bills submitted in these situations.) Include the patient days and charges in total patient days and charges but do not include them in program patient days and charges. In this situation, enter no primary payer payment on line 8. In addition, exclude amounts paid by other primary payers for outpatient dialysis services reimbursed under the composite rate system.

However, when the payment by the primary payer does not satisfy the beneficiary's obligation, the program pays the lesser of (a) the amount it otherwise pays (without regard to the primary payer payment or deductible 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. Primary payer payment is credited toward the beneficiary's deductible and coinsurance obligation.

When the primary payment does not satisfy the beneficiary's liability, include the covered days and charges in program days and charges, and include the total days and charges in total days and charges for cost apportionment purposes. Enter the primary payer payment on line 8 to the extent that primary payer payment is not credited toward the beneficiary's deductible and coinsurance.

Do not enter on line 8 primary payer payments credited toward the beneficiary's deductible and coinsurance.

Line 9--Enter line 7 minus line 8.

Line 10--Enter the Part A deductibles.

Line 11--Enter line 9 less line 10.

Line 12--Enter the Part A coinsurance.

Line 13--Enter the result of subtracting line 12 from line 11.

Line 14--Enter program allowable bad debts reduced by recoveries. If recoveries exceed the current year's bad debts, lines 14 and 15 will be negative. (See CMS Pub. 15-1, chapter 3.)

Line 15--Multiply the amount (including negative amounts) from line 14 by 70 percent for cost reporting periods beginning prior to October 1, 2012, and 65 percent for cost reporting periods that begin on or after October 1, 2012.

Line 16--Enter the gross allowable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. This amount must also be reported on line 14.

Line 17--Enter the sum of lines 13 and 15.

Line 18--Enter the amount from Worksheet E-4, line 49, for the hospital.

Line 19--Enter the routine service other pass through costs from Worksheet D, Part III, column 9, sum of lines 30 and 31 for a freestanding facility. Add to this amount the ancillary service other pass through costs from Worksheet D, Part IV, column 11, line 200.

Line 20--Enter the outlier reconciliation amount by entering the sum of lines 51 and 53.

Line 21--Enter any other adjustments. For example, if you change the recording of vacation pay from the cash basis to accrual basis, enter the adjustment. (See CMS Pub. 15-1, chapter 21, §2146.4.) Specify the adjustment in the space provided. See line 21.98 to report the recovery of accelerated depreciation.

Line 21.50--Enter the Pioneer ACO demonstration payment adjustment amount. Obtain this amount from the PS&R. Do not use this line for services rendered on or after January 1, 2017. Report any ACO demonstration payment adjustments for services on or after January 1, 2017, on line 21.99 or line 22.02, accordingly.

Line 21.98--Enter the program share of any recovery of accelerated depreciation applicable to prior periods resulting from your termination or a decrease in Medicare utilization. (See CMS Pub. 15-1, chapter 1, §§136 - 136.16, and 42 CFR 413.134(d)(3)(i).) This line is identified as "Recovery of accelerated depreciation."

Line 21.99--Enter any demonstration payment adjustment amounts for demonstration projects in which the provider participated where the demonstration adjustment amounts are subject to the sequestration adjustment. Obtain this amount from the PS&R.

Line 22--Enter the sum of lines 17, 18, and 19, plus or minus lines 20, and 21, and minus lines 21.50, 21.98, and 21.99.

Line 22.01--For cost reporting periods that overlap or begin on or after April 1, 2013, calculate the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur during the sequestration period, divided by total days in the entire cost reporting period, rounded to six decimal places), rounded to four decimal places) times line 22]. Do not

apply the sequestration calculation when gross reimbursement (line 22) is less than zero. In accordance with §3709 of the CARES Act, as amended by §102 of the CAA 2021, §1 of Public Law 117-7, and §2 of the PAMA 2021, do not apply the sequestration adjustment to the period of May 1, 2020, through March 31, 2022. In accordance with §2 of the PAMA 2021, for cost reporting periods that overlap or begin on or after April 1, 2022, calculate the sequestration adjustment amount for the period of April 1, 2022, through June 30, 2022, as follows: [(1 percent times (total days in the cost reporting period that occur from April 1, 2022, through June 30, 2022, divided by total days in the entire cost reporting period, rounded to six decimal places), rounded to four decimal places), times line 22]; and for cost reporting periods that overlap or begin on or after July 1, 2022, calculate the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur on or after July 1, 2022, through the end of the cost reporting period, divided by total days in the entire cost reporting period, rounded to six decimal places), rounded to four decimal places) times line 22].

Line 22.02--Enter any demonstration payment adjustment amounts for demonstration projects in which the provider participated where the demonstration adjustment amounts are not subject to the sequestration adjustment. Obtain this amount from the PS&R.

Line 23--Enter the amount of interim payments from Worksheet E-1, column 2, line 4. For contractor final settlements, report on line 24 the amount on line 5.99.

Line 25--Enter line 22 minus the sum of lines 22.01, 22.02, 23, and 24. Transfer this amount to Worksheet S, Part III, line 1.

Line 26--Enter the program reimbursement effect of protested items. Estimate the reimbursement effect of the nonallowable items by applying a reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See CMS Pub. 15-2, chapter 1, §115.2.) Attach a schedule showing the details and computations.

DO NOT COMPLETE THE REMAINDER OF WORKSHEET E-3, PART IV. LINES 50 THROUGH 53 ARE FOR CONTRACTOR USE ONLY.

Line 50--Enter the original outlier amount from line 2. For cost reporting periods beginning on or after October 1, 2015, and ending before October 1, 2018, enter the sum of the amounts reported on lines 1.02 and 2.

Line 51--Enter the outlier reconciliation adjustment amount in accordance with CMS Pub. 100-04, chapter 3, §150.26 - §150.28.

Line 52--Enter the interest rate used to calculate the time value of money. (See CMS Pub. 100-04, chapter 3, §150.26 - §150.28.)

Line 53--Enter the time value of money.

4033.5 Part V - Calculation of Reimbursement Settlement for Medicare Part A Services - Cost Reimbursement.--Use Worksheet E-3, Part V, to calculate reimbursement settlement for Medicare Part A services furnished under cost reimbursement for (1) CAHs, including those participating in the PARHM demonstration; and (2) new children's or new cancer hospitals exempt from the rate of increase limits in accordance with 42 CFR 413.40(f).

For hospitals participating in the PARHM demonstration during this cost reporting period and (1) the hospital participated in the PARHM demonstration for the entire cost reporting period, select the "PARHM Demonstration" box only and complete this worksheet; or (2) the hospital participated in the PARHM demonstration for a portion of the cost reporting period, select the "PARHM Demonstration" box and complete Worksheet E-3, Part V, for the portion of the cost reporting period included in the demonstration. Select the "Hospital" box and complete a separate Worksheet E-3, Part V, for the portion of the cost reporting period not included in the demonstration.

Line Descriptions

Line 1--Enter the inpatient operating costs for the hospital (CAH, new children's hospital, or new cancer hospital) from Worksheet D-1, Part II, line 49.

Line 2--Enter the amount of nursing and allied health managed care payments, if applicable. Only complete this line if your facility is a CAH.

Line 3--If you are approved as a CTC, enter the cost of organ acquisition from Worksheet D-4, Part III, column 1, line 69, when this worksheet is completed for the hospital (or the hospital component of a health care complex). Make no entry on line 3 in other situations because the Medicare program reimburses only CTCs for organ acquisition costs.

Line 3.01--Transfer the Medicare inpatient cellular therapy acquisition cost from Worksheet D-6, Part III, line 10, column 1.

Line 4--Enter the sum of lines 1 through 3.01.

Line 5--Enter the amounts paid or payable by workers' 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:

- Workers' compensation,
- No fault coverage,
- General liability coverage,
- Working aged provisions,
- Disability provisions, and
- Working ESRD provisions.

Generally, when payment by the primary payer satisfies the total liability of the program beneficiary, for cost reporting purposes only, the services are treated as if they were non-program services. (The primary payment satisfies the beneficiary's liability when you accept that payment as payment in full. This is noted on no-pay bills submitted in these situations.) Include the patient days and charges in total patient days and charges but not in program patient days and charges. In this situation, enter no primary payer payment on line 5. In addition, exclude amounts paid by other primary payers for outpatient dialysis services reimbursed under the composite rate system. However, when the payment by the primary payer does not satisfy the beneficiary's obligation, the program pays the lesser of (a) the amount it otherwise pays (without regard to the primary payer payment or deductible 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. Primary payer payment is credited toward the beneficiary's deductible and coinsurance obligation.

When the primary payment does not satisfy the beneficiary's liability, include the covered days and charges in program days and charges and include the total days and charges in total days and charges for cost apportionment purposes. Enter the primary payer payment on line 5 to the extent that primary payer payment is not credited toward the beneficiary's deductible and coinsurance. Do not enter on line 5 primary payer payments credited toward the beneficiary's deductible and coinsurance.

Line 6--For a new children's or new cancer hospital that is cost reimbursed, enter the result of line 4 minus line 5.

For CAHs: For cost reporting periods beginning before October 1, 2014, if Worksheet S-2, line 167, is "Y", then multiply the amount on line 4 by 101 percent minus the amount on line 5.

For cost reporting periods beginning in FFY 2015 and subsequent years, if the CAH is a meaningful user (Worksheet S-2, line 167, is "Y"), then multiply the amount on line 4 by 101 percent minus the amount on line 5.

If the CAH is not a meaningful user of EHR for cost reporting periods beginning in FFY 2015 and subsequent years, (Worksheet S-2, line 167, is "N") and it does not qualify for a hardship exception (Worksheet S-2, line 168.01, is "N"), calculate line 6 as follows:

For cost reporting periods beginning in FFY 2015 (October 1, 2014, through September 30, 2015), (multiply the amount on line 4 by 100.66 percent) minus the amount on line 5.
For cost reporting periods beginning in FFY 2016 (October 1, 2015, through September 30, 2016), (multiply the amount on line 4 by 100.33 percent) minus the amount on line 5.
For cost reporting periods beginning in FFY 2017 and each subsequent fiscal year (cost reporting periods beginning on or after October 1, 2016), (multiply the amount on line 4 by 100 percent) minus the amount on line 5.

Computation of Lesser of Reasonable Cost or Customary Charges-- This part provides for the computation of the lesser of reasonable cost of services furnished to beneficiaries or customary charges made by you for the same services, as defined in 42 CFR 413.13(a). A new children's or new cancer hospital exempt from the rate of increase limits must complete lines 7 through 16.

CAHs do not complete lines 7 through 16 as they are exempt from the application of the LCC principle.

Line Descriptions

Lines 7 through 16--These lines provide for the accumulation of charges which relate to the reasonable cost on line 6.

Do not include on these lines (1) the portion of charges applicable to the excess cost of luxury items or services (see CMS Pub. 15-1, chapter 21, §2104.3) and (2) your charges to beneficiaries for excess costs as described in CMS Pub. 15-1, chapter 25, §§2570-2577.

Line 7--Enter the program inpatient routine service charges from your records for the applicable component. Include charges for both routine and special care units. The amounts entered include covered late charges billed to the program when the patient's medical condition is the cause of the stay past the checkout time. Also, these amounts include charges relating to a stay in an intensive care type hospital unit for a few hours when your normal practice is to bill for the partial stay.

Line 8--Enter the total charges for inpatient ancillary services from Worksheet D-3, column 2, sum of lines 50 through 98.

Line 9--If you are an approved CTC, enter the organ acquisition charges from Worksheet D-4, Part III, column 3, line 69, when Worksheet E-3, Part V, is completed for the hospital or the hospital component of a health care complex.

Line 10--Enter the sum of lines 7 through 9.

Lines 11 through 14--These lines provide for the reduction of program charges when you do not actually impose such charges on most of the patients liable for payment for services on a charge basis or when you fail to make reasonable efforts to collect such charges from those patients. If line 13 is greater than zero, multiply line 10 by line 13, and enter the result on line 14. If you impose these charges and make reasonable efforts to collect the charges from patients liable for payment for services on a charge basis, you are not required to complete lines 11 through 13. Enter on line 14 the amount from line 10. In no instance may the customary charges on line 14 exceed the actual charges on line 10. (See 42 CFR 413.13(e).)

Line 15--Enter the excess of the customary charges on line 14 over the reasonable cost on line 6.

Line 16--Enter the excess of reasonable cost on line 6 over the customary charges on line 14. Transfer line 16 to line 21.

Line 17--Teaching hospitals participating in an approved GME program, electing to be reimbursed for services of physicians on the basis of reasonable cost (see 42 CFR 415.160 and CMS Pub. 15-1, chapter 21, §2148), enter the cost of physicians. For cost reporting periods ending before June 30, 2014, transfer the amount from Worksheet D-5, Part II, column 3, line 20. For cost reporting periods ending on or after June 30, 2014, transfer the amount from Worksheet D-5, Part IV, line 20. CAHs do not complete this line.

Computation of Reimbursement Settlement

Line 18--New children's or new cancer hospitals enter the amount from Worksheet E-4, line 49. CAHs do not complete this line.

Line 19--Enter the sum of lines 6 and 17.

Line 20--Enter the Part A deductibles billed to Medicare beneficiaries.

Line 21-- Enter the amount from line 16. If you are a nominal charge provider, enter zero.

Line 22--Enter line 19 minus lines 20 and 21.

Line 23--Enter from PS&R or your records the coinsurance billed to Medicare beneficiaries.

Line 24--Enter line 22 minus line 23.

Line 25--Enter from your records program allowable bad debts net of recoveries. If recoveries exceed the current year's bad debts, lines 25 and 26 will be negative. (See 42 CFR 413.89.)

Line 26--No reduction is required for CAHs for cost reporting periods beginning prior to October 1, 2012, enter the amount from line 25.

Multiply the amount from line 25 (including negative amounts) by 88 percent for cost reporting periods beginning on or after October 1, 2012, 76 percent for cost reporting periods beginning on or after October 1, 2013, and 65 percent for cost reporting periods beginning on or after October 1, 2014.

Line 27--Enter the gross allowable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. This amount must also be reported on line 25.

Line 28--Enter the sum of lines 24 and 26.

Line 29--Enter any other adjustments. See line 29.98 to report the recovery of accelerated depreciation.

Line 29.50--Enter the Pioneer ACO demonstration payment adjustment amount. Obtain this amount from the PS&R. Do not use this line for services rendered on or after January 1, 2017. Report any ACO demonstration payment adjustments for services on or after January 1, 2017, on line 29.99 or line 30.02, accordingly.

Line 29.98--Enter the program share of any recovery of accelerated depreciation applicable to prior periods resulting from your termination or a decrease in Medicare utilization. (See CMS Pub. 15-1, chapter 1, §§136 through 136.16 and 42 CFR 413.134(d)(3)(i).) This line is identified as "Recovery of accelerated depreciation."

Line 29.99--Enter any demonstration payment adjustment amounts for demonstration projects in which the provider participated where the demonstration adjustment amounts are subject to the sequestration adjustment. Obtain this amount from the PS&R.

Line 30--Enter line 28, plus or minus line 29, and minus lines 29.50, 29.98, and 29.99.

Line 30.01--For cost reporting periods that overlap or begin on or after April 1, 2013, calculate the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur during the sequestration period, divided by total days in the entire cost reporting period, rounded to six decimal places), rounded to four decimal places) times line 30]. Do not apply the sequestration calculation when gross reimbursement (line 30) is less than zero. In accordance with §3709 of the CARES Act, as amended by §102 of the CAA 2021, §1 of Public Law 117-7, and §2 of the PAMA 2021, do not apply the sequestration adjustment to the period of May 1, 2020, through March 31, 2022. In accordance with §2 of the PAMA 2021, for cost reporting periods that overlap or begin on or after April 1, 2022, calculate the sequestration adjustment amount for the period of April 1, 2022, through June 30, 2022, as follows: [(1 percent times (total days in the cost reporting period that occur from April 1, 2022, through June 30, 2022, divided by total days in the entire cost reporting period, rounded to six decimal places), rounded to four decimal places), times line 30]; and for cost reporting periods that overlap or begin on or after July 1, 2022, calculate the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur on or after July 1, 2022, through the end of the cost reporting period, divided by total days in the entire cost reporting period, rounded to six decimal places), rounded to four decimal places) times line 30].

Line 30.02--Enter any demonstration payment adjustment amounts for demonstration projects in which the provider participated where the demonstration adjustment amounts are not subject to the sequestration adjustment. Obtain this amount from the PS&R.

Line 30.03--This line is a subset of line 30.01. Calculate the sequestration adjustment amount for the portion of the cost reporting period that the hospital participated in the PARHM demonstration. Calculate the sequestration adjustment amount as [(2 percent times (total days in the cost reporting period that occur during the sequestration period, divided by total days in the entire cost reporting period, rounded to six decimal places), rounded to four decimal places) times the sum of lines 2, 3, 18, and 26]. In accordance with §3709 of the CARES Act, as amended by §102 of the CAA 2021, §1 of Public Law 117-7, and §2 of the PAMA 2021, do not apply the sequestration adjustment to the period of May 1, 2020, through March 31, 2022. In accordance with §2 of the PAMA 2021, for cost reporting periods that overlap or begin on or after April 1, 2022, calculate the sequestration adjustment amount for the period of April 1, 2022, through June 30, 2022, as follows: [(1 percent times (total days in the cost reporting period that occur from April 1, 2022, through June 30, 2022, divided by total days in the entire cost reporting period, rounded to six decimal places), rounded to four decimal places), times the sum of (lines 2, 3, 18, and 26)]; and for cost reporting periods that overlap or begin on or after July 1, 2022, calculate the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur on or after July 1, 2022, through the end of the cost reporting period, divided by total days in the entire cost reporting period, rounded to six decimal places), rounded to four decimal places) times the sum of (lines 2, 3, 18, and 26)].

Line 31--Enter interim payments from Worksheet E-1, column 2, line 4. For contractor final settlement, report on line 32 the amount from line 5.99.

Line 31.01--This line is a subset of line 31. Enter the interim pass-through payments received (or receivable) for the portion of the cost reporting period that the hospital participated in the PARHM demonstration. These payments should include bi-weekly pass through payments as well as any lump sum adjustments received for bad debts, organ acquisition costs, and medical education (DGME and NAHE).

Line 33--Enter line 30 minus the sum of lines 30.01, 30.02, 31, and 32. Transfer this amount to Worksheet S, Part III, columns as appropriate, line 1. For providers participating in the PARHM demonstration, do not transfer amounts from this line. See line 33.01 for instruction.

Line 33.01--For providers participating in the PARHM demonstration, complete this line for the settlement of pass-through payments paid outside of the PARHM demonstration. The amount reported on this line is a subset of the amount reported on line 33. Enter the sum of lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01. Transfer this amount to Worksheet S, Part III, columns as appropriate, line 1.01.

Line 34--Enter the program reimbursement effect of protested items. Estimate the reimbursement effect of the nonallowable items by applying a reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See CMS Pub. 15-2, chapter 1, §115.2.) Attach a schedule showing the details and computations for this line.

4033.6 Part VI - Calculation of Reimbursement Settlement - Title XVIII Part A PPS SNF Services.--For title XVIII SNFs reimbursed under PPS (including a distinct part SNF based in a REH), complete this part for settlement of Part A services. For Part B services, all SNFs complete Worksheet E, Part B.

When this part is completed for a component, show both the hospital and component numbers.

Computation of Net Costs of Covered Services

Line Descriptions

Prospective Payment Amount

Line 1--Compute the sum of the following amounts obtained your books and records or from the PS&R:

- The Resource Utilization Group (RUG) payments made for PPS discharges during the cost reporting period, and
- The RUG payments made for PPS transfers during the cost reporting period.

Line 2--Enter the amount from Worksheet D, Part III, column 9, line 44.

Line 3--Enter the amount from Worksheet D, Part IV, column 11, line 200.

Line 4--Enter the sum of lines 1 through 3.

Line 5--Do not use this line as vaccine costs are included on line 1 of Worksheet E, Part B. Line 5 is shaded on Worksheet E-3, Part VI.

Line 6--Enter any deductible amounts imposed.

Line 7--Enter any coinsurance amounts.

Line 8--Enter from your records program allowable bad debts for deductibles and coinsurance net of bad debt recoveries. If recoveries exceed the current year's bad debts, line 8 will be negative. (See 42 CFR 413.89.)

Line 9--Enter the allowable bad debts for deductibles and coinsurance for dual eligible beneficiaries, net of recoveries of bad debts for dual eligible beneficiaries. This amount is included in the amount reported on line 8. If recoveries of bad debts for dual eligible beneficiaries exceed the current year's bad debts for dual eligible beneficiaries, line 9 will be negative.

Line 10--SNF Bad Debt--Calculate this line as follows for cost reporting periods beginning prior to October 1, 2012: [((line 8 - line 9) * 70 percent) + line 9]. This is the adjusted SNF reimbursable bad debt in accordance with the Deficit Reduction Act (DRA) 2005, section 5004.

In accordance with DRA 2005 SNF Bad Debt as amended by section 3201(b) of the Middle Class Tax Relief and Job Creation Act of 2012, calculate this line as follows: for cost reporting periods beginning on or after October 1, 2012, calculate this line as follows: [((line 8 - line 9) * 65 percent) + (line 9 * 88 percent)]. For cost reporting periods beginning on or after October 1, 2013, calculate this line as follows: [((line 8 - line 9) * 65 percent) + (line 9 * 76 percent)]. For cost reporting periods beginning on or after October 1, 2014, multiply the amount on line 8 by 65 percent.

Line 11--Enter the title XVIII reasonable compensation paid to physicians for services on utilization review committees to an SNF. Include on this line the amount eliminated from total costs on Worksheet A-8. Transfer this amount from Worksheet D-1, Part III, line 85.

Line 12--Enter the result of line 4 plus line 5, minus the sum of lines 6 and 7, plus lines 10 and 11.

Line 13--Enter the amounts paid or payable by workers' compensation and other primary payers where program liability is secondary to that of the primary payer for inpatient services. Enter only the primary payer amounts applicable to Part A routine and ancillary services.

Line 14--Enter any other adjustments. For example, if you change the recording of vacation pay from the cash basis to accrual basis, enter the adjustment. (See CMS Pub. 15-1, chapter 21, §2146.4.) Specify the adjustment in the space provided. See line 14.98 to report the recovery of accelerated depreciation.

Line 14.50--Enter the Pioneer ACO demonstration payment adjustment amount. Obtain this amount from the PS&R. Do not use this line for services rendered on or after January 1, 2017. Report any ACO demonstration payment adjustments for services on or after January 1, 2017, on line 14.99 or line 15.02, accordingly.

Line 14.98--Enter the program share of any recovery of accelerated depreciation applicable to prior periods resulting from your termination or a decrease in Medicare utilization. (See CMS Pub. 15-1, chapter 1, §§136 through 136.16, and 42 CFR 413.134(d)(3)(i).) This line is identified as "Recovery of accelerated depreciation."

Line 14.99--Enter any demonstration payment adjustment amounts for demonstration projects in which the provider participated where the demonstration adjustment amounts are subject to the sequestration adjustment. Obtain this amount from the PS&R.

Line 15--Enter the result of line 12, plus or minus line 14, minus lines 13, 14.50, 14.98, and 14.99.

Line 15.01--For cost reporting periods that overlap or begin on or after April 1, 2013, calculate the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur during the sequestration period, divided by total days in the entire cost reporting period, rounded to six decimal places), rounded to four decimal places) times line 15]. Do not apply the sequestration calculation when gross reimbursement (line 15) is less than zero.

For cost reporting periods that overlap or begin on or after May 1, 2020, enter the sequestration adjustment amount from the PS&R (claims-based amounts). In accordance with §3709 of the CARES Act, as amended by §102 of the CAA 2021, §1 of Public Law 117-7, and §2 of the PAMA 2021, do not apply the sequestration adjustment to the period of

May 1, 2020, through March 31, 2022. In accordance with §2 of the PAMA 2021, the sequestration adjustment is 1 percent for the portion of the cost reporting period from April 1, 2022, through June 30, 2022; and 2 percent for the portion of the cost reporting period on or after July 1, 2022.

Line 15.02--Enter any demonstration payment adjustment amounts for demonstration projects in which the provider participated where the demonstration adjustment amounts are not subject to the sequestration adjustment. Obtain this amount from the PS&R.

Line 15.75.--For cost reporting periods that overlap or begin on or after May 1, 2020, calculate the sequestration adjustment for non-claims based amounts as [(2 percent times (total days in the cost reporting period that occur during the sequestration period, divided by total days in the entire cost reporting period, rounded to six decimal places), rounded to four decimal places) times the sum of (lines 10 and 11, plus or minus line 14 and its subscripts not previously identified (do not use lines 14.50, 14.98, and 14.99 in this calculation))]. If the sum of lines 10 and 11, plus or minus line 14 and its subscripts not previously identified is less than zero, do not calculate the sequestration adjustment. In accordance with §3709 of the CARES Act, as amended by §102 of the CAA 2021, §1 of Public Law 117-7, and §2 of the PAMA 2021, do not apply the sequestration adjustment to the period of May 1, 2020, through March 31, 2022. In accordance with §2 of the PAMA 2021, for cost reporting periods that overlap or begin on or after April 1, 2022, calculate the sequestration adjustment amount for the period of April 1, 2022, through June 30, 2022, as follows: [(1 percent times (total days in the cost reporting period that occur from April 1, 2022, through June 30, 2022, divided by total days in the entire cost reporting period, rounded to six decimal places), rounded to four decimal places), times the sum of (lines 10 and 11, plus or minus line 14 and its subscripts not previously identified (do not use lines 14.50, 14.98, and 14.99 in this calculation))]; and for cost reporting periods that overlap or begin on or after July 1, 2022, calculate the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur on or after July 1, 2022, through the end of the cost reporting period, divided by total days in the entire cost reporting period, rounded to six decimal places), rounded to four decimal places) times the sum of (lines 10 and 11, plus or minus line 14 and its subscripts not previously identified (do not use lines 14.50, 14.98, and 14.99 in this calculation))].

Line 16--For title XVIII, enter the total interim payments from Worksheet E-1, column 2, line 4.

Line 17--For contractor final settlement, report the amount from Worksheet E-1, column 2, line 5.99.

Line 18--Enter line 15 minus the sum of the amounts on lines 15.01, 15.02, 15.75, 16, and 17. Transfer this amount to Worksheet S, Part III, line 5 or 7, as appropriate.

Line 19--Enter the program reimbursement effect of protested items. Estimate the reimbursement effect of the nonallowable items by applying a reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See CMS Pub. 15-2, chapter 1, §115.2.) Attach a schedule showing the details and computations.

4033.7 Part VII - Calculation of Reimbursement Settlement - All Other Health Services for Titles V or XIX Services.--This worksheet calculates reimbursement for titles V or XIX services for hospitals, subproviders, other nursing facilities and ICF/IIDs.

Use a separate copy of this part for each of these reporting situations. Enter check marks in the appropriate spaces at the top of each page of this part to indicate the component and program for which it is used. When this part is completed for a component, show both the hospital and component numbers. Enter check marks in the appropriate spaces to indicate the applicable reimbursement method for inpatient services (e.g., TEFRA, OTHER).

Computation of Net Costs of Covered Services

Line Descriptions

Line 1--Enter the appropriate inpatient operating costs.

Cost Reimbursement

Hospital/CAH or Subprovider - Worksheet D-1, Part II, line 49.
Skilled Nursing Facility, Other Nursing Facility, ICF/IID - Worksheet D-1, Part III, line 86. If Worksheet S-2, line 92, is answered "yes", and multiple Worksheets D-1 are prepared, add the multiple Worksheets D-1, and enter the result.

TEFRA

Hospital or Subprovider - Worksheet D-1, Part II, line 63

NOTE: If you are a new provider reimbursed under TEFRA, use Worksheet D-1, Part II, line 49.

Line 2--Enter the cost of outpatient services for titles V or XIX, which is the sum of Worksheet D, Part V, columns 6 and 7, and subscripts, where applicable.

Line 3--For titles V and XIX, enter in column 1 the amount paid or payable by the State program for organ acquisition.

Line 4--Enter the sum of lines 1 through 3.

Line 5--Enter in column 1 the amounts paid or payable by workers' compensation and other primary payers where program liability is secondary to that of the primary payer for inpatient services for titles V and XIX.

Line 6--Enter in column 2 the primary payer amounts applicable to outpatient services for titles V and XIX.

Line 7--Enter line 4 minus the sum of lines 5 and 6.

Computation of Lesser of Reasonable Cost or Customary Charges--You are paid the lesser of the reasonable cost of services furnished to beneficiaries or your customary charges for the same services. This part provides for the computation of the lesser of reasonable cost or customary charges as defined in 42 CFR 413.13(a).

Line Descriptions

Lines 8 through 11--These lines provide for the accumulation of charges which relate to the reasonable cost on line 4.

Do not include on these lines (1) the portion of charges applicable to the excess cost of luxury items or services (see CMS Pub. 15-1, chapter 21, §2104.3), and (2) your charges to beneficiaries for excess costs as described in CMS Pub. 15-1, chapter 25, §§2570-2577.

Line 8--Enter in column 1 the program inpatient routine service charges from your records for the applicable component for title V or XIX. This includes charges for both routine and special care units.

The amounts entered on line 8 include covered late charges billed to the program when the patient's medical condition is the cause of the stay past the checkout time. Also, these amounts include charges relating to a stay in an intensive care type hospital unit for a few hours when your normal practice is to bill for the partial stay.

Line 9--Enter in column 1, the charges from Worksheet D-3, column 2, line 202. Enter in column 2, the sum of the appropriate program ancillary charges from Worksheet D, Part V, columns 3 and/or 4, plus subscripts as applicable, line 202.

Line 10--Enter in column 1, for title V or XIX, the organ acquisition charges from line 3.

Line 11--Enter in column 1, for title V or XIX, the amount of the incentive resulting from the target amount computation on Worksheet D-1, Part II, line 58, if applicable.

Line 12--Enter the sum of the amounts recorded on lines 8 through 11.

Lines 13 through 16--These lines provide for the reduction of program charges when you do not actually impose such charges on most of the patients liable for payment for services on a charge basis or fail to make reasonable efforts to collect such charges from those patients. If line 15 is greater than zero, multiply line 12 by line 15, and enter the result on line 16. If you do impose these charges and make reasonable efforts to collect the charges from patients liable for payment for services on a charge basis, you are not required to complete lines 13 through 15. Enter on line 16, the amount from line 12. In no instance may the customary charges on line 16 exceed the actual charges on line 12.

Line 17--Enter the excess of the customary charges over the reasonable cost. If the amount on line 16 is greater than the amount on line 4, enter the excess.

Line 18--Enter the excess of total reasonable cost over the total customary charges. If the amount on line 4 exceeds the amount on line 16, enter the excess.

Line 19--Enter for title V or XIX, columns 1 and 2, the cost of services rendered by interns and residents as follows from Worksheet D-2:

	Col. 1 Title V	Col. 2 Title V	Col. 1 Title XIX	Col. 2 Title XIX
Hospital	Part I, col. 8, line 9	Part I, col. 8, line 27	Part I, col. 10, line 9	Part I, col. 10, line 27
Subprovider	Part I, col. 8, lines 10-12 as applicable		Part I, col. 10, lines 10-12 as applicable	
Nursing Facility, ICF/IID	Part I, col. 8, line 14		Part I, col. 10, line 14	

Line 20--Teaching hospitals or subproviders participating in an approved GME program, electing to be reimbursed for services of physicians on the basis of reasonable cost (see 42 CFR 415.160 and CMS Pub. 15-1, chapter 21, §2148), enter the cost of physicians. For cost reporting periods ending before June 30, 2014, transfer the amounts from Worksheet D-5, Part II, column 3, as follows:

Title	From Worksheet D-5, Part II, column 3	To Worksheet E-3, Part VII, line 20:
V	Line 18	Column 1
V	Line 19	Column 2
XIX	Line 22	Column 1
XIX	Line 23	Column 2

For cost reporting periods ending on or after June 30, 2014, transfer the amounts from Worksheet D-5, Part IV, as follows:

Title	From Worksheet D-5, Part IV	To Worksheet E-3, Part VII, line 20:
V	Line 18	Column 1
V	Line 19	Column 2
XIX	Line 22	Column 1
XIX	Line 23	Column 2

Line 21--Enter the lesser of line 4 or line 16. If this is a CAH, or otherwise exempt from lower of cost or charges, transfer the amount from line 4.

Prospective Payment Amount

NOTE: Lines 22 through 26 must only be completed for PPS providers.

Line 22--Enter the total IPPS payments for titles V and/or XIX, as applicable, in column 1. Enter the total OPPS payments for title V or XIX, as applicable, in column 2. Obtain this from your books and records.

Line 23--Enter the amount of outlier payments made for the IPPS discharges during the period, in column 1. Enter the outlier payment for the OPPS in column 2.

Line 24--Enter in column 1 the payment for inpatient program capital costs from Worksheet L, Part I, line 12; or Part II, line 5, as applicable.

Line 25--Enter in column 1 the result of Worksheet L, Part III, line 13 less Worksheet L, Part III, line 17. If this amount is negative, enter zero on this line.

Line 26--Enter in column 1, the routine and ancillary service other pass through costs from Worksheet D, Part III, column 9, line 200, and from Worksheet D, Part IV, column 11, line 200, respectively. Enter in column 2, the amount from Worksheet D, Part IV, column 13, line 200.

Line 27--For each column, enter the sum of lines 22 through 26.

Line 28--For title V or XIX only, enter the customary charges for the IPPS in column 1, and the OPPS in column 2.

Line 29--For each column, enter the sum of lines 21 and 27.

Computation of Reimbursement Settlement

Line 30--For each column, enter the amount, if any, from line 18.

Line 31--For each column, enter the sum of lines 19 and 20 plus line 29 minus lines 5 and 6.

Line 32--For each column, enter any deductible amounts imposed.

Line 33--For each column, enter any coinsurance amounts imposed.

Line 34--For each column, enter from your records reimbursable bad debts for deductibles and coinsurance net of bad debt recoveries.

Line 35--Enter in column 1, the reasonable compensation paid to physicians for services on utilization review committees to an SNF. Include the amount on this line in the amount eliminated from total costs on Worksheet A-8. Transfer this amount from Worksheet D-1, Part III, line 85.

Line 36--For each column, enter the sum of lines 31, 34, and 35, minus the sum of lines 32 and 33.

Line 37--For each column, enter any other adjustments. For example, if you change the recording of vacation pay from the cash basis to the accrual basis, enter the adjustment. (See CMS Pub. 15-1, chapter 21, §2146.4.) Specify the adjustment in the space provided.

Line 38--For each column, enter the result of line 36 plus or minus line 37.

Line 39--Enter the amount from Worksheet E-4, line 31, in column 1.

Line 40--For each column, enter the sum of lines 38 and 39.

Line 41--For each column, enter the interim payments obtained from your records.

Line 42--For each column, enter the result of line 40 minus line 41. Transfer the sum of columns 1 and 2 to Worksheet S, Part III, column 1 (title V) or column 5 (title XIX), line as appropriate.

Line 43--Enter the program reimbursement effect of protested items. Estimate the reimbursement effect of the nonallowable items by applying a reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See CMS Pub. 15-2, chapter 1, §115.2.) Attach a schedule showing the details and computations.

4034. WORKSHEET E-4 - DIRECT GRADUATE MEDICAL EDUCATION (GME) AND ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

Use this worksheet to calculate each program's payment (i.e., titles XVIII, V, and XIX) for direct GME costs as determined under 42 CFR 413.75 through 413.83. This worksheet applies to the direct GME cost applicable to interns and residents in approved teaching programs in hospitals, hospitals with excluded units, and CAH-based excluded units. Do not complete this worksheet for interns and residents training in the general acute care part of a CAH; those CAH costs are reimbursed on a reasonable cost basis on Worksheet E-3, Part V. The direct medical education costs of the nursing programs and paramedical education programs continue to be paid on a reasonable cost basis as determined under 42 CFR 413.85. However, the nursing program and paramedical education costs, formerly paid through the ESRD composite rate as an exception, are paid on this worksheet on the basis of reasonable cost under 42 CFR 413.85. Effective for cost reporting periods beginning on or after October 1, 1997, the unweighted direct GME FTE is limited to the hospital's FTE count for the most recent cost reporting period ending on or before December 31, 1996. This limit applies to allopathic and osteopathic residents but excludes dentistry and podiatry. The GME payment is also based on the inclusion of Medicare HMO patients treated in the hospital. This worksheet will also calculate payment for direct GME as determined under 42 CFR 413.79(c)(3) and (4) and IME as determined under 42 CFR 412.105(f)(1)(iv)(B) and (C) for hospitals that received an adjustment (reduction or increase) to their FTE resident caps for direct GME and/or IME under section 422 of Public Law 108-173.

NOTE: For cost reporting periods beginning prior to December 27, 2020, do not complete this worksheet for a cost reporting period prior to the base period used for calculating the per resident amount (PRA) in situations where the hospital did not train residents in approved residency training programs or did not participate in the Medicare program during the base period but either condition changed in a cost reporting period beginning on or after July 1, 1985. 42 CFR 413.77(e)(1) specified that in this situation, any GME costs for the cost reporting period prior to the base period are reimbursed on a reasonable cost basis.

For cost reporting periods beginning prior to December 27, 2020, complete this worksheet if this is the first month in which residents were on duty during the first month of the cost reporting period or if residents were on duty during the entire prior cost reporting period. (See 42 CFR 413.77(e)(1).) For cost reporting periods beginning on or after December 27, 2020, this exception at 42 CFR 413.77(e)(1) for reasonable cost payment for direct GME no longer applies. Complete Worksheet E-4 in accordance with 42 CFR 413.78(b)(2) if the answer to Worksheet S-2, Part I, line 56, column 1, is "Y".

This worksheet consists of five sections:

1. Computation of Total Direct GME Amount
2. Computation of Program Patient Load
3. Direct Medical Education Costs for ESRD Composite Rate - Title XVIII only
4. Apportionment of Medicare Reasonable Cost (title XVIII only)
5. Allocation of Medicare Direct GME Costs Between Part A and Part B

Computation of Total Direct GME Amount--This section computes the total approved amount.

For IPPS hospitals participating in the PARHM demonstration during this cost reporting period and (1) the hospital participated in the PARHM demonstration for the entire cost reporting period, select the "PARHM Demonstration" box only and complete this worksheet; or (2) the hospital participated in the PARHM demonstration for a portion of the cost reporting period, select the "PARHM Demonstration" box and complete Worksheet E-4 for the portion of the cost reporting period included in the demonstration. Select the "Hospital" box and complete a separate Worksheet E-4, for the portion of the cost reporting period not included in the demonstration.

Line Descriptions

Line 1--Enter the unweighted resident FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before December 31, 1996 (42 CFR 413.79(c)(2)). The count includes the increase due to primary care residents that were on approved leaves of absence (42 CFR 413.79(i)) and, for hospitals located in a rural area, the 30 percent increase to the count in accordance with 42 CFR 413.79 (c)(2)(i). Temporarily reduce the cap of a hospital that closed a program(s), if the regulations at 42 CFR 413.79(h)(3)(ii) are applicable. (Effective October 1, 2001.) If this cost report is less than a full 12 months, contact your contractor.

Line 1.01--Enter the FTE cap adjustment if your hospital qualifies under section 131 of the CAA 2021 for a reset to your FTE cap, and this cost report is after the cap-building window has closed for the qualifying new program(s). During the new program cap-building window, report the FTEs on line 15. See 86 FR 73418 (December 27, 2021).

Line 2--Enter the unweighted resident FTE count for allopathic and osteopathic programs that meet the criteria for an adjustment to the cap for new programs in accordance with 42 CFR 413.79(e). For hospitals qualifying for a cap adjustment under 42 CFR 413.79(e)(1) or (e)(3), the cap is effective beginning with the fourth program year of the first new program accredited or begun on or after January 1, 1995, but before October 1, 2012. For urban hospitals that participate in training residents in a new program for the first time on or after October 1, 2012, under 42 CFR 413.79(e)(1), the cap is effective beginning with the cost reporting period that coincides with or follows the start of the sixth program year of the first new program started (see (79 FR 50110 (August 22, 2014)). For rural hospitals that participate in training residents in a new program on or after October 1, 2012, under 42 CFR 413.79(e)(3), each new program in which the rural hospital participates has its own initial years before the rural hospital's FTE resident cap is adjusted based on each new program. Therefore, the rural hospital's FTE resident cap is adjusted for each new program effective with the hospital's cost reporting period that coincides with or follows the start of the sixth program year of each new program started (see 79 FR 50110 (August 22, 2014)). For hospitals qualifying for a cap adjustment under 42 CFR 413.79(e)(2), the cap for each new program accredited or begun on or after January 1, 1995, and before August 6, 1997, is reported on this line and is effective in the fourth program year of each of those new programs (see 66 FR August 1, 2001, 39881). The cap adjustment reported on this line should not include any resident FTEs that were already included in the cap on line 1. Do not report new program FTEs during the time frame prior to the effective date of the hospital's FTE cap on this line. New program FTEs during the time frame prior to the effective date of the hospital's FTE cap are reported on line 15.

RURAL TRACK PROGRAMS IN EFFECT PRIOR TO §127 OF THE CAA 2021: For urban hospitals that already have an FTE cap on line 1 but start a rural track program in accordance with 42 CFR 413.75(k), enter the unweighted allopathic or osteopathic FTE count for residents in all years of the rural track program that meet the criteria for an add-on to the cap under 42 CFR 413.79(k). (If the rural track program is a new program under 42 CFR 413.79(l) and the hospital qualifies for a cap adjustment under 42 CFR 413.79(e)(1) or (e)(3), do not report FTE residents in the rural track program on this line during the time frame prior to the effective date of the hospital's FTE cap). Only enter rural track cap adjustments in effect in a cost reporting period beginning prior to October 1, 2022.

Line 2.26--RURAL TRACK PROGRAMS IN EFFECT UNDER §127 OF THE CAA 2021: For rural track program FTE cap limitation adjustments effective for cost reporting periods beginning on or after October 1, 2022, for both urban and rural hospitals that participate in a rural track program (defined at 42 CFR 413.75(b), under section 127 of the CAA 2021, enter the rural track program FTE cap limitation adjustment after the cap-building window has closed for the particular rural track program (see 86 FR 73418 (December 27, 2021)). During the cap-building window, report the FTEs on line 15. Further subscript this line through line 2.49 for each additional rural track program FTE limitation at either the urban hospital or rural hospital.

Line 3--Enter the section 422 reduction amount to the direct GME cap as specified under 42 CFR 413.79(c)(3).

Line 3.01--Enter the section 5503 reduction amount to the direct GME cap as specified under 42 CFR 413.79(m). If this cost report straddles July 1, 2011, then calculate the prorated section 5503 reduction amount off the cost report and enter the result on this line. (Prorate the cap reduction amount by multiplying it by the ratio of the number of days from July 1, 2011, to the end of the cost reporting period to the total number of days in the cost reporting period). Otherwise enter the full cap reduction amount.

Line 3.02--Enter the adjustment (increase or decrease) to the hospital's rural track FTE limitation(s) from line 2 for rural track programs with a rural track Medicare GME affiliation agreement, in accordance with 87 FR 49075 (August 10, 2022).

Line 4--Enter the adjustment (increase or decrease) for the unweighted resident FTE count for allopathic or osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(f), and (63 FR 26336 (May 12, 1998), and 67 FR 50069 (August 1, 2002)). Note: Affiliation adjustments on this line must not include FTEs from rural track programs on lines 2 through 2.49.

Line 4.01--Enter, as applicable, all or a portion of the amount of the FTE cap slots the hospital was awarded under section 5503 of ACA. The amount of the section 5503 award that is reported on this line is the amount of the section 5503 award that is being "used" in this cost reporting period. In the 5-year evaluation period following implementation of section 5503 (that is, July 1, 2011, through June 30, 2016), at least 75 percent of the slots are to be "used" for additional primary care and/or general surgery residents, while 25 percent of the amount that is reported may be (but need not be) "used" for other purposes. During the 5-year evaluation period, failure to meet the requirements at 42 CFR 413.79(n)(2) of the regulations means loss of a hospital's section 5503 slots. Therefore, for portions of cost reporting periods occurring during the 5-year evaluation period (July 1, 2011, and before July 1, 2016), do not automatically report the full amount of the section 5503 slots; only enter the amount of the section 5503 award that equates to at least 75 percent of the FTEs being "used" for additional primary care and/or general surgery FTEs, and no more than 25 percent being used for other FTEs. If, during the 5-year evaluation period, your hospital has not added any primary care or general surgery residents in accordance with receipt of the section 5503 award, leave this line blank and do not report any of the section 5503 award on this line in this cost reporting period. For portions of cost reporting periods occurring during the 5-year evaluation period (July 1, 2011, and before July 1, 2016), if the amount reported on Worksheet S-2, Part I, line 61.02, column 3, is less than the amount on line 61.01, column 3, then report zero on this line.

Line 4.02--Enter the amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. Further subscript this line (lines 4.03 through 4.20) as necessary if the hospital receives FTE cap slot awards on more than one occasion under section 5506. Refer to the letter from CMS awarding this hospital the slots under section 5506 to determine the effective date of the cap increase. If the section 5506 award is phased in over more than one effective date, only report the portions of the section 5506 award as they become effective. If the effective date of the cap increase is not the same as your fiscal year beginning date, then prorate the cap increase accordingly. (Prorate the cap increase amount by multiplying it by the ratio of the number of days from the effective date of the cap increase to the end of the cost reporting period to the total number of days in the cost reporting period.)

Line 4.21--Enter the amount of increase if the hospital was awarded FTE cap slots under section 126 of the CAA 2021, effective beginning July 1, 2023. If this cost report straddles July 1, calculate a prorated cap increase by multiplying the increase by the ratio of the number of days from July 1, to the end of the cost reporting period, to the total number of days in the cost reporting period. Use subscripted lines 4.22 through 4.27 if the hospital receives FTE cap slot awards on more than one occasion under section 126 of the CAA 2021, effective July 1 of a year.

Line 4.28--Enter the amount of increase if the hospital was awarded FTE cap slots under section 4122 of the CAA 2023, effective beginning July 1, 2026. If this cost report straddles July 1, 2026, calculate a prorated cap increase by multiplying the increase by the ratio of the number of days from July 1, 2026, to the end of the cost reporting period, to the total number of days in the cost reporting period.

Line 5--Enter the result of line 1 plus line 1.01 plus line 2, plus lines 2.26 through 2.49, minus line 3, minus line 3.01, plus or minus line 3.02, plus or minus line 4, plus lines 4.01 through 4.28. However, if the resulting cap is less than zero, enter zero on this line.

Line 6--Enter the unweighted resident FTE count for allopathic or osteopathic programs for the current year from your records, other than those in the initial years of the program (i.e., the program has not yet completed one cycle of the program (the "period of years") or the minimum accredited length of the program). The residents in programs within the "period of years" are exempt from the rolling average rules. (42 CFR 413.79(d)(5) and (e).) Exclude FTE residents displaced by hospital or program closures that are in excess of the cap for which a temporary cap adjustment is needed (42 CFR 413.79(h)).

Line 7--Enter the lesser of lines 5 or 6.

Line 8--Enter in column 1, the weighted FTE count for primary care physicians and OB/GYN residents in an allopathic or osteopathic program for the current year. Enter in column 2, the weighted FTE count for all other physicians in an allopathic or osteopathic program for the current year. Exclude FTE residents in the initial period of years of the new program, which for urban or rural hospitals that began training residents in a new program under 42 CFR 413.79(e)(1) or (e)(3), prior to October 1, 2012, means that the program has not yet completed one cycle of the program (i.e., "period of years,") or minimum accredited length of the program. (42 CFR 413.79(d)(5) and (e)). For new programs started prior to October 1, 2012, contact your contractor for instructions on how to complete this line if you have a new program for which the period of years is less than or more than three years. For urban hospitals that began participating in training residents in a new program for the first time on or after October 1, 2012, under 42 CFR 413.79(e)(1), do not include FTE residents in a new program on this line if this cost reporting period is prior to the cost reporting period that coincides with or follows the start of the sixth program year of the first new program started (i.e., the initial years) (see 79 FR 50110 (August 22, 2014)). For rural hospitals participating in a new program on or after October 1, 2012, under 42 CFR 413.79(e)(3), each new program in which the rural hospital participates has its own initial years before the rural hospital's FTE resident cap is adjusted based on each new program. Therefore, for rural hospitals, do not include FTE residents in a new program on this line if this cost reporting period is prior to the cost reporting period that coincides with or follows the start of the sixth program year of each individual new program started (see 79 FR 50110 (August 22, 2014)). For both urban and rural hospitals, report FTE residents in the initial years of the new program and/or the new rural track program on line 15. Exclude FTE residents displaced by hospital or program closures that are in excess of the cap for which a temporary cap adjustment is needed (42 CFR 413.79(h)). Enter in column 3, the sum of columns 1 and 2.

Line 9--For cost reporting periods that begin prior to October 1, 2022, and if Worksheet S-2, Part I, line 68, is "N", if line 6 is less than or equal to line 5, enter the amounts from line 8, columns 1 and 2, in columns 1 and 2, respectively, of this line. Otherwise, multiply the amount in each column of line 8 by (line 5/line 6). Enter in column 3, the sum of columns 1 and 2. (See 42 CFR 413.79(c)(2)(iii).)

For cost reporting periods that begin on or after October 1, 2022, or if Worksheet S-2, Part I, line 68, is "Y", if the total weighted FTE count from line 8, column 3, is less than or equal to the amount on line 5, then enter the amounts from line 8, columns 1 and 2, in columns 1 and 2, respectively, of this line. Otherwise, if the total weighted FTE count from line 8, column 3, is greater than the FTE cap on line 5, then enter in column 1 the result of line 8, column 1 (primary care & OB/GYN weighted FTEs), divided by line 8, column 3 (total weighted FTEs), times the FTE cap on line 5. Enter in column 2 the result of line 8, column 2 (other weighted FTEs), divided by line 8, column 3 (total weighted FTEs), times the FTE cap on line 5. Enter in column 3 the sum of columns 1 and 2. See 87 FR 49066 (August 10, 2022) and 42 CFR 413.79(c)(2)(iii).

Line 10--Enter in column 2, the weighted dental and podiatric resident FTE count for the current year.

Line 10.01--Enter in column 2, the unweighted dental and podiatric resident FTE count for the current year. This amount is used for informational purposes only and does not impact the calculations on this worksheet.

Line 11--Enter in column 1, the amount from column 1, line 9. Enter in column 2, the sum of the amounts in column 2, lines 9 and 10.

Line 12--For cost reporting periods that begin prior to October 1, 2022, and if Worksheet S-2, Part I, line 68, is "N", enter in column 1, the weighted FTE count for primary care residents for the prior year, other than those in the initial years of the program that meet the criteria for an exception to the averaging rules (42 CFR 413.79(d)(5)). However, if the period of years during which the FTE residents in any of your new training programs were exempted from the rolling average has expired (see 42 CFR 413.79(d)(5)), also enter on this line the count of FTE residents in that specific primary care (or OB/GYN) program included in Form CMS-2552-96, Worksheet E-3, Part IV, line 3.22, or Form CMS-2552-10, Worksheet E-4, from line 15 of the prior year's cost report. If subject to the cap in the prior year Form CMS-2552-96 cost report, report the result of Worksheet E-3, Part IV, line 3.07, times (line 3.04/line 3.05). If subject to the cap in the prior year Form CMS-2552-10 cost report, report the result of Worksheet E-4, column 1, line 8, times (line 5/line 6).

Enter in column 2, the weighted FTE count for nonprimary care residents for the prior year, other than those in the initial years of the program that meet the criteria for an exception to the averaging rules (42 CFR 413.79(d)(5)). However, if the period of years during which the FTE residents in any of your new training programs were exempted from the rolling average has expired (see 42 CFR 413.79(d)(5)), also enter on this line the count of FTE residents in that specific nonprimary care program included in Form CMS-2552-96, Worksheet E-3, Part IV, line 3.16, or Form CMS-2552-10, Worksheet E-4, from line 15 of the prior year's cost report. If subject to the cap in the prior year Form CMS-2552-96 cost report, report the result of Worksheet E-3, Part IV, line 3.08, times (line 3.04/line 3.05), plus line 3.11. If subject to the cap in the prior year Form CMS-2552-10 cost report, report the result of Worksheet E-4, column 2, line 8, times (line 5/line 6), plus line 10.

For cost reporting periods that begin on or after October 1, 2022, or if Worksheet S-2, Part I, line 68, is "Y", if the prior year total weighted FTE count from line 8, column 3, is less than or equal to line 5 from the prior year, then enter the amount from line 8, column 1, in column 1 of this line; and the sum of lines 8 and 10, column 2, in column 2 of this line. If subject to the cap in the prior year (if the prior year total weighted FTE count from line 8, column 3, is greater than the FTE cap on line 5 from the prior year), then enter in column 1 the result of line 8, column 1 (primary care & OB/GYN weighted FTEs), divided by line 8, column 3 (total weighted FTEs), times the FTE cap on line 5. Enter in column 2 the result of line 8, column 2 (other weighted FTEs), divided by line 8, column 3 (total weighted FTEs), times the FTE cap on line 5, plus the amount on line 10, column 2. See 87 FR 49066 (August 10, 2022). However, if the period of years during which the FTE residents in any of your new training programs were exempted from the rolling average has expired (see 42 CFR 413.79(d)(5)), also enter on this line, in column 1 or column 2, as applicable, the count of FTE residents in that specific primary care (or OB/GYN) program or non-primary care program included in Form CMS-2552-10, Worksheet E-4, from line 15 of the prior year's cost report.

Line 13--For cost reporting periods that begin prior to October 1, 2022, and if Worksheet S-2, Part I, line 68, is "N", enter in column 1, the weighted FTE count for primary care (or OB/GYN) residents for the cost reporting year before last, other than those in the initial years of the program that meet the criteria for an exception to the averaging rules (42 CFR 413.79(d)(5)). However, if the period of years during which the FTE residents in any of your new training programs were exempted from the rolling average has expired (see 42 CFR 413.79(d)(5)), also enter on this line the count of FTE residents in that specific primary care (or OB/GYN) program included on

Form CMS-2552-96, line 3.22, or Form CMS-2552-10, from line 15 of that year's cost report. If subject to the cap in the year before last Form CMS-2552-96 cost report, report the result of line 3.07, times (line 3.04/line 3.05). If subject to the cap in that year Form CMS-2552-10 cost report, report the result of column 1, line 8, times (line 5/line 6).

Enter in column 2, the weighted FTE count for nonprimary care residents for the cost reporting year before last, other than those in the initial years of the program that meet the criteria for an exception to the averaging rules (42 CFR 413.79(d)(5)). However, if the period of years during which the FTE residents in any of your new training programs were exempted from the rolling average has expired (see 42 CFR 413.79(d)(5)), also enter on this line the count of FTE residents in that specific nonprimary care program included in Form CMS-2552-96, line 3.16, or Form CMS-2552-10, from line 15 of that year's cost report. If subject to the cap in the cost reporting year before last, Form CMS-2552-96 cost report, report the result of line 3.08, times (line 3.04/line 3.05), plus line 3.11. If subject to the cap in that year Form CMS-2552-10 cost report, report the result of column 2, line 8, times (line 5/line 6), plus line 10.

For cost reporting periods that begin on or after October 1, 2022, or if Worksheet S-2, Part I, line 68, is "Y", if the penultimate year total weighted FTE count from line 8, column 3, is less than or equal to line 5 from the penultimate year, then enter the amount from line 8, column 1, in column 1 of this line; and the sum of lines 8 and 10, column 2, in column 2 of this line. If subject to the cap in the penultimate year, (if the penultimate year total weighted FTE count from line 8, column 3, is greater than the FTE cap on line 5 from the penultimate year) then enter in column 1 the result of line 8, column 1 (primary care & OB/GYN weighted FTEs), divided by line 8, column 3 (total weighted FTEs) times the FTE cap on line 5. Enter in column 2 the result of line 8, column 2 (other weighted FTEs), divided by line 8, column 3 (total weighted FTEs) times the FTE cap on line 5, plus the amount on line 10, column 2. See 87 FR 49066 (August 10, 2022). However, if the period of years during which the FTE residents in any of your new training programs were exempted from the rolling average has expired (see 42 CFR 413.79(d)(5)), also enter on this line, in column 1 or column 2, as applicable, the count of FTE residents in that specific primary care (or OB/GYN) program or non-primary care program included in Form CMS-2552-10, Worksheet E-4, from line 15 of that year's cost report.

Line 14--Enter the rolling average FTE count in each column, by adding lines 11 through 13, and dividing by 3.

Line 15--Enter the weighted number of FTE residents in the initial years of a program in column 1 for primary care and OB/GYN, and in column 2 for nonprimary care FTEs. For a new program started prior to October 1, 2012, contact your contractor for instructions on how to complete this line if you have a new program for which the period of years is less than or more than three years. For urban hospitals that began participating in training residents in a new program for the first time on or after October 1, 2012 under 42 CFR 413.79(e)(1), include FTE residents in a new program on this line if this cost reporting period is prior to the cost reporting period that coincides with or follows the start of the sixth program year of the first new program started (see 79 FR 50110 (August 22, 2014)). For rural hospitals participating in a new program(s) on or after October 1, 2012, under 42 CFR 413.79(e)(3), include FTE residents in a particular new program on this line if this cost reporting period is prior to the cost reporting period that coincides with or follows the start of the sixth program year of that new program (see 79 FR 50110 (August 22, 2014)).

For hospitals receiving an adjusted FTE cap for new program(s) under section 131 of the CAA 2021, enter the FTEs on this line prior to the cost reporting period that coincides with or follows the start of the sixth program year of the new program(s) (see 86 FR 73418 (December 27, 2021)).

Effective for cost reporting periods beginning on or after October 1, 2022, for urban and rural hospitals participating in a rural track program(s), enter the FTEs prior to the cost reporting period that coincides with or follows the start of the sixth program year of that rural track program (see 86 FR 73418 (December 27, 2021)).

Line 15.01--Enter the unweighted number of FTE residents in the initial years of a program in column 1 for primary care and OB/GYN, and in column 2 for nonprimary care. Use line 15 instructions to determine the unweighted FTE resident counts for this line. This amount is used for informational purposes only and does not impact the calculations on this worksheet.

Line 16--Enter the temporary weighted FTE residents that were displaced by program or a hospital closure in column 1 for primary care, and in column 2 for nonprimary care, which you would not be able to count without a temporary cap adjustment. (42 CFR 413.79(h).)

Line 16.01--Enter the temporary unweighted FTE residents that were displaced by program or a hospital closure in column 1 for primary care, and in column 2 for nonprimary care, which you would not be able to count without a temporary cap adjustment. (42 CFR 413.79(h).) This amount is used for informational purposes only and does not impact the calculations on this worksheet.

Line 17--Enter the sum of lines 14 through 16.

Line 18--Enter in column 1, the primary care and OB/GYN per resident amount. Enter in column 2, the nonprimary care per resident amount.

Line 18.01--Enter in columns 1 and 2 the same single revised per resident amount received in accordance with section 131 of the CAA 2021.

Line 19--Enter the result of multiplying line 17 by line 18. Enter in column 3, the sum of columns 1 and 2. If this hospital received a PRA in accordance with section 131 of the CAA 2021 on line 18.01, then multiply line 17 by line 18.01 and enter in column 3, the sum of columns 1 and 2.

Line 20--Section 422 Direct GME FTE Cap--Enter the number of unweighted allopathic and osteopathic direct GME FTE resident cap slots the hospital received under 42 CFR §413.79(c)(4).

Line 21--Direct GME FTE Resident Unweighted Count Over/Under the Cap--Subtract line 7 from line 6 and enter the result here. If the result is zero or negative, the hospital does not need to use the direct GME section 422 additional cap and lines 22 through 24 will not be completed.

Line 22--Section 422 Allowable Direct GME FTE Resident Count--For cost reporting periods that begin prior to October 1, 2022, and if Worksheet S-2, Part I, line 68, is "N", if the count on line 21 is less than or equal to the count on line 20, then divide line 8 by line 6, and multiply the resulting ratio by the amount on line 21. If the count on line 21 is greater than the count on line 20, then divide line 8 by line 6, and multiply the resulting ratio by the amount on line 20. For cost reporting periods that begin on or after October 1, 2022, or if Worksheet S-2, Part I, line 68, is "Y", if the weighted FTE count on line 8 is less than or equal to the adjusted FTE cap on line 5, the hospital entered the weighted FTEs from line 8 on line 9. In this instance, the additional section 422 cap slots are unnecessary; do not complete lines 22 through 24. If the weighted FTE count on line 8 is greater than the adjusted FTE cap on line 5, the hospital entered the adjusted FTE cap on line 9. In this instance, subtract line 9 from line 8. If line 8 minus line 9 equals or exceeds the section 422 DGME FTE cap on line 20, then enter the amount from line 20 on line 22. If line 8 minus line 9 is less than line 20, enter the result line 8 minus line 9 on line 22. See 87 FR 49066 (August 10, 2022).

Line 23--Enter the locality adjusted national average per resident amount as specified at 42 CFR 413.77(g), inflated to the hospital's cost reporting period.

Line 24--Enter the product of lines 22 and 23. This is the allowable section 422 GME cost.

Line 25--Enter the sum of lines 19 and 24. This is the total Part A direct GME cost.

Computation of Program Patient Load--This section computes the ratio of program inpatient days to the total inpatient days. For this calculation, total inpatient days include inpatient days of the hospital along with its subproviders, including distinct part units excluded from the PPS. Record hospital inpatient days of Medicare beneficiaries whose stays are paid by risk basis HMOs and organ acquisition days as non-Medicare days. Do not count inpatient days applicable to nursery, hospital-based SNFs and other nursing facilities, and other non-hospital level of care units for the purpose of determining the Medicare patient load.

The BBRA provided that payments that are made to teaching hospitals for costs of direct GME associated with services to MA enrollees will be reduced by an estimated percentage in each CY. Specifically, the law provides that the estimated reductions in MA direct GME payments must equal the estimated total additional MA nursing and allied health education payments. Accordingly, for portions of cost reporting periods occurring in a calendar year, all hospitals that receive MA direct GME payments (including those that do not receive additional nursing and allied health payments under the BIPA provision) will have these payments reduced by the percent reduction in accordance with CR 11642 or subsequent applicable CRs.

Complete lines 26 through 30, columns 2 and 2.01, as applicable. Calendar year providers complete only column 2.

Line Descriptions

Line 26--Effective for cost reporting periods beginning prior to October 1, 2013, enter in column 1, for title XVIII, the sum of the days reported on Worksheet S-3, Part I, column 6, lines 1, 8 through 12, 16, and 17, and subscripts as applicable.

Effective for cost reporting periods beginning on or after October 1, 2013, enter in column 1, for title XVIII, the sum of the days reported on Worksheet S-3, Part I, column 6, or column 6.01 (for the PARHM demonstration worksheet), lines 1, 8 through 12, 16, and 17, and subscripts as applicable, and line 32. For title V or XIX, enter the amounts from columns 5 or 7, respectively, sum of lines 1, 8 through 12, 16, and 17, and subscripts, as applicable, plus column 7, line 32, for title XIX.

For title XVIII, if you are a calendar year provider or not impacted by CR 11642, enter in column 2, the Medicare managed care days from Worksheet S-3, Part I, column 6, or column 6.01 (for the PARHM demonstration worksheet), lines 2, 3, and 4. For title XIX, enter in column 2, Medicaid managed care days from Worksheet S-3, Part I, column 7, lines 2, 3, and 4.

If you are impacted by CR 11642 or subsequent CRs, the response to Worksheet S-2, Part I, line 56, column 2, is "Y", for title XVIII, and you are not a calendar year end provider enter in column 2, the portion of the Medicare managed care days reported on Worksheet S-3, Part I, column 6, or column 6.01 (for the PARHM demonstration worksheet), lines 2, 3, and 4, occurring prior to January 1; and enter in column 2.01, the portion of the Medicare managed care days reported on Worksheet S-3, Part I, column 6, or column 6.01 (for the PARHM demonstration worksheet), lines 2, 3, and 4, occurring on or after January 1.

Line 27--Effective for cost reporting periods beginning prior to October 1, 2013, transfer to columns 1, 2, and 2.01, respectively, the sum of the days reported on Worksheet S-3, Part I, column 8, lines 1, 8 through 12, 16, and 17, and subscripts as applicable.

Effective for cost reporting periods beginning on or after October 1, 2013, transfer to columns 1, 2, and 2.01, the sum of the days reported on Worksheet S-3, Part I, column 8, lines 1, 8 through 12, 16, 17, and subscripts as applicable, and line 32.

Line 28--In each column, divide line 26 by line 27 and enter the result (expressed as a decimal). Column 1 is the title XVIII Part A inpatient utilization and columns 2 and 2.01 is the Medicare managed care inpatient utilization.

Line 29--Multiply the amount on line 25, column 1, by the amount reported in each column of line 28. Enter in column 3, the sum of columns 1, 2, and 2.01.

Line 29.01--If the response to Worksheet S-2, Part I, line 56, column 2, is "Y", enter in columns 2 and 2.01, the applicable reduction percentage to MA direct GME payments. Enter in column 2, the MA reduction percentage for the portion of the cost reporting period prior to January 1; and enter in column 2.01, the MA reduction percentage for the portion of the cost reporting period on or after January 1. Calendar year providers complete only column 2.

CY	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Percent reduction to MA DGME	9.77	7.85	7.16	6.41	5.86	5.32	4.99	4.44	4.12	4.07	3.73

CY	2021	2022	2023	2024
Percent reduction to MA DGME	3.26	3.27	2.74	2.33

Line 30--In column 2, enter the amount on line 29, column 2, multiplied by the reduction factor reported in the 65 FR 47038 and 47039 (August 1, 2000). This is the reduction for direct GME payments for Medicare Advantage. If the response to Worksheet S-2, Part I, line 56, column 2, is "Y", enter in column 2 the result of line 29, column 2, multiplied by the reduction factor on line 29.01, column 2, and enter in column 2.01 the result of line 29, column 2.01, multiplied by the reduction factor on line 29.01, column 2.01. Enter in column 3, the sum of columns 2 and 2.01.

Line 31--Enter the sum of columns 1, 2, and 2.01, line 29, less the amount in columns 2 and 2.01, line 30.

Direct Medical Education Costs for ESRD Composite Rate Title XVIII Only--This section computes the title XVIII nursing program and paramedical education costs applicable to the ESRD composite rate. These costs are reimbursable based on the reasonable cost principles under 42 CFR 413.85 separate from the ESRD composite rate.

Line Descriptions

Line 32--Enter the amount from Worksheet B, Part I, sum of columns 20 and 23, lines 74 and 94.

Line 33--Enter the amount from Worksheet C, Part I, column 8, sum of lines 74 and 94. This amount represents the total charges for renal and home dialysis.

Line 34--Divide line 32 by line 33 and enter the result. This amount represents the ratio of ESRD direct medical education costs to total ESRD charges.

Line 35--Enter from your records the Medicare outpatient ESRD charges.

Line 36--Enter the result of multiplying line 34 by line 35. This represents the Medicare outpatient ESRD costs. Transfer this amount to Worksheet E, Part B, line 29.

Apportionment of Medicare Reasonable Cost of GME--This section determines the ratio of Medicare reasonable costs applicable to Part A and Part B. The allowable costs of GME that per resident amounts are established include GME costs attributable to the entire hospital complex (including non-hospital portions of a health care complex). Therefore, the reasonable costs used in the apportionment between Part A and Part B include the hospital, hospital-based providers, and distinct part units. Do not complete this section for titles V and XIX.

Line Descriptions

Line 37--Include the Part A reasonable cost for the entire hospital complex computed by adding the following amounts:

- Hospital and Subprovider(s) - Sum of each Worksheet D-1, Part II, line 49;
- Hospital-Based HHAs - Worksheet H-4, Part I, column 1, line 1;
- Swing-Bed SNF - Worksheet E-2, line 1, column 1;
- Hospital-Based PPS SNF - Sum of Worksheet D-1, Part III, line 74, and Worksheet E-3, Part VI, column 1, line 4.

Line 38--TEFRA providers enter the organ acquisition costs from Worksheet(s) D-4, Part III, column 1, line 69. All other providers enter the sum of organ acquisition costs from Worksheet(s) D-4, Part III, column 1, line 69, plus HSCT acquisition costs from Worksheet D-6, Part III, line 10, column 1.

Line 39--Enter the cost of teaching physicians from Worksheet(s) D-5, Part II, column 3, line 20, or D-5, Part IV, column 1, line 20, as applicable.

Line 40--Enter the total Medicare Part A primary payer amounts for the hospital complex from the applicable worksheets.

- PPS hospital and/or subproviders - Worksheet E, Part A, line 60;
- TEFRA hospital and/or subproviders - Worksheet E-3, Part I, line 5;
- IPF PPS hospital and/or subproviders - Worksheet E-3, Part II, line 17;
- IRF PPS hospital and/or subproviders - Worksheet E-3, Part III, line 18;
- LTCH PPS hospital - Worksheet E-3, Part IV, line 8;
- Cost reimbursed hospital and/or subproviders - Worksheet E-3, Part V, line 5;
- Hospital-based HHAs - Each Worksheet H-4, Part I, column 1, line 9;
- Swing-Bed SNF and/or NF - Worksheet E-2, column 1, line 9; and
- Hospital-based PPS SNF - Worksheet E-3, Part VI, column 1, line 13.

Line 41--Enter the sum of lines 37 through 39 minus line 40.

Line 42--Enter the Part B Medicare reasonable cost. Enter the sum of the amounts on each title XVIII Worksheet E, Part B, columns 1 and 1.01, sum of lines 1, 2, 9, 10, 22, and 23; Worksheet E-2, column 2, line 8; Worksheet H-4, Part I, sum of columns 2 and 3, line 1; Worksheet J-3, column 1, line 1; Worksheet M-3, line 16; and Worksheet N-2, sum of columns 11 and 12, line 11.

Line 43--Enter the Part B primary payer amounts. Enter the sum of the amounts on each Worksheet E, Part B, line 31; Worksheet E-2, column 2, line 9; Worksheet H-4, Part I, sum of columns 2 and 3, line 9; Worksheet J-3, line 4; Worksheet M-3, sum of columns 1 and 2, line 17; and Worksheet N-4, line 5.

Line 44--Enter line 42 minus line 43.

Line 45--Enter the sum of lines 41 and 44.

Line 46--Divide line 41 by line 45 and enter the result.

Line 47--Divide line 44 by line 45 and enter the result.

Allocation of Medicare Direct GME Costs Between Part A and Part B--Use this section to compute the GME payments for title XVIII, Part A and Part B, and to compute the total GME payments applicable to titles V and XIX.

Line Descriptions

Line 48--Enter the amount from line 31.

Line 49--Complete for title XVIII only. Multiply line 46 by line 48 and enter the result. If you are a hospital subject to IPPS, transfer this amount to Worksheet E, Part A, line 52. Although this amount includes the Part A GME payments for subproviders, for ease of computation, transfer this amount to the primary hospital component worksheet only. If you are freestanding facility subject to TEFRA, transfer this amount to Worksheet E-3, Part I, line 15. If you are a freestanding IPF PPS, transfer this amount to Worksheet E-3, Part II, line 27. If you are a freestanding IRF PPS, transfer this amount to Worksheet E-3, Part III, line 28. If you are a freestanding LTCH PPS, transfer this amount to Worksheet E-3, Part IV, line 18.

Line 50--Complete for title XVIII only. Multiply line 47 by line 48 and enter the result. Transfer this amount to Worksheet E, Part B, line 28. Although this amount includes the Part B GME payments for subproviders, for ease of computation, transfer this amount to the hospital component only.

4035. WORKSHEET E-5 - OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT

This worksheet is for contractor use only for cost reporting periods beginning on or after October 1, 2020. The contractor completes this worksheet to report outlier reconciliation amounts during the cost report tentative settlement if the hospital meets the criteria based on information available at tentative settlement. Do not adjust or revise this worksheet after tentative settlement; calculate the outlier reconciliation amount for final settlement on Worksheet E, Part A, lines 90 through 96.

Line 1--Enter the sum of the operating outlier amounts from the provider's submitted Worksheet E, Part A, lines 2.03 and 2.04, sum of all columns.

Line 2--Enter the capital outlier amount from the provider's submitted Worksheet L, Part I, line 2.

Line 3--Enter the operating outlier reconciliation adjustment amount.

Line 4--Enter the capital outlier reconciliation adjustment amount.

Line 5--Enter the interest rate used to calculate the time value of money. (See CMS Pub. 100-04, chapter 3, §§20.1.2.6.)

Line 6--Enter the operating time value of money for operating related expenses.

Line 7--Enter the capital time value of money for capital related expenses.

SECTIONS 4036 THROUGH 4037 ARE RESERVED FOR FUTURE USE.

4038. WORKSHEET E-90 - SUPPLEMENTAL TO FORM CMS-2552-10: PAYMENT ADJUSTMENT FOR ESTABLISHING AND MAINTAINING ACCESS TO A BUFFER STOCK OF ESSENTIAL MEDICINES

This supplemental form calculates the inpatient payment adjustment for the additional resource costs of establishing and maintaining access to no less than a 6-month buffer stock of one or more essential medicines for cost reporting periods beginning on or after October 1, 2024. The payment adjustment is limited to 1886(d) hospitals that have 100 or fewer beds, as defined in 42 CFR 412.105(b), and that are not part of a chain organization, i.e., independent (Worksheet S-2, Part I, line 140, column 1, is "N" for no). The qualifying hospital must complete this supplemental form with its Medicare Hospital and Hospital Health Care Complex Cost Report, Form CMS-2552-10 to receive the essential medicines payment adjustment.

Definitions.--

Essential medicines--As defined in 42 CFR 412.113(g).

Independent hospital--A hospital that is not part of a chain organization (as defined in CMS Pub. 15-2, chapter 39, §3900, a group of two or more health care facilities that are owned, leased, or through any other device, controlled by one organization).

4038.1 Part I - Additional Resource Cost of Essential Medicines.--Report the additional resource cost, as defined in 42 CFR 412.113(g), of establishing and maintaining access to no less than a 6-month buffer stock of one or more essential medicines. Do not include the cost of the medication. Do not include cost to establish and maintain a buffer stock for nonreimbursable cost centers.

Line 1--Enter the additional resource cost directly incurred by the hospital to establish and maintain no less than a 6-month buffer stock of one or more essential medicines in accordance with 42 CFR 412.113(g).

Line 2--Enter the contractual amount paid to outside suppliers to establish and maintain no less than a 6-month buffer stock of one or more essential medicines according to 42 CFR 412.113(g).

Line 3--Sum lines 1 and 2 to calculate the total cost to establish and maintain the buffer stock of essential medicines.

4038.2 Part II - Calculation of Medicare Payment Adjustment for Essential Medicines.--Calculate the Medicare portion of the additional resource cost incurred by the hospital for establishing and maintaining access to no less than a 6-month buffer stock of one or more essential medicines.

Line 1--Transfer the Medicare routine and ancillary cost from Worksheet D-1, Part II, line 49.

Line 2--Transfer the Medicare acquisition cost by summing the amounts reported on Worksheet E, Part A, line 55, and Worksheet E, Part A, line 55.01.

Line 3--Transfer the cost of physicians' services in a teaching hospital from Worksheet E, Part A, line 56.

Line 4--Calculate the total Medicare reasonable cost by summing line 1 through line 3.

Line 5--Transfer the total facility cost from Worksheet C, Part I, line 202, column 5.

Line 6--Calculate the percentage of Medicare reasonable cost relative to total facility cost by dividing the amount on line 4 by the amount on line 5, rounding the result to two decimal places.

Line 7--Calculate the Medicare payment adjustment amount for essential medicines by multiplying the total cost to establish and maintain the buffer stock of essential medicines from Part I, line 3, by the Medicare percentage on Part II, line 6. Transfer the amount of the payment adjustment for essential medicines to Worksheet E, Part A, line 70.76.

4039. WORKSHEET E-95 - SUPPLEMENTAL TO FORM CMS-2552-10: PAYMENT ADJUSTMENT FOR DOMESTIC NIOSH-APPROVED SURGICAL N95 RESPIRATORS

This supplemental form calculates the inpatient and outpatient payment adjustments for domestically-made National Institute for Occupational Safety and Health (NIOSH)-approved surgical N-95 respirators purchased by an 1886(d) hospital (IPPS hospital) and/or a hospital paid for outpatient services under the hospital outpatient prospective payment system (OPPS hospital) for cost reporting periods beginning on or after January 1, 2023. Only an 1886(d) hospital and/or a hospital paid for outpatient services under the hospital OPPS completes this supplemental form; the hospital must complete and submit this supplemental form as part of its Medicare cost report, Form CMS-2552-10.

Definitions.--

Domestic NIOSH-approved surgical N-95 respirator (domestic respirator)--For purposes of this policy, a domestic NIOSH-approved surgical N-95 respirator is domestic if all of its components are grown, reprocessed, reused, or produced in the United States.

Non-domestic NIOSH-approved surgical N-95 respirator (non-domestic respirator)--For purposes of this policy, any other NIOSH-approved surgical N-95 respirator is non-domestic.

4039.1 Part I - Domestic NIOSH-Approved Surgical N-95 Respirators Payment Adjustment Eligibility and Data.--On this part, the hospital identifies its eligibility to receive a payment adjustment for the purchase of domestic respirators. The hospital reports the cost and quantity of domestic respirators and non-domestic respirators, and, if eligible, uses this data to compute a payment adjustment amount.

Line 1--If the hospital purchased domestic respirators, enter "Y" for yes in column 1; otherwise, enter "N" for no. If the hospital purchased non-domestic respirators, enter "Y" for yes in column 2; otherwise enter "N" for no. If either column 1 or 2 is "Y", complete line 2.

Line 2--If line 1, column 1 or column 2, is "Y", complete columns 1 through 4, from the hospital's books and records, by entering:

- in column 1, the total cost of domestic NIOSH-approved surgical N-95 respirators purchased by the hospital or hospital healthcare complex, excluding the cost of domestic respirators for nonreimbursable cost centers; if none purchased, enter zero.
- in column 2, the number of domestic NIOSH-approved surgical N-95 respirators purchased by the hospital or hospital healthcare complex, excluding the number of domestic respirators for nonreimbursable cost centers; if none purchased, enter zero.
- in column 3, the total cost of non-domestic NIOSH-approved surgical N-95 respirators purchased by the hospital or hospital healthcare complex, excluding the cost of domestic respirators for nonreimbursable cost centers; if none purchased, enter zero.
- in column 4, the number of non-domestic NIOSH-approved surgical N-95 respirators purchased by the hospital or hospital healthcare complex, excluding the number of domestic respirators for nonreimbursable cost centers; if none purchased, enter zero.

4039.2 Part II - Calculation of Cost Differential for Domestic NIOSH-Approved Surgical N-95 Respirators.--This part calculates the additional cost incurred by the hospital for purchasing domestic respirators.

Line 1--Transfer the cost of domestic respirators purchased from Part I, line 2, column 1, to column 1; and transfer the cost of non-domestic respirators purchased from Part I, line 2, column 3, to column 2.

Line 2--Transfer the number of domestic respirators purchased from Part I, line 2, column 2, to column 1; and transfer the number of non-domestic respirators purchased from Part I, line 2, column 4, to column 2.

Line 3--For columns 1 and 2, calculate the average cost per respirator by dividing line 1 (the total cost of respirators purchased) by line 2 (the number of respirators purchased), rounding the result to two decimal places. If the hospital purchased no domestic or non-domestic respirators, enter zero in the respective column.

Line 4--Calculate the hospital-specific unit cost differential for domestic respirators as line 3, column 1, (the average cost per domestic respirator), minus line 3, column 2, (the average cost per non-domestic respirator). If the result is less than zero, enter zero.

Line 5--Calculate the total cost differential for the purchase of domestic respirators by multiplying line 2, column 1, (the number of domestic respirators purchased) by line 4, column 3, (the hospital-specific unit cost differential), rounding the result to zero decimal places.

4039.3 Part III - Calculation of Domestic NIOSH-Approved Surgical N-95 Respirators Payment Adjustment.--This part calculates the domestic N95 respirator payment adjustment.

Line 1--Transfer Medicare costs of the hospital and hospital healthcare complex as follows:

- In column 1, transfer Medicare inpatient costs from the hospital Worksheet D-1, Part II, line 49, plus Medicare inpatient costs from the PARHM Worksheet D-1, Part II, line 49, if the hospital participated in PARHM.
- In column 2, transfer Medicare outpatient costs from the hospital Worksheet D Part V, line 202, sum of columns 5, 6, and 7, plus Medicare outpatient costs from the PARHM Worksheet D, Part V, line 202, sum of columns 5, 6, and 7.
- In column 3, transfer Medicare outpatient costs from the IPF subprovider Worksheet D, Part V, line 202, sum of columns 5, 6, and 7.
- In column 4, transfer Medicare outpatient costs from the IRF subprovider Worksheet D, Part V, line 202, sum of columns 5, 6, and 7.

Line 1.01--Effective for cost reporting periods beginning on or after October 1, 2023, transfer Medicare acquisition costs of the hospital and hospital healthcare complex from Worksheet E, Part A, and Worksheet E, Part B, as follows:

- In column 1, transfer the sum of:
  - the hospital Worksheet E, Part A, line 55, plus
  - the hospital Worksheet E, Part A, line 55.01, plus
  - if a PARHM demonstration participant, the PARHM Worksheet E, Part A, line 55, plus
  - if a PARHM demonstration participant, the PARHM Worksheet E, Part A, line 55.01.
- In column 2, transfer the sum of:
  - the hospital Worksheet E, Part B, line 10, plus
  - if a PARHM demonstration participant, the PARHM Worksheet E, Part B, line 10.

Line 1.02--Effective for cost reporting periods beginning on or after October 1, 2023, transfer Medicare cost of physicians' services in a teaching hospital from Worksheet E, Part A, and Worksheet E, Part B, as follows:

- In column 1, transfer the sum of:
  - the hospital Worksheet E, Part A, line 56, plus
  - if a PARHM demonstration participant, the PARHM Worksheet E, Part A, line 56.
- In column 2, transfer the sum of:
  - the hospital Worksheet E, Part B, line 23, plus
  - if a PARHM demonstration participant, the PARHM Worksheet E, Part B, line 23.
- In column 3, transfer the amount from the hospital based IPF Worksheet E, Part B, line 23
- In column 4, transfer the amount from the hospital based IRF Worksheet E, Part B, line 23

Line 1.15--Effective for cost reporting periods beginning on or after October 1, 2023, sum lines 1, 1.01, and 1.02 for each column 1 through 4.

Line 2--In column 5, transfer the total facility costs from Worksheet C, Part I, line 202, column 5.

Line 3--For cost reporting periods beginning prior to October 1, 2023, for each column 1 through 4, calculate the percentage of Medicare costs to total facility costs as line 1 divided by line 2, column 5, rounding the result to six decimal places. For cost reporting periods beginning on or after October 1, 2023, for each column 1 through 4, calculate the percentage of Medicare costs to total facility costs as line 1.15 divided by line 2, column 5, rounding the result to six decimal places.

Line 4--Calculate the domestic NIOSH-approved surgical N-95 respirators payment adjustment for columns 1, 2, 3, and 4, by multiplying the domestic respirators cost differential from Part II, line 5, column 3, by the Medicare percentage from Part III, line 3, of each column, rounding the result to zero decimal places. In column 5, enter the sum of columns 1, 2, 3, and 4. Transfer the payment adjustments as follows:

- For a hospital Part A, payment adjustment in column 1, transfer the hospital Part A payment adjustment to Worksheet E, Part A, line 70.75.
- For a hospital Part B, payment adjustment in column 2, transfer the hospital Part B payment adjustment to the hospital Worksheet E, Part B, line 39.75.
- For an IPF subprovider Part B, payment adjustment in column 3, transfer the IPF subprovider Part B payment adjustment to the IPF subprovider Worksheet E, Part B, line 39.75.
- For an IRF subprovider Part B, payment adjustment in column 4, transfer the IRF subprovider Part B payment adjustment to the IRF subprovider Worksheet E, Part B, line 39.75.

4040. FINANCIAL STATEMENT WORKSHEETS

Prepare these worksheets from your accounting books and records.

Complete all worksheets in the "G" series. Complete Worksheets G and G-1 if you maintain fund-type accounting records, complete separate amounts for General, Specific Purpose, Endowment and Plant funds on Worksheets G and G-1. If you do not maintain fund-type accounting records, complete the general fund column only. Cost reports received with incomplete G worksheets are returned to you for completion. If you do not follow this procedure, you are considered as having failed to file a cost report. Where applicable, Worksheets G, G-1, G-2 and G-3 must be consistent with financial statements prepared by Certified Public Accountants.

4040.1 Worksheet G - Balance Sheet.--Combine the amounts on each line on the Worksheet G for lines 5 (Other receivables), 9 (Other current assets), 44 (Other current liabilities), and 49 (Other long term liabilities), as appropriate, to report the sum of account balances and adjustments. Maintain supporting documentation for the appropriate lines.

Enter accumulated depreciation as a negative amount.

Column 1--General Fund--Use only this fund column when you do not maintain fund-type accounting records. This fund is similar to a general ledger account and records all assets and liabilities of the entity.

Column 2--Specific Purpose Fund--These accounts are used for funds held for specific purposes such as research and education.

Column 3--Endowment Fund--These accounts are for amounts restricted for endowment purposes.

Column 4--Plant Fund--These accounts are for amounts restricted for the replacement and expansion of the plant.

Line 1--Cash on Hand and in Banks--The amounts on this line represent the amount of cash on deposit in banks and immediately available for use in financing activities, amounts on hand for minor disbursements and amounts invested in savings accounts and certificates of deposit. Typical accounts would be cash, general checking accounts, payroll checking accounts, other checking accounts, imprest cash funds, saving accounts, certificates of deposit, treasury bills and treasury notes, and other cash accounts.

Line 2--Temporary Investments--The amounts on this line represent current securities evidenced by certificates of ownership or indebtedness. Typical accounts would be marketable securities and other current investments.

Line 3--Notes Receivable--The amounts on this line represent current unpaid amounts evidenced by certificates of indebtedness.

Line 4--Accounts Receivable--Include on this line all unpaid inpatient and outpatient billings. Include direct billings to patients for deductibles, co-insurance and other patient chargeable items if they are not included elsewhere.

Line 6--Less: Allowance for Uncollectable Notes and Accounts--These are valuation (or contra-asset) accounts whose credit balances represent the estimated amount of uncollectible receivables from patients and third-party payers. Enter this amount as a negative.

Line 7--Inventory--Enter the costs of unused hospital supplies. Perpetual inventory records may be maintained and adjusted periodically to physical count. The extent of inventory control and detailed record-keeping will depend upon the size and organizational complexity of the hospital. Hospital inventories may be valued by any generally accepted method, but the method must be consistently applied from year to year.

Line 8--Prepaid Expenses--Enter the costs incurred which are properly chargeable to a future accounting period.

Line 9--Other Current Assets --This line is used to record any other current assets not included in other asset categories.

Line 10--Due from Other Funds--There are four funds: General Fund, Specific Purpose Fund, Endowment Fund and Plant Fund. These are represented in columns 1 through 4, respectively. Amounts reported in each column should be the amount due from other funds in another column on Worksheet G, line 43 (Due to Other Funds).

The sum of the amounts on line 10, columns 1 through 4 must equal the sum of the amounts on line 43, columns 1 through 4.

Line 12--Land--This balance reflects the cost of land used in hospital operations. Included here is the cost of off-site sewer and water lines, public utility, charges for servicing the land, governmental assessments for street paving and sewers, the cost of permanent roadways and of grading of a non-depreciable nature. Unlike building and equipment, land does not deteriorate with use or with the passage of time; therefore, no depreciation is accumulated.

The cost of land includes (1) the cash purchase price, (2) closing costs such as title and attorney's fees, (3) real estate broker's commission, and (4) accrued property taxes and other liens on the land assumed by the purchaser.

Land 13--Land Improvements--Amounts on this line include structural additions made to land, such as driveways, parking lots, sidewalks, as well as the cost of shrubbery, fences and walls, landscaping, on-site sewer and water lines, and underground sprinklers. The cost of land improvements includes all expenditures necessary to make the improvements ready for their intended use.

Line 15--Buildings--This line includes the cost of all buildings and subsequent additions used in hospital operations (including purchase price, closing costs, (attorney fees, title insurance, etc.,) and real estate broker commission). Included are all architectural, consulting and legal fees related to the acquisition or construction of buildings, and interest paid for construction financing.

Line 17--Leasehold Improvements--All expenditures for the improvement of a leasehold used in hospital operations are included on this line.

Line 19--Fixed Equipment--Include the cost of building equipment that has the following general characteristics:

1. Affixed to the building, not subject to transfer or removal.
2. A life of more than one year, but less than that of the building to which it is affixed.
3. Used in hospital operations.

Fixed equipment includes such items as boilers, generators, engines, pumps, and refrigeration machinery, wiring, electrical fixtures, plumbing, elevators, heating system, air conditioning system, etc.

Line 21--Automobiles and Trucks--Enter the cost of automobiles and trucks used in hospital operations.

Line 23--Major movable Equipment--Costs of equipment included on this line has the following general characteristics:

1. Ability to be moved, as distinguished from fixed equipment (but not automobiles or trucks).
2. A more or less fixed location in the building.
3. A unit cost large enough to justify the expense incident to control by means of an equipment ledger and greater than or equal to $5,000.
4. Sufficient individuality and size to make control feasible by means of identification tags.
5. A minimum life of usually three years or more.
6. Used in hospital operations.

Line 25--Minor Equipment-Depreciable--Costs of equipment included on this line has the following general characteristics:

1. Ability to be moved, as distinguished from fixed equipment.
2. A more or less fixed location in the building
3. A unit cost large enough to justify the expense incident to control by means of an equipment ledger but less than $5,000.
4. Sufficient individuality and size to make control feasible by means of identification tags.
5. A minimum life of usually three years or more.
6. Used in hospital operations.

Line 27--Health Information Technology (HIT) Designated Assets--The amounts included here are the acquisition costs of HIT acquired assets in accordance with ARRA 2009, section 4102. Acute care hospitals are required to depreciate such assets in accordance with their applicable depreciation schedules. CAHs are required to identify such assets on this line, but do not depreciate such assets as they will be fully expensed during the year of acquisition.

Line 29--Minor Equipment-Nondepreciable--Costs of equipment included on this line has the following general characteristics:

1. Location generally not fixed; subject to requisition or use by various departments of the hospital.
2. Relatively small size.
3. Subject to storeroom control.
4. Fairly large number in use.
5. Generally, a useful life of usually approximately three years or less.
6. Used in hospital operations.

Minor equipment includes such items as, but is not limited to wastebaskets, bed pans, syringes, catheters, basins, glassware, silverware, pots and pans, sheets, blankets, ladders, and surgical instruments.

Lines 14, 16, 18, 20, 22, 24, 26 and 28--Less Accumulated Depreciation--These balances, respectively, include the depreciation accumulated on the related assets used in hospital operations. Enter this amount as a negative.

Line 31--Investments--This field contains the cost of investments purchased with hospital funds and the fair market value (at date of donation) of securities donated to the hospital.

Line 32--Deposits on Leases--Report the amount of deposits on leases. This includes security deposits.

Line 33--Due from Owners/Officers--Report the unpaid amount of the amount loaned to the owners and/or officers by the hospital.

Line 34--Other Assets--This is the amount of assets not reported on line 9 (other current assets) or any other line 1 through 33. This could include intangible assets such as goodwill, unamortized loan costs and other organization costs.

Line 35--Total Other Assets--Sum of lines 31 through 34.

Line 36--Total Assets--Sum of lines 11, 30 and 35.

Line 37--Accounts Payable--This amount reflects the amounts due trade creditors and others for supplies and services purchased.

Line 38--Salaries, Wages and Fees Payable--This amount reflects the actual or estimated liabilities of the hospital for salaries and wages/fees payable.

Line 39--Payroll Taxes Payable--This amount reflects the actual or estimated liabilities of the hospital for amounts payable for payroll taxes withheld from salaries and wages, payroll taxes to be paid by the hospital and other payroll deductions, such as hospitalization insurance premiums.

Line 40--Notes and Loans Payable (Short-Term)--The amounts on this line represent current amounts owing as evidenced by certificates of indebtedness coming due in the next 12 months.

Line 41--Deferred Income--Deferred income is received or accrued income which is applicable to services to be rendered within the next accounting period. Deferred income applicable to accounting periods extending beyond the next accounting period is included as other current liabilities. These amounts also reflect the effects of any timing differences between book and tax or third-party reimbursement accounting.

Line 42--Accelerated Payments--Accelerated payments are payments not yet due to be repaid to the contractor.

Line 43--Due to Other Funds--There are four funds: General Fund, Specific Purpose Fund, Endowment Fund and Plant Fund. These are in columns 1 through 4 respectively. Amounts are reported in the fund owing the amount. Each amount recorded as "due to" must also be reported on Worksheet G, line 10 (Due From Other Funds).

The sum of the amounts on line 10, columns 1 through 4 must equal the sum of the amounts on line 41, columns 1 through 4.

Line 44--Other Current Liabilities--This line is used to record any current liabilities not reported on lines 37 through 43.

Line 45--Total Current Liabilities--Enter the sum of lines 37 through 44.

Line 46--Mortgage Payable--This amount reflects the long-term financing obligation used to purchase real estate/property.

Line 47--Notes Payable--These amounts reflect liabilities of the hospital to vendors, banks and other, evidenced by promissory notes due and payable longer than one year.

Line 48--Unsecured Loans--These amounts are not loaned on the basis of collateral.

Line 49--Other Long-Term Liabilities--This line is used to record any long-term liabilities not reported on lines 46 through 48.

Line 50--Total Long-Term Liabilities--Enter the sum of lines 46 through 49.

Line 51--Total Liabilities--Enter the sum of lines 45 and 50.

Line 52--General Fund Balance--This represents the difference between the total of General Fund assets and General Fund Liabilities in column 1. This amount usually equals the end of period fund balance on Worksheet G-1, column 2, line 19.

Line 53--Specific Purpose Fund--This represents the difference between the total of Specific Purpose Fund assets and Specific Purpose Fund Liabilities in column 2.

Line 54--Donor Created - Endowment Fund Balance - Restricted--The sum of the amounts on lines 54, 55, and 56, represent the difference between the total of Endowment Fund assets and Endowment Fund Liabilities in column 3.

Line 55--Donor Created - Endowment Fund Balance - Unrestricted.

Line 56--Governing Body Created - Endowment Fund Balance.

Line 57--Plant Fund Balance - Invested in Plant--The sum of the amounts on lines 57 and 58, represent the difference between the total of Plant Fund assets and Plant Fund Liabilities in column 4.

Line 58--Plant Fund Balance - Reserves for Plant Improvement, Replacement and Expansion--The credit balances of the restricted funds reported on lines 54 through 56, represent the net amount of each restricted fund's assets available for its designated purpose. The accounts should be credited for all income earned on restricted fund assets, as well as gains on the disposal of such assets. If, however, such items are treated as General Fund income (considering legal requirements and donor intent), the restricted Fund Balance account is charged, and the Due to General Fund account credited, for such income.

For Investor-Owned Corporations, the accounts on lines 53 through 58 include stock, paid in capital and retained earnings. For Investor-Owned Partnerships, the amounts on lines 53 through 58 include capital and partner's draw. For Investor-Owned - Division of a Corporation, the amounts on lines 53 through 58 include the division's or subsidiary's stock, paid in capital and divisional equity.

Line 59--Total Fund Balances--Enter the sum of lines 52 through 58.

Line 60--Total Liabilities and Fund Balances--Enter the sum of lines 51 and 59.

For each Fund, the amount on line 36 equals the amount on line 60.

4040.2 Worksheet G-1 - Statement of Changes in Fund Balances.--

Columns 1 and 2--General Fund.

Columns 3 and 4--Specific Purpose Fund--These accounts are used for funds held for specific purposes such as research and education.

Columns 5 and 6--Endowment Fund--These accounts are for amounts restricted for endowment purposes.

Columns 7 and 8--Plant Fund--These accounts are for amounts restricted for the replacement and expansion of the plant.

Line 1--Fund Balance at Beginning of Period--The fund balance at the beginning of the period comes from the prior year cost report Worksheet G-1, line 19, columns 2, 4, 6 and 8, respectively.

Line 2--Net Income--Transfer to column 2, the amount from Worksheet G-3, line 29. Columns 1, 3, 4, 5, 6, 7 and 8 are not completed.

Line 3--Total--For column 2, enter the sum of lines 1 and 2. Leave columns 1, 3, 5, and 7 blank. For columns 4, 6, and 8, bring down the amount on line 1.

Lines 4 through 9--Additions--Most income is included in the net income reported on line 2. Any increases affecting the fund balance not included in net income are reported on these lines. A description (not exceeding 36 characters) is entered for each entry on lines 4 through 9.

Line 10--Total Additions--In columns 2, 4, 6, and 8, enter the sum of lines 4 through 9 columns 1, 3, 5, and 7, respectively.

Line 11--Subtotals--Enter the sum of lines 3 and 10 for columns 2, 4, 6, and 8. Leave columns 1, 3, 5, and 7 blank.

Lines 12 through 17--Deductions--Most expenses are included in the net income reported on line 2. Any decreases affecting the fund balance not included in net income are reported on these lines. A description (not exceeding 36 characters) is entered for each entry on lines 12 through 17.

Line 18--Total Deductions--In columns 2, 4, 6, and 8, enter the sum of lines 12 through 17, columns 1, 3, 5, and 7, respectively.

Line 19--Fund Balance at the end of Period per Balance Sheet--Enter the result of line 11 minus line 18 for columns 2, 4, 6, and 8. Leave columns 1, 3, 5, and 7 blank. The amount in line 19, column 2 must agree with Worksheet G, line 52, column 1. The amount on line 19, column 4, must agree with Worksheet G, line 53, column 2. The amount on line 19, column 6 must agree with the sum of Worksheet G, column 3, lines 54 through 56. The amount on line 19, column 8, must agree with the sum of Worksheet G, column 4, lines 57 and 58.

These amounts will also be used to start next year's Worksheet G-1.

4040.3 Worksheet G-2, Parts I & II - Statement of Patient Revenues and Operating Expenses.--This worksheet requires the reporting of total patient revenues for the entire facility and operating expenses for the entire facility. If cost report total revenues and total expenses differ from those on your filed financial statements, submit a reconciliation report with the cost report submission. If you have more than one hospital-based HHA and/or more than one outpatient rehabilitation provider, subscript the appropriate lines on Worksheet G-2, Part I, to report the revenue for each multiple based facility separately.

Part I - Patient Revenues--Enter total patient revenues associated with the appropriate cost centers on lines 1 through 9, 11 through 15, and 18 through 25.

Line 1--Hospital--Enter revenues generated by the hospital component of the complex. Obtain these amounts from your accounting books and/or records.

Line 2--Subprovider - IPF--Enter revenues generated by the IPF (also referred to as the IPF excluded unit) of the complex. Obtain this amount from your accounting books and/or records.

Line 3--Subprovider - IRF--Enter revenues generated by the IRF (also referred to as the IRF excluded unit) of the complex. Obtain this amount from your accounting books and/or records.

Line 4--Subprovider - Other--Enter revenues generated by components identified as subproviders of the complex that were not identified on lines 2 or 3. Subscript this line as necessary. Obtain these amounts from your accounting books and/or records.

Line 5--Swing-Bed SNF--Enter the swing-bed SNF revenue from your accounting books and/or records.

Line 6--Swing-Bed NF--Enter the swing-bed NF revenue from your accounting books and/or records.

Line 7--Skilled Nursing Facility--Enter the skilled nursing facility revenue from your accounting books and/or records.

Line 8--Nursing Facility--Enter the nursing facility revenue from your accounting books and/or records.

Line 9--Other Long Term Care-- Enter the revenue generated from other long term care subproviders from your accounting books and/or records. Subscript this line as necessary.

Line 10--Total General Inpatient Routine Care--Sum of lines 1 through 9.

Line 11--Intensive Care Unit--Enter the intensive care unit revenue from your accounting books and/or records.

Line 12--Coronary Care Unit--Enter the coronary care unit revenue from your accounting books and/or records.

Line 13--Burn Intensive Care Unit--Enter the burn intensive care unit revenue from your accounting books and/or records.

Line 14--Surgical Intensive Care Unit--Enter the surgical intensive care unit revenue from your accounting books and/or records.

Line 15--Other Special Care-- Enter all other intensive care unit revenue not identified on lines 11 through 14 from your accounting books and/or records. Subscript this line as necessary.

Line 16--Total Intensive Care Type Inpatient Hospital--Sum of lines 11 through 15.

Line 17--Total Inpatient Routine Care Services--Sum of lines 10 and 16.

Line 18--Ancillary Services--Enter in the appropriate column revenue from inpatient ancillary services and outpatient ancillary services from your accounting books and/or records.

Line 19--Outpatient Services--Enter in the appropriate column revenue from outpatient ancillary services from your accounting books and/or records.

Line 20--Rural Health Clinic (RHC)--Enter RHC revenue from your accounting books and/or records. Subscript this line to identify each rural health clinic separately.

Line 21--Federally Qualified Health Center (FQHC)--Enter FQHC revenue from your accounting books and/or records. Subscript this line to identify each FQHC separately.

Line 22--Home Health Agency--Enter HHA revenue from your accounting books and/or records. If there is more than one HHA, include the revenues for all HHAs on this line.

Line 23--Ambulance Services--Enter from your accounting books and/or records the revenue relative to the ambulance service cost reported on Worksheet A, line 95.

Line 24--Outpatient Rehabilitation Providers--Enter in column 2 only, the revenue generated from CMHC, CORF, outpatient therapy providers (OPTs, OOTs and OSPs), and any other outpatient rehabilitation providers. Subscript this line to identify each outpatient rehabilitation provider separately. Obtain this information from your accounting books and/or records.

Line 25--Ambulatory Surgical Center(s)--Enter from your accounting books and/or records the revenue relative to the ASC costs report on Worksheet A, lines 75, and 115.

Line 26--Hospice--Enter from your accounting books and/or records in the appropriate column, the revenue generated from hospice services rendered. If there is more than one hospice, include the revenues for all hospices on this line.

Line 27--Enter in the appropriate column all other revenues not identified on lines 18 through 26.

Line 28--Total Patient Revenues--Enter the sum of lines 17 through 27.

Column 3--For lines 1 through 28, enter the sum of columns 1 and 2, as applicable, in column 3.

Part II - Operating Expenses--Enter the expenses incurred that arise during the ordinary course of operating the hospital complex.

Line 29--Operating Expenses--This amount is transferred from Worksheet A, line 200, column 3.

Lines 30 through 35--Add (Specify)--Identify on these lines additional operating expenses not included in line 29.

Line 36--Total Additions--Enter on line 36, column 2, the sum of lines 30 through 35, column 1.

Lines 37 through 41--Deduct (specify)--Identify on these lines deductions from operating expenses not accounted for included in line 29.

Line 42--Total Deductions--Enter on line 42, column 2, the sum of lines 37 through 41, column 1.

Line 43--Total Operating Expenses--Enter on line 43, column 2, the result of line 29, column 2, plus line 36, column 2, less line 42, column 2.

4040.4 Worksheet G-3, Statement of Revenues and Expenses.--

This worksheet requires the reporting of total revenues for the entire facility and total operating expenses for the entire facility. If cost report total revenues and total expenses differ from those on your filed financial statements, submit a reconciliation report with the cost report submission.

Line 1--Total Patient Revenue--Transfer from Worksheet G-2, Part I, line 28, column 3.

Line 2--Less: Allowance and Discounts on Patient's Accounts--Enter on this line total patient revenues not received. This includes:

Provision for Bad Debts,
Contractual Adjustments,
Charity Discounts,
Teaching Allowances,
Policy Discounts,
Administrative Adjustments,
Implicit price concessions, and
Other Deductions from Revenue.

Line 3--Net Patient Revenues--Subtract line 2 from line 1.

Line 4--Less: Total Operating Expenses--Transfer from Worksheet G-2, Part II, line 43.

Line 5--Net Income from Service to Patients--Subtract line 4 from line 3.

Lines 6 through 23--Enter on the appropriate line 6 through 23 all other revenue not reported on line 1. Obtain these amounts from your accounting books and/or records.

Line 24--Other (Specify)--Enter from hospital books. Enter all other revenue not reported on lines 6 through 23. Obtain this from your accounting books and/or records. Subscript this line as necessary.

Line 24.50--COVID-19 PHE Funding--Enter the aggregate revenue received for COVID-19 public health emergency (PHE) funding including both provider relief fund (PRF) and Small Business Association Loan Forgiveness amounts.

Line 24.51 through 24.60--Other (specify) Funding--Enter any COVID-19 related funding not included on line 24.50 such as, but not limited to, payroll retention credits and state emergency relief funds.

Line 25--Total Other Income--Enter the sum of lines 6 through 24.

Line 26--Total--Enter the sum of lines 5 and 25.

Line 27--Other Expenses (Specify)--Enter all other expenses not reported on lines 6 through 24. Subscript this line as necessary.

Line 28--Total Other Expenses--Enter the sum of line 27 and subscripts.

Line 29--Net Income (or Loss) for the Period--Enter the result of line 26 minus line 28.

4041. WORKSHEET H - ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

This worksheet provides for the recording of direct HHA costs such as salaries, fringe benefits, transportation, and contracted services as well as other costs from your accounting books and records to arrive at the identifiable agency cost. This data is required by 42 CFR 413.20. It also provides for the necessary reclassifications and adjustments to certain accounts prior to the cost finding calculations. The direct costs reported in columns 1, 2, and 4 are obtained from your accounting books and records. All of the cost centers listed do not apply to all agencies**.**

The HHA must maintain the records necessary to determine the split in salary (and employee-related benefits) between two or more cost centers and must adequately substantiate the method used to split the salary and employee-related benefits. These records must be available for audit by your contractor. Your contractor can accept or reject the method used to determine the split in salary. Any deviation or change in methodology to determine splits in salary and employee benefits must be requested in writing and approved by your contractor before any change is effectuated. Where approval of a method has been requested in writing and this approval has been received (prior to the beginning of the cost reporting period), the approved method remains in effect for the requested period and all subsequent periods until you request in writing to change to another method or until your contractor determines that the method is no longer valid due to changes in your operations.

Column 1--Enter all salaries and wages (a salary is the gross amount paid to the employee before taxes and other items are withheld, including deferred compensation, overtime, incentive pay, and bonuses) for the HHA in this column for the actual work performed within the specific area or cost center. For example, if the administrator spends 100 percent of his/her time in the HHA and performs skilled nursing care which accounts for 25 percent of that person's time, then 75 percent of the administrator's salary is entered on line 5 (A&G - HHA), and 25 percent of the administrator's salary is entered on line 6 (skilled nursing care). Enter the sum of column 1, lines 1 through 23, on line 24.

Column 2--Enter all payroll-related employee benefits for the HHA in the appropriate cost center in this column. See CMS Pub. 15-1, chapter 21, §§2144-2145 for a definition of fringe benefits. Entries are made using the same basis as that used for reporting salaries and wages in column 1. Therefore, using the same example as given for column 1, 75 percent of the administrator's payroll-related fringe benefits is entered on line 5 (A&G - HHA) and 25 percent of the administrator's payroll-related fringe benefits is entered on line 6 (skilled nursing care). Enter the sum of column 2, lines 1 through 23, on line 24.

Report payroll-related employee benefits in the cost center where the applicable employee's compensation is reported. This assignment is performed on an actual basis or upon the following basis:

- FICA based on actual expense by cost center;
- Pension and retirement and health insurance (non-union) based on gross salaries of participating individuals by cost centers;
- Union health and welfare based on gross salaries of participating union members by cost center; and
- All other payroll-related benefits based on gross salaries by cost center.

Include nonpayroll-related employee benefits in the administrative and general-HHA cost center. Costs for such items as personal education, recreation activities, and day care are included in the administrative and general - HHA cost center.

Column 3--If the transportation costs (i.e., owning or renting vehicles, public transportation expenses, or payments to employees for driving their private vehicles) can be directly assigned to a particular cost center, enter those costs in the appropriate cost center. If these costs are not identifiable to a particular cost center, enter them on line 4. Enter the sum of column 3, lines 1 through 23 on line 24.

Column 4--Enter the contracted and purchased services amounts in the appropriate cost center in this column. If a contracted/purchased service covers more than one cost center, then include the amount applicable to each cost center on each affected cost center line. Enter the sum of column 4, lines 1 through 23 on line 24.

Column 5--From your books and records, enter on the applicable lines all other identifiable costs which have not been reported in columns 1 through 4. Enter the sum of column 5, lines 1 through 23, on line 24.

Column 6--Add the amounts in columns 1 through 5 for each cost center and enter the totals in column 6.

Column 7--Enter any reclassifications among the cost center expenses listed in column 6 which are needed to effect proper cost allocation. This column need not be completed by all providers, but is completed only to the extent reclassifications are needed and appropriate in the particular circumstances. Show reductions to expenses as negative amounts.

Column 8--Add column 7 to column 6 and extend the net balances to column 8.

Column 9--In accordance with 42 CFR 413ff, enter on the appropriate lines the amounts of any adjustments to expenses required under the Medicare principles of reimbursement. (See §4016.)

Column 10--Adjust the amounts in column 8 by the amounts in column 9 and extend the net balance to column 10.

Transfer the amounts in column 10, lines 1 through 24, to the corresponding lines on Worksheet H-1, Part I, column 0.

Line Descriptions

Lines 1 and 2--These cost centers include depreciation, leases and rentals for the use of facilities and/or equipment, interest incurred in acquiring land or depreciable assets used for patient care, insurance on depreciable assets used for patient care, and taxes on land or depreciable assets used for patient care.

Line 3--Enter the direct expenses incurred in the operation and maintenance of the plant and equipment, maintaining general cleanliness and sanitation of the plant, and protecting employees, visitors, and agency property.

Line 4--Enter all of the cost of transportation except those costs previously directly assigned in column 3. This cost is allocated during the cost finding process.

Line 5--Use this cost center to record the expenses of several costs which benefit the entire facility. Examples include fiscal services, legal services, accounting, data processing, taxes, and malpractice costs.

Line 6--Skilled nursing care is a service that must be provided by or under the supervision of a registered nurse. The complexity of the service, as well as the condition of the patient, are factors to be considered when determining whether skilled nursing services are required. Additionally, the skilled nursing services must be required under the plan of treatment.

Line 7--Enter the direct costs of physical therapy services by or under the direction of a registered physical therapist as prescribed by a physician. The therapist provides evaluation, treatment planning, instruction, and consultation.

Line 8--These services include (1) teaching of compensatory techniques to permit an individual with a physical impairment or limitation to engage in daily activities; (2) evaluation of an individual's level of independent functioning; (3) selection and teaching of task-oriented therapeutic activities to restore sensory-integrative function; and (4) assessment of an individual's vocational potential, except when the assessment is related solely to vocational rehabilitation.

Line 9--These are services for the diagnosis and treatment of speech and language disorders that create difficulties in communication.

Line 10--These services include (1) assessment of the social and emotional factors related to the individual's illness, need for care, response to treatment, and adjustment to care furnished by the facility; (2) casework services to assist in resolving social or emotional problems that may have an adverse effect on the beneficiary's ability to respond to treatment; and (3) assessment of the relationship of the individual's medical and nursing requirements to his or her home situation, financial resources, and the community resources available upon discharge from facility care.

Line 11--Enter the cost of home health aide services. The primary function of a home health aide is the personal care of a patient. The services of a home health aide are given under the supervision of a registered professional nurse and, if appropriate, a physical, speech, or occupational therapist. The assignment of a home health aide to a case must be made in accordance with a written plan of treatment established by a physician which indicates the patient's need for personal care services. The specific personal care services to be provided by the home health aide must be determined by a registered professional nurse and not by the home health aide.

Line 12--The cost of medical supplies reported in this cost center are those costs which are directly identifiable supplies furnished to individual patients and for which a separate charge is made. These supplies are generally specified in the patient’s plan of treatment and furnished under the specific direction of the patient’s physician.

Medical supplies which are not reported on this line are those minor medical and surgical supplies which would not be expected to be specifically identified in the plan of treatment or for which a separate charge is not made. These supplies (e.g., cotton balls, alcohol prep) are items that are frequently furnished to patients in small quantities (even though in certain situations, these items may be used in greater quantity) and are reported in the (A&G) cost center.

Line 13--Enter the costs of vaccines exclusive of the cost of administering the vaccines. A visit by an HHA nurse for the sole purpose of administering a vaccine is not covered as an HHA visit under the home health benefit, even though the patient may be an eligible home health beneficiary receiving services under a home health plan of treatment. Section 1862(a)(1)(B) of the Act excludes Medicare coverage of vaccines and their administration other than the Part B coverage contained in §1861 of the Act.

If the vaccine is administered in the course of an otherwise covered home health visit, the visit is covered as usual, but the cost and charges for the vaccine and its administration must be excluded from the cost and charges of the visit. The HHA is entitled to separate payment for the vaccine and its administration under the Part B vaccine benefit.

The cost of administering pneumococcal, influenza, COVID-19, and hepatitis B vaccines, and monoclonal antibody products for treatment of COVID-19 is reimbursed under the OPPS, but the actual cost of the pneumococcal, influenza, COVID-19, and hepatitis B vaccines, and monoclonal antibody products for treatment of COVID-19 are cost reimbursed. Additionally, the cost of administering the osteoporosis drugs are included in the skilled nursing visit while the actual cost of the osteoporosis drug is reimbursed at reasonable cost.

Enter the cost for the COVID-19 vaccine and monoclonal antibody products to treat COVID-19, authorized and furnished for use during the COVID-19 PHE. The COVID-19 vaccine and monoclonal antibody product costs and its administration will be reimbursed in the same way influenza vaccine cost and its administration is reimbursed. When COVID-19 vaccine doses are provided by the government without charge, do not report the cost for such vaccines on this line. In addition, Medicare will not provide payment for the monoclonal antibody products to treat COVID-19 that health care providers receive for free, as will be the case upon the product's initial availability in response to the COVID-19 PHE.

Enter on this line the vaccine and drug cost (exclusive of the cost to administer these vaccines) incurred for pneumococcal, influenza (includes COVID-19), and hepatitis B vaccines, and monoclonal antibody products for treatment of COVID-19 as well as osteoporosis drugs.

Some of the expenses includable in this cost center are the costs of syringes, cotton balls, bandages, etc., but the cost of travel is not permissible as a cost of administering vaccines, nor is the travel cost includable in the A&G cost center. The travel cost is nonreimbursable. Attach a schedule detailing the methodology employed to develop the administration of these vaccines. These vaccines are reimbursable under Part B only.

Line 14--Enter the direct expenses incurred in renting or selling DME items to the patient for the purpose of carrying out the plan of treatment. Also, include all the direct expenses incurred by you in requisitioning and issuing the DME to patients.

Lines 15 through 23--Lines 15 through 23 identify nonreimbursable services commonly provided by HHAs. These include home dialysis aide services (line 15), respiratory therapy (line 16), private duty nursing (line 17), clinic (line 18), health promotion activities (line 19), day care program (line 20), home delivered meals program (line 21), and homemaker service (line 22). The cost of all other nonreimbursable services are aggregated on line 23. If you are reporting costs for telemedicine, these costs are to be reported on line 23.50. Use this line throughout all applicable worksheets.

4042. WORKSHEET H-1 - COST ALLOCATION - HHA GENERAL SERVICE COST

Worksheet H-1, Part I, provides for the allocation of the expenses of each HHA general service cost center to those cost centers which receive the services. The cost centers serviced by the general service cost centers include all cost centers within the HHA, (i.e., other general service cost centers, reimbursable cost centers, and nonreimbursable cost centers). Obtain the total direct expenses from Worksheet H, column 10. To facilitate transferring amounts from Worksheet H to Worksheet H-1, Part I, the same cost centers with corresponding line numbers (lines 1 through 24) are listed on both worksheets.

Worksheet H-1, Part II, provides for the proration of the statistical data needed to equitably allocate the expenses of the HHA general service cost centers on Worksheet H-1, Part I. If there is a difference between the total accumulated costs reported on the Part II statistics and the total accumulated costs calculated on Part I, use the reconciliation column on Part II for reporting any adjustments. See §4020 for the appropriate usage of the reconciliation columns. For componentized A&G cost centers, the accumulated cost center line number must match the reconciliation column number.

To facilitate the allocation process, the general format of Parts I and II are identical. The column and line numbers for each general service cost center are identical on both parts. In addition, the line numbers for each general, reimbursable, and nonreimbursable cost centers are identical on the two parts of the worksheet. The cost centers and line numbers are also consistent with Worksheet H.

The statistical bases shown at the top of each column on Worksheet H-1, Part II, are the recommended bases of allocation of the cost centers indicated. If a different basis of allocation is used, the provider must indicate the basis of allocation actually used at the top of the column.

Most cost centers are allocated on different statistical bases. However, for those cost centers where the basis is the same (e.g., square feet), the total statistical base over which the costs are to be allocated will differ because of the prior elimination of cost centers that have been closed.

When closing the general service cost center, first close those cost centers that render the most services to and receive the least services from other cost centers. The cost centers are listed in this sequence from left to right on the worksheet. However, the circumstances of an agency may be such that a more accurate result is obtained by allocating to certain cost centers in a sequence different from that followed on these worksheets.

NOTE: The HHA can elect to change the order of allocation and/or allocation statistics, as appropriate, for the current cost reporting period if a request is received by the contractor, in writing, 90 days prior to the end of that reporting period. The contractor has 60 days to make a decision and notify the provider of that decision or the change is automatically accepted. The change must be shown to more accurately allocate the overhead or demonstrate simplification in maintaining the changed statistics. If a change in statistics is requested, the provider must maintain both sets of statistics until an approval is made. If both sets are not maintained and the request is denied, the provider reverts back to the previously approved methodology. The provider must include with the request all supporting documentation and a thorough explanation of why the alternative approach should be used. (See CMS Pub. 15-1, chapter 23, §2313.)

EXCEPTION: A small freestanding HHA, as defined in 42 CFR 413.24(d), does not have to request written permission to use the procedures outlined for small HHAs below.

On Worksheet H-1, Part II, enter on the first line in the column of the cost center being allocated the total statistical base over which the expenses are allocated (e.g., in column 1, capital-related - buildings and fixtures, enter on line 1 the total square feet of the building on which depreciation was taken). For all cost centers to which the capital-related cost is allocated, enter that portion of the total statistical base applicable to each. The sum of the statistical base applied to each cost center receiving the services must equal the total base entered on the first line. Use accumulated cost for allocating A&G expenses.

Do not include any statistics related to services furnished under arrangements unless:

- Both Medicare and non-Medicare costs of arranged for services are recorded in your records; or

- Your contractor determines that you are able to (and do) gross up the costs and charges for services to non-Medicare patients so that both cost and charges are recorded as if you had furnished such services directly to all patients. (See CMS Pub. 15-1, chapter 23, §2314.)

Enter on Worksheet H-1, Part II, line 25, the total expenses of the cost center to be allocated. Obtain this amount from Worksheet H-1, Part I, from the same column and line number used to enter the statistical base on Worksheet H-1, Part II. In the case of capital-related costs - buildings and fixtures, this amount is on Worksheet H-1, Part I, column 1, line 1.

NOTE: On Worksheet H-1, Parts I and II, the first line of each column must equal line 24 of the column. Therefore, when totaling a column exclude from line 24 the amount on the first line of that column.

Divide the amount entered on Worksheet H-1, Part II, line 25, by the total statistical base entered in the same column on the first line. Enter the resulting unit cost multiplier on line 26. Round the unit cost multiplier to six decimal places.

Multiply the unit cost multiplier by that portion of the total statistical base applicable to each cost center receiving the services rendered. Enter the result of each computation on Worksheet H-1, Part I, in the corresponding column and line.

After the unit cost multiplier has been applied to all the cost centers receiving costs, the total expenses (line 24) of all of the cost centers receiving the allocation on Worksheet H-1, Part I, must equal the amount entered on the first line of the cost center being allocated.

The preceding procedures must be performed for each general service cost center. Each cost center must be completed on both Part I and Part II before proceeding to the next cost center.

After all the costs of the general service cost centers have been allocated on Worksheet H-1, Part I, enter in column 6, line 24 the sum of the expenses on lines 6 through 23. The total expenses entered in column 6, line 24, equals the total expenses entered in column 0, line 24.

Column Descriptions

Column 1--Depreciation on buildings and fixtures and expenses pertaining to buildings and fixtures such as insurance, interest, rent, and real estate taxes are combined in this cost center to facilitate cost allocation. Allocate all expenses to the cost centers on the basis of square footage of the occupied area. The square footage may be weighted if the person who occupies a certain area of space spends their time in more than one function. For example, if a person spends 10 percent of time in one function, 20 percent in another function, and 70 percent in still another function, the square footage may be weighted according to the percentages of 10 percent, 20 percent, and 70 percent to the applicable functions.

Column 2--Allocate all expenses (e.g., interest, personal property tax) for movable equipment to the appropriate cost centers on the basis of dollar value.

Column 3--Allocate all expenses for plant operation and maintenance based on square feet.

Column 4--The cost of vehicles owned or rented by the agency and all other transportation costs which were not directly assigned to another cost center on Worksheet H, column 3, is included in this cost center. Allocate this expense to the cost centers to which it applies on the basis of miles applicable to each cost center.

This basis of allocation is not mandatory, and a provider may use weighted trips rather than actual miles as a basis of allocation for transportation costs which are not directly assigned. However, an HHA must request the use of the alternative method in accordance with CMS Pub. 15-1, chapter 23, §2313. The HHA must maintain adequate records to substantiate the use of this allocation.

Column 5--The A&G expenses are allocated on the basis of accumulated costs after reclassifications and adjustments. Therefore, obtain the amounts to be entered on Worksheet H-1, Part II, column 5, from Worksheet H-1, Part I, columns 0 through 4.

A negative cost center balance in the statistics for allocating A&G expenses causes an improper distribution of this overhead cost center. Negative balances are excluded from the allocation statistics when A&G expenses are allocated on the basis of accumulated cost.

A&G costs applicable to contracted services may be excluded from the total cost (Worksheet H-1, Part I, column 0) for purposes of determining the basis of allocation (Worksheet H-1, Part II, column 5) of the A&G costs. This procedure may be followed when the HHA contracts for services to be performed for the HHA and the contract identifies the A&G costs applicable to the purchased services. The contracted A&G costs must be added back to the applicable cost center after allocation of the HHA A&G cost before the reimbursable costs are transferred to Worksheet H-2. A separate worksheet must be included to display the breakout of the contracted A&G costs from the applicable cost centers before allocation and the adding back of these costs after allocation. Contractor approval does not have to be secured in order to use the above described method of cost finding for A&G.

Column 6--For lines 6 through 23, add the amounts on each line in columns 4A and 5, and enter the result for each line in this column.

Transfer the amounts in column 6 to Worksheet H-2, Part I, column 0, as follows:

From Worksheet H-1, Part I, Column 6	To Worksheet H-2, Part I, Column 0
Line 6	Line 2
Line 7	Line 3

From Worksheet H-1, Part I, Column 6	To Worksheet H-2, Part I, Column 0
8	4
9	5
10	6
11	7
12	8
13	9
14	10
15	11
16	12
17	13
18	14
19	15
20	16
21	17
22	18
23	19

4043. WORKSHEET H-2 - ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Use this worksheet only if you operate a certified hospital-based HHA as part of your complex. If you have more than one hospital-based HHA, complete a separate worksheet for each facility.

4043.1 Part I - Allocation of General Service Costs to HHA Cost Centers.--Worksheet H-2, Part I, provides for the allocation of the expenses of each general service cost center of the hospital to those cost centers which receive the services. Worksheet H-2, Part II, provides for the proration of the statistical data needed to equitably allocate the expenses of the general service cost centers on Worksheet H-2, Part I.

Obtain the total direct expenses (column 0, line 20) from Worksheet A, column 7, line 101. Obtain the cost center allocations (column 0, lines 1 through 19) from Worksheet H-1, Part I, lines as indicated, the sum of which agrees with the amount entered on column 0, line 20. The amounts on line 20, columns 0 through 23 and column 25, must agree with the corresponding amounts on Worksheet B, Part I, columns 0 through 23 and column 25, line 101. Complete the amounts entered on lines 1 through 19, columns 1 through 23, and column 25, in accordance with the instructions in §4043.2.

NOTE: Worksheet B, Part I, established the method used to reimburse direct GME cost (i.e., reasonable cost or the per-resident amount). Therefore, this worksheet must follow that method. If Worksheet B, Part I, column 25, excluded the costs of interns and residents, column 25, on this worksheet must also exclude these costs.

In column 24, Part I, enter the total of columns 4A through 23.

In column 27, Part I, enter on line 21, the unit cost multiplier (column 26, line 1, divided by the sum of column 26, line 20 minus column 26, line 1). Round the unit cost multiplier to six decimal places. Multiply each amount in column 26, lines 2 through 19, by the unit cost multiplier on line 21, and enter the result on the corresponding line of column 27. On line 20, enter the total of the amounts on lines 2 through 19. The total on line 20 must equal the amount in column 26, line 1.

In column 28, Part I, enter on lines 2 through 19, the sum of columns 26 and 27. The total on line 20 must equal the total in column 27, line 20.

4043.2 Part II - Allocation of General Service Costs to HHA Cost Centers -Statistical Basis.--To facilitate the allocation process, the general format of Worksheet H-2, Parts I and II, is identical. Worksheet H-2, Part II, provides for the proration of the statistical data needed to equitably allocate the expenses of the hospital's general service cost centers on Worksheet H-2, Part I.

The statistical basis shown at the top of each column on Worksheet H-2, Part II, is the recommended basis of allocation of the cost center indicated.

Lines 1 through 19--On Worksheet H-2, Part II, for all cost centers to which the general service cost center is being allocated, enter that portion of the total statistical base applicable to each.

Line 20--Enter the total of lines 1 through 19, for each column. The total in each column must be the same as shown for the corresponding column on Worksheet B-1, line 101.

Line 21--Enter the total expenses for the cost center allocated. Obtain this amount from Worksheet B, Part I, line 101, from the same column used to enter the statistical base on Worksheet H-2, Part II (e.g., in the case of capital-related cost buildings and fixtures, this amount is on Worksheet B, Part I, column 1, line 101).

Line 22--Enter the unit cost multiplier which is obtained by dividing the cost entered on line 21 by the total statistic entered in the same column on line 20. Round the unit cost multiplier to six decimal places.

Multiply the unit cost multiplier by that portion of the total statistic applicable to each cost center receiving the services. Enter the result of each computation on Worksheet H-2, Part I, in the corresponding column and line.

After the unit cost multiplier has been applied to all the cost centers receiving the services, the total cost (Part I, line 20) must equal the total cost on Part II, line 21.

Perform the preceding procedures for each general service cost center.

4044. WORKSHEET H-3 - APPORTIONMENT OF PATIENT SERVICE COSTS

This worksheet provides for the apportionment of home health patient service costs to titles V, XVIII, and XIX. Titles V and XIX use the columns identified as Part A for each program.

4044.1 Part I - Computation of the Aggregate Program Cost.--This part provides for the computation of the total cost and reasonable program cost by discipline based on program patient care visits as required by 42 CFR 413.20, 42 CFR 413.24, and 42 CFR 484.200. For HHA services rendered on or after October 1, 2000, §1895 of the Act requires an HHA to be paid based on a PPS subject to periodic updates.

Cost Per Visit Computation

Column Descriptions

Column 1--Enter the cost for each discipline from Worksheet H-2, Part I, column 28, lines as indicated. Enter the total on line 7.

Column 2--Where the hospital complex maintains separate Physical Therapy, Occupational Therapy and/or Speech Pathology departments, and these departments provide services to patients of the hospital's HHA, transfer the amounts from Worksheet H-3 Part II, column 3, lines 1 through 3, to lines 2 through 4, as appropriate. Enter the total on line 7.

Column 3--Enter the sum of columns 1 and 2.

Column 4--Enter the total agency visits from your records for each type of discipline on lines 1 through 6. Total visits reported in column 4 reflect visits rendered for the entire fiscal year and equal the visits reported on S-3, Part I, regardless of when the episode was completed.

Column 5--Compute the average cost per visit for each type of discipline. Divide the number of visits (column 4) into the cost (column 3) for each discipline.

Columns 6 and 9--To determine title XVIII, Part A; V; and XIX; cost of service, multiply the number of Medicare covered visits in completed episodes made to beneficiaries (column 6) (from your records) by the average cost per visit amount in column 5, for each discipline. Enter the product in column 9.

NOTE: Statistics in column 7, lines 1 through 7, reflect statistics for services that are part of a home health plan, and thus not subject to deductibles and coinsurance. OBRA 1990 provides for the limited coverage of injectable drugs for osteoporosis. While covered as a home health benefit under Part B, these services are subject to deductibles and coinsurance. Report charges for osteoporosis injections in column 8, line 16, in addition to statistics for services that are not part of a home health plan.

Columns 7 and 10--To determine the Medicare Part B cost of service, not subject to deductibles and coinsurance, multiply the number of Medicare covered visits made in completed episodes to Part B beneficiaries (column 7) (from your records) by the average cost per visit amount in column 5 for each discipline. Enter the product in column 10. Note if the PS&R reports Part B services separately as "subject to and not subject to" deductibles and coinsurance, add the two reports together for each discipline.

Columns 6, 7, 9, 10 and 12--Enter visits and costs as applicable in columns 6, 7, 9, 10, and 12.

NOTE: The sum of visits reported in columns 6 and 7 must equal the corresponding amounts on Worksheet S-4, column 5, lines 21, 23, 25, 27, 29, and 31. These visits are reported for episodes completed during the fiscal year.

Columns 8 and 11--Do not use these columns.

Column 12--Enter the total program cost for each discipline (sum of columns 9 and 10). Add the amounts on lines 1 through 6, and enter this total on line 7.

Visits by CBSA--Lines 8 through 14--HHAs are paid for home health services under title XVIII on the basis of the geographic location at which the service is furnished. Enter for each discipline the CBSA code of the location where the home health service was furnished. Subscript each discipline line to accommodate multiple CBSAs serviced by your HHA.

Column Descriptions

Column 1--Enter the CBSA code in which the corresponding HHA visits were rendered for each discipline on lines 8 through 13.

Columns 2 and 3--Enter the visit count for each of the corresponding disciplines for each CBSA.

Column 4, lines 8 through 14--These lines are shaded to prevent data input.

Line 14--Enter the total program visits for each discipline by adding lines 8 through 13, and subscripts, and enter this total on line 14.

Supplies and Drugs Cost Computation.--Certain services covered by the program and furnished by an HHA are not included in the cost per visit for apportionment purposes. Since an average cost per visit and HHA PPS do not apply to these items, develop and apply the ratio of total cost to total charges to program charges to arrive at the program cost for these services.

Column 1--Enter the facility costs in column 1, lines 15 and 16, from Worksheet H-2, Part I, column 28, lines 8 and 9, respectively.

Column 2--Enter the shared ancillary costs from Worksheet H-3, Part II, column 3, lines 4 and 5.

Columns 3 through 5--In column 3, enter the sum total of columns 1 and 2, on lines 15 and 16, respectively. Enter in column 4, lines 15 and 16, respectively, the total charges for such services in accordance with the instructions in §4041, lines 12 and 13. Develop a ratio of total cost (column 3) to total charges (column 4) (from your records) and enter this ratio in column 5.

Columns 6 through 8--Enter in the appropriate column the program charges for drugs and medical supplies charged to patients subject to cost reimbursement. The actual vaccine/drug cost for pneumococcal, influenza, COVID-19, hepatitis B, osteoporosis, and monoclonal antibody products for treatment of COVID-19 are cost reimbursed.

Do not enter charges for drugs and medical supplies subject to reimbursement on the basis of a fee schedule.

Line Descriptions for Columns 6 through 8

Line 15--Columns 6 through 11 are shaded to prevent the input of medical supplies charged to patients as all medical supplies are covered under the HHA PPS benefit. Effective for cost reporting periods ending on or after October 1, 2014, enter in columns 6 through 11, medical supplies covered under the HHA PPS benefit. This information is captured for statistical purposes only.

Line 16--This line represents pneumococcal, influenza, COVID-19, and hepatitis B vaccine costs and injectable osteoporosis drugs, and monoclonal antibody products for treatment of COVID-19, but not the administration of these medications. Enter the program covered charges for drugs charged to patients for items not reimbursed on the basis of a fee schedule or the OPPS. Enter in column 7 the program charges for pneumococcal, influenza, and COVID-19 vaccines, and monoclonal antibody products for treatment of COVID-19, all exclusive of their respective administration costs. Enter in column 8, the program charges for hepatitis B vaccine and injectable osteoporosis drugs exclusive of their respective administration costs.

Columns 6 and 9--To determine the Medicare cost, multiply the program charges (column 6) by the ratio (column 5) for each line. Enter the product in column 9.

Columns 7 and 10--To determine the Medicare Part B cost, multiply the Medicare charges (column 7) by the ratio (column 5) for each line. Enter the product in column 10.

Columns 8 and 11--To determine the Medicare Part B cost, multiply the Medicare charges (column 8) by the ratio (column 5) for each line. Enter the result in column 11.

4044.2 Part II - Apportionment of Cost of HHA Services Furnished by Shared Hospital Departments.--Use this part only where the hospital complex maintains a separate department for any of the cost centers listed on lines 1 through 5 of this part of the worksheet, and these departments provide services to patients of the hospital's HHA. Subscript lines 1 through 5, as applicable, if subscripted on Worksheet C, Part I.

Column 1--Where applicable, enter in column 1 the cost-to-charge ratio from Worksheet C, Part I, column 9, lines as indicated.

Column 2--Where hospital departments provide services to the HHA, enter on the appropriate lines the charges applicable to the hospital-based HHA.

Column 3--Multiply the amounts in column 2 by the ratios in column 1, and enter the result in column 3. Transfer the amounts in column 3 to Worksheet H-3, Part I, as indicated. If lines 1 through 5 are subscripted, transfer the aggregate of each line.

4045. WORKSHEET H-4 - CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

This worksheet provides for the reimbursement calculation of titles V; XVIII, Parts A and B; and XIX. This computation is required by 42 CFR 413.9, 42 CFR 413.13, and 42 CFR 413.30.

Worksheet H-4 consists of the following two parts:

Part I - Computation of the Lesser of Reasonable Cost or Customary Charges
Part II - Computation of HHA Reimbursement Settlement

4045.1 Part I - Computation of Lesser of Reasonable Cost or Customary Charges.--Services not paid based on a fee schedule or the OPPS are paid the lesser of the reasonable cost of services furnished to beneficiaries or the customary charges made by the providers for the same services. This part provides for the computation of the lesser of reasonable cost or customary charges as defined in 42 CFR 413.13(a).

NOTE: Nominal charge providers are not subject to the lesser of cost or charges (LCC). Therefore, a nominal charge provider only completes lines 1, 2, and 9, of Part I. Transfer the resulting cost to Part II, line 10.

Line Descriptions

Line 1--This line provides for the computation of reasonable cost reimbursed program services. Enter the cost of services from Worksheet H-3, Part I, as follows:

To Worksheet H-4, Line 1	From Worksheet H-3,
Col. 1, Part A	Part I, col. 9, line 16
Col. 2, Part B - Not subject to deductibles and coinsurance	Part I, col. 10, line 16
Col. 3, Part B - Subject to deductibles and coinsurance	Part I, col. 11, line 16

The above table reflects the transfer of the cost of pneumococcal, influenza, and COVID-19 vaccines and monoclonal antibody products for treatment of COVID-19, from Worksheet H-3, Part I, column 10, line 16, to column 2 of this worksheet, and the cost of hepatitis B vaccines and injectable osteoporosis drugs from worksheet H-3, Part I, column 11, line 9, to column 3 of this worksheet.

Lines 2 through 6--These lines provide for the accumulation of charges which relate to the reasonable cost on line 1. Do not include on these lines (1) the portion of charges applicable to the excess costs of luxury items or services (see CMS Pub. 15-1, chapter 21, §2104.3) and (2) provider charges to beneficiaries for excess costs as described in CMS Pub. 15-1, chapter 25, §2570. When provider operating costs include amounts that flow from the provision of luxury items or services, such amounts are not allowable in computing reimbursable costs.

Enter only the charges for applicable Medicare covered pneumococcal, influenza, COVID-19, and hepatitis B vaccines and injectable osteoporosis drugs and monoclonal antibody products for treatment of COVID-19, which are all cost reimbursed.

Line 2--Enter from your records in the applicable column the program charges for Part A, Part B not subject to deductibles and coinsurance, and Part B subject to deductibles and coinsurance.

Enter in column 2, the charges for Medicare covered pneumococcal, influenza, COVID-19 vaccines and monoclonal antibody products for treatment of COVID-19 (from Worksheet H-3, line 16, column 7). In column 3, enter the charges for Medicare covered hepatitis B vaccines and osteoporosis drugs (from Worksheet H-3, line 16, column 8).

Lines 3 through 6--These lines provide for the reduction of program charges when the provider does not actually impose such charges (in the case of most patients liable for payment for services on a charge basis) or fails to make reasonable efforts to collect such charges from those patients. If line 5 is greater than zero, multiply line 2 by line 5, and enter the result on line 6. Providers which do impose these charges and make reasonable efforts to collect the charges from patients liable for payment for services on a charge basis are not required to complete lines 3, 4, and 5, but enter on line 6 the amount from line 2. (See 42 CFR 413.13(b).) In no instance may the customary charges on line 6 exceed the actual charges on line 2.

Line 7--Enter in each column the excess of total customary charges (line 6) over the total reasonable cost (line 1). In situations when, in any column, the total charges on line 6 are less than the total cost on line 1 of the applicable column, enter zero on line 7.

Line 8--Enter in each column the excess of total reasonable cost (line 1) over total customary charges (line 6). In situations when, in any column, the total cost on line 1 is less than the customary charges on line 6 of the applicable column, enter zero on line 8.

Line 9--Enter the amounts paid or payable by workers' compensation and other primary payers where program liability is secondary to that of the primary payer. There are several situations under which program payment is secondary to a primary payer. Some of the most frequent situations in which the Medicare program is a secondary payer include:

- Workers' compensation,
- No fault coverage,
- General liability coverage,
- Working aged provisions,
- Disability provisions, and
- Working ESRD beneficiary provisions.

Generally, when payment by the primary payer satisfies the total liability of the program beneficiary, for cost reporting purposes only, the services are considered to be nonprogram services. (The primary payment satisfies the beneficiary's liability when the provider accepts that payment as payment in full. The provider notes this on no-pay bills submitted in these situations.) The patient visits and charges are included in total patient visits and charges, but are not included in program patient visits and charges. In this situation, no primary payer payment is entered on line 9.

However, when the payment by the primary payer does not satisfy the beneficiary's obligation, the program pays the lesser of (a) the amount it otherwise pays (without regard to the primary payer payment or deductible 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. Primary payer payment is credited toward the beneficiary's deductible and coinsurance obligation.

When the primary payer payment does not satisfy the beneficiary's liability, include the covered days and charges in both program visits and charges and total visits and charges for cost apportionment purposes. Enter the primary payer payment on line 9, to the extent that primary payer payment is not credited toward the beneficiary's deductible and coinsurance. Do not enter on line 9 the primary payer payments that are credited toward the beneficiary's deductible and coinsurance. The primary payer rules are more fully explained in 42 CFR 411.

4045.2 Part II - Computation of HHA Reimbursement Settlement.--

Line 10--Enter in column 1 the amount in Part I, column 1, line 1, less the amount in column 1, line 9. Enter in column 2, the sum of the amounts from Part I, columns 2 and 3, line 1, less the sum of the amounts in columns 2 and 3, on line 9. This line will only include pneumococcal, influenza, hepatitis B and injectable osteoporosis drugs reduced by primary payer amounts.

Lines 11 through 24--Enter in column 1 only, for lines 11 through 14, as applicable, the appropriate PPS reimbursement amount for each episode of care payment category as indicated on the worksheet. Enter in column 1 only, on lines 15 and 16, as applicable, the appropriate PPS outlier reimbursement amount for each episode of care payment category as indicated on the worksheet. Enter on lines 18 through 20, the total DME, oxygen, prosthetics and orthotics payments, respectively, associated with home health PPS services (bill types 32 and 33). For lines 18 through 20, do not include any payments associated with services paid under bill type 34X. Obtain these amounts from your PS&R report.

Line 21--Enter in column 2, the Part B deductibles billed to program patients. Include any amounts of deductibles satisfied by primary payer payments.

Line 22--Sum lines 10 through 20 minus line 21.

Line 23--If there is an excess of reasonable cost over customary charges in any column on line 8, enter the amount of the excess in the appropriate column.

Line 24--Sum line 22 minus line 23.

Line 25--Enter in column 2, all coinsurance billable to program beneficiaries including amounts satisfied by primary payer payments. Coinsurance is applicable for services reimbursable under §1832(a)(2) of the Act.

NOTE: If the component qualifies as a nominal charge provider, enter 20 percent of the costs subject to coinsurance on this line. Compute this amount by subtracting Part B deductibles on line 21, and primary payment amounts in column 3, line 9, from Part B costs subject to coinsurance in column 3, line 1. Multiply the resulting amount by 20 percent and enter the result on this line.

Line 26--Sum line 24 minus line 25.

Line 27--In column 2, enter the allowable bad debts in the appropriate columns. If recoveries exceed the current year's bad debts, line 27 will be negative.

Line 27.01--In column 2, enter the result of line 27 (including negative amounts) times 65 percent.

Line 28--In column 2, enter the gross allowable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. This amount must also be included in the amount reported on line 27.

Line 29--Enter the result of line 26 plus 27.01.

Line 30--Enter any other adjustments. Enter reductions to expenses as an absolute value and additions to expenses as a negative.

Line 30.50--Enter the Pioneer ACO demonstration payment adjustment amount. Obtain this amount from the PS&R. Do not use this line for services rendered on or after January 1, 2017. Report any ACO demonstration payment adjustments on or after January 1, 2017, on line 30.99 or line 31.02, accordingly.

Line 30.99--Enter any demonstration payment adjustment amounts for demonstration projects in which the provider participated where the demonstration adjustment amounts are subject to the sequestration adjustment. Obtain this amount from the PS&R.

Line 31--Enter the result of line 29, minus line 30, and minus lines 30.50, and 30.99.

Line 31.01--Enter the sequestration adjustment amount from the PS&R report (claims-based amount). In accordance with §3709 of the CARES Act, as amended by §102 of the CAA 2021, §1 of Public Law 117-7, and §2 of the PAMA 2021, do not apply the sequestration adjustment to the period of May 1, 2020, through March 31, 2022. In accordance with §2 of the PAMA 2021, the sequestration adjustment is 1 percent for the portion of the cost reporting period from April 1, 2022, through June 30, 2022; and 2 percent for the portion of the cost reporting period on or after July 1, 2022.

Line 31.02--Enter any demonstration payment adjustment amounts for demonstration projects in which the provider participated where the demonstration adjustment amounts are not subject to the sequestration adjustment. Obtain this amount from the PS&R.

Line 31.75--For cost reporting periods that overlap or begin on or after May 1, 2020, calculate separately in columns 1 and 2 the sequestration adjustment for non-claims based amounts as [(2 percent times (total days in the cost reporting period that occur during the sequestration period, divided by total days in the entire cost reporting period, rounded to six decimal places), rounded to four decimal places) times the sum of line 10, column 1; or line 10, column 2, plus line 27.01, column 2]. If the sum is less than zero, do not calculate the sequestration adjustment. In accordance with §3709 of the CARES Act, as amended by §102 of the CAA 2021, §1 of Public Law 117-7, and §2 of the PAMA 2021, do not apply the sequestration adjustment to the period of May 1, 2020, through March 31, 2022. In accordance with §2 of the PAMA 2021, for cost reporting periods that overlap or begin on or after April 1, 2022, calculate the sequestration adjustment amount for the period of April 1, 2022, through June 30, 2022, as follows: [(1 percent times (total days in the cost reporting period that occur from April 1, 2022, through June 30, 2022, divided by total days in the entire cost reporting period, rounded to six decimal places), rounded to four decimal places), times the sum of line 10, column 1; or line 10, column 2, plus line 27.01, column 2]; and for cost reporting periods that overlap or begin on or after July 1, 2022, calculate the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur on or after July 1, 2022, through the end of the cost reporting period, divided by total days in the entire cost reporting period, rounded to six decimal places), rounded to four decimal places) times the sum of (line 10, column 1; or line 10, column 2, plus line 27.01, column 2].

Line 32--Enter the interim payment amount from Worksheet H-5, line 4. For contractor final settlement, report on line 33 the amount from Worksheet H-5, line 5.99. For titles V and XIX, enter the interim payments from your records.

Line 34--The amounts show the balance due the provider or the program by entering the result of line 31 minus the sum of lines 31.01, 31.02, 31.75, 32, and 33. Transfer to Worksheet S, Part III, line 9, as applicable.

Line 35--Enter the program reimbursement effect of protested items. The reimbursement effect of the nonallowable items is estimated by applying a reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See CMS Pub. 15-2, chapter 1, §115.2.) A schedule showing the supporting details and computations for this line must be attached.

4046. WORKSHEET H-5 - ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HOME HEALTH AGENCIES FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Complete this worksheet for Medicare interim payments only. (See 42 CFR 413.64.)

The column headings designate two categories of payments: Part A and Part B.

Complete the identifying information on lines 1 through 4. The remainder of the worksheet is completed by your contractor. Do not include on this worksheet any payments made for DME or medical supplies charged to patients that are paid on the basis of a fee schedule.

Line Descriptions

Line 1--Enter the total Medicare interim payments paid to the HHA for cost and HHA PPS reimbursed services. The amount entered reflects payments for all episodes concluded in this fiscal year. **Do not include any payments received for fee scheduled services.** 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 includes amounts withheld from your interim payments due to an offset against overpayments 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. If you are reimbursed under the periodic interim payment method of reimbursement, enter the periodic interim payments received for this cost reporting period.

Line 2--Enter the total Medicare 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--Enter the total amount of the interim payments (sum of lines 1, 2, and 3.99). Transfer these totals to the appropriate column on Worksheet H-4, Part II, line 32.

DO NOT COMPLETE THE REMAINDER OF WORKSHEET H-5. THE REMAINDER OF THE WORKSHEET IS COMPLETED BY YOUR CONTRACTOR. (EXCEPTION: IF WORKSHEET S, PART I, LINE 5, IS "5" (AMENDED COST REPORT), THE PROVIDER MAY COMPLETE THIS SECTION.)

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 NPR has been issued, report all settlement payments prior to the current reopening settlement on line 5.

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. Enter in column 2 the amount on Worksheet H-4, Part II, column 1, line 34. Enter in column 4 the amount on Worksheet H-4, Part II, column 2, line 34.

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

Line 7--Enter the total of the amounts on lines 4, 5.99, and 6. Enter in column 2, the amount on Worksheet H-4, Part II, column 1, line 31 less the amount on lines 31.01 and 31.02. Enter in column 4, the amount on Worksheet H-4, Part II, column 2, line 31, less the amount on lines 31.01 and 31.02.

Line 8--Enter the contractor name, the contractor number and NPR date in columns 0, 1 and 2, respectively.

4047. ANALYSIS OF RENAL DIALYSIS DEPARTMENT COSTS

This worksheet provides for the analysis of the direct and indirect expenses related to the renal dialysis cost centers, allocation of cost between inpatient and outpatient renal dialysis services where separate cost centers are not maintained, and the allocation of the cost to the various modes of outpatient dialysis treatment. The ancillary renal dialysis cost center is serviced by the general cost centers and includes all reimbursable cost centers within the provider organization which provide services to the renal dialysis department. The cost used in the analysis for the renal dialysis department is obtained, in part, from Worksheets A; B, Part I; and C. Complete a separate Worksheet I series for lines 74 and 94 of Worksheet A. In other words, complete one Worksheet I series for line 74, and one for line 94, if appropriate.

4048. WORKSHEET I-1 - ANALYSIS OF RENAL DIALYSIS DEPARTMENT COSTS

This part provides for recording the direct salaries and other direct expenses applicable to the total inpatient and outpatient renal dialysis cost center or outpatient renal dialysis cost center where you maintain a separate and distinct outpatient renal dialysis cost center. If you have more than one renal dialysis department, and/or more than one home dialysis department, submit one Worksheet I series combining the renal dialysis departments and a separate Worksheet I series combining the home dialysis departments. You must also have on file, as supporting documentation, a Worksheet I series for each renal dialysis department and for each home dialysis department along with the appropriate workpapers. File this documentation with exception requests in accordance with CMS Pub. 15-1, chapter 27, §2720. Do not combine the cost of the renal dialysis with home program dialysis reported separately on Worksheet A, lines 74 and 94.

This worksheet also provides for recording the indirect expenses applicable to the total renal or outpatient renal dialysis department obtained from Worksheet B, Part I, columns 1 through 23, line 74, as adjusted for post stepdown adjustments, if any. When completing a separate Worksheet I for home program dialysis, transfer the direct expenses from Worksheet B, Part I, columns 1 through 23, line 94. Do not combine the cost of the renal department with home program dialysis; these costs are listed separately on Worksheet A, lines 74 and 94, respectively.

Column Descriptions

Column 1--Enter on lines 1 through 8, the amounts included from Worksheet A, column 7, for salaries only. Enter on lines 10 through 16, and 18 through 26, the amounts from Worksheet B, Part I, all columns for lines 74 and 94. The subtotal on Worksheet I-1, line 27, agrees with the sum of Worksheet B, Part I, column 26, line 74, or line 94 if a home dialysis cost center was established and used on Worksheet A.

Column 2--This column lists the statistical bases for allocating costs on Worksheet I-3.

Column 3--Enter paid hours per type of staff listed on lines 1 through 6.

Column 4--Enter FTEs by dividing column 3 by 2080 hours.

Line Descriptions

Lines 1 through 6--Enter on these lines the direct patients care salaries after adjustments and reclassification reported in column 7 of Worksheet A. Direct patient care salary includes only the salary of staff providing direct patient care services. Also include fees paid to non-employees providing direct patient care services. Time spent furnishing administrative or management services by direct patient care personnel is reported on line 8, non-patient care salary.

Line 7--Include on this line amounts paid to physicians for their administrative services of managing the renal department after reclassifications and adjustments reported in column 7 of Worksheet A. These payments are subject to the limitation contained in CMS Pub. 15-1, chapter 8, §40.6. Also include payments to physicians for their medical services if the box on line 21 of Worksheet S-5 is marked the initial method. No payment to physicians for patient medical services should appear on this line if the monthly capitation payment (MCP) box is marked on Worksheet S-5. Under the MCP, contractors pay physicians directly for their medical services.

Line 8--Enter the amount of salaries paid to non-patient care personnel after reclassifications and adjustments that you report in column 7 of Worksheet A.

Lines 10 through 13--Include on the appropriate lines costs directly charged to the renal department after reclassifications and adjustments.

Line 14.--For cost reporting periods beginning before January 1, 2023, this cost center includes the direct cost of total dialysis supplies used in furnishing dialysis services. It includes the cost of supplies that are covered under the composite rate payment and separately billable supplies.

For cost reporting periods beginning on or after January 1, 2023, this cost center includes the direct cost of dialysis supplies used in furnishing dialysis services including:

- the direct cost of dialysis supplies that are used for adult patients.
- the direct cost of dialysis supplies that are used for pediatric patients (patients under age 18 years) and that are not included on line 14.01.

Include the cost of supplies covered under the composite rate payment and separately billable supplies.

Line 14.01.--For cost reporting periods beginning on after January 1, 2023, this cost center includes the cost of medical supplies used exclusively for pediatric patients, e.g., crit-lines, low volume lines and dialyzers, catheter kits, fistula needles and tape, saline flushes, bandages, chlorhexidine, tego caps for catheters, biopatch for catheter dressing, oxygen, suction, emergency supplies, monitors for vitals, and blood pressure cuffs. Do not include the costs of supplies used for both pediatric and adult patients; report the cost of supplies used for both pediatric and adult patients on line 14.

Lines 15 and 16--Report on line 16, other direct costs that cannot be specifically identified on lines 11 through 15. Line 15 must include all ESA costs effective for cost reporting periods beginning on or after October 1, 2015.

Lines 17--Add lines 9 through 16. The total in column 1 must agree with the total on Worksheet A, column 7 for line 74 or line 94, as appropriate.

Lines 18 through 26--Enter the allocated general service costs from Worksheet B, Part I, lines 74 or 94, as listed in the chart below.

NOTE: Line 25 excludes the costs of all ESAs administered to ESRD patients in the renal department and home program identified on Worksheet B-2, lines 1, 2, 3 or 4.

Worksheet I-1, Part I, Column 1, Line Number	General Service Cost Centers	Worksheet B, Part I, Lines 74 or 94, Columns
18	Capital-Related Costs-Buildings and Fixtures	1
19	Capital-Related Costs-Moveable Equipment	2
20	Employee Benefits	4
21	Administrative and General	5
22	Maintenance & Repairs, Operation of Plant and Housekeeping	Sum of 6, 7, and 9
23	Medical Education Programs	Sum of 20, 21, 22, 23, and 25 (medical education only)
24	Central Services & Supplies	14
25	Pharmacy	15
26	Other Allocated Costs	Sum of 8, 10, 11, 12, 13, 16, 17, 18, and 19

Line 27--For cost reporting periods beginning prior to October 1, 2015, add lines 17 through 26. This total must agree with the total on Worksheet B, Part I, column 26, line 74 or line 94, if a home dialysis cost center was established. Effective for cost reporting periods beginning on or after October 1, 2015, add lines 17 through 26. This total must agree with the total on Worksheet B, Part I, column 24, line 74, or line 94 if a home dialysis cost center was established, less the sum of columns 21 and 22, as appropriate.

Lines 28, 29, and 30--These lines provide for the allocation of costs associated with routine dialysis services furnished to renal patients from other ancillary departments. Enter the cost to charge ratio from Worksheet C, Part I, column 9. Payment for routine laboratory services, as defined in CM Pub. 100-02, chapter 11, §30.2, is paid for under the composite payment rate. No separate payment is made for routine laboratory tests. The costs of these services are allocated to the renal department based on the provider's laboratory cost to charge ratio from Worksheet C, Part I, column 9, line 60. Providers must maintain a log of routine laboratory charges for allocating routine laboratory costs to the renal department. The lab charges reported on Worksheet C do not include the lab charges for ESRD therefore those charges must be grossed up in accordance with CMS Pub. 15-1, chapter 23, §2314. The cost to charge ratio must be recalculated and applied against the charges reported in column 3 of this worksheet. Do not gross up ESRD charges. Instead, the cost to charge ratio for lab charges reported on Worksheet C will be used.

Line 31--Enter the sum lines 27 through 30.

4049. WORKSHEET I-2 - ALLOCATION OF RENAL DEPARTMENT COSTS TO TREATMENT MODALITIES

The purpose of this schedule is to allocate costs to the different services furnished in the renal department. Line 1 combines the costs reported on Worksheet I-1 for allocating costs to the different services furnished in the renal department.

Line 1--Enter the amounts from Worksheet I-1, column 1, as follows:

Worksheet I-2 Description	Worksheet I-2 Column	From Worksheet I-1, column 1:
Capital & Main Building Costs	1	Sum of lines 11, 18, and 22
Capital, Machine & Repair Costs	2	Sum of lines 12, 13, and 19
Registered Nurses Direct Patient Care Salary	3	Line 1
Other Direct Patient Care Salary	4	Sum of lines 2, 3, 4, 5, and 6
Employee Benefits	5	Sum of lines 10 and 20
Drugs	6	Sum of lines 15 and 25, minus Worksheet S-5, line 22 (and subscripts), col. 2 (renal dialysis department), or col. 3 (home program dialysis)
Medical Supplies	7	Sum of lines 14 and 24
Medical Supplies-Pediatric	7.01	Line 14.01
Routine Ancillary Services	8	Sum of lines 28, 29, and 30
Subtotal	9	Not applicable
Overhead	10	Sum of lines 7, 8, 16, 21, and 26

Complete columns 1 through 8, and 10, in conjunction with Worksheet I-3, which contains the statistical bases for allocating costs to the proper lines. For each line item in columns 1 through 8, and 10, multiply the statistic entered in the corresponding line and column of Worksheet I-3 by the unit cost multiplier on line 18.

Lines 2 through 11--These lines identify the type of dialysis treatments, including pediatric dialysis services and acute kidney injury (AKI) renal dialysis services. Medicare began paying for AKI services furnished to Medicare beneficiaries on January 1, 2017 (see 42 CFR 413, Subpart K); report AKI services for cost reporting periods ending on or after September 30, 2018. The total costs (column 11) for these individual dialysis services are transferred to Worksheet I-4.

For cost reporting periods beginning prior to January 1, 2023, transfer the total on Worksheet I-2, column 11, to Worksheet I-4 per the following instructions:

From Worksheet I-2, column 11	To Worksheet I-4, column 2
Lines 2 and 2.01	Line 1
Lines 3 and 3.01	Line 2
Line 4	Line 3
Line 5	Line 4
Line 6	Line 5
Line 7	Line 6
Line 8	Line 7
Line 9	Line 8
Line 10	Line 9
Line 11	Line 10

For cost reporting periods beginning on or after January 1, 2023, transfer the total cost as follows:

From Worksheet I-2, column 11	To Worksheet I-4, column 2
Sum of lines 2 and 2.02	Line 1
Line 2.01	Line 1.01
Sum of lines 3 and 3.02	Line 2
Line 3.01	Line 2.01
Sum of lines 4 and 4.01	Line 3
Line 4.02	Line 3.01
Sum of lines 5 and 5.01	Line 4
Line 5.02	Line 4.01
Sum of lines 6 and 6.01	Line 5
Line 6.02	Line 5.01
Sum of lines 7 and 7.01	Line 6
Line 7.02	Line 6.01
Sum of lines 8 and 8.01	Line 7
Line 8.02	Line 7.01
Sum of lines 9 and 9.01	Line 8
Line 9.02	Line 8.01
Sum of lines 10 and 10.01	Line 9
Line 10.02	Line 9.01
Sum of lines 11 and 11.01	Line 10
Line 11.02	Line 10.01

If you complete a Worksheet I-2 for the renal department and the home program dialysis department, complete a separate Worksheet I-4.

Lines 12 through 16--These services are not paid for under the composite payment rate system. Therefore, the costs of these services are not transferred to Worksheet I-4. Exclude these costs in the calculation of reimbursement composite payment rate bad debts. (See 42 CFR 413.89(i)(2).)

Line 12--Report inpatient costs. Inpatient dialysis services are paid under the DRG system for Medicare patients.

Line 13--Report the costs of support services furnished to Method II home patients. Payment for Method II home patient dialysis services are subject to the rules in 42 CFR 414.330. Under Method II, a renal provider is only allowed to bill for support services and not dialysis equipment or supplies. Payment for support services is limited to the lower of the provider's reasonable cost or the payment limit as defined in the regulation, which is $121.15 per patient per month. This amount includes payment for support services and routine laboratory tests furnished to home patients. Beginning January 1, 2011, Method II is no longer an option for home dialysis items and services under Medicare. Therefore, beginning January 1, 2011, all home dialysis patients are Method I.

Line 14--Report the direct costs of EPO net of discounts furnished in the renal department. Include all costs for patients receiving outpatient, home, or training dialysis treatments. This amount includes EPO cost furnished in the renal department or any other department if furnished to an end stage renal dialysis patient. Enter EPO amount for informational purposes only. This amount is not included in the total on line 17. For cost reporting periods beginning on or after October 1, 2015, this line will be identified as "ESAs" and providers must enter the direct costs of all ESAs net of discounts furnished in the renal department on this line.

Line 15--Report the direct costs of Aranesp net of discounts furnished in the renal department. Include all costs for patients receiving outpatient, home, or training dialysis treatments. This amount includes Aranesp cost furnished in the renal department or any other department if furnished to an end stage renal dialysis patient. Enter Aranesp amount for informational purposes only. This amount is not included in the total on line 17. For cost reporting periods beginning on or after October 1, 2015, do not complete this line and enter all ESA amounts on line 14.

Line 16--Report the costs of other services furnished and billed in the renal department that are paid for outside the composite payment rate.

Line 17--Add columns and enter totals. Since lines 14 and 15, column 9, are shaded, no costs for EPO and Aranesp and all other ESA's are included in the total for line 17, column 9; and, for column 6, exclude lines 14 and 15 from the total.

Line 18--Enter the amount of medical educational program costs from Worksheet I-1, line 23. Payment for medical educational program costs allocated to the renal department is not included in the composite payment rate.

Line 19--Add lines 17 and 18. This total, plus the amounts in column 6, lines 14 and 15, agrees with the sum of Worksheet I-1, column 1, line 31.

Column Description

Columns 1 through 8--For each line, multiply the unit cost multiplier on Worksheet I-3, line 18, by the statistical base, and enter the result on the corresponding line and column on Worksheet I-2.

Column 9--Add columns 1 through 8 for each line, except lines 14 and 15, and enter the total.

Column 10--Multiply the unit cost multiplier on Worksheet I-3, column 10, line 18, by the line amounts in column 9 of Worksheet I-2, and enter the amount in column 10.

Column 11--Add columns 9 and 10 for each line, and enter the result.

4050. WORKSHEET I-3 - DIRECT AND INDIRECT RENAL DIALYSIS COST ALLOCATION - STATISTICAL BASIS

To accomplish the allocation of your direct and indirect costs reported on Worksheet I-1 to the different services provided in the department, you must maintain renal department statistics. To facilitate the allocation process, the format of Worksheets I-2 and I-3 is identical.

Line 1--Transfer the amounts on Worksheet I-2, line 1, columns 1 through 10, to Worksheet I-3, line 1, columns 1 through 10.

Lines 2 through 16--Enter on these lines and in the appropriate columns, the statistic for allocating costs to the appropriate line item. The statistical basis used in each column is defined in the column heading and on Worksheet I-1.

NOTE: If you wish to change your allocation basis for a particular general cost center, you must receive written approval from your contractor before the start of your cost reporting period for which the alternative method is used. (See §4017 for Worksheets B and B-1.)

Line 12--Enter, in the area provided, the number of inpatient dialysis treatments furnished during the cost reporting period.

Line 17--Add the statistical basis for each column, except columns 9 and 10.

Line 18--Calculate the unit cost multiplier by dividing the amount on line 1 by the total statistical basis on line 17 for each column. Multiply the unit cost multiplier by the statistical base, and enter the cost on the appropriate line and column number on Worksheet I-2.

Column Descriptions

Column 1--Use the square footage of the renal department to allocate capital and maintenance building costs.

Column 2--Use percentage of time to allocate capital and maintenance equipment costs.

Columns 3 and 4--Use paid hours to allocate registered nurses and direct patient care salary.

Column 5--Use total direct patient care salaries in columns 4 and 5 of Worksheet I-2 to allocate employee benefits.

Columns 6, 7, and 7.01--Use cost of requisitions to allocate drug, medical supplies, and pediatric medical supplies.

Column 8--Use routine laboratory charges to allocate laboratory costs.

Column 10--Use subtotal costs in column 9, Worksheet I-2 to allocate overhead cost. To compute the unit cost multiplier, transfer the amount from Worksheet I-2, line 17, column 9, to Worksheet I-3, line 17, column 10. Do not allocate overhead costs to lines 14 or 15.

4051. WORKSHEET I-4 - COMPUTATION OF AVERAGE COST PER TREATMENT FOR OUTPATIENT RENAL DIALYSIS

This worksheet records the apportionment of total outpatient cost to the types of dialysis treatment furnished by you and shows the computation of expenses of dialysis items and services that you furnished to Medicare dialysis patients. This information is used for overall program evaluation, determining the appropriateness of program reimbursement rates, and meeting statutory requirements for determining the cost of ESRD care.

Complete separate worksheets to report the costs of the renal dialysis department and the home program dialysis department.

If you have more than one renal dialysis and/or home program dialysis department, submit one Worksheet I-4 combining the renal dialysis departments and/or one Worksheet I-4 combining the home dialysis departments as only one average payment composite rate will apply to each modality. Enter on the combined Worksheet I-4 each provider's satellite number if you are separately certified as a satellite facility.

In accordance with section 1881(b)(12)(A) of the Act, as added by section 623(d)(1) of MMA 2003, the ESRD payment is replaced by a calculated ESRD composite rate. Section 153(b) of MIPPA amended section 1881(b) of the Act effective for services rendered on or after January 1, 2011, the calculated ESRD composite rate is replaced by an ESRD bundled payment system.

For cost reporting periods that straddle January 1, 2011, report the rates for each modality on Worksheet I-4 as follows: For the portion of the cost reporting period prior to January 1, 2011, enter the average composite rate for each modality in column 7. For the portion of the cost reporting period on and after January 1, 2011, enter the average ESRD PPS payment rate for each modality in column 7.02. For cost reporting periods that straddle January 1, 2012, January 1, 2013, and January 1, 2014, report the average ESRD PPS payment rate for each modality on Worksheet I-4 as follows: For the portion of the cost reporting period prior to January 1, enter the average ESRD PPS payment rate for each modality in column 7.01. For the portion of the cost reporting period on and after January 1, enter the average ESRD PPS payment rate for each modality in column 7.02.

Columns 1 through 3 refer to total outpatient statistics (i.e., to all outpatient dialysis services furnished) whether reimbursed directly by the program or not.

Column 1--Enter on the appropriate lines the total number of outpatient treatments/patient weeks by renal dialysis department or home program department. These statistics include all treatments furnished to all patients in the outpatient renal department, both Medicare and non-Medicare.

Column 2--Enter on the appropriate lines the total cost transferred from Worksheet I-2, column 11, lines as appropriate. For cost reporting periods beginning prior to January 1, 2023, transfer from Worksheet I-2, the sum of lines 2 and 2.01, column 11, to line 1, column 2; transfer from Worksheet I-2, the sum of lines 3 and 3.01, column 11, to line 2, column 2.

For cost reporting periods beginning on or after January 1, 2023, transfer total cost as follows, except that lines marked by an asterisk in the note column apply for cost reporting periods beginning on or after January 1, 2025:

NOTE	FROM WORKSHEET I-2, COLUMN 11	TO WORKSHEET I-4, COLUMN 2
	Sum of lines 2 and 2.02	Line 1
	Line 2.01	Line 1.01
	Sum of lines 3 and 3.02	Line 2
	Line 3.01	Line 2.01
	Sum of lines 4 and 4.01	Line 3
*	Line 4.02	Line 3.01
	Sum of lines 5 and 5.01	Line 4
*	Line 5.02	Line 4.01
	Sum of lines 6 and 6.01	Line 5
*	Line 6.02	Line 5.01
	Sum of lines 7 and 7.01	Line 6
*	Line 7.02	Line 6.01
	Sum of lines 8 and 8.01	Line 7
*	Line 8.02	Line 7.01
	Sum of lines 9 and 9.01	Line 8
*	Line 9.02	Line 8.01
	Sum of lines 10 and 10.01	Line 9
*	Line 10.02	Line 9.01
	Sum of lines 11 and 11.01	Line 10
*	Line 11.02	Line 10.01

Column 3--Determine the amounts entered on the appropriate lines by dividing the cost entered on each line in column 2 by the number of treatments entered on each line in column 1.

Line 9--Report continuous ambulatory peritoneal dialysis (CAPD) in terms of weeks. Compute patient weeks by totaling the number of weeks each Method I patient was dialyzed at home using CAPD.

Line 10--Report continuous cycling peritoneal dialysis (CCPD) in terms of weeks. Compute patient weeks by totaling the number of weeks each Method I patient was dialyzed at home by CCPD.

Medicare Treatments

Columns 4 through 7 refer only to treatments furnished to Medicare beneficiaries that were billed to the facility and reimbursed by the program directly. (Amounts entered in these columns are reconcilable to your records.)

Column 4--Enter on the appropriate lines the number of treatments billed to the Medicare program directly. Obtain this information from your records and/or the PS&R. For cost reporting periods that straddle January 1, 2011, enter on column 4 the total number of treatments or patient weeks billed to Medicare for services rendered prior to January 1, 2011.

Column 4.01--For cost reporting periods that straddle January 1, 2012, January 1, 2013, or January 1, 2014, enter the total number of treatments or patient weeks billed to Medicare for services rendered prior to January 1.

Column 4.02--For cost reporting periods that straddle or begin January 1, 2011, January 1, 2012, or January 1, 2013, enter the total number of treatments or patient weeks billed to Medicare for services rendered on and after January 1. For cost reporting periods that straddle January 1, 2014, enter the total number of treatments or patient weeks billed to Medicare for services rendered on and after January 1.

For cost reporting periods beginning on or after January 1, 2014, enter the number of ESRD PPS treatments billed to Medicare in column 4 and eliminate columns 4.01 and 4.02.

Column 5--Determine the amounts entered on the appropriate lines by multiplying the number of treatments entered on each line in column 4 by the average cost per treatment entered on the corresponding line in column 3. For cost reporting periods that straddle or begin on or after January 1, 2011, enter total expenses determined by multiplying the sum of columns 4, 4.01, and 4.02, by the average cost per treatment entered on each corresponding line in column 3. Transfer the total expenses from this column, line 11 to Worksheet I-5, line 1. If you complete a Worksheet I-4 for renal dialysis and a Worksheet I-4 for home dialysis, add the sum of the cost from this column, line 11, and transfer the total to Worksheet I-5, line 1.

Column 6--Total Program Payment--Enter the total program payment by the type of treatment for the reporting period. Since this amount is calculated on a patient basis and is case mix adjusted, the total program payment will be provider specific for each modality. For cost reporting periods that straddle January 1, 2011, enter in column 6, the total program payment by the type of treatment for services rendered prior to January 1, 2011. For cost reporting periods beginning on or after January 1, 2014, enter the total program payment by the type of treatment. Obtain this from the PS&R. Transfer the total from column 6, line 11, to Worksheet I-5, line 2, column 1.

Column 6.01--For cost reporting periods that straddle January 1, 2012, January 1, 2013, or January 1, 2014, enter the total program payment by the type of treatment for Medicare for services rendered prior to January 1. Obtain this from the PS&R. Transfer the total from column 6.01, line 11, to Worksheet I-5, line 2.01, column 1.

Column 6.02--For cost reporting periods that straddle or begin January 1, 2011, January 1, 2012, or January 1, 2013, enter the total program payment by the type of treatment for Medicare for services rendered on and after January 1. For cost reporting periods that straddle January 1, 2014, enter the total program payment by the type of treatment for services rendered on and after January 1. Obtain this from the PS&R. Transfer the total from column 6.02, line 11, to Worksheet I-5, line 2.02, column 1.

For cost reporting periods beginning on or after January 1, 2014, enter the total program payment by the type of treatment in column 6 and eliminate columns 6.01 and 6.02.

The ESRD Medicare payment rate is an average payment calculated based on the total Medicare payments by type of treatment divided by the total ESRD Medicare treatments.

Column 7--Average Payment Rate--For cost reporting periods that straddle January 1, 2011, for the portion of the cost reporting period prior to January 1, 2011, enter the total average payment rate by the type of treatment for the reporting period. Determine the amounts entered on the appropriate lines by dividing the total payments on each corresponding line in column 6 by the number of treatments entered on each line in column 4.

Column 7.01--For cost reporting periods that straddle January 1, 2012, January 1, 2013, or January 1, 2014, report the average ESRD PPS payment rate for each modality in column 7.01 for the portion of the cost reporting period prior to January 1 by entering the result of column 6.01 divided by column 4.01.

Column 7.02--For cost reporting periods that straddle or begin January 1, 2011, January 1, 2012, or January 1, 2013, report the average ESRD PPS payment rate for each modality in column 7.02 for the portion of the cost reporting period on and after January 1, by entering the result of column 6.02 divided by column 4.02. For cost reporting periods that straddle January 1, 2014, report the average ESRD PPS payment rate for each modality in column 7.02 for the portion of the cost reporting period on and after January 1.

The ESRD composite payment rates and the ESRD PPS payment rates are average payments calculated based on the total Medicare payments (by type of treatment) divided by the total corresponding ESRD treatments per the facility's PS&R data. For example, the total Medicare payment for hemodialysis is divided by the total ESRD hemodialysis treatments.

For cost reporting periods beginning on or after January 1, 2014, enter all ESRD PPS payment rates in column 7, and eliminate columns 7.01 and 7.02 and.

Line 11--Enter in columns 1 and 4 the sum total of lines 1 through 8. Enter in columns 2, 5, and 6 the sum total of lines 1 through 10.

Line 12--Report "total provider treatments" on this line. This line is informational only. This line will be used for contractor verification. Continuous cycling peritoneal dialysis (CCPD) and continuous ambulatory peritoneal dialysis (CAPD) are daily treatment modalities, and ESRD facilities are paid the equivalent of three hemodialysis treatments for each week that CCPD and CAPD treatments are provided.

Compute hemodialysis equivalent treatments for lines 9 and 10 by multiplying the number of weeks reported in column 1 by three treatments for each week. Add to this amount the treatments computed on line 11, column 1.

4052. WORKSHEET I-5 - CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B

This worksheet provides for the calculation of reimbursable Part B bad debts relating to outpatient renal dialysis treatments. If you have completed more than one Worksheet I-2 (i.e., one for renal dialysis department and one for home program dialysis), make a consolidated bad debt computation.

Part I - Calculation of Reimbursable Bad Debts Title XVIII - Part B--Under the composite rate payment system for services prior to January 1, 2011, the contractor pays the facility its allowable ESRD bad debts, up to the facility's unreimbursed reasonable costs as determined under Medicare principles. Under the ESRD PPS payment system, effective for dates of service on and after January 1, 2011, the contractor pays the facility for allowable ESRD bad debts, up to the facility's unreimbursed reasonable costs for those items and services associated with the basic case-mix adjusted composite rate portion of the ESRD PPS payment rate. Allowable bad debts must relate to specific Medicare deductibles and coinsurance amounts.

Determination of bad debt amounts for the basic case-mix adjusted composite rate payment portion of the ESRD PPS payment, is based on the percentage of basic composite rate payment costs to total costs on a facility specific basis. The facility specific composite rate percentage is applied to the facility's total bad debt amounts associated with the ESRD PPS payment. The resulting bad debt amount is used to determine the allowable Medicare bad debt payment in accordance with 42 CFR 413.89 and 42 CFR 413.178 of the regulations. During the transition periods, apply the facility specific composite cost percentage to the bad debt amounts associated with the transition portion of the ESRD PPS payment.

The resulting bad debt amount will be added to the bad debt amount associated with the transition portion of the facility's ESRD reasonable costs to determine the total allowable Medicare bad debt (For example, a facility that does not elect 100 percent PPS, will be in transition period 1 for services rendered beginning January 1, 2011, through December 31, 2011. Under transition period 1, services rendered during this period are paid based on 75 percent composite rate and 25 percent ESRD PPS payment rate. The facility specific composite cost percentage will be applied to 25 percent of the bad debts and the resulting bad debt amount will be added to the transitional 75 percent to determine the total allowable bad debt pertaining to services rendered during this period).

EXCEPTION: The transition period payment method will not apply to ESRD services rendered on and after January 1, 2011, by a facility that (1) elected 100 percent of the payment amount to be based on the ESRD PPS Payment, or (2) was certified for Medicare participation and began providing dialysis services on or after January 1, 2011.

Column 1--Enter the total amounts by line description.

Column 2--This column is used to compute the appropriate reduction to each amount reported in column 1, based on the facility's transition period and application of their facility specific composite cost ratio.

Line 1--Enter the amount from Worksheet I-4, column 5, line 11. The amount reported is reflective of the provider's calculated basic composite rate payment cost.

Line 2--Enter the amount from Worksheet I-4, column 6, line 11. For cost reporting periods that overlap January 1, 2011, enter in column 1 the amount from Worksheet I-4, column 6, line 11. Enter in column 2, the amount reported in column 1. For cost reporting periods beginning on or after January 1, 2014, enter in column 1, the sum of the amount from Worksheet I-4, column 6, line 11. Enter in column 2, the amount reported in column 1 times the facility specific composite cost ratio from, line 14. For cost reporting periods beginning on or after January 1, 2014, do not complete lines 2.01 and 2.02.

Line 2.01--Enter in column 1, the sum of the amount from Worksheet I-4, column 6.01, line 11. Enter in column 2, the portion of the amount reported in column 1 as it relates to the ESRD PPS payment times the facility specific composite cost ratio from line 14. Add to this amount the composite cost portion of the payment. For cost reporting periods beginning on or after January 1, 2014, do not complete this line.

Line 2.02--Enter in column 1, the sum of the amount from Worksheet I-4, column 6.02, line 11. Enter in column 2, the portion of the amount reported in column 1 as it relates to the ESRD PPS payment times the facility specific composite cost ratio from line 14. Add to this amount the composite cost portion of the payment. For cost reporting periods beginning on or after January 1, 2014, do not complete this line.

Line 2.03--Enter the sum of lines 2, 2.01, and 2.02, in columns 1 and 2 accordingly.

Line 2.04--Enter the amount for outlier payments applicable to Medicare (Part B) patients from your records. (Informational only)

Line 3--Enter the amount shown in your records for deductibles billed to Medicare (Part B) for dialysis treatments. For cost reporting periods that overlap January 1, 2011, enter in column 1, the amount shown in your records for deductibles billed to Medicare (Part B) patients for dialysis treatments. Include only deductibles amounts that are related to the payments listed on line 2, column 1, and apply to Medicare beneficiaries under the composite payment rate. Enter in column 2, the amount reported in column 1. For cost reporting periods beginning on or after January 1, 2014, enter in column 1, the amount shown in your records for deductibles billed to Medicare (Part B) patients. Enter in column 2, the amount reported in column 1 times the facility specific composite cost ratio from line 14.

For cost reporting periods beginning on or after January 1, 2014, do not complete lines 3.01 and 3.02.

Line 3.01--Enter in column 1, the amount shown in your records for deductibles billed to Medicare (Part B) patients. Include only deductible amounts that are related to the payments listed on line 2.01, column 1, and apply to Medicare beneficiaries under the ESRD PPS payment rate. Enter in column 2, the portion of the amount reported in column 1, as it relates to the ESRD PPS payment times the facility specific composite cost ratio from line 14. Add to this amount the composite cost portion of the payment.

Line 3.02--Enter in column 1, the amount shown in your records for deductibles billed to Medicare (Part B) patients. Include only deductible amounts that are related to the payments listed on line 2.02, column 1, and apply to Medicare beneficiaries under the ESRD PPS payment rate. Enter in column 2, the portion of the amount reported in column 1, as it relates to the ESRD PPS payment times the facility specific composite cost ratio from line 14. Add to this amount the composite cost portion of the payment.

Line 3.03--Enter the sum of lines 3, 3.01 and 3.02, columns 1 and 2, respectively.

Line 4--Enter the amount shown in your records for coinsurance billed to Medicare (Part B) for dialysis treatments. For cost reporting periods that overlap January 1, 2011, enter in column 1, the amount shown in your records for coinsurance billed to Medicare (Part B) patients for dialysis treatments. Include only coinsurance amounts that are related to the payments listed on line 2, column 1, and apply to Medicare beneficiaries under the composite payment rate. Enter in column 2, the amount reported in column 1. For cost reporting periods beginning on or after January 1, 2014, enter in column 1 the amount shown in your records for coinsurance billed to Medicare (Part B) patients. Enter in column 2, the amount reported in column 1 times the facility specific composite cost ratio from line 14.

For cost reporting periods beginning on or after January 1, 2014, do not complete lines 4.01 and 4.02.

Line 4.01--Enter in column 1, the amount shown in your records for coinsurance billed to Medicare (Part B) patients. Include only coinsurance amounts that are related to the payments listed on line 2.01, column 1, and apply to Medicare beneficiaries under the ESRD PPS payment rate. Enter in column 2, the portion of the amount reported in column 1, as it relates to the ESRD PPS payment times the facility specific composite cost ratio from line 14. Add to this amount the composite cost portion of the payment.

Line 4.02--Enter in column 1, the amount shown in your records for coinsurance billed to Medicare (Part B) patients. Include only coinsurance amounts that are related to the payments listed on line 2.02, column 1, and apply to Medicare beneficiaries under the ESRD PPS payment rate. Enter in column 2, the portion of the amount reported in column 1, as it relates to the ESRD PPS payment times the facility specific composite cost ratio from line 14. Add to this amount the composite cost portion of the payment.

Line 4.03--Enter the sum of lines 4, 4.01 and 4.02, columns 1 and 2, respectively.

Line 5--Enter the uncollectible portion of the amounts entered on lines 3 and 4 reduced by any amount recovered during the cost reporting period. For cost reporting periods that overlap or begin on or after January 1, 2011, enter in column 1, the bad debt amount for deductible and coinsurance, net of recoveries, for services rendered prior to January 1, 2011. Transfer this amount to column 2. (See 42 CFR 413.89.) Do not use this line for cost reporting periods beginning on or after 1/1/2017.

Line 5.01--Enter in column 1, the bad debt amount for deductible and coinsurance, net of recoveries, for services rendered on or after January 1, 2011, but before January 1, 2012. Enter in column 2, 75 percent of the amount in column 1, plus 25 percent of the amount in column 1 times the facility specific composite cost ratio on line 14. If the provider indicated "Y" on Worksheet S-5, line 10.02, and elected 100 percent PPS, do not complete this line, but complete line 5.04. Do not use this line for cost reporting periods beginning on or after 1/1/2020.

Line 5.02--Enter in column 1, the bad debt amount for deductible and coinsurance, net of recoveries, for services rendered on or after January 1, 2012, but before January 1, 2013. Enter in column 2, 50 percent of the amount in column 1, plus 50 percent of the amount in column 1 times the facility specific composite cost ratio on line 14. If the provider indicated "Y" on Worksheet S-5, line 10.02, and elected 100 percent PPS, do not complete this line, but complete line 5.04. Do not use this line for cost reporting periods beginning on or after 1/1/2020.

Line 5.03--Enter in column 1, the bad debt amount for deductible and coinsurance, net of recoveries, for services rendered on or after January 1, 2013, but before January 1, 2014. Enter in column 2, 25 percent of the amount in column 1, plus 75 percent of the amount in column 1, times the facility specific composite cost ratio on line 14. If the provider indicated "Y" on Worksheet S-5, line 10.02, and elected 100 percent PPS, do not complete this line, but complete line 5.04. Do not use this line for cost reporting periods beginning on or after 1/1/2020.

Line 5.04--Enter in column 1, the bad debt amount for deductible and coinsurance, net of recoveries, for services rendered on or after January 1, 2014. Enter in column 2, 100 percent of the amount in column 1, times the facility specific composite cost ratio on line 14. If the provider indicated "Y" on Worksheet S-5, line 10.02, and elected 100 percent PPS, DO NOT complete lines 5.01, 5.02, or 5.03, but enter in column 1, the bad debt amount for deductible and coinsurance, net of recoveries for all services rendered on or after January 1, 2011. Enter in column 2, 100 percent of the amount in column 1, times the facility specific composite cost ratio on line 14.

Line 5.05--Enter in column 1, the sum of lines 5 through 5.04, column 1. This amount must reconcile to the provider's bad debt listing(s). Enter in column 2, the sum of lines 5 through 5.04, column 2.

Line 6--Enter the result of line 5.05, column 2 (including negative amounts), times 88 percent for cost reporting periods beginning on or after October 1, 2012, 76 percent for cost reporting periods beginning on or after October 1, 2013, and 65 percent for cost reporting periods beginning on or after October 1, 2014.

Line 7--Enter the gross allowable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. This amount must also be included in the amount on line 5.05, column 1 (i.e., line 7 is a subset of line 5.05, column 1).

Line 8--Enter the sum of lines 3 and 4, less line 5, in column 1. For cost reporting periods that overlap or begin on or after January 1, 2011, enter in column 2, the sum of lines 3.03, column 2, and line 4.03, column 2, less line 5.05, column 2.

Line 9--Subtract line 3 from line 2, and enter 80 percent of the difference in column 1. For cost reporting periods that overlap or begin on or after January 1, 2011, subtract line 3.03, column 2, from line 2.03, column 2, and enter 80 percent of the difference in column 2.

Line 10--Enter the result of line 1, minus the sum of lines 8 and 9, in column 1. If the result is negative, enter zero and do not complete line 11. For cost reporting periods that overlap or begin on or after January 1, 2011, enter in column 2, the result of line 1 minus the sum of lines 8 and 9, column 2. For cost reporting periods beginning on or after January 1, 2013, do not complete this line.

Line 11--Enter in column 1, the lesser of line 5 or line 10, column 1. For cost reporting periods that overlap or begin on or after January 1, 2011, enter in column 1, the lesser of line 5.05, column 2, or line 10, column 2. For cost reporting periods that begin on or after October 1, 2012, enter in column 1, the lesser of line 6, column 1, or line 10, column 2. For cost reporting periods beginning on or after January 1, 2013, enter in column 1, the result of line 6, column 1. Transfer the amount on this line to Worksheet E, Part B, line 33.

Part II - Calculation of Facility Specific Composite Cost Percentage.--A facility specific composite cost percentage is applied to the facility's total bad debt amounts and associated cost data necessary to compute the ESRD facility bad debt payments. This percentage is computed by dividing your facility's basic composite rate costs by your total allowable expenses.

Line 12--For cost reporting periods that overlap or begin on or after January 1, 2011, enter the total allowable expenses from Worksheet I-4, column 2, line 11, plus Worksheet B-2, sum of the absolute values of lines 1 through 6, column 4.

Line 13--Enter total base composite rate costs from Worksheet I-4, column 2, line 11.

Line 14--Compute the facility specific composite cost percentage (line 13 divided by line 12).

Part III - ESRD Payments - Information Only

Line 15.--For cost reporting periods that begin on or after January 1, 2023, if your response on Worksheet S-5, line 10.01, is "Y", enter the amount of your low volume payments.

Lines 16 through 20.--For cost reporting periods beginning on or after January 1, 2023, enter the payments for Transitional Drug Add-on Payment Adjustment Amount (TDAPA), Transitional Add-on Payment Adjustment for New and Innovative Equipment and Supplies Amount (TPNIES), Capital Related Assets Transitional Add-on Payment Adjustment for New and Innovative Equipment and Supplies Amount (CRA TPNIES), Home Dialysis Payment Adjustment Amount (HDPA), and Performance Payment Adjustment (PPA), respectively, from the PS&R. (Report for informational purposes.)

4053. WORKSHEET J-1 - ALLOCATION OF GENERAL SERVICE COSTS TO COMMUNITY MENTAL HEALTH CENTERS

Use this worksheet only if you operate as part of your complex a certified hospital-based community mental health center (CMHC) furnishing services to Medicare titles XVIII, XIX, and V. Additionally, while comprehensive outpatient rehabilitation facilities (CORFs), outpatient rehabilitation facilities (ORFs) which generally furnish outpatient physical therapy (OPT), outpatient occupational therapy (OOT), or outpatient speech pathology (OSP) services, do not complete the J series worksheets they must complete the applicable Worksheet A cost center for the purpose of overhead allocation. Only those cost centers that represent services for which the facility is certified are used. If you have more than one hospital-based CMHC, complete a separate worksheet for each facility.

4053.1 Part I - Allocation of General Service Costs to Community Mental Health Center Cost Centers.--Worksheet J-1, Part I, provides for the allocation of the expenses of each general service cost center to those cost centers which receive the services. Obtain the total direct expenses (column 0, line 22) from Worksheet A, column 7, lines as appropriate:

Component	From Worksheet A, Column 7
CMHC	line 99 and subscripts

Obtain the cost center allocations (column 0, lines 1 through 21) from your records, the sum of which must equal the amount entered on column 0, line 22. The amounts on line 22, columns 0 through 23, and column 25, must equal the corresponding amounts on Worksheet B, Part I, columns 0 through 23, and column 25, lines as appropriate:

Component	Worksheet B, Part I, Columns 0 through 23 and 25
CMHC	line 99 and subscripts

Complete the amounts entered on lines 1 through 21, columns 1 through 23, and column 25, in accordance with the instructions contained in §4053.2.

NOTE: Worksheet B, Part I, established the method used to reimburse direct GME cost (i.e., reasonable cost or the per resident amount). Therefore, this worksheet must follow that method. If Worksheet B, Part I, column 25, excluded the costs of interns and residents, column 25, on this worksheet must also exclude these costs.

In column 24, Part I, enter the total of columns 4A through 23.

In column 27, Part I, enter the unit cost multiplier (column 26, line 1, divided by the sum of column 26, line 22, minus column 26, line 1) on line 23. Round the unit cost multiplier to six decimal places. Multiply each amount in column 26, lines 2 through 21, by the unit cost multiplier on line 23, and enter the result on the corresponding line of column 27. On line 22, enter the total of the amounts on lines 2 through 21. The total on line 22 equals the amount in column 26, line 1.

In column 28, Part I, enter on lines 2 through 21, the sum of columns 26 and 27. The total on line 22 equals the total in column 26, line 22.

4053.2 Part II - Allocation of General Service Costs to Community Mental Health Center Cost Centers - Statistical Basis.--Worksheet J-1, Part II, provides for the proration of the statistical data needed to equitably allocate the expenses of the hospital's general service cost centers on Worksheet J-1, Part I. If there is a difference between the total accumulated costs reported on the Part II statistics and the total accumulated costs calculated on Part I, use the reconciliation

column on Part II for reporting any adjustments. See §4020 for the appropriate usage of the reconciliation columns. For subscripted (componentized) A&G cost centers, the accumulated cost center line must match the reconciliation column number.

To facilitate the allocation process, the general format of Worksheet J-1, Parts I and II, is identical. The statistical basis shown at the top of each column on Worksheet J-1, Part II, is the recommended basis of allocation of the cost center indicated and must be consistent with the statistical basis utilized on Worksheet B, Part I.

Lines 1 through 21--On Worksheet J-1, Part II, for all cost centers to which the general service cost center is being allocated, enter that portion of the total statistical base applicable to each.

Line 22--Enter the total of lines 1 through 21 for each column. The total in each column must be the same as shown for the corresponding column on Worksheet B-1, lines as appropriate:

Component	Worksheet B-1, Corresponding Column
CMHC	line 99

Line 23--Enter the total expenses for the cost center allocated. Obtain this amount from Worksheet B, Part I, lines as appropriate (see §4020), from the same column used to enter the statistical base on Worksheet J-1, Part II (e.g., for a CMHC provider, in the case of capital-related cost buildings and fixtures, this amount is on Worksheet B, Part I, column 1, line 99).

Line 24--Enter the unit cost multiplier which is obtained by dividing the cost entered on line 23 by the total statistic entered in the same column on line 22. Round the unit cost multiplier to six decimal places.

Multiply the unit cost multiplier by that portion of the total statistic applicable to each cost center receiving the services. Enter the result of each computation on Worksheet J-1, Part I, in the corresponding column and line.

After the unit cost multiplier has been applied to all the cost centers receiving the services, the total cost (line 22, Part I) must equal the total cost on line 23, Part II.

Perform the preceding procedures for each general service cost center.

4054. WORKSHEET J-2 - COMPUTATION OF COMMUNITY MENTAL HEALTH CENTER PROVIDER COSTS

Use this worksheet only if you operate a hospital-based CMHC. If you have more than one hospital-based CMHC, complete a separate worksheet for each facility.

4054.1 Part I - Apportionment of CMHC Cost Centers.--

Column 1--Enter on each line the total cost for the cost center as previously computed on Worksheet J-1, Part I, column 28. To facilitate the apportionment process, the line numbers are the same on both worksheets. Do not transfer lines 19 and 20 from Worksheet J-1.

Column 2--Enter the charges for each cost center. Obtain the charges from your records.

Column 3--For each cost center, enter the ratio derived by dividing the cost in column 1, by the charges in column 2.

Columns 4, 6, and 8--For each cost center, enter the charges from your records for title V in column 4 and title XIX in column 8. Enter 0 (zero) for each line in column 6 for title XVIII charges as CMHCs are reimbursed under the OPPS. Not all facilities are eligible to participate in all programs.

Columns 5, 7, and 9--For each cost center, enter the costs obtained by multiplying the charges in columns 4, 6, and 8, by the ratio in column 3.

Line 20--Enter the totals of lines 1 through 19, in columns 1, 2, and 4 through 9.

4054.2 Part II - Apportionment of Cost of CMHC Services Furnished by Shared Hospital Departments.--Use this part only when the hospital complex maintains a separate department for any of the cost centers listed on this worksheet, and the department provides services to patients of the hospital's CMHC.

Column 3--For each of the cost centers listed, enter the ratio of cost to charges that is shown on Worksheet C, Part I, column 9, from the appropriate line for each cost center.

Columns 4, 6, and 8--For each cost center, enter the charges from your records for title V in column 4, and title XIX in column 8. Enter 0 (zero) for each line in column 6 for title XVIII charges as CMHCs are reimbursed under the OPPS.

Columns 5, 7, and 9--For each cost center, enter the costs obtained by multiplying the charges in columns 4, 6, and 8, respectively, by the ratio in column 3.

Line 28--Enter the totals for columns 4 through 9.

Line 29--Enter the total costs from Part I, columns 5, 7, and 9, line 20, plus columns 5, 7, and 9, line 28, respectively, and transfer to Worksheet J-3, line 1.

4055. WORKSHEET J-3 - CALCULATION OF REIMBURSEMENT SETTLEMENT - COMMUNITY MENTAL HEALTH CENTER PROVIDER SERVICES

Submit a separate Worksheet J-3 for each title (V, XVIII, or XIX) under which reimbursement is claimed. If you have more than one hospital-based CMHC, complete a separate worksheet for each facility.

Line 1--Enter the cost of the component's services from Worksheet J-2, Part II, line 29 from columns 5, 7, or 9, as applicable (column 5 for title V, column 7 for title XVIII (enter 0 (zero)), and column 9 for title XIX).

Line 2--Enter the gross PPS payments received for services rendered during the cost reporting period excluding outliers. Obtain this amount from the PS&R and/or your records.

Line 3--Enter the total outliers payments received. Obtain this amount from the PS&R and/or your records.

Line 4--Enter the amounts paid and payable by workers' compensation and other primary payers where program liability is secondary to that of the primary payer (from your records).

Line 5--Title XVIII CMHCs enter the result obtained by subtracting line 4 from the sum of lines 2 and 3. Titles V and XIX providers not reimbursed under PPS enter the total reasonable costs by subtracting line 4 from line 1.

Line 6--Enter the charges for the applicable program services from Worksheet J-2, sum of Parts I and II, columns 4, 6, and 8, as appropriate, lines 20 and 28.

Lines 7 through 10--These lines provide for the reduction of program charges where the provider does not actually impose charges on most of the patients liable for payment for services on a charge basis or fails to make reasonable efforts to collect such charges from those patients. If line 9 is greater than zero (0), enter on line 10, the product of multiplying the ratio on line 9 by line 6.

Providers that do impose charges and make reasonable efforts to collect the charges from patients liable for payment for services on a charge basis are not required to complete lines 7, 8, and 9, but enter on line 10, the amount from line 6. (See 42 CFR 413.13(e).) In no instance may the customary charges on line 10 exceed the actual charges on line 6.

Do not include on these lines (1) the portion of charges applicable to the excess costs of luxury items or services (see CMS Pub. 15-1, chapter 21, §2104.3), and (2) provider charges to beneficiaries for excess costs as described in CMS Pub. 15-1, chapter 25, §2570. When provider operating costs include amounts that flow from the provision of luxury items or services, such amounts are not allowable in computing reimbursable costs.

Lines 11 and 12--Lines 11 and 12 provide for the computation of the lesser of reasonable cost or customary charges as defined in 42 CFR 413.13(a).

Enter on line 11, the excess of total customary charges (line 10) over the total reasonable cost (line 5). In situations where the total charges on line 10 are less than the total cost on line 5, enter 0 (zero) on line 11.

Enter on line 12, the excess of total reasonable cost (line 5) over total customary charges (line 10). In situations when in any column the total cost on line 5 is less than the customary charges on line 10, enter zero (0) on line 12.

NOTE: CMHCs not subject to reasonable cost reimbursement do not complete lines 11 and 12.

Line 13--Enter the total reasonable costs from line 5.

Line 14--Enter the Part B deductibles billed to program patients (from your records) excluding coinsurance amounts.

Line 16--If there is an excess of reasonable cost over customary charges, enter the amount from line 12.

Line 18--CMHCs enter 0 (zero) as these services are reimbursed under the OPPS. For titles V and XIX, enter 100 percent less the applicable coinsurance.

Line 19--Enter the actual coinsurance billed to program patients (from your records).

Line 20--For title XVIII, enter the difference of line 17 minus line 19. For titles V and XIX, enter the difference of line 18 minus line 19.

Line 21--Enter allowable bad debts, net of recoveries, applicable to any deductibles and coinsurance (from your records). If recoveries exceed the current year's bad debts, line 21 will be negative. (See 42 CFR 413.89.)

Line 22--Enter the result of line 21 (including negative amounts) times 88 percent for cost reporting periods beginning on or after October 1, 2012, 76 percent for cost reporting periods beginning on or after October 1, 2013, and 65 percent for cost reporting periods beginning on or after October 1, 2014.

Line 23--Enter the gross allowable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. This amount must also be reported on line 21.

Line 24--Enter the result of line 20 plus line 21. For cost reporting periods beginning on or after October 1, 2012, enter the result of line 20 plus line 22.

Line 25--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 chapter 21, §2146.4), enter the adjustment. Specify the adjustment in the space provided.

Line 25.50--Enter the Pioneer ACO demonstration payment adjustment amount. Obtain this amount from the PS&R. Do not use this line for services rendered on or after January 1, 2017. Report any ACO demonstration payment adjustments for services on or after January 1, 2017, on line 25.99 or line 26.02, accordingly.

Line 25.99--Enter any demonstration payment adjustment amounts for demonstration projects in which the provider participated where the demonstration adjustment amounts are subject to the sequestration adjustment. Obtain this amount from the PS&R.

Line 26--Enter the result of line 24 plus or minus line 25, and minus lines 25.50 and 25.99.

Line 26.01--For cost reporting periods that overlap or begin on or after April 1, 2013, calculate the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur during the sequestration period, divided by total days in the entire cost reporting period, rounded to six decimal places), rounded to four decimal places) times line 26]. Do not apply the sequestration calculation when gross reimbursement (line 26) is less than zero. In accordance with §3709 of the CARES Act, as amended by §102 of the CAA 2021, §1 of Public Law 117-7, and §2 of the PAMA 2021, do not apply the sequestration adjustment to the period of May 1, 2020, through March 31, 2022. In accordance with §2 of the PAMA 2021, for cost reporting periods that overlap or begin on or after April 1, 2022, calculate the sequestration adjustment amount for the period of April 1, 2022, through June 30, 2022, as follows: [(1 percent times (total days in the cost reporting period that occur from April 1, 2022, through June 30, 2022, divided by total days in the entire cost reporting period, rounded to six decimal places), rounded to four decimal places), times line 26]; and for cost reporting periods that overlap or begin on or after July 1, 2022, calculate the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur on or after July 1, 2022, through the end of the cost reporting period, divided by total days in the entire cost reporting period, rounded to six decimal places), rounded to four decimal places) times line 26].

Line 26.02--Enter any demonstration payment adjustment amounts for demonstration projects in which the provider participated where the demonstration adjustment amounts are not subject to the sequestration adjustment. Obtain this amount from the PS&R.

Line 27--Enter the total interim payments applicable to this cost reporting period. For title XVIII, transfer this amount from Worksheet J-4, column 2, line 4.

Line 28--For contractor final settlement, report on this line the amount from Worksheet J-4, line 5.99.

Line 29--Enter the balance due provider/program (line 26 minus lines 26.01, 26.02, 27, and 28), and transfer this amount to Worksheet S, Part III, columns as appropriate, lines as appropriate.

Line 30--Enter the program reimbursement effect of nonallowable cost report items which you are disputing. Compute the reimbursement effect in accordance with CMS Pub. 15-2, chapter 1, §115.2. Attach a schedule showing the supporting details and computation.

4056. WORKSHEET J-4 - ANALYSIS OF PAYMENTS TO HOSPITAL-BASED COMMUNITY MENTAL HEALTH CENTER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Complete this worksheet for Medicare interim payments only. If you have more than one hospital-based CMHC, complete a separate worksheet for each facility.

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

Line Descriptions

Line 1--Enter the total program interim payments paid to the CMHC. 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 includes 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. It 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 J-3, line 27.

DO NOT COMPLETE THE REMAINDER OF WORKSHEET J-4. LINES 5 THROUGH 7 ARE FOR CONTRACTOR USE ONLY. **(EXCEPTION: IF WORKSHEET S, PART I, LINE 5 IS "5" (AMENDED COST REPORT), THE PROVIDER MAY COMPLETE THIS SECTION.)**

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 NPR has been issued, report all settlement payments prior to the current reopening settlement on line 5.

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, when an amount is due from the provider to the 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 J-3, line 26 less the amount on lines 26.01 and 26.02.

Line 8--Enter the contractor name, the contractor number, and NPR date, in columns 0, 1 and 2, respectively.

4057. WORKSHEET K - ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

In accordance with 42 CFR 413.20, the methods of determining costs payable under title XVIII involve making use of data available from the institution's basic accounts, as usually maintained, to arrive at equitable and proper payment for services. The K series worksheets must be completed by all hospital-based hospices. This worksheet provides for recording the trial balance of expense accounts from your accounting books and records. It also provides for reclassification and adjustments to certain accounts. The cost centers on this worksheet are listed in a manner, which facilitates the transfer of the various cost center data to the cost finding worksheets (e.g., on Worksheets K, K-4, Parts I and II, the line numbers are consistent, and the total line is set at 39). Not all of the cost centers listed apply to all providers using these forms. Effective for cost reporting periods beginning on or after October 1, 2015, do not complete these worksheets, but complete the O series worksheets.

Column 1--Obtain salaries to be reported from Worksheet K-1, column 9, line 3 through 38.

Column 2--Obtain employee benefits to be reported from Worksheet K-2, column 9, lines 3 through 38.

Column 3--If the transportation costs (i.e., owning or renting vehicles, public transportation expenses, or payments to employees for driving their private vehicles) can be directly identified to a particular cost center, enter those costs in the appropriate cost center. If these costs are not identified to a particular cost center enter them on line 27.

Column 4--Obtain the contracted services to be reported from Worksheet K-3, col. 9, lines 3 through 38.

Column 5--Enter in the applicable lines all costs which have not been reported in columns 1 through 4.

Column 6--Enter the sum of columns 1 through 5 for each cost center.

Column 7--Enter any reclassifications among cost center expenses in column 6 which are needed to effect proper cost allocation. This column need not be completed by all providers, but is completed only to the extent reclassifications are needed and appropriate in the particular circumstances. Show reductions to expenses as negative amounts.

Column 8--Adjust the amounts entered in column 6 by the amounts in column 7 (increases and decreases) and extend the net balances to column 8. The total of column 8, line 39 must equal the total of column 6, line 39.

Column 9--In accordance with 42 CFR 413.9(c)(3), enter on the appropriate lines the amounts of any adjustments to expenses required under Medicare principles of reimbursements. (See §4016.)

Column 10--Adjust the amounts in column 8 by the amounts in column 9, (increases or decreases) and extend the net balances to column 10.

Transfer the amount in column 10, line 1 through 38, to the corresponding lines on Worksheet K-4, Part I, column 0, lines 1 through 38.

Line Descriptions

Lines 1 and 2--Capital Related Cost - Buildings and Fixtures and Capital Related Cost -Movable Equipment--These cost centers should include depreciation, leases and rentals for the use of the facilities and/or equipment, interest incurred in acquiring land and depreciable assets used for patient care, insurance on depreciable assets used for patient care and taxes on land or depreciable assets used for patient care.

Do not include in these cost centers the following costs: costs incurred for the repair or maintenance of equipment or facilities; amounts included in the rentals or lease or lease payments for repair and/or maintenance agreements; interest expense incurred to borrow working capital or for any purpose other than the acquisition of land or depreciable assets used for patient care; general liability of depreciable assets; or taxes other than those assessed on the basis of some valuation of land or depreciable assets used for patient care.

Line 3--Plant Operation and Maintenance--This cost center contains the direct expenses incurred in the operation and maintenance of the plant and equipment, maintaining general cleanliness and sanitation of plant, and protecting the employees, visitors, and agency property.

Plant Operation and Maintenance include the maintenance and service of utility systems such as heat, light, water, air conditioning and air treatment. This cost center also includes the cost of maintenance and repair of building, parking facilities and equipment, painting, elevator maintenance, performance of minor renovation of buildings, and equipment. The maintenance of grounds such as landscape and paved areas, streets on the property, sidewalk, fenced areas, fencing, external recreation areas and parking facilities are part of this cost center. The care or cleaning of the interior physical plant, including the care of floors, walls, ceilings, partitions, windows (inside and outside), fixtures and furnishings, and emptying of trash containers, as well as the costs of similar services purchased from an outside organization which maintains the safety and well-being of personnel, visitors and the provider's facilities, are all included in this cost center.

Line 4--Transportation-Staff--Enter all of the cost of transportation except those costs previously directly assigned in column 3. This cost is allocated during the cost finding process.

Line 5--Volunteer Service Coordination--Enter all of the cost associated with the coordination of service volunteers. This includes recruitment and training costs.

Line 6--Administrative and General--Use this cost center to record expenses of several costs which benefit the entire facility. If the option to componentize (also known as fragmentation or subscripting) A&G costs into more than one cost center is elected, eliminate line 6. Componentized A&G lines must begin with subscripted line 6.01 and continue in sequential order (i.e., 6.01 A&G shared costs, 6.02 A&G reimbursable costs, etc.). Examples include fiscal services, legal services, accounting, data processing, taxes, and malpractice costs.

Line 7--Inpatient - General Care--This cost center includes costs applicable to patients who receive this level of care because their condition is such that they can no longer be maintained at home. Generally, they require pain control or management of acute and severe clinical problems which cannot be managed in other settings. The costs incurred on this line are those direct costs of furnishing routine and ancillary services associated with inpatient general care for which other provisions are not made on this worksheet.

Costs incurred by a hospice in furnishing direct patient care services to patients receiving general inpatient care either directly from the hospice or under a contractual arrangement in an inpatient facility is to be included in the visiting service costs section.

For a hospice that maintains its own inpatient beds, these costs include (but are not limited to) the costs of furnishing 24 hours nursing care within the facility, patient meals, laundry and linen services, and housekeeping. Plant operation and maintenance cost would be recorded on line 3.

For a hospice that does not maintain its own inpatient beds, but furnishes inpatient general care through a contractual arrangement with another facility, record contracted/purchased costs on Worksheet K-3. Do not include any costs associated with providing direct patient care. These costs are recorded in the visiting services section.

Line 8--Inpatient - Respite Care--This cost center includes costs applicable to patients who receive this level of care on an intermittent, nonroutine and occasional basis. The costs included on this line are those direct costs of furnishing routine and ancillary services associated with inpatient respite care for which other provisions are not made on this worksheet. Costs incurred by the hospice in furnishing direct patient care services to patients receiving inpatient respite care either directly by the hospice or under a contractual arrangement in an inpatient facility are to be included in visiting service costs section.

For a hospice that maintains its own inpatient beds, these costs include (but are not limited to) the costs of furnishing 24 hours nursing care within the facility, patient meals, laundry and linen services and housekeeping. Plant operation and maintenance costs would be recorded on line 3.

For a hospice that does not maintain its own inpatient beds, but furnishes inpatient respite care through a contractual arrangement with another facility, record contracted/purchased costs on Worksheet K-3. Do not include any costs associated with providing direct patient care. These costs are recorded in the visiting service costs section**.**

Line 9--Physician Services--In addition to the palliation and management of terminal illness and related conditions, hospice physician services also include meeting the general medical needs of the patients to the extent that these needs are not met by the attending physician. The amount entered on this line includes costs incurred by the hospice or amounts billed through the hospice for physicians' direct patient care services.

Line 10--Nursing Care--Generally, nursing services are provided as specified in the plan of care by or under the supervision of a registered nurse at the patient's residence.

Line 11--Nursing Care-Continuous Home Care--Enter the continuous home care portion of costs for nursing services provided by a registered nurse, licensed practical nurse, or licensed vocational nurse as specified in the plan of care by or under the supervision of a registered nurse at the patient's residence.

Line 12--Physical Therapy--Physical therapy is the provision of physical or corrective treatment of bodily or mental conditions by the use of physical, chemical, and other properties of heat, light, water, electricity, sound massage, and therapeutic exercise by or under the direction of a registered physical therapist as prescribed by a physician. Therapy and speech-language pathology services may be provided for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

Line 13--Occupational Therapy--Occupational therapy is the application of purposeful goal-oriented activity in the evaluation, diagnostic, for the persons whose function is impaired by physical illness or injury, emotional disorder, congenial or developmental disability, and to maintain health. Therapy and speech-language pathology services may be provided for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

Line 14--Speech/Language Pathology--These are physician-prescribed services provided by or under the direction of a qualified speech-language pathologist to those with functionally impaired communications skills. This includes the evaluation and management of any existing disorders of the communication process centering entirely, or in part, on the reception and production of speech and language related to organic and/or nonorganic factors. Therapy and speech-language pathology services may be provided for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

Line 15--Medical Social Services--This cost center includes only direct expenses incurred in providing Medical Social Services. Medical Social Services consist of counseling and assessment activities, which contribute meaningfully to the treatment of a patient's condition. These services must be provided by a qualified social worker, under the direction of a physician.

Lines 16 through 18--Counseling--Counseling services must be available to the terminally ill individual, their family members, and other persons caring for the individual at home. Counseling, including dietary counseling, may be provided both for the purpose of training the individual's family or other care giver to provide care, and for the purpose of helping the individual and those caring for him or her to adjust to the individual's approaching death. This includes dietary, spiritual, and other counseling services provided while the individual is enrolled in the hospice. Costs associated with the provision of such counseling are accumulated in the appropriate counseling cost center. Costs associated with bereavement counseling are recorded on line 35.

Line 19--Home Health Aide and Homemaker--Enter the cost of home health aide and homemaker services. Home health aide services are provided under the general supervision of a registered professional nurse and may be provided by only individuals who have successfully completed a home health aide training and competency evaluation program or competency evaluation program as required in 42 CFR 484.36.

Home health aides may provide personal care services. Aides may also perform household services to maintain a safe and sanitary environment in areas of the home used by the patient, such as changing the bed or light cleaning and laundering essential to the comfort and cleanliness of the patient.

Homemaker services may include assistance in personal care, maintenance of a safe and healthy environment and services to enable the individual to carry out the plan of care.

Line 20--Home Health Aide and Homemaker-Continuous Home Care--Enter the continuous care portion of cost for home health aide and/or homemaker services provided as specified in the plan of care and under the supervision of a registered nurse.

Line 21--Other-- Enter on this line any other visiting cost which cannot be appropriately identified in the services already listed.

Line 22--Drugs, Biological and Infusion Therapy--Only drugs as defined in §1861(t) of the Act and which are used primarily for the relief of pain and symptom control related to the individual's terminal illness are covered. The amount entered on this line includes costs incurred for drugs or biologicals provided to the patients while at home. If a pharmacist dispenses prescriptions and provides other services to patients while the patient is both at home and in an inpatient unit, a reasonable allocation of the pharmacist cost must be made and reported respectively on line 22 (drugs and Biologicals) and line 7 (Inpatient General Care) or line 8 (Inpatient Respite Care) of Worksheet K.

A hospice may, for example, use the number of prescriptions provided in each setting to make that allocation, or may use any other method that results in a reasonable allocation of the pharmacist's cost in relation to the service rendered.

Infusion therapy may be used for palliative purposes if you determine that these services are needed for palliation. For the purposes of a hospice, infusion therapy is considered to be the therapeutic introduction of a fluid other than blood, such as saline solution, into a vein.

Line 23--Analgesics--Enter the cost of analgesics.

Line 24--Sedatives/Hypnotics--Enter the cost of sedatives/hypnotics.

Line 25--Other Specify--Specify the type and enter the cost of any other drugs which cannot be appropriately identified in the drug cost center already listed.

Line 26--Durable Medical Equipment/Oxygen--DME, as defined in 42 CFR 410.38, as well as other self-help and personal comfort items related to the palliation or management of the patient's terminal illness, are covered. Equipment is provided by the hospice for use in the patient's home while he or she is under hospice care.

Line 27--Patient Transportation--Enter all of the cost of transportation except those costs previously directly assigned in column 3. This cost is allocated during the cost finding process.

Line 28--Imaging Services--Enter the cost of imaging services including MRI.

Line 29--Labs and Diagnostics--Enter the cost of laboratory and diagnostic tests.

Line 30--Medical Supplies--The cost of medical supplies reported in this cost center are those costs which are directly identifiable supplies furnished to individual patients.

These supplies are generally specified in the patient's plan of treatment and furnished under the specific direction of the patient's physician.

Line 31--Outpatient Service--Use this line for any outpatient services costs not captured elsewhere. This cost can include the cost of an emergency room department.

Lines 32 through 33--Radiation Therapy and Chemotherapy--Radiation, chemotherapy and other modalities may be used for palliative purposes if you determine that these services are needed for palliation. This determination is based on the patient's condition and your care giving philosophy.

Line 34--Other--Enter any additional costs involved in providing visiting services which has not been provided for in the previous lines.

Lines 35 through 38--Hospice Nonreimbursable Service--Enter in the appropriate lines the applicable costs. Bereavement program costs consist of counseling services provided to the individual's family after the individual's death. In accordance with §1814 (i)(1)(A) of the Act, bereavement counseling is a required hospice service, but is not reimbursable.

Line 39--Total--Line 39, column 10, should agree with Worksheet A, line 116, column 7.

4058. WORKSHEET K-1 - COMPENSATION ANALYSIS - SALARIES AND WAGES

Enter all salaries and wages for the hospice on this worksheet for the actual work performed within the specific area or cost center in accordance with the column headings. For example, if the administrator also performs visiting services which account for 25 percent of that person's time, then enter 75 percent of the administrator's salary on line 6 (A&G), and 25 percent of the administrator's salary enter on line 10 (nursing care).

The records necessary to determine the split in salary between two or more cost centers must be maintained by the hospice and must adequately substantiate the method used to split the salary. These records must be available for audit by the contractor and the contractor can accept or reject the method used to determine the split in salary. When approval of a method has been requested in writing and this approval has been received prior to the beginning of a cost reporting period, the approved method remains in effect for the requested period and all subsequent periods until you request in writing to change to another method or until the contractor determines that the method is no longer valid due to changes in your operations.

Definitions

Salary--This is gross salary paid to the employee before taxes and other items are withheld, includes deferred compensation, overtime, incentive pay, and bonuses. (See CMS Pub. 15-1, chapter 21.)

Administrator (Column 1)--

Possible Titles: President, Chief Executive Officer

Duties: This position is the highest occupational level in the agency. This individual is the chief management official in the agency. The administrator develops and guides the organization by taking responsibility for planning, organizing, implementing, and evaluating. The administrator is responsible for the application and implementation of established policies. The administrator may act as a liaison among the governing body, the medical staff, and any departments.

The administrator provides for personnel policies and practices that adequately support sound patient care and maintains accurate and complete personnel records. The administrator implements the control and effective utilization of the physical and financial resources of the provider.

Director (Column 2)--

Possible Titles: Medical Director, Director of Nursing, or Executive Director

Duties: The medical director is responsible for helping to establish and assure that the quality of medical care is appraised and maintained. This individual advises the chief executive officer on medical and administrative problems and investigates and studies new developments in medical practices and techniques.

The nursing director is responsible for establishing the objectives for the department of nursing. This individual administers the department of nursing and directs and delegates management of professional and ancillary nursing personnel.

Medical Social Worker (Column 3)--This individual is a person who has at least a bachelor's degree from a school accredited or approved by the council of social work education. These services must be under the direction of a physician and must be provided by a qualified social worker.

Supervisors (Column 4)--Employees in this classification are primarily involved in the direction, supervision, and coordination of the hospice activities.

When a supervisor performs two or more functions, e.g., supervision of nurses and home health aides, the salaries and wages must be split in proportion with the percent of the supervisor's time spent in each cost center, provided the hospice maintains the proper records (continuous time records) to support the split. If continuous time records are not maintained by the hospice, enter the entire salary of the supervisor on line 6 (A&G), and allocate to all cost centers through stepdown. However, if the supervisor's salary is all lumped in one cost center, e.g., nursing care, and the supervisor's title coincides with this cost center, e.g., nursing supervisor, no adjustment is required.

Total Therapists (Column 6)--Include in column 6, on the line indicated, the cost attributable to the following services:

Physical therapy	-	line 12
Occupational therapy	-	line 13
Speech pathology	-	line 14

Therapy and speech-language pathology may be provided for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skill.

Physical therapy is the provision of physical or corrective treatment of bodily or mental conditions by the use of physical, chemical, and other properties of heat, light, water, electricity, sound, massage, and therapeutic exercise by or under the direction of a registered physical therapist as prescribed by a physician.

Occupational therapy is the application of purposeful, goal-oriented activity in the evaluation, diagnosis, and/or treatment of persons whose ability to work is impaired by physical illness or injury, emotional disorder, congenital or developmental disability, or the aging process, in order to achieve optimum functioning, to prevent disability, and to maintain health.

Speech-language pathology is the provision of services to persons with impaired functional communications skills by or under the direction of a qualified speech-language pathologist as prescribed by a physician. This includes the evaluation and management of any existing disorders of the communication process centering entirely, or in part, on the reception and production of speech and language related to organic and/or nonorganic factors.

Aides (Column 7)--Included in this classification are specially trained personnel employed for providing personal care services to patients. These employees are subject to Federal wage and hour laws. This function is performed by specially trained personnel who assist individuals in carrying out physician instructions and established plans of care. The reason for the home health aide services must be to provide hands-on, personal care services under the supervision of a registered professional nurse.

Aides may provide personal care services and household services to maintain a safe and sanitary environment in areas of the home used by the patient, such as changing the bed or light cleaning and laundering essential to the comfort and cleanliness of the patient. Additional services include, but are not limited to, assisting the patient with activities of daily living.

All Other (Column 8)--Employees in this classification are those not included in columns 1 through 7. Included in this classification are dietary, spiritual, and other counselors. Counseling Services must be available to both the terminally ill individual and the family members or other persons caring for the individual at home. Counseling, including dietary counseling, may be provided both for the purpose of training the individual's family or other care giver to provide care, and for the purpose of helping the individual and those caring for him or her to adjust to the individual's approaching death. This includes dietary, spiritual and other counseling services provided while the individual is enrolled in the hospice.

Total (Column 9)--Add the amounts of each cost center, columns 1 through 8, and enter the total in column 9. Transfer these totals to Worksheet K, column 1, lines as applicable. To facilitate transferring amounts from Worksheet K-1 to Worksheet K, the same cost centers with corresponding line numbers are listed on both worksheets. Not all of the cost centers are applicable to all agencies. Therefore, use only those cost centers applicable to your hospice.

4059. WORKSHEET K-2 - COMPENSATION ANALYSIS - EMPLOYEE BENEFITS (PAYROLL RELATED)

Enter all payroll-related employee benefits for the hospice on this worksheet. See CMS Pub. 15-1, chapter 20, for a definition of fringe benefits. Use the same basis as that used for reporting salaries and wages on Worksheet K-1. Therefore, using the same example as given for Worksheet K-1,

enter 75 percent of the administrator's payroll-related fringe benefits on line 6 (A&G) and enter 25 percent of the administrator's payroll-related fringe benefits on line 10 (nursing care). Payroll-related employee benefits must be reported in the cost center in which the applicable employee's compensation is reported.

This assignment can be performed on an actual basis or the following basis:

- FICA - actual expense by cost center;
- Pension and retirement and health insurance (nonunion) (gross salaries of participating individuals by cost center);
- Union health and welfare (gross salaries of participating union members by cost center); and
- All other payroll-related benefits (gross salaries by cost center). Include non-payroll-related employee benefits in the A&G cost center, e.g., cost for personal education, recreation activities, and day care.

Add the amounts of each cost center, columns 1 through 8, and enter the total in column 9. Transfer these totals to Worksheet K, column 2, corresponding lines. To facilitate transferring amounts from Worksheet K-2 to Worksheet K, the same cost centers with corresponding line numbers are listed on both worksheets.

4060. WORKSHEET K-3 - HOSPICE COMPENSATION ANALYSIS - CONTRACTED SERVICES/PURCHASED SERVICES

The hospice may contract with another entity for the provision of non-core hospice services. However, nursing care, medical social services and counseling are core hospice services and must routinely be provided directly by hospice employees. Supplemental services may be contracted in order to meet unusual staffing needs that cannot be anticipated and that occur so infrequently it would not be practical to hire additional staff to fill these needs. You may also contract to obtain physician specialty services. If contracting is used for any services, maintain professional, financial and administrative responsibility for the services and assure that all staff meet the regulatory qualification requirements.

Enter on this worksheet all contracted and/or purchased services for the hospice. Enter the contracted/purchased cost on the appropriate cost center line within the column heading which best describes the type of services purchased. Costs associated with contracting for general inpatient or respite care would be recorded on this worksheet. For example, where physical therapy services are purchased, enter the contract cost of the therapist in column 6, line 12. If a contracted/purchased service covers more than one cost center, then the amount applicable to each cost center is included on each affected cost center line. Add the amounts of each cost center, columns 1 through 8, and enter the total in column 9. Transfer these totals to Worksheet K, column 4, corresponding lines. To facilitate transferring amounts from Worksheet K-3 to Worksheet K, the same cost centers with corresponding line numbers are listed on both worksheets.

4061. WORKSHEET K-4, PART I - COST ALLOCATION - GENERAL SERVICE COSTS AND, PART II - COST ALLOCATION - STATISTICAL BASIS

Worksheet K-4 provides for the allocation of the expenses of each general service cost center to those cost centers, which receive the services. The cost centers serviced by the general service cost centers include all cost centers within the provider organization (i.e., other general service cost centers, reimbursable cost centers, nonreimbursable cost centers). Obtain the total direct expenses from Worksheet K, column 10. To facilitate transferring amounts from Worksheet K to Worksheet K-4, Part I, the same cost centers with corresponding line numbers (lines 3 through 39) are listed on both worksheets.

Worksheet K-4, Part II, provides for the proration of the statistical data needed to equitably allocate the expenses of the general service cost centers on Worksheet K-4, Part I.

To facilitate the allocation process, the general format of Worksheets K-4, Parts I and II, are identical. The column and line numbers for each general service cost center are identical on the two worksheets. In addition, the line numbers for each general, reimbursable, nonreimbursable, and special purpose cost centers are identical on the two worksheets. The cost centers and line numbers are also consistent with Worksheets K, K-1, K-2, and K-3.

The statistical bases shown at the top of each column on Worksheet K-4, Part II, are the recommended bases of allocation of the cost centers indicated. If a different basis of allocation is used, the provider must indicate the basis of allocation actually used at the top of the column.

Most cost centers are allocated on different statistical bases. However, for those cost centers where the basis is the same (e.g., square feet), the total statistical base over which the costs are to be allocated will differ because of the prior elimination of cost centers that have been closed.

Close the general service cost centers in accordance with 42 CFR 413.24(d)(1) which states, in part, that the cost of nonrevenue-producing cost centers serving the greatest number of other centers, while receiving benefits from the least number of centers, is apportioned first. This is clarified in CMS Pub. 15-1, chapter 23, §2306.1, which further clarify the order of allocation for stepdown purposes. Consequently, first close those cost centers that render the most services to and receive the least services from other cost centers. The cost centers are listed in this sequence from left to right on the worksheet. However, the circumstances of an agency may be such that a more accurate result is obtained by allocating to certain cost centers in a sequence different from that followed on these worksheets.

NOTE: A change in order of allocation and/or allocation statistics is appropriate for the current fiscal year cost if received by the contractor, in writing, within 90 days prior to the end of that fiscal year. The contractor has 60 days to make a decision, or the change is automatically accepted. The change must be shown to more accurately allocate the overhead or, if the allocation is accurate, it should be changed due to simplification of maintaining the statistics. If a change in statistics is made, the provider must maintain both sets of statistics until an approval is made. If both sets are not maintained and the request is denied, the provider reverts back to the previously approved methodology. The provider must include with the request all supporting documentation and a thorough explanation of why the alternative approach should be used. (See CMS Pub. 15-1, chapter 23, §2313.)

If the amount of any cost center on Worksheet K, column 10, has a credit balance, show this amount as a credit balance on Worksheet K-4, Part I, column 0. Allocate the costs from the applicable overhead cost centers in the normal manner to the cost center showing a credit balance.

After receiving costs from the applicable overhead cost centers, if a general service cost center has a credit balance at the point it is allocated, do not allocate the general service cost center. Rather, enter the credit balance on the first line of the column and on line 39. This enables column 6, line 39, to cross foot to columns 0 and 5A, line 39. After receiving costs from the applicable overhead cost centers, if a revenue producing cost center has a credit balance on Worksheet K-4, Part I, column 6, do not carry forward a credit balance to any worksheet.

On Worksheet K-4, Part II, enter on the first line in the column of the cost center the total statistics applicable to the cost center being allocated (e.g., in column 1, capital-related cost - buildings and fixtures, enter on line 1, the total square feet of the building on which depreciation was taken). Use accumulated cost for allocating A&G expenses.

Such statistical base does not include any statistics related to services furnished under arrangements except where both Medicare and non-Medicare costs of arranged-for services are recorded in your records.

For all cost centers (below the cost center being allocated) to which the service rendered is being allocated, enter that portion of the total statistical base applicable to each.

The total sum of the statistical base applied to each cost center receiving the services rendered must equal the total statistics entered on the first line.

Enter on Worksheet K-4, Part II, line 39, the total expenses of the cost center to be allocated. Obtain this amount from Worksheet K-4, Part I from the same column and line number of the same column. In the case of capital-related costs - buildings and fixtures, this amount is on Worksheet K-4, Part I, column 1, line 1.

Divide the amount entered on line 39, by the total statistical base entered in the same column on the first line. Enter the resulting unit cost multiplier on line 40. Round the unit cost multiplier to six decimal places.

Multiply the unit cost multiplier by that portion of the total statistical base applicable to each cost center receiving the services rendered. Enter the result of each computation on Worksheet K-4, Part I, in the corresponding column and line.

After the unit cost multiplier has been applied to all the cost centers receiving costs, the total expenses (line 39) of all of the cost centers receiving the allocation on Worksheet K-4, Part I, must equal the amount entered on the first line of the cost center being allocated.

The preceding procedures must be performed for each general service cost center. Each cost center must be completed on Worksheets K-4, Parts I and II, before proceeding to the next cost center.

After all the costs of the general service cost centers have been allocated on Worksheet K-4, Part I, enter in column 7, the sum of the expenses on lines 7 through 38. The total expenses entered in column 7, line 39, must equal the total expenses entered in column 0, line 39.

Column Descriptions

Column 1--Depreciation on buildings and fixtures and expenses pertaining to buildings and fixtures such as insurance, interest, rent, and real estate taxes are combined in this cost center to facilitate cost allocation.

Allocate all expenses to the cost centers on the basis of square footage of the space occupied. The square footage may be weighted if the person who occupies a certain area of space spends their time in more than one function. For example, if a person spends 10 percent of time in one function, 20 percent in another function, and 70 percent in still another function, the square footage may be weighted according to the percentages of 10 percent, 20 percent, and 70 percent, to the applicable functions.

Column 2--Allocate all expenses (e.g., interest, and personal property tax) for movable equipment to the appropriate cost centers on the basis of dollar value.

Column 4--The cost of vehicles owned or rented by the agency and all other transportation costs which were not directly assigned to another cost center on Worksheet K, column 3, is included in this cost center. Allocate this expense to the cost centers to which it applies on the basis of miles applicable to each cost center.

This basis of allocation is not mandatory, and a provider may use weighted trips rather than actual miles as a basis of allocation for transportation costs, which are not directly assigned. However, a hospice must request the use of the alternative method in accordance with CMS Pub. 15-1, chapter 23, §2313. The hospice must maintain adequate records to substantiate the use of this allocation.

Column 6--The A&G expenses are allocated on the basis of accumulated costs after reclassifications and adjustments.

Therefore, obtain the amounts to be entered on Worksheet K-4, Part II, column 6, from Worksheet K-4, Part I, columns 0 through 5.

A negative cost center balance in the statistics for allocating A&G expenses causes an improper distribution of this overhead cost center. Negative balances are excluded from the allocation statistics when A&G expenses are allocated on the basis of accumulated cost.

A&G costs applicable to contracted services may be excluded from the total cost (Worksheet K-4, Part I, column 0) for purposes of determining the basis of allocation (Worksheet K-4, Part II, column 5) of the A&G costs. This procedure may be followed when the hospice contracts for services to be performed for the hospice and the contract identifies the A&G costs applicable to the purchased services

The contracted A&G costs must be added back to the applicable cost center after allocation of the hospice A&G cost before the reimbursable costs are transferred to Worksheet K-5. A separate worksheet must be included to display the breakout of the contracted A&G costs from the applicable cost centers before allocation and the adding back of these costs after allocation. Contractor approval does not have to be secured in order to use the above described method of cost finding for A&G.

Worksheet K-4, Part II, Column 6A--Enter the costs attributable to the difference between the total accumulated cost reported on Worksheet K-4, Part I, column 5A, line 39, and the accumulated cost reported on Worksheet K-4, Part II, column 6, line 6. Enter any amounts reported on Worksheet K-4, Part I, column 5A, for (1) any service provided under arrangements to program patients only that is not grossed up and (2) negative balances. Including these costs in the statistics for allocating A&G expenses causes an improper distribution of overhead.

In addition, report on line 6 the A&G costs reported on Worksheet K-4, Part I, column 6, line 6, since these costs are not included on Worksheet K-4, Part II, column 6, as an accumulated cost statistic.

The accumulated cost center line number must match the reconciliation column number. Include in the column number the alpha character "A" (i.e., if the accumulated cost center for A&G is line 6 (A&G), the reconciliation column designation must be 6A).

Worksheet K-4, Part II, Column 6--The A&G expenses are allocated on the basis of accumulated costs. Therefore, enter the amount from Worksheet K-4, Part I, column 5A.

4062. WORKSHEET K-5 - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

This worksheet distributes the hospital's overhead to the specific cost centers of the hospice.

4062.1 Part I - Allocation of General Service Costs to Hospice Cost Centers.--Worksheet K-5, Part I, provides for the allocation of the expenses of each general service cost center of the hospital to those cost centers which receive the services.

Obtain the direct total expenses (column 0, lines 2 through 33) from Worksheet K-4 Part I, lines 7 through 38. The amounts on columns 0 through 23 and column 25, line 34, must agree with the corresponding amounts on Worksheet B, Part I, columns 0 through 23, and column 25, line 116.

Complete the amounts entered on lines 1 through 33, columns 1 through 23, and column 25, in accordance with the instructions in §4062.2.

NOTE: Worksheet B, Part I, established the method used to reimburse direct GME cost (i.e., reasonable cost or the per resident amount). Therefore, this worksheet must follow that method. If Worksheet B, Part I, column 25, excluded the costs of interns and residents, column 25 on this worksheet must also exclude these costs.

In column 24, enter the total of columns 4A through 23.

In column 27, for lines 2 through 33, multiply the amount in column 26, by the unit cost multiplier on line 35, and enter the result in this column. The total of the amounts on lines 2 through 33 must equal the amount in column 26, line 1.

In column 28, enter on lines 2 through 33, the sum of columns 26 and 27. The total on line 34 equals the total in column 26, line 34.

4062.2 Part II - Allocation of General Service Costs to Hospice Cost Centers - Statistical Basis.--Worksheet K-5, Part II, provides for the proration of the statistical data needed to equitably allocate the expenses of the hospital's general service cost centers on Worksheet K-5, Part I. To facilitate the allocation process, the general format of Worksheet K-5, Parts I and II, is identical.

The statistical basis shown at the top of each column on Worksheet K-5, Part II, is the recommended basis of allocation of the cost center indicated and must be consistent with the statistical basis utilized on Worksheet B, Part I.

Lines 1 through 33--On Worksheet K-5, Part II, for all cost centers to which the general service cost center is being allocated, enter that portion of the total statistical base applicable to each.

Line 34--Enter the total of lines 1 through 33, for each column. The total in each column must be the same as shown for the corresponding column on Worksheet B-1, line 116.

Line 35--Enter the total expenses for the cost center allocated. Obtain this amount from Worksheet B, Part I, columns as indicated, line 116.

Line 36--Enter the unit cost multiplier which is obtained by dividing the cost entered on line 35, by the total statistic entered in the same column on line 34. Round the unit cost multiplier to six decimal places.

Multiply the unit cost multiplier by that portion of the total statistic applicable to each cost center receiving the services. Enter the result of each computation on Worksheet K-5, Part I, in the corresponding column and line.

After the unit cost multiplier has been applied to all the cost centers receiving the services, the total cost (Part I, line 34) must equal the total cost on Part II, line 34.

Perform the preceding procedures for each general service cost center.

4062.3 Part III - Computation of the Total Hospice Shared Costs.--This worksheet provides for the shared therapy, drugs, or medical supplies from the hospital to the hospice.

Column Description

Column 1--Where applicable, enter in column 1 the cost to charge ratio from Worksheet C, Part I, column 9, lines as indicated.

Column 2--Where hospital departments provide services to the hospice, enter on the appropriate lines the charges, from the provider's records, applicable to the hospital-based hospice.

Column 3--Multiply the amount in column 2 by the ratios in column 1, and enter the result in column 3.

Line 11--Sum of column 3, lines 1 through 10.

4063. WORKSHEET K-6 - CALCULATION OF HOSPICE PER DIEM COST

Worksheet K-6 calculates the average cost per day for a hospice patient. It is only an average and should not be misconstrued as the absolute.

Line 1--Transfer the total cost from Worksheet K-5, Part I, column 28, line 34 less column 28, line 33, plus Worksheet K-5, Part III, column 3, line 11. This line reflects the true cost including shared cost and excluding any non-hospice related activity.

Line 2--Enter the total unduplicated days from Worksheet S-9, column 6, line 5.

Line 3--Calculate the aggregate cost per day by dividing the total cost from line 1 by the total number of days from line 2.

Line 4--Enter the unduplicated Medicare days from Worksheet S-9, column 1, line 5.

Line 5--Calculate the aggregate Medicare cost by multiplying the average cost from column 4, line 3, by the number of unduplicated Medicare days on column 1, line 4, to arrive at the average Medicare cost.

Line 6--Enter the unduplicated Medicaid days from Worksheet S-9, column 2, line 5.

Line 7--Calculate the aggregate Medicaid cost by multiplying the average cost from line 3 by the number of unduplicated Medicaid days on line 6, to arrive at the average Medicaid cost.

Line 8--Enter the unduplicated SNF days from Worksheet S-9, column 3, line 5.

Line 9--Calculate the aggregate SNF cost by multiplying the average cost from line 3 by the number of unduplicated SNF days on line 8, to arrive at the average SNF cost.

Line 10--Enter the unduplicated NF days from Worksheet S-9, column 4, line 5.

Line 11--Calculate the aggregate NF cost by multiplying the average cost from line 3 by the number of unduplicated NF days on line 10, to arrive at the average NF cost.

Line 12--Enter the unduplicated Other days from Worksheet S-9, column 5, line 5.

Line 13--Enter the aggregate cost for other days by multiplying the average cost from line 3, by the number of unduplicated Other days on line 12, to arrive at the average other cost.

4064. WORKSHEET L - CALCULATION OF CAPITAL PAYMENT

Worksheet L, Parts I through III, calculate program settlement for PPS inpatient hospital capital-related costs in accordance with 42 CFR 412, Subpart M. Only provider components paid under the IPPS complete this worksheet.

Worksheet L consists of the following three parts:

Part I - Fully Prospective Method
Part II - Payment Under Reasonable Cost
Part III - Computation of Exception Payments

COMPLETE EITHER PART I OR PART II, OR PARTS I AND III.

At the top of the worksheet, indicate by checking the applicable boxes the health care program, provider component, and the IPPS capital payment method for which the worksheet is prepared.

4064.1 Part I – Fully Prospective Method.--This part computes settlement under the fully prospective method only, as defined in 42 CFR 412.340. Use the fully prospective method for the IPPS capital settlement when the hospital's base year hospital-specific rate is below the adjusted federal rate and for IPPS hospitals with cost reporting periods beginning after the capital PPS transition. To be eligible for capital DSH payment, a hospital must meet the requirements set forth in 42 CFR 412.320(a).

If your facility experienced a geographic redesignation in accordance with 42 CFR 412.102 (Worksheet S-2, Part I, lines 22.03 and/or 22.04, column 1, is "Y"), and the hospital contains at least 100 beds (as counted in accordance with 42 CFR 412.105(b)), subscript column 1 (add column 1.01) for lines 1 and 1.01. Enter in column 1, the capital DRG payments for the portion of the reporting period the hospital is classified as urban, and enter in column 1.01, the capital DRG payments for the portion of the reporting period the hospital is classified as rural.

If your facility experience a geographic reclassification in accordance with 42 CFR 412.103, from urban to rural (Worksheet S-2, Part I, lines 26 and 27, column 1, are "1" and "2", respectively), or from rural to urban (Worksheet S-2, Part I, lines 26 and 27, column 1, are "2" and "1", respectively), and the hospital contains at least 100 beds (as counted in accordance with 42 CFR 412.105(b)), subscript column 1 (add column 1.01) for lines 1 and 1.01.

For discharges occurring prior to October 1, 2023, hospitals with a geographic reclassification from urban to rural under §412.103 are considered rural for purposes of determining eligibility for capital DSH payments in accordance with §412.320(a)(1)(iii). Enter in column 1, the capital DRG payments for the portion of the reporting period the hospital is classified as urban, and enter in column 1.01, the capital DRG payments for the portion of the reporting period the hospital is classified as rural.

For discharges occurring on or after October 1, 2023, hospitals with a geographic reclassification from urban to rural under §412.103 (Worksheet S-2, Part I, line 22.05, column 1 = Y) are considered urban for purposes of determining eligibility for capital DSH payments in accordance with §412.320(a)(1)(iii). Enter in column 1, the capital DRG payments for the portion of the reporting period the hospital is classified as urban, and the capital DRG payments for the portion of the reporting period classified as rural.

For IPPS hospitals participating in the PARHM demonstration during this cost reporting period and (1) the hospital participated in the PARHM demonstration for the entire cost reporting period, select the "PARHM Demonstration" box only and complete this worksheet; or (2) the hospital participated in the PARHM demonstration for a portion of the cost reporting period, select the "PARHM Demonstration" box and complete Worksheet L, for the portion of the cost reporting period included in the demonstration. Select the "Hospital" box and complete a separate Worksheet L, for the portion of the cost reporting period not included in the demonstration.

Line Descriptions

Line 1--Enter the amount of the federal rate portion of the capital DRG payments for other than outlier during the period. If your facility experienced a geographic redesignation (see 42 CFR 412.102) or geographic reclassification (see 42 CFR 412.103), enter in column 1 the federal rate portion of the capital DRG payments for other than outliers for discharges occurring during the urban classification portion of the cost reporting period. Enter in column 1.01, the federal rate portion of the capital DRG payments for other than outliers for discharges occurring during the rural classification portion of the cost reporting period.

Line 1.01--Enter the amount of the federal rate portion of the capital DRG payments for other than outlier during the period associated with Model 4 BPCI. If your facility experienced a geographic redesignation (see 42 CFR 412.102(a) and (b)) or geographic reclassification (see 42 CFR 412.103), enter in column 1, the federal rate portion of the capital DRG payments for other than outliers associated with Model 4 BPCI for discharges occurring during the urban classification portion of the cost reporting period. Enter in column 1.01, the federal rate portion of the capital DRG payments for other than outliers associated with Model 4 BPCI for discharges occurring during the rural classification portion of the cost reporting period.

Line 2--Enter the amount of the federal rate portion of the capital outlier payments made for PPS discharges during the period. (See 42 CFR 412.312(c).)

Line 2.01--Enter the amount of the federal rate portion of the capital outlier payments made for PPS discharges during the period associated with Model 4 BPCI. (See 42 CFR 412.312(c).)

Indirect Medical Education Adjustment

Lines 3 through 6

Line 3--Enter the result of dividing the sum of total patient days (Worksheet S-3, Part I, column 8, lines 14 and 30) by the number of days in the cost reporting period (365, or 366 in case of leap year). Effective for cost reporting periods beginning on or after October 1, 2013, also include in total patient days, the labor and delivery days from Worksheet S-3, Part I, column 8, line 32. Do not include statistics associated with an excluded unit (subprovider).

NOTE FOR LINE 3: Reduce total patient days by nursery days (Worksheet S-3, Part I, column 8, line 13), and swing-bed days (Worksheet S-3, Part I, column 8, lines 5 and 6).

Line 4--Obtain the intern and resident amount from Worksheet E, Part A, line 18, plus line 25.

Line 5--Enter the result of the following calculation: $\{e^{.2822 \times \text{line } 4/\text{line } 3}\}-1$ where e = 2.71828. See 42 CFR 412.322(a)(3) for limitation of the percentage of I&Rs to average daily census. Line 4 divided by line 3 cannot exceed 1.5.

Line 6--Multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01.

Capital Disproportionate Share Adjustment

Lines 7 through 11

Enter the amount of the federal rate portion of the additional capital payment amounts relating to the DSH adjustment. Complete these lines if you answered yes to line 45 on Worksheet S-2, Part I. (See 42 CFR 412.312(b)(3).) For hospitals qualifying for disproportionate share in accordance with 42 CFR 412.106(c)(2) (Pickle Amendment hospitals), do not complete lines 7 through 9, and enter 11.89 percent on line 10.

Line 7--Enter the percentage of SSI recipient patient days (from your contractor or your records) to Medicare Part A patient days. Transfer this amount from Worksheet E, Part A, line 30.

Line 8--Enter the percentage resulting from the calculation of Medicaid patient days (Worksheet S-2, Part I, columns 1 through 6, line 24) to total days reported on Worksheet S-3, Part I, column 8, line 14, plus column 8, line 32, minus the sum of lines 5 and 6, plus employee discount days reported on Worksheet S-3, Part I, column 8, line 30. This amount must agree with the amount reported on Worksheet E, Part A, line 31.

Line 9--Add lines 7 and 8, and enter the result.

Line 10--Enter the percentage that results from the following calculation: $(e^{.2025 \times \text{line } 9})-1$ where e equals 2.71828. If Worksheet S-2, Part I, line 22, column 2, is "Y" (Pickle Amendment hospital), enter 11.89 percent.

Line 11--Enter the result of line 10 multiplied by the sum of lines 1 and 1.01, column 1.

Line 12--Enter the sum of lines 1 and 1.01, columns 1 and 1.01, plus lines 2, 2.01, 6, and 11. For title XVIII, transfer this amount to Worksheet E, Part A, line 50.

4064.2 Part II - Payment Under Reasonable Cost.--This part computes capital settlement under reasonable cost principles subject to the reduction pursuant to 42 CFR 412.324(b). Use the reasonable cost method for capital settlement determinations for new providers under 42 CFR 412.324(b) for the first two years or for titles V or XIX determinations, if applicable. This part may also be completed for cost reporting periods beginning on or after October 1, 2002, for the first two years for new providers under 42 CFR 412.304(c)(2)(i) (response to Worksheet S-2, Part I, line 47, column 2, is "Y", and line 48, column 2 is "N").

Line Descriptions

Line 1--Enter the amount of program inpatient routine service capital costs. This amount is the sum of the program inpatient routine capital costs from the appropriate Worksheet D, Part I, column 7, sum of the amounts on lines 30 through 35, and 43 for the hospital (lines 40 through 42 as applicable, for the subprovider).

Line 2--Enter the amount of program inpatient ancillary capital costs. This amount is the sum of the amounts of program inpatient ancillary capital costs from the appropriate Worksheet D, Part II, column 5, line 200.

Line 3--Enter the sum of lines 1 and 2.

Line 4--Enter a reduction factor of 85 percent.

Line 5--Multiply line 3 by line 4. For title XVIII, transfer the amount to Worksheet E, Part A, line 50.

4064.3 Part III - Computation of Exception Payments.--This part computes minimum payment levels by class of provider eligible for additional exception payment for extraordinary circumstances pursuant to 42 CFR 412.312(e). Complete this part only if the provider component completed Part I of this worksheet. Complete this part only if the provider qualifies for the exception payment for extraordinary circumstances pursuant to 42 CFR 412.348(f) (the facility indicates "Y" to question 46 on Worksheet S-2, Part I).

Line 1--Enter the amount of program inpatient routine service and ancillary service capital costs. This amount is the sum of the program inpatient routine service capital costs from the appropriate Worksheet D, Part I, column 7, sum of lines 30 through 35, and 43, for the hospital, lines 40 through 42, as applicable for the subprovider, and program inpatient ancillary service capital costs from Worksheet D, Part II, column 5, line 200.

Line 2--Enter program inpatient capital costs for extraordinary circumstances as provided by 42 CFR 412.348(f), if applicable, from Worksheet L-1, sum of Part II, column 7, sum of lines 30 through 35, and 43, for the hospital; lines 40 through 42, as applicable for the subproviders; and Part III, column 5, line 200.

Line 3--Enter line 1 less line 2.

Line 4--Enter the appropriate minimum payment level percentage: The minimum payment levels for portions of cost reporting periods beginning on or after October 1, 2001, are:

- SCHs (located in either an urban or a rural area) - 90 percent;
- Urban hospitals with at least 100 beds and a disproportionate patient percentage of at least 20.2 percent - 80 percent; and
- All other hospitals - 70 percent.

For providers that qualify for an exception payment for extraordinary circumstances pursuant to 42 CFR 412.348(f) in conjunction with 42 CFR 412.312(e) the appropriate minimum payment level is 70 percent.

The minimum payment levels will be revised, if necessary, to keep total payments under the exceptions process at no more than 10 percent of capital prospective payments.

If you were an SCH during a portion of the cost reporting period, compute the minimum payment level percentage by dividing the number of days in your cost reporting period for which you were not an SCH (70 percent factor applicable) by the total number of days in the cost reporting period. Multiply that ratio by 70 percent. Divide the number of days in your cost reporting period for which you were an SCH (90 percent factor applicable) by the total number of days in the cost reporting period. Multiply that ratio by 90 percent. Add the amounts from steps 1 and 2 to compute the capital cost minimum payment level percentage. Display exception percentage in decimal format, e.g., 70 percent is displayed as .70 or 0.70.

Line 5--Enter the product of line 3 multiplied by line 4.

Line 6--Hospitals that did not qualify as SCHs during the cost reporting period enter a reduction factor of 85 percent. SCHs enter 100 percent. If you were a SCH during a portion of the cost reporting period, compute the capital cost reduction percentage by dividing the number of days in your cost reporting period for which you were not a SCH (reduction factor applicable) by the total number of days in the cost reporting period. Multiply that ratio by 15 percent and subtract the amount from 100. Enter the resulting extraordinary circumstance percentage adjustment in decimal format, e.g., 85 percent is displayed as .85 or 0.85.

Line 7--Enter the product of line 2 multiplied by line 6.

Line 8--Enter the sum of lines 5 and 7.

Line 9--Enter the amount from Part I, line 12, if applicable.

Line 10--Enter line 8 less line 9.

Lines 11 through 14--A hospital is entitled to an additional payment if its capital payments for the cost reporting period is less than the applicable minimum payment level. The additional payment equals the difference between the applicable minimum payment level and the capital payments that the hospital would otherwise receive. This additional payment amount is reduced for any amounts by which the hospital's cumulative payments exceed its cumulative minimum payment levels. The offsetting amounts will be determined based on the amounts by which the hospital's cumulative payments exceed its cumulative minimum payment levels in the lesser of the preceding 10-year period or the period of time under which the hospital is subject to the PPS for capital related costs.

A positive amount on line 10 represents the amount of capital payments under the minimum payment level in the current year. This amount must be offset for the amount by which the hospital's cumulative payments exceed its cumulative minimum payment levels in prior years, as reported on line 11. If the net amount on line 12 remains a positive amount, this amount represents the current year's additional payment for capital payments under the minimum payment level. Report this amount on line 13. If the net amount on line 12 is a negative amount, this amount represents the reduced amount by which the accumulated capital payment amounts exceeded the accumulated minimum payment levels. In this case, no additional payment is made in the current year. Transfer the amount on line 12 to line 14, and carry it forward to the following cost reporting period.

A negative amount on line 10 represents the amount of capital payments over the minimum payment level in the current year. Add any carry forward of prior years' amounts of the hospital's cumulative payments in excess of cumulative minimum payment levels, as reported on line 11, to the current year excess on line 12. The net amount on line 12 represents the total amount by which the accumulated capital payment amounts exceeded the accumulated minimum payment levels. No additional payment is made in the current year. Transfer the amount on line 12 to line 14, and carry it forward to the subsequent cost reporting period.

Line 11--The offsetting amounts will be determined based on the amounts by which the hospital's cumulative payments exceed its cumulative minimum payment levels in the lesser of the preceding 10-year period or the period of time under which the hospital is subject to the PPS for capital related costs. Enter the appropriate offset amount as computed pursuant to 42 CFR 412.312(e)(3).

Line 12--Enter the sum of lines 10 and 11.

Line 13--If the amount on line 12 is positive, enter the amount on this line.

Line 14--If the amount on line 12 is negative, enter the amount on this line.

Complete lines 15 through 17 only when line 12 is a positive amount.

Line 15--Enter the current years allowable operating and capital payments calculated from Worksheet E, Part A, line 47, plus the capital payments reported on line 9 above, minus 75 percent of the current year's operating disproportionate share payment amount reported on Worksheet E, Part A, line 34.

Line 16--Current year operating and capital costs from Worksheet D-1, line 49 minus the sum of Worksheet D, Part III, lines 30 through 35, column 9 (PPS subproviders use lines 40 through 42, as applicable, column 9), and Worksheet D, Part IV, column 11, line 200.

Line 17--Enter on this line the current year's exception offset amount. This is computed as line 15 minus line 16. If this amount is negative, enter zero on this line. If the amount on line 13 is greater than line 17, transfer the amount on line 13, less any reported amount on line 17, to Worksheet E, Part A, line 51.

4065. WORKSHEET L-1 - ALLOCATION OF ALLOWABLE CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES

This worksheet provides for the determination of direct and indirect capital-related costs associated with capital expenditures for extraordinary circumstances, allocated to inpatient operating costs. Only complete this worksheet for providers that qualify for an additional payment for extraordinary circumstances under 42 CFR 412.348(f) (the facility indicates "Y" to question 46 on Worksheet S-2, Part I).

4065.1 Part I - Allocation of Allowable Capital Costs for Extraordinary Circumstances.--Use this part in conjunction with Worksheet B-1. The format and allocation process employed is similar to that used on Worksheets B, Part I and B-1. Any cost center subscripted lines and/or columns added to Worksheet B, Part I, are also added to this worksheet in the same sequence.

Column 0--Assign capital expenditures relating to extraordinary costs to specific cost centers on this worksheet, column 0. Enter on the appropriate lines those capital-related expenditure amounts relating to extraordinary costs which were directly assigned on Worksheet B, Part II. Enter on lines 3 and 4, as applicable, the remaining capital expenditure amounts relating to extraordinary costs which have not been directly assigned.

Columns 1 through 23--Transfer amounts on the top lines of columns 1 and 2, from column 0, line as applicable. For example, transfer line 1, column 0 to line 1, column 1. For all other columns, the top line represents the cross-total amount.

For each column, enter on line 203 of this worksheet, Part I, the total statistics of the cost center being allocated. Obtain the individual statistics from Worksheet B-1 from the same column and line number used to allocate cost on this worksheet. (For example, obtain the amount of capital-related costs - buildings and fixtures from Worksheet B-1, column 1, line 1.)

Divide the total capital expenses entered in the same column on the first line by the amount entered on line 203. Enter the resulting unit cost multiplier on line 204. Round the unit cost multiplier to six decimal places.

Multiply the unit cost multiplier by that portion of the total statistics applicable to each cost center receiving the services. The applicable cost center statistics are reported on Worksheet B-1. Enter the result of each computation on this worksheet in the corresponding column and line. (See §4000.1 for rounding standards.)

After the unit cost multiplier has been applied to all the cost centers receiving the services rendered, the total cost (line 197) of all the cost centers receiving the allocation on this worksheet must equal the amount entered on the first line. Perform the preceding procedures for each general service cost center. Complete the column for one cost center before proceeding to the column for the next cost center.

After the capital-related costs of all the general service cost centers have been allocated, enter in column 24 the sum of columns 2A through 23 for lines 30 through 196. (See §4020 for exception regarding negative cost centers.)

When an adjustment is required to capital costs for extraordinary circumstances after cost allocation, show the amount applicable to each cost center in column 25. Submit a supporting schedule showing the computation of the adjustment.

Transfer from Worksheet L-1, Part I, Column 26	To Worksheet L-1, Part II
Line 30 - Adults and Pediatrics	Column l, line 30 for the hospital
Lines 31 through 35 - Intensive Care Type Inpatient Hospital Units	Column 1, lines 31 through 35
Lines 40 through 42, as applicable – Subprovider	Column l, lines 40 through 42, as applicable
Line 43 - Nursery	Column 1, line 43 for titles V and XIX

Transfer from Worksheet L-1, Part I, Column 26	To Worksheet L-1, Part III
Lines 50 through 78 - Ancillary Services	Column l, lines 50 through 78
Lines 88 through 91 and 93 - Outpatient Service Cost	Column l, lines 88 through 91 and 93
Subscripts of line 92 - Distinct Part Observation Bed Units	Column 1, subscripts of line 92
Lines 88, 89, 94, 97, and 98	Column l, lines 88, 89, 94, 97, and 98

4065.2 Part II - Computation of Program Inpatient Routine Service Capital Costs for Extraordinary Circumstances.--This part computes the amount of capital costs for extraordinary circumstances applicable to hospital inpatient routine service costs. Complete only one Worksheet L-1, Part II, for each title. Report hospital and subprovider information on the same worksheet, lines as appropriate.

Column 1--Enter on each line the capital costs for extraordinary circumstances as appropriate. Obtain this amount from Worksheet L-1, Part I, column 26.

Column 2--Compute the amount of the swing-bed adjustment. If you have a swing-bed agreement or have elected the swing-bed optional method of reimbursement, determine the amount for the cost center in which the swing-beds are located by multiplying the amount in column 1 by the ratio of the amount entered on Worksheet D-1, line 26, to the amount entered on Worksheet D-1, line 21.

Column 3--Enter column 1 minus column 2.

Column 4--Enter on each line the total patient days, excluding swing-bed days, by cost center from the corresponding lines of Worksheet D, Part I, column 4.

Column 5--Divide the cost of each cost center in column 3 by the total patient days in column 4 for each line to determine the per diem cost capital cost for extraordinary circumstances. Enter the resultant per diem cost in column 5.

Column 6--Enter the program inpatient days for the corresponding cost centers from Worksheet D, Part I, column 6.

Column 7--Multiply the per diem in column 5, by the inpatient program days in column 6, to determine the program's share of capital costs for extraordinary circumstances applicable to inpatient routine services, as applicable, and enter the result.

4065.3 Part III - Computation of Program Inpatient Ancillary Service Capital Costs for Extraordinary Circumstances.--This part computes the program inpatient ancillary capital costs for extraordinary circumstances for titles V; XVIII, Part A; and XIX. Complete a separate copy of this part for the hospital and each subprovider for titles V; XVIII, Part A; and XIX; as applicable. In this case, enter the subprovider component number in addition to showing the provider number.

Make no entries on this worksheet for any cost centers with a negative balance on Worksheet B, Part I, column 26.

Column 1--Enter on each line the capital-related costs for each cost center as appropriate. Obtain this amount from Worksheet L-1, Part I, column 26.

NOTE: Compute capital costs for extraordinary circumstances relating to non-distinct observation bed units. To compute extraordinary circumstances relating to non-distinct observation bed units, develop a ratio of total observation bed costs to total general routine costs. Compute this ratio, rounded to six decimal places, by dividing the amount from Worksheet L-1, Part I, column 26, line 30, by the amount on Worksheet D-1, line 37. Then multiply this ratio by the general routine capital costs for extraordinary circumstances from Supplemental Worksheet L-1, Part I, column 26, line 30, to obtain the capital costs for extraordinary circumstances relating to non-distinct observation bed units for line 92, column 1. Transfer distinct part observation bed unit costs from Worksheet L-1, Part I, the appropriate subscript of column 26, line 92.

Column 2--Enter on each line the charges applicable to each cost center as shown on Worksheet C, Part I, column 6.

Column 3--Divide the cost of each cost center in column 1 by the charges in column 2, for each line to determine the cost/charge ratio. Round the ratios to six decimal places, e.g., round .0321514 to 032151. Enter the resultant departmental ratios in column 3.

Column 4--Enter on each line the appropriate titles V; XVIII, Part A; or XIX; inpatient charges. Transfer these charges from the corresponding lines of Worksheet D, Part II, column 4.

Column 5--Multiply the ratio in column 3, by the charges in column 4, to determine the program's share of capital costs for extraordinary circumstances applicable to titles V; XVIII, Part A; or XIX; inpatient ancillary services, as appropriate.

4066. WORKSHEET M-1 - ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Use this worksheet only if you operate a certified hospital-based RHC/FQHC. Use only those cost centers that represent services for which the clinic/center is certified. If you have more than one hospital-based RHC/FQHC, complete separate worksheets for each hospital-based RHC/FQHC, unless the clinic/center has received prior contractor approval to file a consolidated cost report (see CMS Pub. 100-4, chapter 9, §30). Effective for cost reporting periods beginning on or after October 1, 2014, hospital-based FQHCs do not complete the M series worksheets, but must complete the N series worksheets.

This worksheet is for the recording of direct hospital-based RHC/FQHC costs from your accounting books and records to arrive at the identifiable RHC/FQHC cost. This data is required by 42 CFR 413.20. The worksheet also provides for the necessary reclassifications and adjustments to certain accounts prior to the cost finding calculations.

Column Descriptions

Columns 1 through 3--The expenses listed in these columns must be in accordance with your accounting books and records. If the cost elements of a cost center are maintained separately on your books, a reconciliation of costs per the accounting books and records to those on this worksheet must be maintained by you and are subject to review by your contractor.

Enter on the appropriate lines in columns 1 through 3, the total expenses incurred during the reporting period. Detail the expenses as Salaries (column 1) and Other (column 2). The sum of columns 1 and 2 must equal column 3.

Column 4--Enter any reclassifications among the cost center expenses listed in column 3 which are needed to effect proper cost allocation. This column need not be completed by all hospital-based RHCs/FQHCs, but is completed only to the extent reclassifications are needed and appropriate in the particular circumstances. See §4014 for examples of reclassifications that may be needed. Submit with the cost report copies of any work papers used to compute the reclassifications reported in this column. The net total of the entries in column 4 must equal zero on line 30 if no reclassifications were reported on Worksheet A, column 4, of the appropriate line 88 and/or 89.

Column 5--Add column 4 to column 3, and extend the net balances to column 5. The total of column 5 must equal the total of column 3 on line 30, if no reclassifications were reported on Worksheet A, column 4, of the appropriate line 88 and/or 89.

Column 6--In accordance with 42 CFR 413.9(c)(3), enter on the appropriate lines the amounts of any adjustments to expenses required under the Medicare principles of reimbursement. (See §4016.) Submit with the cost report copies of any work papers used to compute the adjustments reported in this column.

NOTE: The allowable cost of the services furnished by Public Health Service personnel may be included in your hospital-based RHCs/FQHCs costs. Obtain this amount from your contractor, and include this as an adjustment to the appropriate lines on column 6.

Column 7--Adjust the amounts in column 5 by the amounts in column 6, and extend the net balance to column 7. The total facility costs on line 32 must equal the net expenses for cost allocation on Worksheet A for the hospital-based cost center.

Line Descriptions

Lines 1 through 9--Enter the costs of your health care staff.

Lines 7.10 and 7.11--Effective for services rendered on or after January 1, 2024, enter the costs for marriage and family therapists (MFT) on line 7.10 and the costs for mental health counselors (MHC) on line 7.11.

Line 10--Enter the sum of the amounts on lines 1 through 9.

Line 11--Enter the cost of physician medical services furnished under agreement.

Line 12--Enter the expenses of physician supervisory services furnished under agreement.

Line 14--Enter the sum of the amounts on lines 11 through 13.

Lines 15 through 20--Enter the expenses of other health care costs.

Line 20--Do not complete this line. Per 42 CFR 413.78(a), the GME payment to the hospital includes all residents working in the hospital healthcare complex; therefore, no separate payment is made to the hospital-based RHC/FQHC for GME costs.

Line 21--Enter the sum of the amounts on lines 15 through 20. For cost reporting periods ending on or after October 1, 2014, enter the sum of the amounts on lines 15 through 19.

Line 22--Enter the sum of the amounts on lines 10, 14, and 21. Reduce that result by the amount reported on line 20 if you are entitled to claim GME costs on line 20. Transfer this amount to Worksheet M-2, line 10.

Lines 23 through 27--Enter the expenses applicable to services that are not reimbursable under the RHC/FQHC benefit.

Line 25.01 - Telehealth.--This cost center includes the cost of telehealth distant-site services as described in CMS Pub. 100-02, chapter 13, §190.

Line 25.02 - Chronic Care Management (CCM).--This cost center includes the structured recording of patient health information, an electronic health care plan addressing all health issues, access to chronic care management services, managing care transitions, and coordinating and sharing patient information with practitioners and providers outside the practice. CCM services are reimbursed as an add-on payment based on the Medicare Physician Fee Schedule (MPFS). See 80 FR 71080 (November 16, 2015).

Line 26--Enter the cost applicable to other than RHC services (excluding overhead) not entered on lines 23 through 25.02.

Line 27--Do not complete this line.

Line 28--Enter the sum of the amounts on lines 23 through 27. For cost reporting periods ending on or after October 1, 2014, enter the sum of the amounts on lines 23 through 26. Transfer the total amount in column 5 to Worksheet M-2, line 11.

Line 29--Enter the overhead expenses directly costed to the hospital-based RHC/FQHC. These expenses may include rent, insurance, interest on mortgage or loans, utilities, depreciation of buildings and fixtures, depreciation of equipment, housekeeping and maintenance expenses, and property taxes. Submit with the cost report supporting documentation to detail and compute the facility costs reported on this line.

Line 30--Enter the expenses related to the administration and management of the hospital-based RHC/FQHC that are directly costed to the facility. These expenses may include office salaries, depreciation of office equipment, office supplies, legal fees, accounting fees, insurance, telephone service, fringe benefits, and payroll taxes. Submit with the cost report supporting documentation to detail and compute the administrative costs reported on this line.

Line 31--Enter the sum of the amounts on lines 29 and 30. Transfer the total amount in column 5 to Worksheet M-2, line 14.

Line 32--Enter the sum of the amounts on lines 22, 28, and 31. This is the total hospital-based RHC/FQHC cost. This amount should agree with the amount reported for the hospital-based RHC/FQHC on Worksheet A, column 7, reduced by any amounts claimed on line 20 above.

4067. WORKSHEET M-2 - ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Use this worksheet only if you operate a certified hospital-based RHC/FQHC as part of your healthcare complex. If you have more than one hospital-based RHC/FQHC, complete a separate worksheet for each hospital-based RHC/FQHC.

Visits and Productivity--Worksheet M-2 summarizes the number of hospital-based RHC/FQHC visits furnished by the health care staff and calculates the number of visits to be used in the rate determination. Lines 1 through 9 list the types of practitioners (positions) for whom hospital-based RHC/FQHC visits must be counted and reported. Effective for services rendered on or after January 1, 2024, also include in each applicable cost center the IOP visits for services rendered to all patients. Effective for cost reporting periods ending after December 31, 2024, productivity standards no longer apply.

Column descriptions

Column 1--Record the number of all FTE personnel in each of the applicable staff positions in the hospital-based RHCs/FQHCs practice. (See CMS Pub. 100-04, chapter 9, §40.3 for a definition of FTEs).

Column 2--Record the total visits (Medical, Mental Health and, for purposes of this column, IOP visits) actually furnished to all patients by all personnel in each of the applicable staff positions in the reporting period. Count visits in accordance with instructions in 42 CFR 405.2463(a) defining a visit and 42 CFR 410.44 defining an IOP service.

Column 3--Productivity standards established by CMS are applied as a guideline that reflects the total combined services of the staff. Apply a level of 4200 visits for each physician and a level of 2100 visits for each non-physician practitioner. You are not subject to the productivity standards if you answered "Yes" to question 12 of Worksheet S-8. If so, then enter the revised standards established by you and your contractor. Effective for cost reporting periods ending after December 31, 2024, do not complete column 3.

Column 4--For lines 1 through 3, enter the product of column 1 and column 3. This is the minimum number of hospital-based RHC/FQHC visits the personnel in each staff position are expected to furnish. Effective for cost reporting periods ending after December 31, 2024, do not complete column 4.

Column 5--On line 4, enter the greater of the subtotal of the actual visits in column 2 or the minimum visits in column 4. Contractors have the authority to waive the productivity guideline in cases where you have demonstrated reasonable justification for not meeting the standard. In such cases, the contractor will substitute your actual visits if an exception is granted. Effective for cost reporting periods ending after December 31, 2024, transfer the visits from column 2, lines 4 through 9, to column 5, lines 4 through 9, and do not apply productivity standards.

On lines 5 through 7, and 9, enter the actual number of visits for each type of position.

Line descriptions

Line 1--Enter the number of FTEs and total visits furnished to hospital-based RHC/FQHC patients by staff physicians working at the hospital-based RHC/FQHC on a regular ongoing basis. Also include on this line, physician data (FTEs and visits) for services furnished to hospital-based RHC/FQHC patients by staff physicians working under contractual agreement with you on a regular ongoing basis in the hospital-based RHC/FQHC facility. These physicians are subject to productivity standards. (See 42 CFR 405.2468(d)(2)(v).)

Line 4--Enter the total of lines 1 through 3, for columns 1, 2 and 4.

Line 5--Enter the number of FTEs and total visits furnished to hospital-based RHC/FQHC patients by visiting nurses working at the hospital-based RHC/FQHC. Visiting nurses provide skilled nursing services to the homebound for services which require the skills of a nurse based on the complexity of the service, e.g., intravenous or intramuscular injections or insertions of catheters. (See CMS Pub. 100-02, chapter 13, §180.)

Line 6--Enter the number of FTEs and total visits furnished to hospital-based RHC/FQHC patients by clinical psychologists working at the hospital-based RHC/FQHC. Clinical psychologist services may include the diagnosis, treatment and consultation of a patient. (See CMS Pub. 100-02, chapter 13, §140.)

Line 7--Enter the number of FTEs and total visits furnished to hospital-based RHC/FQHC patients by clinical social worker working at the hospital-based RHC/FQHC. Clinical social worker services may include the diagnosis, treatment and consultation of a patient. (See CMS Pub. 100-02, chapter 13, §140.)

Line 7.01--Enter the number of FTEs for registered dieticians or nutritional professionals and total visits furnished to hospital-based FQHC patients for medical nutrition therapy (MNT) services provided in hospital-based FQHCs. MNT services apply to hospital-based FQHCs only. (See CMS Pub. 100-02, chapter 13, §210.2.4).

Line 7.02--Enter the number of FTEs for registered dieticians or nutritional professionals and total visits furnished to hospital-based FQHC patients for diabetes self-management training (DSMT) services provided in hospital-based FQHCs. DSMT services apply to hospital-based FQHCs only. (See CMS Pub. 100-02, chapter 13, §210.2.4.)

Line 7.03 - Marriage and Family Therapist.--Enter the number of FTEs for MFTs and total visits furnished to hospital-based RHC patients for MFT services provided in hospital-based RHCs.

Line 7.04 - Mental Health Counselor.--Enter the number of FTEs for MHCs and total visits furnished to hospital-based RHC patients for MHC services provided in hospital-based RHCs.

Line 8--Enter the total of lines 4 through 7 (and subscripts).

Line 9--Enter the number of visits furnished to hospital-based RHC/FQHC patients by physicians under agreement with you who do not furnish services to patients on a regular ongoing basis in the hospital-based RHC/FQHC. Physicians' services under agreements with you are (1) all medical services performed at your site by a non-staff physician who is not the owner or an employee of the facility, and (2) medical services performed at a location other than your site by such a physician for which the physician is compensated by you. While all physician services at your site are included in RHC/FQHC services, physician services furnished in other locations by physicians who are not on your full-time staff are paid to you only if your agreement with the physician provides for compensation for such services.

Determination of Total Allowable Cost Applicable to Hospital-Based RHC/FQHC Services.--Use lines 10 through 18 to determine the amount of overhead costs incurred by both the parent provider and the hospital-based RHC/FQHC.

Line 10--Enter the cost of health care services from Worksheet M-1, column 7, line 22.

Line 11--Enter the total nonreimbursable costs from Worksheet M-1, column 7, line 28.

Line 12--Enter the sum of lines 10 and 11 for the cost of all services (excluding overhead).

Line 13--Enter the percentage of hospital-based RHC or FQHC services. This percentage is determined by dividing the amount on line 10 (the cost of health care services) by the amount on line 12 (the cost of all services, excluding overhead).

Line 14--Enter the total hospital-based RHC/FQHC overhead costs incurred from Worksheet M-1, column 7, line 31.

Line 15--Enter the overhead costs incurred by the parent provider allocated to the hospital-based RHC/FQHC. This amount is the difference between the total costs after cost allocation on Worksheet B, Part I, column 26 and Worksheet B, Part I, column 0. If GME costs are claimed on line 20 of Worksheet M-1, do not include the GME costs allocated to the RHC/FQHC in columns 21 and 22 of Worksheet B, Part I.

Line 16--Enter the sum of lines 14 and 15 to determine the total overhead costs related to the hospital-based RHC/FQHC.

Line 17--Do not complete this line. Per 42 CFR 413.78(a), the GME payment to the hospital includes all residents working in the hospital healthcare complex; therefore, no separate payment is made to the hospital-based RHC/FQHC for GME costs.

Line 18--Enter the amount from line 16.

Line 19--Enter the overhead amount applicable to hospital-based RHC/FQHC services. It is determined by multiplying the amount on line 13 (the ratio of hospital-based RHC/FQHC services to total services) by the amount on line 18 (total overhead costs).

Line 20--Enter the total allowable cost of hospital-based RHC/FQHC services, the sum of line 10 (cost of hospital-based RHC/FQHC health care services) and line 19 (overhead costs applicable to hospital-based RHC/FQHC services).

4068. WORKSHEET M-3 - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES

This worksheet applies to title XVIII only and provides for the reimbursement calculation for services rendered. Use this worksheet to determine the interim all-inclusive rate of payment and the total program payment for the cost reporting period for each hospital-based RHC/FQHC reported.

Determination of Rate for Hospital-Based RHC/FQHC Services--Worksheet M-3 calculates the cost per visit for hospital-based 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 M-2, line 20.

Line 2--Report injection/infusion costs on this line from Worksheet M-4, line 15.

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

Line 4--For cost reporting periods ending on or before December 31, 2024, enter the greater of the minimum or actual visits by the health care staff from Worksheet M-2, column 5, line 8. For cost reporting periods ending after December 31, 2024, enter the number of visits by health care staff from Worksheet M-2, column 5, line 8

Line 5--Enter the visits made by physicians under agreement from Worksheet M-2, 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 payment limits are updated every January 1; however, the possibility exists that payment limits may also be updated other than on January 1. Complete columns 1, 2, and 3, if applicable (add column 3 for lines 8 through 14 if the cost reporting period overlaps three payment limit periods) for lines 8 and 9, to identify costs and visits affected by different payment limits within a cost reporting period, as may be the case when implementing §130 of CAA 2021, effective for services rendered on or after April 1, 2021, where an RHC may span three payment limit periods within a single cost reporting period (see CR 12185, dated May 4, 2021, or subsequent applicable CRs). If only one payment limit is applicable during the cost reporting period (calendar year reporting period), complete column 2 only.

Line 8--Enter the per visit payment limit. Obtain this amount from your contractor.

NOTE: For services rendered prior to April 1, 2021, if you are based in a small hospital with less than 50 beds (the bed count is based on the same calculation used on Worksheet E, Part A, line 4), in accordance with 42 CFR 412.105(b), do not apply the per visit payment limit. Transfer the adjusted cost per visit (line 7) to line 9, columns 1 and/or 2.

NOTE: In accordance with §1833(f)(3) of the Act, as amended by §130 of the CAA 2021, effective for services on or after April 1, 2021, hospital-based RHCs with less than 50 beds (as calculated above) will have their per visit payment limit calculated in accordance with §1833(f)(3)(B) of the Act by their contractor. See CR 12185, dated May 4, 2021, or subsequent applicable CRs.

For hospital-based RHCs based in small urban hospitals transfer the adjusted cost per visit (line 7) to line 9, column 1 and/or 2.

Line 9--Enter the lesser of the amount on line 7 or line 8.

Calculation of Settlement.--Complete lines 10 through 29 to determine the total program payment due you for covered hospital-based RHC/FQHC services furnished to program beneficiaries during the reporting period. Complete columns 1 and 2 of lines 10 through 14 to identify costs and visits affected by different payment limits during a cost reporting period.

Line descriptions

Line 10--Enter the number of program-covered medical visits from your records or the PS&R.

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 program beneficiary visits for hospital-based RHC/FQHC services during the reporting period).

Line 12--Enter the number of program-covered mental health visits from your records or the PS&R. Do not include IOP services/visits on this line.

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; services from January 1, 2010, through December 31, 2011, the limitation is 68.75 percent; services from January 1, 2012, through December 31, 2012, the limitation is 75 percent; services from January 1, 2013 through December 31, 2013, the limitation is 81.25 percent; and services on or 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 treatment service limit percentage. This limit applies only to therapeutic services, not initial diagnostic services.

NOTE: Section 4104 of ACA eliminates coinsurance and deductible for preventive services, effective for dates of service on or after January 1, 2011. Hospital-based RHCs/FQHCs must provide detailed HCPCS coding for preventive services to ensure coinsurance and deductible are not applied. Hospital-based RHCs/FQHCs must maintain this documentation to apply the appropriate reductions on lines 16.03 and 16.04.

Line 15--Do not complete this line. Per 42 CFR 413.78(a), the GME payment to the hospital includes all residents working in the hospital healthcare complex; therefore, no separate payment is made to the hospital-based RHC/FQHC for GME costs.

Line 16--For cost reporting periods that overlap January 1, 2011, enter in column 1, the sum of lines 11 and 14, column 1, and in column 2, the sum of lines 11 and 14, column 2. For cost reporting periods beginning on or after January 1, 2011, do not use column 1, and enter the total program cost in column 2. This is equal to the sum of the amounts in columns 1 and 2, respectively (and 3, if applicable), lines 11 and 14.

Line 16.01--Enter the total program charges from the contractor's records (PS&R). For cost reporting periods that overlap January 1, 2011, do not complete column 1 and enter total program charges for services rendered on or after January 1, 2011, in column 2. For cost reporting periods beginning on or after January 1, 2011, enter total program charges in column 2.

Line 16.02--Enter the total program preventive charges from the provider's records. For cost reporting periods that overlap January 1, 2011, do not complete column 1 and enter total program preventive charges for services rendered on or after January 1, 2011, in column 2. For cost reporting periods beginning on or after January 1, 2011, enter total program preventive charges in column 2.

Line 16.03--Enter the total program preventive costs. For cost reporting periods that overlap January 1, 2011, do not complete column 1, and enter the total program preventive costs ((line 16.02 divided by line 16.01) times line 16) for services rendered on or after January 1, 2011, in column 2. For cost reporting periods beginning on or after January 1, 2011, enter the total program preventive costs ((line 16.02 divided by line 16.01) times line 16, column 2.

Line 16.04--Enter the total program non-preventive costs. For cost reporting periods that overlap January 1, 2011, do not complete column 1 and enter the total program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) for services rendered on or after January 1, 2011, in column 2. For cost reporting periods beginning on or after January 1, 2011, enter the total program non-preventive costs ((line 16, column 2, minus lines 16.03 and 18, column 2) times .80) in column 2.

Line 16.05--Enter the total program costs. For cost reporting periods that overlap January 1, 2011, enter total program costs (line 16 times .80) for services rendered prior to January 1, 2011, in column 1, and enter the sum of lines 16.03 and 16.04, in column 2. For cost reporting periods beginning on or after January 1, 2011, enter the sum of lines 16.03 and 16.04, in column 2.

Line 17--Enter the primary payer amounts from your records.

Line 18--Enter the amount credited to the hospital-based RHC's program patients to satisfy their deductible liabilities on the visits on lines 10 and 12 as recorded by the contractor from clinic bills processed during the reporting period. Hospital-based RHCs determine this amount from the interim payment lists provided by the contractor. Hospital-based FQHCs enter zero on this line as deductibles do not apply.

Line 19--Enter the coinsurance amount applicable to the hospital-based RHC/FQHC for program patient visits on lines 10 and 12 as recorded by the contractor from clinic/center bills processed during the reporting period. This line captures data for informational and statistical purposes only. This line does not impact the settlement calculation.

Line 20--Enter the net program costs, excluding injections/infusions. For cost reporting periods that overlap January 1, 2011, enter the result of subtracting the amount on line 17 from the amount on line 16.05, columns 1 and 2. For cost reporting beginning on or after January 1, 2011, enter the result of subtracting the amount on line 17 from the amount on line 16.05, column 2.

Line 21--Enter the amount from Worksheet M-4, line 16.

Line 21.50--Enter program RHC IOP OPPS payment amounts for IOP services rendered on or after January 1, 2024. For title XVIII, obtain this amount from the PS&R.

Line 21.55--Calculate the total program IOP services cost in column 2 by multiplying program IOP visits (for title XVIII, from the PS&R) by the adjusted cost per visit on line 7. This amount is used for statistical purposes only. For cost reporting periods ending on or after January 1, 2024, enter the program IOP visits (for title XVIII, from the PS&R) in column 1, and calculate the total program IOP services cost for column 2 by multiplying the visits in column 1 by the adjusted cost per visit from line 7.

Line 21.60--Enter the IOP services deductible and coinsurance amounts and the primary payer amounts. For title XVIII amounts billed to Medicare beneficiaries, obtain this amount from your books and records or the PS&R.

Line 22--Enter the total allowable program cost, sum of the amounts on lines 20, 21, and 21.50, minus line 21.60.

Line 23--Enter your total allowable bad debts, net of recoveries, from your records. If recoveries exceed the current year's bad debts, line 23 will be negative. (See 42 CFR 413.89.)

Line 23.01--Enter the result of line 23 (including negative amounts) times 88 percent for cost reporting periods beginning on or after October 1, 2012, 76 percent for cost reporting periods beginning on or after October 1, 2013, and 65 percent for cost reporting periods beginning on or after October 1, 2014.

Line 24--Enter the gross allowable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. This amount must also be reported on line 23.

Line 25--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, chapter 21, §2146.4), enter the adjustment. Specify the adjustment in the space provided.

Line 25.50--Enter the Pioneer ACO demonstration payment adjustment amount. Do not use this line for services rendered on or after January 1, 2017. Report any ACO demonstration payment adjustments for services on or after January 1, 2017, on line 25.99 or line 26.02, accordingly.

Line 25.99--Enter any demonstration payment adjustment amounts for demonstration projects in which the provider participated where the demonstration adjustment amounts are subject to the sequestration adjustment. Obtain this amount from the PS&R.

Line 26--Enter the sum of lines 22 and 23 plus or minus line 25, and minus lines 25.50 and 25.99. For cost reporting periods beginning on or after October 1, 2012, enter the sum of lines 22 and 23.01 plus or minus line 25 and minus lines 25.50 and 25.99.

Line 26.01--For cost reporting periods that overlap or begin on or after April 1, 2013, calculate the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur during the sequestration period, divided by total days in the entire cost reporting period, rounded to six decimal places), rounded to four decimal places) times line 26]. Do not apply the sequestration calculation when gross reimbursement (line 26) is less than zero. In accordance with §3709 of the CARES Act, as amended by §102 of the CAA 2021, §1 of Public Law 117-7, and §2 of the PAMA 2021, do not apply the sequestration adjustment to the period of May 1, 2020, through March 31, 2022. In accordance with §2 of the PAMA 2021, for cost reporting periods that overlap or begin on or after April 1, 2022, calculate the sequestration adjustment amount for the period of April 1, 2022, through June 30, 2022, as follows: [(1 percent times (total days in the cost reporting period that occur from April 1, 2022, through June 30, 2022, divided by total days in the entire cost reporting period, rounded to six decimal places), rounded to four decimal places), times line 26]; and for cost reporting periods that overlap or begin on or after July 1, 2022, calculate the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur on or after July 1, 2022, through the end of the cost reporting period, divided by total days in the entire cost reporting period, rounded to six decimal places), rounded to four decimal places) times line 26].

Line 26.02--Enter any demonstration payment adjustment amounts for demonstration projects in which the provider participated where the demonstration adjustment amounts are not subject to the sequestration adjustment. Obtain this amount from the PS&R.

Line 27--Enter the total interim payments from Worksheet M-5 made to you for covered services furnished to program beneficiaries during the reporting period (from contractor records).

Line 28--For contractor use only, enter the on line 5.99 of Worksheet M-5.

Line 29--Enter the total amount due to/from the program (line 26 minus lines 26.01, 26.02, 27, and 28). Transfer this amount to Worksheet S, Part III, column 3, line 10 and/or 11 as applicable.

Line 30--Enter the program reimbursement effect of protested items. The reimbursement effect of the nonallowable items is estimated by applying a reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See CMS Pub. 15-1, chapter 1, §115.2.) A schedule showing the supporting details and computations must be attached.

4069. WORKSHEET M-4 - COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

The cost and administration of pneumococcal and influenza vaccine to Medicare beneficiaries are 100 percent reimbursable by Medicare. Effective January 1, 2025, hepatitis B vaccines and their administration are paid at 100 percent of reasonable cost. This worksheet provides for the computation of the cost of these vaccines. Additionally, only use this worksheet for vaccines rendered to patients who, at the time of receiving the vaccine(s), were not inpatients or outpatients of the hospital. If a patient simultaneously received vaccine(s) with any Medicare covered services as an inpatient or outpatient of the hospital, those vaccine costs are reimbursed through the hospital and cannot be claimed by the hospital-based RHC/FQHC. Additionally, in accordance with §3713 of the CARES Act, during the COVID-19 PHE, this worksheet computes the cost of COVID-19 vaccines and monoclonal antibody products for treatment of COVID-19 and their administration to Medicare and MA enrollees for calendar years 2020 and 2021.

For services rendered prior to July 1, 2025, report the applicable data in columns 1, 2, 2.01, and 2.02, for pneumococcal vaccines, influenza vaccines, COVID-19 vaccines, and monoclonal antibody products for treatment of COVID-19, authorized for use during the COVID-19 PHE. For services rendered on or after January 1, 2025, and prior to July 1, 2025, report the data for hepatitis B vaccines, in column 2.03. The data entered in all columns (1, 2, 2.01, 2.02, and 2.03) for lines 4, 11, 13, and 13.01, are mutually exclusive; that is, the injection/infusion costs, the total number of injections/infusions administered, and the total number of Medicare/MA covered injections/infusions must only be represented one time in the appropriate column. Effective for cost reporting periods beginning on or after July 1, 2025, report all data in column 3, do not complete columns 1, 2, 2.01, 2.02 and 2.03.

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

Line 2-- For cost reporting periods beginning prior to July 1, 2025, in columns 1 through 2.03, for each type of vaccine, enter the ratio of the estimated percentage of time involved in administering injections/infusions, including the time involved in administering COVID-19 vaccines and monoclonal antibodies for treatment of COVID-19, to the total health care staff time for the entire cost reporting period. Do not include physician service under agreement time in this calculation.

For cost reporting periods that straddle July 1, 2025, in column 3, enter the sum of the ratios in columns 1, 2, 2.01, 2.02, and 2.03.

For cost reporting periods beginning on or after July 1, 2025, in column 3, enter the ratio of the estimated percentage of time involved in administering all injections/infusions to the total health care staff time for the entire cost reporting period, do not complete columns 1 through 2.03.

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

Line 4--For cost reporting periods beginning prior to July 1, 2025, enter the cost of injections/infusions and related medical supplies from your records in columns 1, 2, 2.01, 2.02, and 2.03. Do not include cost of monoclonal antibody products for COVID-19 provided by the government free of charge, as was the case upon the product's initial availability in response to the COVID-19 PHE. For cost reporting periods that straddle July 1, 2025, completing columns 1, 2, 2.01, 2.02 and 2.03, and in column 3, sum the amounts in columns 1, 2, 2.01, 2.02 and 2.03. For cost reporting periods beginning on or after July 1, 2025, do not complete columns 1 through 2.03; instead enter the cost of injections/infusions and related medical supplies from your records in column 3.

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

Line 6--For cost reporting periods beginning before July 1, 2025, enter the amount from Worksheet M-1, column 7, line 22, in each of columns 1 through 3, as applicable. This is your total direct cost of the facility. For cost reporting periods beginning on or after July 1, 2025, do not complete columns 1 through 2.03 and enter in column 3 only, the amount of total direct cost of the facility from Worksheet M-1, column 7, line 22.

Line 7--For cost reporting periods beginning before July 1, 2025, enter the amount from Worksheet M-2, line 19, in each of columns 1 through 3, as applicable. For cost reporting periods beginning on or after July 1, 2025, do not complete columns 1 through 2.03 and enter in column 3 only, the amount of total facility overhead from Worksheet M-2, line 19.

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 ratio on line 8 and enter the result.

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

Line 11--For cost reporting periods beginning prior to July 1, 2025, enter in columns 1, 2, 2.01, 2.02, and 2.03, respectively, the total number of injections/infusions from your records for the entire cost reporting period. For cost reporting periods that straddle July 1, 2025, in column 3, enter the sum of columns 1, 2, 2.01, 2.02, and 2.03. For cost reporting periods beginning on or after July 1, 2025, in column 3, enter the total number of all injections/infusions administered for vaccines, do not complete columns 1 through 2.03.

Line 12--For each column, enter the cost per injection/infusion by dividing the amount on line 10 by the number on line 11.

Line 13--For services rendered prior to July 1, 2025, enter the number of injections/infusions from your records or the PS&R, in columns 1, 2, 2.01, and 2.02, respectively. In column 2.03, enter the number of hepatitis B injections/infusions administered to Medicare beneficiaries on and after January 1, 2025, through June 30, 2025, from your records. For services rendered on or after July 1, 2025, enter in column 3, the total number of all injections/infusions administered to Medicare beneficiaries from the PS&R. For cost reporting period beginning on or after July 1, 2025, do not complete columns 1 through 2.03.

Line 13.01.--For services rendered in calendar years 2020 and 2021, enter from your records the number of COVID-19 injections/infusions administered to MA enrollees, in columns 2.01 and 2.02, respectively.

Line 14--For each column, enter the program cost for vaccine injections by multiplying the amount on line 12 by the sum of the amounts on lines 13 and 13.01, as applicable.

Line 15--For cost reporting periods beginning prior to July 1, 2025, enter the total cost of injections/infusions and their administration costs in column 2. This is equal to the sum of the amounts in columns 1, 2, 2.01, 2.02 and 2.03, line 10. For cost reporting periods beginning on or after July 1, 2025, transfer the amount from column 3, line 10.

Transfer this amount to Worksheet M-3, line 2.

Line 16--Enter the Medicare cost of injections/infusions and their administration costs in column 2. This is equal to the sum of the amounts in columns 1, 2, 2.01, 2.02, 2.03, and 3, line 14.

Transfer the result to Worksheet M-3, line 21.

4070. WORKSHEET M-5 - ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Complete this worksheet for Medicare interim payments only. If you have more than one hospital-based RHC/FQHC, complete a separate worksheet for each facility.

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

Line Descriptions

Line 1--Enter the total program interim payments paid to the hospital-based RHC/FQHC. The amount entered reflects the sum of all interim payments paid on individual bills (net of adjustment bills) for services, including IOP services paid under OPPS, rendered in this cost reporting period. The amount entered includes 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. It 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 M-3, line 27.

DO NOT COMPLETE THE REMAINDER OF WORKSHEET M-5. LINES 5 THROUGH 7 ARE FOR CONTRACTOR USE ONLY. **(EXCEPTION: IF WORKSHEET S, PART I, LINE 5 IS "5" (AMENDED COST REPORT), THE HOSPITAL-BASED RHC/FQHC MAY COMPLETE THIS SECTION.)**

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 NPR has been issued, report all settlement payments prior to the current reopening settlement on line 5.

Line 6--Enter the net settlement amount (balance due to the hospital-based RHC/FQHC 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, when an amount is due from the hospital-based RHC/FQHC to the program, show the amount and date on which the hospital-based RHC/FQHC 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 M-3, line 26 less the amount on lines 26.01 and 26.02.

Line 8--Enter the contractor name, the contractor number and NPR date in columns 0, 1 and 2, respectively.

4071. WORKSHEET N-1 - RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES FOR HOSPITAL-BASED FQHC

Use the N worksheet series if you operate a certified hospital-based FQHC for cost reporting periods beginning on or after October 1, 2014. Use only those cost centers that represent services for which the hospital-based FQHC is certified. If you have more than one hospital-based FQHC, complete a separate worksheet N series for each hospital-based FQHC, unless the hospital-based FQHC has received prior contractor approval to file a consolidated cost report (see CMS Pub. 100-04, chapter 9, §30).

This worksheet is for recording direct costs of the hospital-based FQHC from your accounting books and records. It also provides for the necessary reclassifications and adjustments to certain accounts. If the cost elements of a cost center are maintained separately on your accounting books, a reconciliation of costs per the accounting books and records to those on this worksheet must be maintained and are subject to review by your contractor. The cost centers listed may not apply to every hospital-based FQHC using these forms. For example, a hospital-based FQHC that does not have transportation costs will not complete line 11. Complete only those lines that are applicable.

Column Descriptions

Column 1--Enter direct salaries and wages plus related salary amounts for paid vacation, holiday, sick, other paid-time-off (PTO), severance, and bonus pay.

Column 2--Enter all costs other than salaries.

Column 3--For each cost center, add the amounts in columns 1 and 2 and enter the total in column 3.

Column 4--For each cost center, enter any reclassifications for expenses listed in column 3. The net total of the entries in column 4, line 100, must equal zero if no reclassifications were reported on Worksheet A, column 4, line 89. Show reductions to expenses as negative numbers. This column is completed only to the extent reclassifications are needed and appropriate in the particular circumstances. See §4014 for examples of reclassifications that may be needed. Submit with the cost report copies of any work papers used to compute the reclassifications reported in this column.

Column 5--For each cost center, enter the total of the amount in column 3 plus or minus the amount in column 4. The total on column 5, line 100 must equal the total on column 3, line 100, if no reclassifications were reported on Worksheet A, column 4, line 89.

Column 6--For each cost center, enter on the appropriate lines the amounts of any adjustments to expenses required under the Medicare principles of reimbursement. (See §4016.) Submit with the cost report copies of any work papers used to compute the adjustments reported in this column.

Column 7--For each cost center, enter the total of the amount in column 5, plus or minus the amount in column 6. The amount on line 100 must equal the net expenses for cost allocation on Worksheet A, column 7, line 89.

Line descriptions

This worksheet groups the trial balance of expenses into general service cost centers, direct patient care cost centers, reimbursable pass through costs, other FQHC services, and nonreimbursable cost centers to facilitate the transfer of costs to the various worksheets.

General Service Cost Centers--

These cost centers include expenses incurred in operating the hospital-based FQHC as a whole that are not directly associated with furnishing patient care such as, but not limited to mortgage, rent, plant operations, administrative salaries, utilities, telephone, and computer hardware and

software costs. General service cost centers furnish services to other general service cost centers and to reimbursable and nonreimbursable cost centers.

Lines 1 and 2 - Cap Rel Costs-Bldg & Fix and Cap Rel Costs-Mvble Equip--These cost centers include the capital-related costs for buildings and fixtures and the capital-related costs for movable equipment including depreciation, leases and rentals for the use of facilities and/or equipment, including electronic health records systems, interest incurred in acquiring land and depreciable assets used for patient care, insurance on depreciable assets used for patient care and taxes on land or depreciable assets used for patient care, and, software and hardware updates to electronic health record systems. Do not include costs incurred for the repair or maintenance of equipment or facilities; amounts specifically included in rentals or lease payments for repair and/or maintenance agreements; interest expense incurred to borrow working capital or for any purpose other than the acquisition of land or depreciable assets used for patient care; general liability insurance or any other form of insurance to provide protection other than the replacement of depreciable assets; or taxes other than those assessed on the basis of some valuation of land or depreciable assets used for patient care. However, if no amount of the lease payment is identified in the lease agreement for maintenance, you are not required to carve out a portion of the lease payment to represent the maintenance portion. Thus, the entire lease payment is considered a capital-related cost subject to the provisions of 42 CFR 413.130(b).

Line 3 - Employee Benefits--This cost center includes the costs of the employee benefits department. In addition, this cost center includes the fringe benefits paid to, or on behalf of, an employee when a provider's accounting system is not designed to accumulate the benefits on a departmentalized or cost center basis. (See CMS Pub. 15-1, chapter 21, §2144.)

Line 4 - Administrative and General--A&G includes a wide variety of administrative costs such as but not limited to cost of fiscal services, legal and accounting services, facility administrative services (not already included in other general service cost centers), etc.

Line 5 - Plant Operation and Maintenance--This cost center includes expenses incurred in the plant operation and maintenance of the hospital-based FQHC. These costs include the maintenance and service of utility systems such as heat, light, water, air conditioning and air treatment. This cost center also includes costs incurred in maintaining the facility and grounds, such as costs of routine painting, plumbing, mowing, and snow removal.

Line 6 - Janitorial--This cost center includes the cost of routine janitorial activities such as mopping, vacuuming, cleaning restrooms, lobbies, waiting areas and otherwise maintaining patient and non-patient care areas.

Line 7 - Medical Records--This cost center includes the cost of the medical records department where patient medical records are maintained. The general library and the medical library are not included in this cost center but are included in the A&G cost center. None of the costs associated with electronic health records systems are reported in this cost center.

Line 8 - Subtotal - Administrative Overhead--Enter the total of lines 1 through 7.

Line 9 - Pharmacy--This cost center includes only the routine costs of drugs (both prescription and over the counter), pharmacy supplies, pharmacy personnel, and pharmacy services provided incident to an FQHC visit. Drugs and pharmacy supplies that can be traced to individual patients that are paid separately (outside the FQHC PPS national encounter rate) under Part B, C, or D, of Medicare must be included on line 67 (Drugs Charged to Patients), of this worksheet. Drugs (both prescription and over the counter), pharmacy supplies, pharmacy personnel and pharmacy services provided by a retail pharmacy are reported on line 77. Do not include the cost of influenza, pneumococcal, hepatitis B (for services provided on or after January 1, 2025), or COVID-19 vaccines, or monoclonal antibody products for treatment of COVID-19, on this line as these costs are reported on lines 47 and 48 (and applicable subscripts), respectively.

Line 10 - Medical Supplies--This cost center includes the cost of routine supplies used in the normal course of caring for patients, such as gloves, masks, swabs, or glycerin sticks, and the non-routine medical supplies that can be traced to individual patients. Do not include the cost of medical supplies used in administering pneumococcal, hepatitis B (for services provided on or after January 1, 2025), influenza, or COVID-19 vaccines, or monoclonal antibody products for treatment of COVID-19, on this line as these costs are reported on lines 47 and 48 (and applicable subscripts), respectively.

Line 11 - Transportation--This cost center includes the cost of owning or renting vehicles, public transportation expenses, parking, tolls, or payments to employees for driving their private vehicles to see patients or for other hospital-based FQHC business.

Line 12 - Other General Service--Use this line to report the costs of other general service costs not previously identified on lines 1 through 11.

Line 13 - Subtotal - Total Overhead--Enter the sum of lines 8 and 9 through 12.

Lines 14 through 22--Reserved for future use.

Direct Care Cost Centers--

Line 23 - Physician--This cost center includes the costs incurred for physicians providing direct patient care services and general supervisory services, participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care, and establishment of governing policies by the governing board. Reclassify the cost for the portion of time physicians spent on general supervisory services or other hospital-based FQHC administrative activities to A&G (line 4).

Line 24 - Physician Services Under Agreement--This cost center includes the costs incurred for physicians who are providing services under agreement.

Line 25 - Physician Assistant--This cost center includes the costs incurred for PAs, including the costs for PAs providing physician services.

Line 26 - Nurse Practitioner--This cost center includes the costs of nursing care provided by nurse practitioners (NPs), including NPs providing physician services.

Line 27 - Visiting Registered Nurse--This cost center only includes the costs of nursing care provided by registered nurses (RNs), who perform visiting nurse services in accordance with CMS Pub. 100-02, chapter 13, §180. Costs associated with RNs who provide services incident to a physician, PA, NP, certified nurse midwife (CNM), CP, or clinical social worker (CSW) (see CMS Pub. 100-02, chapter 13, §§110, 120 and 140), are included in line 36.

Line 28 - Visiting Licensed Practical Nurses--This cost center includes the costs of nursing care provided by licensed practical nurses (LPNs) who perform visiting nurse services in accordance with CMS Pub. 100-02, chapter 13, §180. Costs associated with LPNs who provide services incident to a physician, PA, NP, CNM, CP or CSW (see CMS Pub. 100-02, chapter 13, §§110, 120 and 140), are included in line 36.

Line 29 - Certified Nurse Midwife--This cost center includes the costs of nursing care provided by CNM's.

Line 30 - Clinical Psychologist--This cost center includes the costs of a CP who holds a doctorate in psychology and is licensed or certified by the State in which he or she practices, for diagnostic, assessment, preventative and therapeutic services directed at individuals.

Line 31 - Clinical Social Worker--This cost center includes the costs of a CSW who possesses a master's degree or doctorate in social work and meets specified criteria established by regulation. The CSW must directly examine the patient, or directly review the patient's medical information, to provide diagnosis, treatment and consultation.

Line 31.10 - Marriage and Family Therapist--This cost center includes the costs of a MFT who possesses a master's degree or doctorate which qualifies for licensure or certification as a marriage and family therapist and meets specified criteria established by regulation.

Line 31.11 - Mental Health Counselor--This cost center includes the costs of a MHC who possesses a master's degree or doctorate which qualifies for licensure or certification as a mental health counselor, clinical professional counselor, or professional counselor and meets specified criteria established by regulation.

Line 32 - Laboratory Technician--This cost center includes the costs of a person who, under the supervision of a medical technologist or physician, performs microscopic and bacteriologic tests of human blood, tissue, and fluid for diagnostic and research purposes.

Line 33 - Reg Dietician/Cert DSMT/MNT Educator--This cost center includes the costs of a person who is either a registered dietician or nutritionist who meets specified criteria for providing diabetes self-management training (DSMT) or medical nutrition therapy (MNT) services under the Program.

Line 34 - Physical Therapist--This cost center includes the costs of physical or corrective treatment of bodily or mental conditions by the use of physical, chemical, and other properties of heat, light, water, electricity, sound massage, and therapeutic exercise by or under the direction of a registered physical therapist as prescribed by a physician. Physical therapy services may be provided for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

Line 35 - Occupational Therapist--This cost center includes the costs of purposeful goal-oriented activities in the evaluation, diagnosis, and/or treatment of persons whose function is impaired by physical illness or injury, emotional disorder, congenital or developmental disability, or the aging process, in order to achieve optimum functioning, to prevent disability, and to maintain health. Occupational therapy services may be provided for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

Line 36 - Other Allied Health Personnel--This cost center includes the cost of RNs and LPNs who provide services incident to a physician, PA, NP, CNM, CP, or CSW in accordance with CMS Pub. 100-02, chapter 13, §§110, 120 and 140 and the cost of other allied health personnel that provide diagnostic, technical, therapeutic and direct patient care and support services to the other health professionals they work with and the patients they serve. An example of other allied health personnel is a medical assistant.

Line 37 - Subtotal Direct Patient Care Services--Enter the total of lines 23 through 36.

Lines 38 through 46--Reserved for future use.

Reimbursable Pass Through Costs--

Line 47 - Pneumococcal Vaccines & Med Supplies--This cost center includes the cost of the pneumococcal vaccines and the medical supplies attributable to pneumococcal vaccinations.

Line 48 - Influenza Vaccines & Med Supplies--This cost center includes the cost of the influenza vaccines and the medical supplies attributable to influenza vaccinations.

Line 48.10 - COVID-19 Vaccines & Med Supplies.--Enter the cost of COVID-19 vaccines and the medical supplies attributable to COVID-19 vaccinations, authorized and furnished for use during the COVID-19 PHE. Do not report the cost of COVID-19 vaccines provided by the government free of charge.

Line 48.11 - Monoclonal Antibody Products.--Enter the cost of monoclonal antibody products for treatment of COVID-19, authorized and furnished for use during the COVID-19 PHE. Do not report the cost of monoclonal antibody products for treatment of COVID-19 provided by the government free of charge.

Line 48.12 - Hepatitis B Vaccines & Med Supplies--Effective for services rendered on or after January 1, 2025, enter the cost of the hepatitis B vaccines and the medical supplies attributable to hepatitis B vaccinations.

Line 49 - Subtotal - Reimbursable Pass Through Costs--Enter the total of lines 47 through 48.12.

Lines 50 through 59--Reserved for future use.

Other FQHC Services--

Line 60 - Medicare Excluded Services--This cost center includes the cost of routine dental care, hearing tests, eye exams, etc., that are excluded from coverage under the Program.

Line 61 - Diagnostic & Screening Lab Tests--This cost center includes the technical component cost of diagnostic and laboratory tests such as electrocardiograms and certain preventative services authorized by the Medicare statute or the national coverage determination process. This cost center does not include venipuncture, which is included in the pharmacy cost center when furnished by the hospital-based FQHC.

Line 62 - Radiology - Diagnostic--This cost center includes the technical component of radiological diagnostic tests such as x-rays and imaging services.

Line 63 - Prosthetic Devices--This cost center includes the costs of devices (other than dental) which replace all or part of an internal body organ including colostomy bags and supplies directly related to colostomy care, replacement of such devices, and one pair of conventional eyeglasses or contact lenses furnished subsequent to each cataract surgery with the insertion of an intraocular lens.

Line 64 - Durable Medical Equipment--This cost center includes the direct costs of DME rented or sold (DME, as defined in 42 CFR 410.38) furnished to an individual patient and all direct expenses incurred in requisitioning and issuing DME to patients.

Line 65 - Ambulance Services--Report all ambulance costs on this line for both owned and operated services and services under arrangement.

Line 66 - Telehealth--This cost center includes the cost of telehealth distant-site services as described in CMS Pub. 100-02, chapter 13, §190.

Line 67 - Drugs Charged to Patients--This cost center includes only those costs associated with drugs (both prescription and over the counter), pharmacy supplies, pharmacy personnel and pharmacy services that can be traced to individual patients that are paid separately (outside the FQHC PPS national encounter rate) under Medicare Parts B, C, or D.

Line 68 - Chronic Care Management (CCM)--This cost center includes the structured recording of patient health information, an electronic health care plan addressing all health issues, access to chronic care management services, managing care transitions, and coordinating and sharing patient information with practitioners and providers outside the practice. CCM services are reimbursed as an add-on payment based on the Medicare Physician Fee Schedule (MPFS). See 80 FR 71080 (November 16, 2015).

Line 69 - Other--Use this line to report the costs of other FQHC services not previously identified on lines 60 through 68.

Line 70 - Subtotal Other FQHC Services--Enter the total of lines 60 through 69.

Lines 71 through 76--Reserved for future use.

Nonreimbursable Cost Centers--

Line 77 - Retail Pharmacy--This cost center includes only those costs associated with drugs (both prescription and over the counter), pharmacy supplies, pharmacy personnel and pharmacy services that are sold through a retail pharmacy.

Line 78 - Other Nonreimbursable--Use this line to record the costs applicable to other nonreimbursable cost centers not provided for on this worksheet.

Line 80 through 99--Reserved for future use.

Line 100 - Total--Enter the sum of lines 13, 37, 49, 70, and 79.

4071.1. WORKSHEET N-2 - CALCULATION OF HOSPITAL-BASED FQHC COST PER VISIT

The purpose of Worksheet N-2 is to (1) summarize the hospital-based FQHC medical and mental health visits furnished by practitioners, including health care staff and physicians under agreement, and (2) apportion overhead costs to hospital-based FQHC services to determine the average cost per visit for a medical visit and a mental health visit, by practitioner.

Column 1--Enter the total cost for each practitioner from Worksheet N-1, column 7, as indicated on the worksheet.

Column 2--Enter the total medical visits, mental health visits, and IOP visits, actually furnished to all patients by each practitioner during the cost reporting period. Each visit to the hospital-based FQHC by the beneficiary counts as a single visit, even in the case where a beneficiary returns to the hospital-based FQHC in the same day for a subsequent illness or injury. A beneficiary can have up to three medical visits in a day to include the initial visit and two subsequent visits for illness or injury.

NOTE: Column 2, line 11 must equal Worksheet S-11, Part III, column 5, sum of lines 2, 4, and 6. For each line 1 through 10, column 2 must equal the sum of columns 7, 8, and 8.01.

Column 3--Use this column to allocate costs associated with other direct care costs, sum of Worksheet N-1, column 7, lines 9, 32, 34, 35, and 36. Calculate the UCM related to other direct care costs by dividing the sum of Worksheet N-1, column 7, lines 9, 32, 34, 35, and 36, by Worksheet N-2, column 2, line 11, total medical visits, mental health visits, and IOP visits, and enter the result on line 12. Calculate the costs for lines 1 through 10 by multiplying the visits on each corresponding line, column 2 times the UCM on line 12.

Column 4--Use this column to allocate general service costs, sum of Worksheet N-1, column 7, line 13, minus line 9, plus Worksheet B, Part I, line 89, column 26, minus Worksheet B, Part I, line 89, column zero. Calculate the UCM by dividing Worksheet N-1, column 7, line 13, minus line 9, plus Worksheet B, Part I, line 89, column 26, minus Worksheet B, Part I, line 89, column zero, by Worksheet N-1, column 7, line 100, minus Worksheet N-1, column 7, line 13, plus line 9, and enter the result on line 12. Allocate the general service cost attributable to each practitioner on lines 1 through 10, by multiplying the UCM times the sum of the amounts in columns 1 and 3, for each corresponding line.

Column 5--Enter the sum of columns 1, 3, and 4, for each practitioner.

Column 6--Calculate the average cost per visit by each practitioner by dividing the total cost in column 5 by the total visits in column 2. Enter the result in column 6.

Column 7--Enter the total number of medical visits included in column 2, provided to all patients by each practitioner during the cost reporting period.

Column 8--Enter the total number of mental health visits included in column 2, provided to all patients by each practitioner during the cost reporting period.

Column 8.01.--Enter the total IOP visits included in column 2, provided to all patients by each practitioner during the cost reporting period.

Column 9--Enter the total number of medical visits provided to Medicare beneficiaries by each practitioner during the cost reporting period.

Column 10--Enter the total number of mental health visits provided to Medicare beneficiaries by each practitioner during the cost reporting period.

Column 10.01.--Enter the total number of IOP visits provided to Medicare beneficiaries by each practitioner during the cost reporting period.

NOTE: Worksheet S-11, Part III, column 2, line 2, must equal column 9, line 11; and Worksheet S-11, Part III, column 2, line 4, must equal column 10, line 11; and Worksheet S-11, Part III, column 2, line 6, must equal column 10.01, line 11.

Column 11--Calculate the Medicare cost per medical visit by practitioner by multiplying the average cost per visit in column 6 by the Medicare visits in column 9.

Column 12--Calculate the Medicare cost per mental health visit by practitioner by multiplying the average cost per visit in column 6 by the Medicare visits in column 10.

Column 12.01.--Calculate the Medicare cost per IOP visit by practitioner by multiplying the average cost per visit in column 6 by the Medicare visits in column 10.01.

Line 11--Enter the sum of lines 1 through 10 for the applicable columns.

Line 13, column 6--Calculate the average cost per visit by dividing column 5, line 11 by column 2, line 11.

Line 13, column 11--Calculate the Medicare average cost per medical visit by dividing column 11, line 11 by column 9, line 11.

Line 13, column 12--Calculate the Medicare average cost per mental health visit by dividing column 12, line 11 by column 10, line 11.

Line 13, column 12.01.--Calculate the Medicare average cost per IOP visit by dividing column 12.01, line 11, by column 10.01, line 11.

4071.2. WORKSHEET N-3 - COMPUTATION OF HOSPITAL-BASED FQHC VACCINE COST

The cost and administration of pneumococcal and influenza vaccine to Medicare beneficiaries are paid at 100 percent of reasonable cost. Effective January 1, 2025, hepatitis B vaccines and their administration are paid at 100 percent of reasonable cost. This worksheet provides for the computation of the cost of the pneumococcal and influenza, and hepatitis B vaccines. Use this worksheet for vaccines rendered to hospital-based FQHC patients who, at the time of receiving the vaccine(s), were not inpatients or outpatients of the hospital. If a patient simultaneously received a vaccine(s) with any Medicare covered services as an inpatient or outpatient of the hospital, those vaccine costs are reimbursed through the hospital provider and cannot be claimed by the hospital-based FQHC. Additionally, in accordance with §3713 of the CARES Act, during the COVID-19 PHE, this worksheet computes the cost of COVID-19 vaccines and monoclonal antibody products for treatment of COVID-19 and their administration furnished to Medicare and MA enrollees for calendar years 2020 and 2021.

For services rendered prior to July 1, 2025, report the applicable data in columns 1, 2, 2.01, and 2.02, for pneumococcal vaccines, influenza vaccines, COVID-19 vaccines, and monoclonal antibody products for treatment of COVID-19, authorized for use during the COVID-19 PHE. For services rendered on or after January 1, 2025, and prior to July 1, 2025, report the data for hepatitis B vaccines, in column 2.03. The data entered in all columns (1, 2, 2.01, 2.02 and 2.03) for lines 4, 11, 13, and 13.01, are mutually exclusive. That is, the injection/infusion costs, the total number of injections/infusions administered, and the total number of Medicare covered injections/infusions must only be represented one time in the appropriate column. Effective for cost reporting periods beginning on or after July 1, 2025, report all data in column 3, do not complete columns 1, 2, 2.01, 2.02 and 2.03.

Line 1.--Enter the health care staff cost from Worksheet N-1, column 7, sum of lines 23, and 25 through 36. Physician services under agreement are excluded from this total.

Line 2.--For cost reporting periods beginning prior to July 1, 2025, in columns 1 through 2.03, for each type of vaccine, enter the ratio of the estimated percentage of time involved in administering injections/infusions, including the time involved in administering COVID-19 vaccines and monoclonal antibodies for treatment of COVID-19, to the total health care staff time for the entire cost reporting period. Do not include physician service under agreement time in this calculation. Obtain the estimated percentage of time spent from your accounting books and records.

For cost reporting periods that straddle July 1, 2025, in column 3, enter the sum of the ratios in columns 1, 2, 2.01, 2.02, and 2.03.

For cost reporting periods beginning on or after July 1, 2025, in column 3, enter the ratio of the estimated percentage of time involved in administering all injections/infusions to the total health care staff time for the entire cost reporting period, do not complete columns 1 through 2.03.

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

Line 4.--For cost reporting periods beginning prior to July 1, 2025, enter the cost of injections/infusions and the cost of related medical supplies from Worksheet N-1 column 7, lines 47, 48, 48.10, 48.11, and 48.12, in columns 1, 2, 2.01, 2.02, and 2.03, respectively. For cost reporting periods that straddle July 1, 2025, transfer the sum of the cost from Worksheet *N-1*, column 7, lines 47, 48, 48.10, 48.11, and 48.12, to column 3. For cost reporting periods beginning on or after July 1, 2025, do not complete columns 1 through 2.03; instead transfer the sum of the cost from Worksheet *N-1*, column 7, lines 47, 48, 48.10, 48.11, and 48.12 to column 3.

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

Line 6.--For cost reporting periods beginning before July 1, 2025, enter the total direct costs of the facility from Worksheet N-1, column 7, line 100, minus Worksheet N-1, column 7, line 8, in each of columns 1 through 3, as applicable. For cost reporting periods beginning on or after July 1, 2025, do not complete columns 1 through 2.03 and enter in column 3 only, the total direct costs of the facility from Worksheet N-1, column 7, line 100, minus Worksheet N-1, column 7, line 8.

Line 7.--For cost reporting periods beginning before July 1, 2025, enter the administrative overhead of the facility from Worksheet N-1, column 7, line 8, in each of columns 1 through 3, as applicable. For cost reporting periods beginning on or after July 1, 2025, do not complete columns 1 through 2.03 and enter in column 3 only, the administrative overhead from Worksheet N-1, column 7, line 8.

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 ratio on line 8 and enter the result.

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

Line 11.--For cost reporting periods beginning prior to July 1, 2025, enter in columns 1, 2, 2.01, 2.02, and 2.03, respectively, the total number of injections/infusions from your records for the entire cost reporting period. For cost reporting periods that straddle July 1, 2025, in column 3, enter the sum of columns 1, 2, 2.01, 2.02, and 2.03. For cost reporting periods beginning on or after July 1, 2025, in column 3, enter the total number of all injections/infusions administered for vaccines, do not complete columns 1 through 2.03.

Line 12.--For each column, compute the cost per injection/infusion by dividing the costs on line 10 by the number of injections on line 11 and entering the result.

Line 13.--For services rendered prior to July 1, 2025, enter from your records the number of injections/infusions administered to Medicare beneficiaries, in columns 1, 2, 2.01, 2.02, and 2.03, respectively. In column 2.03, enter the number of hepatitis B injections/infusions administered to Medicare beneficiaries on and after January 1, 2025, through June 30, 2025, from your records. For services rendered on or after July 1, 2025, enter in column 3, the total number of all injections/infusions administered to Medicare beneficiaries from the PS&R. For cost reporting periods beginning on or after July 1, 2025, do not complete columns 1 through 2.03.

Line 13.01.--For services rendered in calendar years 2020 and 2021, enter from your records the number of COVID-19 injections/infusions administered to MA enrollees, in columns 2.01 and 2.02, respectively.

Line 14.--For each column, enter the Medicare cost per injection/infusion by multiplying the cost per vaccine on line 12 by the number of injections/infusions administered to Medicare beneficiaries and MA enrollees on lines 13 and 13.01, as applicable.

Line 15.--For cost reporting periods beginning prior to July 1, 2025, enter the total cost of injections/infusions and administration by entering the sum of the amounts in columns 1, 2, 2.01, 2.02, and 2.03, line 10. For cost reporting beginning on or after July 1, 2025, transfer the amount from column 3, line 10.

Line 16.--Enter the Medicare cost of injections/infusions and administration by entering the sum of the amount in columns 1, 2, 2.01, 2.02, 2.03, and 3, line 14. Transfer this amount to the Worksheet N-4, line 2.

4071.3. WORKSHEET N-4 - CALCULATION OF HOSPITAL-BASED FQHC REIMBURSEMENT SETTLEMENT

This worksheet provides for the reimbursement calculation for hospital-based FQHC services rendered to program patients under the FQHC PPS. It also provides for an accumulation of injection/infusion reimbursement and Medicare Advantage (MA) supplemental payments.

Line 1--FQHC services are paid in accordance with the FQHC PPS. Enter the total PPS payments for hospital-based FQHC visits rendered during the cost reporting period. Obtain this from the PS&R report. Also on this line, enter FQHC IOP PPS payments for IOP services rendered on or after January 1, 2024. Obtain this amount from the PS&R report.

Line 2--Enter the Medicare costs for injections/infusions and their administration from Worksheet N-3, line 16.

Line 3--Medicare advantage supplemental payments are made to a FQHC when the amount paid by the managed care organization is less than the amount paid under the FQHC PPS on a per visit basis. Enter the total amount of Medicare advantage supplemental payments from the PS&R 778 report. This data is captured for informational purposes only and does not impact cost report settlement.

Line 4--Enter the sum of lines 1 and 2.

Line 5--Enter the primary payer amounts from the PS&R.

Line 6--Enter the result of line 4 minus line 5.

Line 7--Enter the Part B coinsurance.

Line 8--Enter the result of line 6 minus line 7.

Line 9--Enter Medicare allowable bad debts, reduced by bad debt recoveries. If recoveries exceed the current year's bad debts, lines 9 and 10 will be negative. (See 42 CFR 413.89.)

Line 10--Multiply the amount (including negative amounts) from line 9 by 65 percent.

Line 11--Enter the gross reimbursable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. These amounts also are included on line 9.

Line 12--Enter the sum of lines 8 and 10.

Line 13--This line is used to enter any other adjustments. Enter the amount in column 1 and include a description of the adjustment in the space provided.

Line 13.99--Enter any demonstration payment adjustment amounts for demonstration projects in which the provider participated where the demonstration adjustment amounts are subject to the sequestration adjustment. Obtain this amount from the PS&R.

Line 14--Enter the result of line 12, plus or minus lines 13 and 13.99.

Line 15--Enter the sequestration adjustment amount as [(2 percent times (total days in the cost reporting period that occur during the sequestration period, divided by total days in the entire cost reporting period, rounded to six decimal places), rounded to four decimal places) times line 14]. Do not apply the sequestration calculation when gross reimbursement (line 14) is less than zero.

For cost reporting periods that overlap or begin on or after May 1, 2020, enter the sequestration adjustment amount from the PS&R (claims-based amounts). In accordance with §3709 of the CARES Act, as amended by §102 of the CAA 2021, §1 of Public Law 117-7, and §2 of the PAMA 2021, do not apply the sequestration adjustment to the period of May 1, 2020, through March 31, 2022. In accordance with §2 of the PAMA 2021, the sequestration adjustment is 1 percent for the portion of the cost reporting period from April 1, 2022, through June 30, 2022; and 2 percent for the portion of the cost reporting period on or after July 1, 2022.

Line 15.25--For cost reporting periods that overlap or begin on or after May 1, 2020, calculate the sequestration adjustment for non-claims based amounts as [(2 percent times (total days in the cost reporting period that occur during the sequestration period, divided by total days in the entire cost reporting period, rounded to six decimal places), rounded to four decimal places) times the sum of (lines 2, 10, and 13 and its subscripts not previously identified (do not use line 13.99 in this calculation))]. If the sum is less than zero, do not calculate the sequestration adjustment. In accordance with §3709 of the CARES Act, as amended by §102 of the CAA 2021, §1 of Public Law 117-7, and §2 of the PAMA 2021, do not apply the sequestration adjustment to the period of May 1, 2020, through March 31, 2022. In accordance with §2 of the PAMA 2021, for cost reporting periods that overlap or begin on or after April 1, 2022, calculate the sequestration adjustment amount for the period of April 1, 2022, through June 30, 2022, as follows: [(1 percent times (total days in the cost reporting period that occur from April 1, 2022, through June 30, 2022, divided by total days in the entire cost reporting period, rounded to six decimal places), rounded to four decimal places), times the sum of (lines 2, 10, and 13 and its subscripts not previously identified (do not use line 13.99 in this calculation))]; and for cost reporting periods that overlap or begin on or after July 1, 2022, calculate the sequestration adjustment amount as follows:

[(2 percent times (total days in the cost reporting period that occur on or after July 1, 2022, through the end of the cost reporting period, divided by total days in the entire cost reporting period, rounded to six decimal places), rounded to four decimal places) times the sum of (lines 2, 10, and 13 and its subscripts not previously identified (do not use line 13.99 in this calculation))].

Line 16--Enter the result of line 14 minus lines 15 and 15.25.

Line 16.01--Enter any demonstration payment adjustment amounts for demonstration projects in which the provider participated where the demonstration adjustment amounts are not subject to the sequestration adjustment. Obtain this amount from the PS&R.

Line 17--Enter the amount of interim payments from Worksheet N-5, column 2, line 4.

Line 18--FOR CONTRACTOR USE ONLY.--Enter the tentative settlement amount from Worksheet N-5, column 2, line 5.99.

Line 19--Enter the total amount due to/from the program (line 16 minus lines 16.01, 17, and 18). Transfer this amount to Worksheet S, Part III, column 3, line 11.

Line 20--Enter the Medicare reimbursement effect of protested items. Estimate the reimbursement effect of the non-allowable items by applying a reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See CMS Pub. 15-2, chapter 1, §115.2.) Attach a schedule showing the supporting details and computations for this line.

4071.4. WORKSHEET N-5 - ANALYSIS OF PAYMENTS TO HOSPITAL-BASED FQHC FOR SERVICES RENDERED

Complete lines 1 through 4 of this worksheet for Medicare interim payments only. The remainder of this worksheet is completed by your contractor.

Line descriptions

Line 1--Enter the total Medicare interim payments paid to the hospital-based FQHC. The amount entered must reflect the sum of all interim payments paid on individual bills (net of adjustment bills) for services, including IOP services paid under OPPS, rendered in this cost reporting period and amounts withheld from your interim payments due to an offset against overpayments applicable to prior cost reporting periods. Do not include MA supplemental payments on this worksheet. Do not include (1) any retroactive lump sum adjustment amounts based on a subsequent revision of the interim rate, (2) tentative or net settlement amounts, or (3) interim payments payable.

Line 2--Enter the total Medicare 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. It 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--Enter the total amount of the interim payments (sum of lines 1, 2, and 3.99). Transfer this amount to Worksheet N-4, line 17.

DO NOT COMPLETE THE REMAINDER OF WORKSHEET N-5. LINES 5 THROUGH 8 ARE FOR CONTRACTOR USE ONLY. (EXCEPTION: IF WORKSHEET S, PART I, LINE 5 IS "5" (AMENDED COST REPORT), THE HOSPITAL-BASED FQHC MAY COMPLETE THIS SECTION.)

Line 5--List separately each tentative settlement payment after the cost report is accepted together with the date of payment. If the cost report is reopened after the NPR has been issued, report all settlement payments prior to the current reopening on this line.

Line 6--Enter the net settlement amount (balance due the hospital-based FQHC or balance due the program) for the NPR, or, if this settlement is after a reopening of the NPR, for this reopening. Enter in column 2, the amount from Worksheet N-4, line 19.

NOTE: On lines 3, 5, and 6, when a hospital-based FQHC to program amount is due, show the amount and date the FQHC 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. Enter amounts due the program as a negative number. The amount in column 2 must equal the amount on Worksheet N-4, line 16, less the amount on line 16.01.

4072. WORKSHEET O - ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

The O series of worksheets must be completed by all hospital-based hospices effective for cost reporting periods beginning on or after October 1, 2015. This worksheet is used to record the trial balance of expense accounts from the provider's accounting books and records. It also provides for reclassifications and adjustments to certain accounts. The cost centers on this worksheet are listed in a manner that facilitates the combination of the various groups of cost centers for purposes of cost finding. Cost centers listed may not apply to every provider using these forms. Complete only those lines that are applicable.

Column Descriptions

For columns 1, 2, 4, and 6, direct patient care service costs (lines 25 through 46) are reported by LOC on Worksheets O-1, O-2, O-3, and O-4. For each cost center on Worksheet O, enter the sum of the amounts from Worksheets O-1, O-2, O-3, and O-4, for salaries, other costs, reclassifications, and adjustments, in columns 1, 2, 4, and 6, respectively.

Column 1--Enter salaries from the provider's accounting books and records. Salaries for the direct patient care service cost centers (lines 25 through 46) must equal the sum of amounts reported on the corresponding lines in column 1 of Worksheets O-1, O-2, O-3, and O-4. The total salaries for column 1, line 100, must equal the salaries reported on Worksheet A, column 1, line 116.

Column 2--Enter all costs other than salaries from the provider's accounting books and records. Other costs for the direct patient care service cost centers (lines 25 through 46) must equal the sum of amounts reported on the corresponding lines in column 2 of Worksheets O-1, O-2, O-3, and O-4. The total other costs for column 2, line 100, must equal the other costs reported on Worksheet A, column 2, line 116.

Column 3--For each cost center, enter the total of column 1 plus 2.

Column 4--Enter any reclassifications among cost center expenses in column 3 that are needed to effect proper cost allocation. This column need not be completed by all providers, but is completed only to the extent reclassifications are needed or reported on Worksheet A, line 116. Show reductions to expenses as negative amounts.

If reclassifications are needed for direct patient care service cost centers (lines 25 through 46), enter the reclassification amounts on the appropriate Worksheets O-1, O-2, O-3, and O-4, column 4, for each level of care.

Reclassifications for the direct patient care service cost centers (lines 25 through 46) must equal the sum of amounts reported on the corresponding lines in column 4 of Worksheets O-1, O-2, O-3, and O-4. The total reclassifications for column 4, line 100, must equal the reclassifications reported on Worksheet A, column 4, line 116.

Column 5--For each cost center, enter the total of the amount in column 3, plus or minus the amount in column 4.

Column 6--In accordance with 42 CFR 413.9(c)(3), enter on the appropriate lines, the amounts of any adjustments to expenses required under Medicare principles of reimbursements. (See §4016.) This column need not be completed by all providers, but is completed only to the extent adjustments are needed or reported on Worksheet A, column 6, line 116. Show reductions to expenses as negative amounts.

If adjustments are needed for direct patient care service cost centers (lines 25 through 46), enter the adjustment amounts on the appropriate Worksheets O-1, O-2, O-3, and O-4, column 6, for each level of care.

Adjustments for the direct patient care service cost centers (lines 25 through 46) must equal the sum of amounts reported on the corresponding lines in column 6 of Worksheets O-1, O-2, O-3, and O-4. The total adjustments for column 6, line 100, must equal the adjustments reported on Worksheet A, column 6, line 116.

Column 7--For each cost center, enter the total of the amount in column 5 plus or minus the amount in column 6. Transfer the amounts in column 7 for cost centers marked with an asterisk (*) to Worksheet O-5, as follows:

From Worksheet O, Column 7, Line Number and Cost Center Description	To Worksheet O-5, Column 1:
1 Cap Rel Costs-Bldg & Fixt	line 1
2 Cap Rel Costs-Mvble Equip	line 2
3 Employee Benefits	line 3
4 Administrative & General	line 4
5 Plant Operation and Maintenance	line 5
6 Laundry & Linen	line 6
7 Housekeeping	line 7
8 Dietary	line 8
9 Nursing Administration	line 9
10 Routine Medical Supplies	line 10
11 Medical Records	line 11
12 Staff Transportation	line 12
13 Volunteer Service Coordination	line 13
14 Pharmacy	line 14
15 Physician Administrative Services	line 15
16 Other General Service	line 16
60 Bereavement Program	line 60
61 Volunteer Program	line 61
62 Fundraising	line 62
63 Hospice/Palliative Medicine Fellows	line 63
64 Palliative Care Program	line 64
65 Other Physician Services	line 65
66 Residential Care	line 66
67 Advertising	line 67
68 Telehealth/Telemonitoring	line 68
69 Thrift Store	line 69
70 Nursing Facility Room and Board	line 70
71 Other Nonreimbursable	line 71

Line Descriptions

The Worksheet O cost centers are segregated into general service, direct patient care service, and nonreimbursable categories to facilitate the transfer of costs to the various worksheets. The general service cost centers appear on Worksheet O-5, and Worksheets O-6, Parts I and Part II, using the same line numbers as Worksheet O. The direct patient care service cost centers appear on Worksheets O-1, O-2, O-3, and O-4, using the same line numbers as Worksheet O.

General service cost centers (lines 1 through 17) include expenses incurred in operating the facility as a whole that are not directly associated with furnishing patient care such as mortgage, rent, plant operations, administrative salaries, utilities, telephone, and computer hardware and software costs. Except where descriptions are provided below, see §4013 for descriptions of general service cost centers.

Lines 1 and 2 - Cap Rel Costs-Bldg & Fixt and Cap Rel Costs-Mvble Equip--Enter in column 2, the capital-related costs for buildings and fixtures and the capital-related costs for moveable equipment on lines 1 and 2, respectively.

Line 3 - Employee Benefits Department--Enter in columns 1 and 2, the salary and other costs of the employee benefits department and fringe benefits paid (see CMS Pub. 15-1, chapter 21, §2144 and CMS Pub. 15-1, chapter 23, §2307).

Line 4 - Administrative & General--Enter in columns 1 and 2, the salary and other costs of A&G.

If the option to subscript A&G costs into more than one cost center is elected (in accordance with CMS Pub. 15-1, chapter 23, §2313), eliminate line 4. Begin numbering the subscripted A&G cost centers with line 4.01 and continue in sequential order.

Line 5 - Plant Operation and Maintenance--This cost center includes expenses incurred in the operation and maintenance of the plant and equipment (see §4013, Maintenance and repairs, and Operation of plant). Enter in columns 1 and 2, the costs of plant operation and maintenance.

Line 6 - Laundry & Linen Service--Enter in columns 1 and 2, the cost of routine laundry and linen services.

Line 7 - Housekeeping--Enter in columns 1 and 2, the cost of routine housekeeping activities for both patient-related and non-patient-related areas.

Line 8 - Dietary--Enter in columns 1 and 2, the cost of preparing meals for patients. Do not include the cost of dietary counseling in this cost center; report dietary counseling on line 35.

Line 9 - Nursing Administration--Enter in columns 1 and 2, the cost of overall management and direction of the nursing services. Do not include the cost of direct nursing services reported on lines 27 through 29. The salary cost of direct nursing services, including the salary cost of nurses who render direct service in more than one patient care area, is directly assigned to the various patient care cost centers in which the services were rendered. However, if your accounting system fails to specifically identify all direct nursing services to the applicable direct patient care cost centers, then the salary cost of all direct nursing service is included in this cost center.

Line 10 - Routine Medical Supplies--Enter in columns 1 and 2, the cost of supplies used in the normal course of caring for patients, such as gloves, masks, swabs, or glycerin sticks, that generally are not traceable to individual patients. Do not include the costs of non-routine medical supplies that can be traced to individual patients; report non-routine medical supplies on line 42.

Line 11 - Medical Records--Enter in columns 1 and 2, the cost of the medical records department where patient medical records are maintained. The general library and the medical library are not included in this cost center but are included in the A&G cost center.

Line 12 - Staff Transportation--Enter in columns 1 and 2, the cost of owning or renting vehicles, public transportation expenses, parking, tolls, or payments to employees for driving their private vehicles to see patients or for other hospice business. Staff transportation costs do not include patient transportation costs; report patient transportation costs on line 39.

Line 13 - Volunteer Service Coordination--Enter in columns 1 and 2, the cost of the overall coordination of service volunteers including their recruitment and training costs of volunteers.

Line 14 - Pharmacy--Enter in columns 1 and 2, the costs of drugs (both prescription and over-the-counter), pharmacy supplies, pharmacy personnel, and pharmacy services. Do not report the cost of palliative chemotherapy drugs on this line; report the cost of palliative chemotherapy on line 45.

Line 15 - Physician Administrative Services--Enter in columns 1 and 2, the costs for physicians' A&G supervisory activities that are included in the hospice payment rates. These activities include participating in the establishment, review and updating of plans of care, supervising care and services, conducting required face-to-face encounters for recertification, and establishing governing policies. These activities are generally performed by the physician serving as the medical director and the physician member of the interdisciplinary group. Nurse practitioners may not serve as or replace the medical director or physician member of the interdisciplinary group.

Line 16--Use this line to identify expenses for other general service costs not identified on lines 1 through 15 and 17.

Line 17 - Patient/Residential Care Services--Do not use this line on this worksheet. This cost center is used on Worksheet O-6 to accumulate in-facility costs not separately identified as HIRC, HGIP, or residential care services that are not part of a separate and distinct residential care unit (e.g., depreciation related to in-facility areas that provide HIRC, HGIP or residential care). The amounts allocated to this cost center on Worksheet O-6 are allocated to HIRC, HGIP and residential care services that are not part of a separate and distinct residential care unit, based on in-facility days. This cost center does not include any costs related to contracted inpatient services.

When a residential care unit is separate and distinct and only used for resident care services (such as hospice home care provided in a residential unit), costs are reported directly on line 66.

Lines 18 through 24--Reserved for future use.

Direct patient care service costs (lines 25 through 46) are reported by LOC on Worksheets O-1, O-2, O-3, and O-4. For each cost center on Worksheet O, enter the sum of the amounts from Worksheets O-1, O-2, O-3, and O-4, for salaries, other costs, reclassifications, and adjustments in columns 1, 2, 4, and 6, respectively.

Line 25 - Inpatient Care - Contracted--This cost center includes the contractual costs paid to another facility for use by the hospice for hospice inpatient care (HIRC or HGIP) in accordance with 42 CFR 418.108(c). This cost center does not include the cost of any direct patient care services or nonreimbursable services provided by hospice staff in the contracted setting. Costs of any services provided by hospice staff in the contracted setting are included in the appropriate direct patient care service or nonreimbursable cost center. Costs in this cost center are excluded from the allocation of A&G costs.

Line 26 - Physician Services--This cost center includes the costs incurred by the hospice for physicians, or nurse practitioners providing physician services, for direct patient care services and general supervisory services, participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care, and establishment of governing policies by the physician member of the interdisciplinary group. (See 42 CFR 418.304.) Reclassify the cost for the portion of time physicians spent on general supervisory services or other hospice administrative activities to Physician Administrative Services (line 15). This cost center must not include costs associated with palliative care or other nonreimbursable physician services. Those nonreimbursable physician services must be reported in the appropriate nonreimbursable cost center.

Line 27 - Nurse Practitioner--This cost center includes the costs of nursing care provided by nurse practitioners. Do not include costs for nurse practitioners providing physician services on this line; report the costs for nurse practitioners providing physician services on line 26.

Line 28 - Registered Nurse--This cost center includes the costs of nursing care provided by registered nurses other than nurse practitioners.

Line 29 - LPN/LVN--This cost center includes the costs of nursing care provided by licensed practical nurses (LPN) or licensed vocational nurses (LVN). Do not include costs for certified nursing assistant (CNA) services on this line; report the costs for CNA services on line 37.

Line 30 - Physical Therapy--This cost center includes the costs of physical or corrective treatment of bodily or mental conditions by the use of physical, chemical, and other properties of heat, light, water, electricity, sound massage, and therapeutic exercise by or under the direction of a registered physical therapist as prescribed by a physician. Physical therapy services may be provided for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

Line 31 - Occupational Therapy--This cost center includes the costs of purposeful goal-oriented activities in the evaluation, diagnosis, and/or treatment of persons whose function is impaired by physical illness or injury, emotional disorder, congenital or developmental disability, or the aging process, in order to achieve optimum functioning, to prevent disability, and to maintain health. Occupational therapy services may be provided for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

Line 32 - Speech/Language Pathology--This cost center includes the costs of physician-prescribed services provided by or under the direction of a qualified speech/language pathologist to those with functionally impaired communications skills. This includes the evaluation and management of any existing disorders of the communication process centering entirely, or in part, on the reception and production of speech and language related to organic and/or nonorganic factors. Speech/language pathology services may be provided for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

Line 33 - Medical Social Services--This cost center includes the cost of the medical social services defined in CMS Pub. 100-02, chapter 9, §40.1.2. Costs for nonreimbursable activities included in this cost center must be reclassified to the appropriate nonreimbursable cost center.

Line 34 - Spiritual Counseling--This cost centers includes the cost of spiritual counseling services. Costs for nonreimbursable activities included in this cost center must be reclassified to the appropriate nonreimbursable cost center.

Line 35 - Dietary Counseling--This cost center includes the costs of dietary counseling services.

Line 36 - Counseling - Other--This cost center includes the cost of counseling services not already identified as spiritual, dietary or bereavement counseling. Effective for services rendered on or after January 1, 2024, in accordance with the CAA 2023, §4121, also include the costs incurred for MFT services and MHC services. MFTs and MHCs provide services for the diagnosis and treatment of mental illness. Costs for nonreimbursable activities included in this cost center must be reclassified to the appropriate nonreimbursable cost center.

Line 37 - Hospice Aide and Homemaker Services--This cost center includes the costs of:

- Hospice aide services such as personal care services and household services to maintain a safe and sanitary environment in areas of the home used by the patient; and,

- Homemaker services such as assistance in the maintenance of a safe and healthy environment and services to enable the individual to carry out the plan of care.

Include the cost of CNAs that meet the criteria for an aide in this cost center.

Line 38 - Durable Medical Equipment/Oxygen--This cost center includes the costs of DME and oxygen, as defined in 42 CFR 410.38 and 42 CFR 418.202(f), furnished to individual HRHC or HCHC patients. Report DME costs by the LOC the patient was receiving at the time the DME/oxygen was delivered. If the LOC of a patient changed after delivery of the DME/Oxygen, the hospice may report the costs proportionally between HRHC and HCHC based on patient days.

Line 39 - Patient Transportation--This cost center includes the costs of ambulance transports of hospice patients, related to the terminal prognosis and occurring after the effective date of the hospice election, that are the responsibility of the hospice. (See CMS Pub. 100-02, chapter 9, §40.1.9.) When a patient is transferred to a new LOC, report the transportation cost to that LOC. For example, a patient in a HGIP LOC is transferred to HRHC LOC and transported to their home, the transportation cost associated with the transfer must be included in the HRHC LOC.

Line 40 - Imaging Services--This cost center includes the costs of imaging services.

Line 41 - Labs and Diagnostics--This cost center includes the costs of laboratory and diagnostic tests.

Line 42 - Medical Supplies - Non-routine--This cost center includes the costs of medical supplies furnished to individual patients for which a separate charge would be applicable. These supplies are specified in the patient's plan of treatment and furnished under the specific direction of the patient's physician. Do not include the cost of routine medical supplies used in the normal course of caring for patients, (such as gloves, masks, swabs, or glycerin sticks) on this line; report routine medical supplies on line 10. When a provider does not track the use of non-routine medical supplies by LOC, the provider may report the costs proportionally between LOCs based on patient days.

Line 42.50 - Drugs Charged to Patients--This cost center includes the costs of drugs furnished to individual patients for which a separate charge would be applicable. These drugs are specified in the patient’s plan of treatment and furnished under the specific direction of the patient’s physician. When a provider does not track the use of drugs by LOC, the provider must report the costs on line 14.

Line 43 - Outpatient Services--This cost center includes the costs of outpatient services costs not captured elsewhere. This cost can include the cost of an emergency room department visit when related to the terminal condition.

Lines 44 and 45 - Palliative Radiation Therapy and Palliative Chemotherapy--These cost centers include costs of radiation, chemotherapy and other modalities used for palliative purposes based on the patient’s condition and the hospice’s caregiving philosophy.

Line 46--Use this line to identify expenses for other direct patient care costs not identified on lines 40 through 45.

Lines 47 through 49--Reserved for future use.

Lines 50 through 53--Reserved for use on Worksheets O-6, Parts I and II.

Lines 54 through 59--Reserved for future use.

Nonreimbursable cost centers (lines 60 through 71) include costs of nonreimbursable services and programs. Report the costs applicable to nonreimbursable cost centers to which general service costs apply. If additional lines are needed for nonreimbursable cost centers other than those shown, subscript one or more of these lines with a numeric code. The subscripted lines must be

appropriately labeled to indicate the purpose for which they are being used. However, when the expense (direct and all applicable overhead) attributable to any non-allowable cost area is so insignificant as to not warrant establishment of a nonreimbursable cost center, remove the expense on Worksheet A-8. (See CMS Pub. 15-1, chapter 23, §2328.)

Line 60 - Bereavement Program--Enter in columns 1 and 2, the salary and other costs of bereavement services, defined as emotional, psychosocial, and spiritual support and services provided before and after the death of the patient to assist with grief, loss, and adjustment (42 CFR 418.3). Bereavement counseling is a required hospice service, but it is not reimbursable (see §1814(I)(1)(A) of the Act).

Line 61 - Volunteer Program--Enter in columns 1 and 2, the salary and other costs of volunteer programs. (See CMS Pub. 15-1, chapter 7.)

Line 62 - Fundraising--Enter in columns 1 and 2, the salary and other costs of fundraising. (See CMS Pub. 15-1, chapter 21, §2136.)

Line 63 - Hospice/Palliative Medicine Fellows--Enter in columns 1 and 2, the salary and other costs of hospice and palliative medicine fellows.

Line 64 - Palliative Care Program--Enter in columns 1 and 2, the salary and other costs of palliative care provided to non-hospice patients. This includes physician services.

Line 65 - Other Physician Services--Enter in columns 1 and 2, the salary and other costs of other physician services that are provided outside of a palliative care program to non-hospice patients.

Line 66 - Residential Care--Enter in columns 1 and 2, the salary and other costs of residential care for patients living in the hospice, but who are not receiving inpatient hospice services. Patients living in the hospice are considered residents, where the hospice is their home. These patients are liable for their room and board charges; however, the outpatient hospice care services provided must be recorded in the direct patient care cost centers on the appropriate HRHC and/or HCHC LOC worksheet.

Lines 67 - Advertising--Enter in columns 1 and 2, the salary and other costs of nonallowable community education, business development, marketing and advertising (see CMS Pub. 15-1, chapter 21, §2136).

Lines 68 - Telehealth/Telemonitoring--Enter in columns 1 and 2, the salary and other costs of telehealth/ telemonitoring services. These costs are nonreimbursable since a hospice is not an approved originating site (see 42 CFR 410.78(b)(3)).

Lines 69 - Thrift Store--Enter in columns 1 and 2, the salary and other costs of thrift stores.

Line 70 - Nursing Facility Room and Board--Enter the costs incurred by a hospice for dually eligible beneficiaries residing in a nursing facility (NF) when room and board is paid by the State to the hospice. The full amount paid to the NF by the hospice must be included on this line and offset by the State payment via an adjustment on Worksheet A-8. The residual cost is the net cost incurred.

For example, a dually eligible beneficiary is residing in a NF and has elected the Medicare hospice benefit. The NF charges $100 per day for room and board. The State pays the hospice $95 for the NF room and board. The hospice has a written agreement with the NF that requires full room and board payment of $100 per day. The hospice receives $95 per day, but pays the NF $100 per day, thereby incurring a net cost of $5 per day.

Line 71--Use this line to identify expenses for other nonreimbursable costs not identified on lines 60 through 70.

Lines 72 through 99--Reserved for future use.

4072.1. WORKSHEETS O-1, O-2, O-3, AND O-4 - ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Worksheet O-1 - Analysis of Hospital-Based Hospice Costs Hospice Continuous Home Care
Worksheet O-2 - Analysis of Hospital-Based Hospice Costs Hospice Routine Home Care
Worksheet O-3 - Analysis of Hospital-Based Hospice Costs Hospice Inpatient Respite Care
Worksheet O-4 - Analysis of Hospital-Based Hospice Costs Hospice General Inpatient Care

Worksheets O-1, O-2, O-3, and O-4 provide for recording the direct patient care costs by LOC, including reclassifications and adjustments. The general format of these worksheets is identical to Worksheet O in order to facilitate the transfer of direct patient care costs to Worksheet O. For each cost center, the sums of the amounts reported in columns 1, 2, 4, and 6, of these worksheets are transferred to the corresponding columns on Worksheet O.

Column 1--For each LOC worksheet, enter salaries from the provider's accounting books and record.

Column 2--For each LOC worksheet, enter all costs other than salaries from the provider's accounting books and records.

Column 3--For each cost center, add the amounts in columns 1 and 2 and enter the total in column 3.

Column 4--For each LOC worksheet, enter any reclassification of direct patient care service costs needed to effect proper cost allocation. For each line, the sum of the reclassification entries on Worksheets O-1, O-2, O-3, and O-4, column 4, must equal the amount on the corresponding line of Worksheet O, column 4.

Column 5--For each cost center, enter the total of the amount in column 3 plus or minus the amount in column 4.

Column 6--For each LOC worksheet, enter any adjustments for direct patient care service costs (lines 25 through 46) required under Medicare principles of reimbursements. (See §4016.) Show reductions to expenses as negative amounts. For each line, the sum of the adjustment entries on Worksheets O-1, O-2, O-3, and O-4, column 6, must equal the amount on the corresponding line of Worksheet O, column 6.

Column 7--For each cost center, enter the total of the amount in column 5 plus or minus the amount in column 6. For each LOC worksheet, transfer the amount on line 100 to the corresponding LOC line on Worksheet O-5, column 1, as follows:

From line 100 of:	To Worksheet O-5, column 1, line:
Worksheet O-1	50
Worksheet O-2	51
Worksheet O-3	52
Worksheet O-4	53

4072.2. WORKSHEET O-5 - COST ALLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET EXPENSES FOR ALLOCATION

Worksheet O-5 determines total expenses of each general service cost center for proper allocation of general service costs to each LOC and to nonreimbursable cost centers. This worksheet combines the direct general service costs reported on Worksheet O, lines 1 through 17, with the overhead allocation of the hospital general service costs reported on Worksheet B, Part I, line 116, columns 1 through 18.

Column Descriptions

Column 1--For each general service and nonreimbursable cost center, transfer the amount from the corresponding cost center on Worksheet O, column 7. For each LOC line, transfer amounts as follows:

Line:	From column 7, line 100 of:
50	Worksheet O-1
51	Worksheet O-2
52	Worksheet O-3
53	Worksheet O-4

The total on line 100 of column 1 must equal the amount on Worksheet A, column 7, line 116.

Column 2--For each general service cost center, transfer the amount from the corresponding column on Worksheet B, Part I, line 116, as follows:

NOTE: If a general service cost center on Worksheet B, Part I, is subscripted, add the amounts on the standard cost center line and its corresponding subscripted lines, and transfer the sum total to column 2 of the applicable line on this worksheet.

Line:	From Worksheet B, line 116, column(s):
1	1
2	2
3	4
4	5, 11, and 12*
5	6 and 7*
6	8
7	9
8	10
9	13
10	14
11	16
12	N/A
13	N/A
14	15
15	N/A
16	18, 20, and 23
17	17

*If Worksheet S-9, column 4, line 12, plus line 13, is zero (no in-facility days), then transfer the amounts from Worksheet B, Part I, columns 5, 6, 7, 11, and 12, line 116, to column 2, line 4, of this worksheet; and enter zero in column 2, line 5, of this worksheet.

Column 3--For each line, enter the sum of columns 1 and 2. The total on line 100 of column 3 must equal the amount on Worksheet B, Part I, column 26, line 116. Transfer the amount from each cost center to the corresponding line on Worksheet O-6, Part I, column 0.

4072.3. WORKSHEET O-6 - PART I - COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS AND WORKSHEET O-6 - PART II - COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS STATISTICAL BASIS

In accordance with 42 CFR 413.24, cost data must be based on an approved method of cost finding and on the accrual basis of accounting except where governmental institutions operate on a cash basis of accounting.

Worksheet O-6, Parts I and II, facilitate the step-down method of cost finding. This method recognizes that general services of the hospice are utilized by other general service, LOC, and nonreimbursable cost centers. Worksheet O-6, Part I, provides for the equitable allocation of general service costs based on statistical data reported on Worksheet O-6, Part II. To facilitate the allocation process, the general format of Worksheet O-6, Part I, is identical to that of Worksheet O-6, Part II. The column and line numbers for each general service cost center are identical on the two worksheets. The direct patient care service cost centers (lines 25 through 46 of Worksheet O) are reported by LOC on lines 50 through 53 of Worksheets O-6, Parts I and II. The line numbers for nonreimbursable cost centers are identical on Worksheet O and Worksheet O-6, Parts I and II.

When certain general service costs are related to in-facility days and are not separately identifiable by LOC or service, Worksheet O-6, Parts I and II, provide for the accumulation of these costs on line 17, Patient/Residential Care Services. The amounts accumulated in this cost center are allocated based on the in-facility days for HIRC, HGIP, and residential care services that are not part of a separate and distinct residential care unit. This cost center does not include any costs related to contracted inpatient services.

The statistical basis shown at the top of each column on Worksheet O-6, Part II, is the recommended basis of allocation. The total statistic for cost centers using the same basis (e.g., square feet) may differ with the closing of preceding cost centers. A hospice can elect to change the allocation statistics, as appropriate for column 2 only, for the current cost reporting period if a request is submitted in accordance with CMS Pub. 15-1, chapter 23, §2313.

Close the general service cost centers in accordance with 42 CFR 413.24(d)(1) so that the cost centers rendering the most services to and receiving the least services from other cost centers are closed first (see CMS Pub. 15-1, chapter 23, §2306.1). If a more accurate result is obtained by allocating costs in a sequence that differs from the recommended sequence, the hospice must request approval in accordance with CMS Pub. 15-1, chapter 23, §2313.

If the amount of any cost center on Worksheet O-5, column 3, has a negative balance, show this amount as a negative balance on Worksheet O-6, Part I, column 0. Allocate the costs from the overhead cost centers to applicable cost centers, including those with a negative balance. Close a general service cost center with a negative balance by entering the negative balance in parentheses on line 99, as well as on the first line of the column and on line 100 of the column, and do not allocate. This enables Worksheet O-6, Part I, column 18, line 100, to cross foot to Worksheet O-6, Part I, column 0, line 100. After receiving costs from overhead cost centers, LOC cost centers with negative balances on Worksheet O-6, Part I, column 18, are not transferred to Worksheet O-7.

On Worksheet O-6, Part II, enter on the first available line of each column the total statistics applicable to the cost center being allocated (e.g., in column 1, Capital-Related Cost - Buildings & Fixtures, enter on line 1 the total square feet of the building on which depreciation was taken). Use accumulated cost for allocating A&G expenses.

Such statistical base, including accumulated cost for allocating A&G expenses, does not include any statistics related to services furnished under arrangements except where:

- Both Medicare and non-Medicare costs of arranged for services are recorded in the hospice's books/records; or

- The contractor determines that the hospice is able to and does gross up the costs and charges for services to non-Medicare patients so that both cost and charges are recorded as if the hospice had furnished such services directly to all patients. (See CMS Pub. 15-1, chapter 23, §2314.)

For each cost center being allocated, enter that portion of the total statistical base applicable to each cost center receiving services. For each column, the sum of the statistics entered for cost centers receiving services must equal the total statistical base entered on the first line.

For each column on Worksheet O-6, Part II, enter on line 100, the total expenses of the cost center to be allocated. Obtain the total expenses from the first line of the corresponding column on Worksheet O-6, Part I, which includes the direct expenses from Worksheet O-6, Part I, column 0, plus the allocated costs from previously closed cost centers. Divide the amount entered on Worksheet O-6, Part II, line 100, by the total statistical base entered in the same column on the first line. Enter the resulting unit cost multiplier (rounded to six decimal places) on line 101.

For each column on Worksheet O-6, Part II, multiply the unit cost multiplier on line 101 by the portion of the total statistical base applicable to each cost center receiving services and enter the result in the corresponding column and line on Worksheet O-6, Part I. For each column on Worksheet O-6, Part I, the sum of the costs allocated (line 100) must equal the total cost on the first line.

After the costs of the general service cost centers have been allocated on Worksheet O-6, Part I, enter on each line of column 18, the sum of the costs in columns 3A through column 17, for lines 50 through 71. The total costs entered on Worksheet O-6, Part I, line 100, column 18, must equal the total costs entered on line 100, column 0.

Column Descriptions

Column 0--For each line, enter the total direct costs from the corresponding line on Worksheet O-5, column 3.

Column 3A--For each line, enter the sum of columns 0 through 3. The sum for each line is the accumulated cost and, unless an adjustment is required, is the Worksheet O-6, Part II, column 4 statistic for allocating A&G costs.

If an adjustment to the accumulated cost statistic on Worksheet O-6, Part II, column 4, is required to properly allocate A&G costs, enter the adjustment amount on Worksheet O-6, Part II, column 4A, for the applicable line. For example, when the hospice contracts for HIRC services and the contractual costs include A&G costs, reduce the HIRC accumulated cost statistic on Worksheet O-6, Part II, line 52, column 4A, by the contractual costs reported on Worksheet O-3, line 25, column 7. Similarly, when the hospice contracts for HGIP services and the contractual costs include A&G costs, reduce the HGIP accumulated cost statistic on Worksheet O-6, Part II, line 53, column 4A, by the contractual costs reported on Worksheet O-4, line 25, column 7.

For each line, the accumulated cost statistic on Worksheet O-6, Part II, column 4, is the difference between the amount on Worksheet O-6, Part I, column 3A and the adjustment amount on Worksheet O-6, Part II, column 4A. Accumulated cost for A&G is not included in the total statistic for the A&G cost center; therefore, transfer the amount on Worksheet O-6, Part I, line 4, column 3A, to Worksheet O-6, Part II, line 4, column 4A.

The total accumulated cost statistic for Worksheet O-6, Part II, line 4, column 4, is the difference between the total on Worksheet O-6, Part I, line 100, column 3A, and the amounts in column 4A of Worksheet O-6, Part II.

A negative cost center balance in the statistics for allocating A&G expenses causes an improper distribution of this overhead cost center. Negative balances are excluded from the allocation statistics when A&G expenses are allocated on the basis of accumulated cost.

Column 18--Transfer the amounts on lines 50 through 53 as follows:

From Worksheet O-6, Part I, Column 18:	To Worksheet O-8, Column 3:
line 50	line 1
line 51	line 6
line 52	line 11
line 53	line 16

4072.4. WORKSHEET O-7 - APPORTIONMENT OF HOSPITAL-BASED HOSPICE SHARED SERVICE COSTS BY LEVEL OF CARE

This worksheet calculates the cost of ancillary services provided by hospital ancillary departments to hospital-based hospice patients.

Column Description

Column 1--For each cost center, enter in column 1, the cost-to-charge ratio from Worksheet C, Part I, column 9, line as indicated in column 0.

Columns 2 through 5--For each cost center, enter the charges, from the provider's records, for ancillary services provided by hospital ancillary departments to hospital-based hospice patients. Enter the charges by LOC in the appropriate LOC column.

Columns 6 through 9--For each column, calculate cost of ancillary services provided by hospital ancillary departments to hospital-based hospice patients as follows:

Column:	Calculation:
6	col. 1 x col. 2
7	col. 1 x col. 3
8	col. 1 x col. 4
9	col. 1 x col. 5

For each column 6 through 9, enter the sum of lines 1 through 10 on line 11.

4072.5. WORKSHEET O-8 - CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Worksheet O-8 calculates the average cost per diem by level of care and in total.

Line1--Enter in column 3, the sum of the total HCHC cost from Worksheet O-6, Part I, line 50, column 18, plus Worksheet O-7, line 11, column 6.

Line 2--Enter in column 3, the total HCHC days from Worksheet S-9, line 10, column 4.

Line 3--Enter in column 3, the average HCHC cost per diem by dividing line 1, column 3, by line 2, column 3.

Line 4--Enter in column 1, the title XVIII - Medicare HCHC days from Worksheet S-9, line 10, column 1. Enter in column 2 the title XIX - Medicaid HCHC days from Worksheet S-9, line 10, column 2.

Line 5--Enter in column 1, the title XVIII - Medicare program cost calculated by multiplying line 3, column 3, by line 4, column 1. Enter in column 2, the title XIX - Medicaid program cost calculated by multiplying line 3, column 3, by line 4, column 2.

Line 6--Enter in column 3, the total HRHC cost from Worksheet O-6, Part I, line 51, column 18, plus Worksheet O-7, line 11, column 7.

Line 7--Enter in column 3, the total HRHC days from Worksheet S-9, line 11, column 4.

Line 8--Enter in column 3, the average HRHC cost per diem by dividing line 6, column 3, by line 7, column 3.

Line 9--Enter in column 1, the title XVIII - Medicare HRHC days from Worksheet S-9, line 11, column 1. Enter in column 2, the title XIX - Medicaid HRHC days from Worksheet S-9, line 11, column 2.

Line 10--Enter in column 1, the title XVIII - Medicare program cost calculated by multiplying line 8, column 3, by line 9, column 1. Enter in column 2, the title XIX - Medicaid program cost calculated by multiplying line 8, column 3, by line 9, column 2.

Line 11--Enter in column 3, the total HIRC cost from Worksheet O-6, Part I, line 52, column 18, plus Worksheet O-7, line 11, column 8.

Line 12--Enter in column 3, the total HIRC days from Worksheet S-9, line 12, column 4.

Line 13--Enter in column 3, the average HIRC cost per diem by dividing line 11, column 3, by line 12, column 3.

Line 14--Enter in column 1, the title XVIII - Medicare HIRC days from Worksheet S-9, line 12, column 1. Enter in column 3, the title XIX - Medicaid HIRC days from Worksheet S-9, line 12, column 2.

Line 15.--Enter in column 1, the title XVIII - Medicare program cost calculated by multiplying line 13, column 3, by line 14, column 1. Enter in column 2, the title XIX - Medicaid program cost calculated by multiplying line 13, column 3, by line 14, column 2.

Line 16--Enter in column 3, the total HGIP cost from Worksheet O-6, Part I, line 53, column 18, plus Worksheet O-7, line 11, column 9.

Line 17--Enter in column 3, the total HGIP days from Worksheet S-9, line 13, column 4.

Line 18--Enter in column 3, the average HGIP cost per diem by dividing line 16, column 3, by line 17, column 3.

Line 19--Enter in column 1, the title XVIII - Medicare HGIP days from Worksheet S-9, line 13, column 1. Enter in column 3, the title XIX - Medicaid HGIP days from Worksheet S-9, line 13, column 2.

Line 20--Enter in column 1, the title XVIII - Medicare program cost calculated by multiplying line 18, column 3, by line 19, column 1. Enter in column 2, the title XIX - Medicaid program cost calculated by multiplying line 18, column 3, by line 19, column 2.

Line 21--Enter in column 3, the sum of lines 1, 6, 11, and 16.

Line 22--Enter in column 3, total days from Worksheet S-9, line 14, column 4.

Line 23--Enter the average cost per diem by dividing line 21, column 3, by line 22, column 3.

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ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 1 - RECORD SPECIFICATIONS

Table 1 specifies the standard record format to be used for electronic cost reporting (ECR). Each electronic cost report submission (file) has four types of records. The first group (type 1 records) contain 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 headings (e.g., Worksheet B-1) are included in the type 2 records. Refer to Table 5 for cost center coding. The data, detailed in Table 3, is identified as type 3 records. The encryption coding at the end of the ECR file, records 1, 1.01, and 1.02 are type 4 records.

The medium for transferring ECR files to contractors is CD, flash drive, or the CMS-approved Medicare Cost Report E-filing (MCREF) portal, [URL: https://mcref.cms.gov]. ECR files must comply with CMS specifications. Providers should seek approval from their contractors regarding the method of submission to ensure that the method of transmission is acceptable.

The following are requirements for all records:

1. All alpha characters must be in upper case.

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

3. No record may exceed 60 characters.

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

```
          1         2         3         4         5         6
12345678901234567890123456789012345678901234567890123456789012345678901234567890
1           1   0101232010121201112O1A09P00520112582010121
1           4       14:30
```

Record #1: This is a cost report file submitted by CCN 010123 for the period from May 1, 2010 (2010121) through April 30, 2011 (2011120). It is filed on the Form CMS-2552-10. It is prepared with vendor number A09's PC based system, version number 5. Position 38 changes with each new test case and/or re-approval and is an alpha character. Positions 39 and 40 will remain constant for approvals issued after the first test case. This file is prepared by the hospital on September 15, 2011 (2011258). The electronic cost report specifications, dated May 1, 2010 (2010121), are used to prepare this file.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 1 - RECORD SPECIFICATIONS

FILE NAMING CONVENTION

Name each cost report ECR file in the following manner:
ECNNNNNN.YYLC, where
1. EC (Electronic Cost Report) is constant;
2. NNNNNN is the six-digit CMS Certification Number;
3. YY is the year in which the provider's cost reporting period ends; and
4. L is a character variable (A through Z) to enable separate identification of files from hospitals with two or more cost reporting periods ending in the same calendar year.
5. C is the number of times this original cost report is being filed.

Name each cost report PI file in the following manner:
PINNNNNN.YYLC, where
1. PI (Print Image) is constant;
2. NNNNNN is the six-digit CMS Certification Number;
3. YY is the year in which the provider's cost reporting period ends; and
4. L is a character variable (A through Z) to enable separate identification of files from hospitals with two or more cost reporting periods ending in the same calendar year.
5. C is the number of times this original cost report is being filed.

RECORD NAME: Type 1 Records - Record Number 1

		Size	Usage	Loc.	Remarks
1.	Record Type	1	X	1	Constant “1”
2.	For Future Use	10	9	2-11	Alpha numeric
3.	Space	1	X	12	
4.	Record Number	1	X	13	Constant “1”
5	Spaces	3	X	14-16	
6.	Hospital CCN Number	6	9	17-22	Field must have six 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 “1” (for Form CMS-2552-10)
10.	Vendor Code	3	X	38-40	To be supplied upon approval. Refer to page 40-703.
11.	Vendor Equipment	1	X	41	P=PC; M=Main Frame

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 1 - RECORD SPECIFICATIONS

RECORD NAME: Type 1 Records - Record Number 1 (Cont.)

		Size	Usage	Loc.	Remarks
12.	Version Number	3	X	42-44	Version of extract software, e.g., 001=1st, 002=2nd, etc. or 101=1st, 102=2nd. The version number must be incremented by 1 with each recompile and release to client(s).
13.	Creation Date	7	9	45-51	YYYYDDD - Julian date; date on which the file was created (extracted from the cost report)
14.	ECR Spec. Date	7	9	52-58	YYYYDDD - Julian date; date of electronic cost report specifications used in producing each file. Valid for cost reporting periods ending on or after *12/31/2025 (2025365)*. Prior approvals: *2025181*, 2024275, 2023274, 2023213, 2023091, 2023001, 2022274, 2021365, 2019365, 2018273, 2018031, 2017305, 2017274, 2016274, 2015274, 2015181, 2014274, 2014181, 2013274, 2012275, 2012182, 2010121.

RECORD NAME: Type 1 Records - Record Numbers 2 - 99

		Size	Usage	Loc.	Remarks
1.	Record Type	1	9	1	Constant "1"
2.	Spaces	10	X	2-11	
3.	Record Number	2	9	12-13	#2 - Reserved for future use. #3 - Vendor information; optional record for use by vendors. Left justified in positions 21 through 60. #4 - The time that the cost report is created. This is represented in military time as alpha numeric. Use positions 21 through 25. Example 2:30PM is expressed as 14:30. #5 to #99 - Reserved for future use.
4.	Spaces	7	X	14-20	Spaces (Optional)
5.	ID Information	40	X	21-60	Left justified to position 21.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 1 - RECORD SPECIFICATIONS

RECORD NAME: Type 2 Records for Labels

		Size	Usage	Loc.	Remarks
1.	Record Type	1	9	1	Constant "2"
2.	Worksheet Indicator	7	X	2-8	Alphanumeric. Refer to Table 2.
3.	Spaces	2	X	9-10	
4.	Line Number	3	9	11-13	Numeric
5.	Subline Number	2	9	14-15	Numeric
6.	Column Number	3	X	16-18	Alphanumeric
7.	Subcolumn Number	2	9	19-20	Numeric
8.	Cost Center Code	5	9	21-25	Numeric. Refer to Table 5 for appropriate cost center code.
9.	Labels/Headings				
	a. Line Labels	35	X	26-60	
	b. Column Headings: Statistical Basis & Code	10	X	21-30	Alphanumeric, left justified
	c. Line Statistics	36	X	21-57	Worksheet I-1 basis

The type 2 records contain text which appears on the printed cost report. Of these, there are three groups: (1) Worksheet A cost center names (labels); (2) column headings for step down entries; and (3) other text appearing in various places throughout the cost report. The standard cost center labels/descriptions are listed below.

Worksheet A cost center labels must be furnished for every cost center with cost or charge data anywhere in the cost report. The line and subline numbers for each label must be the same as the line and subline numbers of the corresponding cost center on Worksheet A. The columns and subcolumn numbers are always set to zero.

Column headings for the General Service cost centers on Worksheets B-1, B, Parts I and II, and Worksheet J-1, Part II (lines 1 through 3), are supplied once, consisting of one to three records. The statistical basis shown on Worksheet B-1 is also reported. The statistical basis consists of one or two records (lines 4 and 5). Statistical basis code is supplied only to Worksheet B-1 columns, is recorded as line 6, and only for capital cost centers, columns 1 and 2, and subscripts, as applicable. The statistical code must agree with the statistical basis indicated on lines 4 and 5 (i.e., code 1 = square footage, code 2 = dollar value, and code 3 = all others). Refer to Table 2 for the special worksheet identifier to be used with column headings and statistical basis and to Table 3 for line and column references. See below for statistical basis line labels for Worksheet I-1. These line labels are required records in the file. (See 9c above for record placement.)

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 1 - RECORD SPECIFICATIONS

Use the following type 2 cost center descriptions for all Worksheet A standard cost center lines.

1 CAP REL COSTS - BLDG & FIXT
2 CAP REL COSTS - MVBLE EQUIP
3 OTHER CAP REL COSTS
4 EMPLOYEE BENEFITS DEPARTMENT
5 ADMINISTRATIVE & GENERAL
6 MAINTENANCE & REPAIRS
7 OPERATION OF PLANT
8 LAUNDRY & LINEN SERVICE
9 HOUSEKEEPING
10 DIETARY
11 CAFETERIA
12 MAINTENACE OF PERSONNEL
13 NURSING ADMINISTRATION
14 CENTRAL SERVICES & SUPPLY
15 PHARMACY
16 MEDICAL RECORDS & LIBRARY
17 SOCIAL SERVICE
19 NONPHYSICIAN ANESTHETISTS
20 NURSING PROGRAM
21 I&R SERVICES - SALARY & FRINGES APPRVD
22 I&R SERVICES - OTHER PRGM COSTS APPRVD
30 ADULTS & PEDIATRICS
31 INTENSIVE CARE UNIT
32 CORONARY CARE UNIT
33 BURN INSTENSIVE CARE UNIT
34 SURGICAL INTENSIVE CARE UNIT
40 SUBPROVIDER - IPF
41 SUBPROVIDER - IRF
43 NURSERY
44 SKILLED NURSING FACILITY
45 NURSING FACILITY
46 OTHER LONG TERM CARE
50 OPERATING ROOM
51 RECOVERY ROOM
52 DELIVERY ROOM & LABOR ROOM
53 ANESTHESIOLOGY
54 RADIOLOGY-DIAGNOSTIC
55 RADIOLOGY - THERAPEUTIC
56 RADIOISOTOPE
57 CT SCAN
58 MRI
59 CARDIAC CATHETERIZATION
60 LABORATORY
61 PBP CLINICAL LAB SERVICES - PRGM ONLY
62 WHOLE BLOOD & PACKED RED BLOOD CELLS
63 BLOOD STORING, PROCESSING & TRANS.
64 INTRAVENOUS THERAPY
65 RESPIRATORY THERAPY
66 PHYSICAL THERAPY
67 OCCUPATIONAL THERAPY
68 SPEECH PATHOLOGY
69 ELECTROCARDIOLOGY
70 ELECTROENCEPHALOGRAPHY
71 MEDICAL SUPPLIES CHARGED TO PATIENTS
72 IMP. DEV. CHARGED TO PATIENTS
73 DRUGS CHARGED TO PATIENTS
74 RENAL DIALYSIS
75 ASC (NON-DISTINCT PART)
77 ALLOGENEIC HSCT ACQUISITION
78 CAR T-CELL IMMUNOTHERAPY
88 RURAL HEALTH CLINIC
89 FEDERALLY QUALIFIED HEALTH CENTER
90 CLINIC
91 EMERGENCY
92 OBSERVATION BEDS (NON-DISTINCT PART)
93.99 PARTIAL HOSPITALIZATION PROGRAM
94 HOME PROGRAM DIALYSIS
95 AMBULANCE SERVICES
96 DURABLE MEDICAL EQUIP - RENTED
97 DURABLE MEDICAL EQUIP - SOLD
100 I&R SERVICES - NOT APPRVD PRGM
101 HOME HEALTH AGENCY
102 OPIOID TREATMENT PROGRAM
105 KIDNEY ACQUISITION
106 HEART ACQUISITION
107 LIVER ACQUISITION
108 LUNG ACQUISITION
109 PANCREAS ACQUISITION
110 INTESTINAL ACQUISITION
111 ISLET ACQUISITION
113 INTEREST EXPENSE
114 UTILIZATION REVIEW - SNF
115 AMBULATORY SURGICAL CENTER (D.P.)
116 HOSPICE
116 HOSPICE
190 GIFT, FLOWER, COFFEE SHOP, CANTEEN
191 RESEARCH
191 RESEARCH
192 PHYSICIAN PRIVATE OFFICES
193 NONPAID WORKERS

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10

TABLE 1 - RECORD SPECIFICATIONS

Type 2 records for Worksheet B-1, columns 1 through 23, lines 1 through 5, and line 6 (for columns 1 through 2 only (capital cost center columns)), are listed below. The numbers running vertical to line 1 descriptions are the general service cost center line designations.

	LINE					
	1	2	3	4	5	6
1	CAP	BLDGS &	FIXTURES	SQUARE	FEET	1
2	CAP	MOVABLE	EQUIPMENT	DOLLAR	VALUE	2
4	EMPLOYEE	BENEFITS	DEPARTMENT	GROSS	SALARIES	
5	ADMINS-	TRATIVE &	GENERAL	ACCUM.	COST	
6	MAIN-	TENANCE &	REPAIRS	SQUARE	FEET	
7	OPERATION	OF PLANT		SQUARE	FEET	
8	LAUNDRY	& LINEN	SERVICE	POUNDS OF	LAUNDRY	
9	HOUSE-	KEEPING		HOURS OF	SERVICE	
10	DIETARY			MEALS	SERVED	
11	CAFETERIA			MEALS	SERVED	
12	MAIN-	TENANCE &	PERSONNEL	NUMBER	HOUSED	
13	NURSING	ADMINIS-	TRATION	DIRECT	NRSING HRS	
14	CENTRAL	SERVICES &	SUPPLY	COSTED	REQUIS.	
15	PHARMACY			COSTED	REQUIS.	
16	MEDICAL	RECORDS &	LIBRARY	TIME	SPENT	
17	SOCIAL	SERVICE		TIME	SPENT	
19	NONPHYSIC.	ANESTHET.		ASSIGNED	TIME	

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 1 - RECORD SPECIFICATIONS

	LINE					
	1	2	3	4	5	6
20	NURSING	PROGRAM		ASSIGNED	TIME	
21	I&R	SALARY &	FRINGES	ASSIGNED	TIME	
22	I&R	PROGRAM	COSTS	ASSIGNED	TIME	
23	PARAMED	EDUCTION		ASSIGNED	TIME	

Type 2 records for Worksheet H-1, Part II, columns 1 through 5, lines 1 through 5, are listed below. The numbers running vertical to line 1 descriptions are the general service cost center line designations.

	LINE				
	1	2	3	4	5
1	CAPITAL	BLDGS &	FIXTURES	SQUARE	FEET
2	CAPITAL	MOVABLE	EQUIPMENT	DOLLAR	VALUE
3	PLANT	OPER. &	MAINT.	SQUARE	FEET
4	TRANS-	PORTAT-	ION	MILEAGE	
5	ADMINIS-	TRATIVE &	GENERAL	ACCUM.	COST

Type 2 records for Worksheet I-1, column 2, statistical basis labels for lines 1 through 8, 10 through 16, 18 through 22, 24 through 26, and 28 through 30, with subscripts as appropriate, for line 30 are listed below.

Line	Description
1	HOURS OF SERVICE
2	HOURS OF SERVICE
3	HOURS OF SERVICE
4	HOURS OF SERVICE
5	HOURS OF SERVICE
6	HOURS OF SERVICE
7	ACCUMULATED COST
8	ACCUMULATED COST
10	SALARY
11	SQUARE FEET
12	PERCENTAGE OF TIME
13	PERCENTAGE OF TIME
14	REQUISITIONS
15	REQUISITIONS
16	ACCUMULATED COST
18	SQUARE FEET
19	PERCENTAGE OF TIME
20	SALARY
21	ACCUMULATED COST
22	SQUARE FEET
24	REQUISITIONS
25	REQUISITIONS
26	ACCUMLATED COST
28	CHARGES
29	CHARGES
30	CHARGES

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 1 - RECORD SPECIFICATIONS

Type 2 records for Worksheet K-4, columns 1 through 6, lines 1 through 5, are listed below. The numbers running vertical to line 1 descriptions are the general service cost center line designations.

	LINE				
	1	2	3	4	5
1	CAPITAL	BLDGS &	FIXTURES	SQUARE	FEET
2	CAPITAL	MOVABLE	EQUIPMENT	DOLLAR	VALUE
3	PLANT	OPER. &	MAINT.	SQUARE	FEET
4	TRANS-	PORTAT-	ION	MILEAGE	
5	VOLUNT.	SERVICES	COORDI.	HOURS OF	SERVICE
6	ADMINIS-	TRATIVE &	GENERAL	ACCUM.	COST

Examples of type 2 records are below. Either zeroes or spaces may be used in the line, subline, column, and subcolumn number fields (positions 11 through 20). Spaces are preferred. (See first two lines of the example.)* Refer to Table 6 for additional cost center code requirements.

Examples:

Worksheet A line labels with embedded cost center codes:

```
*  2A000000  1          0100CAP REL COSTS BLDS & FIXT
*  2A00000000001010000000101CAP REL COSTS WEST WING
   2A000000  2          0200CAP REL COSTS MVBLE EQUIP
   2A000000  5          0500ADMINISTRATIVE AND GENERAL
   2A000000  21         2100I&R SALARY & FRINGES APPRVD
   2A000000  21 1       2101I&R SALARY - SURGERY
```

Examples of column headings for Worksheet B-1, B, Parts I and II, and Worksheet J-1, Part II (lines 1 through 3), statistical bases used in cost allocation on Worksheet B-1, Worksheet J-1, Part II (lines 4 and 5) and statistical codes used for Worksheet B-1 (line 6), are displayed below. Also below are examples of Worksheets H-1, Part II (fourth character indicates the first HHA), and Worksheet I-1, for both renal and home program.

Examples of column headings

2B10000*	1	1	CAP	2B10000*	1	1	CAP
2B10000*	2	1	BLDGS &	2H11002*	1	1	CAPITAL
2B10000*	3	1	FIXTURES	2H11002*	1	1	BLDG &
2B10000*	4	1	SQUARE	2I1D000*	1	2	HRS OF SERVICE
2B10000*	5	1	FEET	2I1D000*	12	2	PERCENTAGE OF TIME
2B10000*	6	1	1	2I1H000*	7	2	ACCUMULATED COST

Worksheet H-1, Part II, records share the same size constraints as the Worksheet B-1 records. Worksheet I-1 may not exceed 36 characters.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 1 - RECORD SPECIFICATIONS

Type 2 records for Worksheet O-6, Part II, columns 1 through 17, lines 1 through 5, are listed below. The numbers running vertical to line 1 descriptions are the general service cost center line designations.

	LINE				
	1	2	3	4	5
1	CAP REL	BLDG	& FIX	SQUARE	FEET
2	CAP REL	MVBLE	EQUIP	DOLLAR	VALUE
3	EMPLOYEE	BENEFITS	DEPARTMENT	GROSS	SALARIES
4	ADMINIS-	TRATIVE &	GENERAL	ACCUM.	COST
5	PLANT	OP &	MAINT	SQUARE	FEET
6	LAUNDRY	& LINEN		IN-FACIL-	ITY DAYS
7	HOUSE-	KEEPING		SQUARE	FEET
8	DIETARY			IN-FACIL-	ITY DAYS
9	NURSING	ADMINIS-	TRATION	DIRECT	NURS. HRS.
10	ROUTINE	MEDICAL	SUPPLIES	PATIENT	DAYS
11	MEDICAL	RECORDS		PATIENT	DAYS
12	STAFF	TRANS-	PORTATION		MILEAGE
13	VOLUNTEER	SVC COOR-	DINATION	HOURS OF	SERVICE
14	PHARMACY				CHARGES
15	PHYSICIAN	ADMIN	SERVICES	PATIENT	DAYS
16	OTHER	GENERAL	SERVICE	SPECIFY	BASIS
17	PATIENT/	RESIDENT	CARE SVCS	IN-FACIL-	ITY DAYS

This page is reserved for future use.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 1 - RECORD SPECIFICATIONS

RECORD NAME: Type 3 Records for Non-label Data

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

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 1 - RECORD SPECIFICATIONS

A sample of type 3 records and a number line for reference are below.

```
         1         2         3         4         5         6
12345678901234567890123456789012345678901234567890123456789
3A000000  4    1                32961
3A000000  21                  1336393
3A000000  21 1 1                185599
3A000000  62 1 1                 17750
3A000000  1    2                1014775
3A000000  1 1  2                1767922
3A000000  2    2                  14596
3A000000  21   2                 768441
3A000000  21 1 2                2746235
3A000000  62 1 2                   4982
3C000001  62   1                  22476
3C000001  62   1                  18021
```

The line numbers are numeric. In several places throughout the cost report (see list below), the line numbers themselves are data. The placement of the line and subline numbers as data must be uniform.

Worksheet A-6, columns 3, 7, and 10
Worksheet A-8, columns 4 and 5
Worksheet A-8-1, Part A, columns 1 and 7
Worksheet A-8-2, column 1
Worksheet B-2, column 3

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 1 - RECORD SPECIFICATIONS

Examples of records (*) with a Worksheet A line number as data and a number line for reference are listed below.

```
          1         2         3         4         5         6
 12345678901234567890123456789012345678901234567890123456789
 3A6000G0  13   0    TO SPREAD INTEREST EXPENSE
 3A6000G0  13   1    G
*3A6000G0  13   3                1.00
 3A6000G0  13   4               221409
*3A6000G0  13   7                87.00
 3A6000G0  13   8               225321
 3A6000G0  14   0    BETWEEN CAPITAL-RELATED COST
 3A6000G0  14   1    G
*3A6000G0  14   3                4.00
 3A6000G0  14   4                3912
```

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 1 - RECORD SPECIFICATIONS

RECORD NAME: TYPE 3 RECORDS

```
          1         2         3         4         5         6
  12345678901234567890123456789012345678901234567890123456789
   3A800000   37    0     PBP ADJUSTMENT - EMERGENCY ROOM
   3A800000   37    1     A
   3A800000   37    2               -250935
*  3A800000   37    4                 61.00
   3A800000   37    0     PBP ADJUSTMENT - HEART ACQUISITION
   3A800000   37    2               -114525
   3A800000   37    4                 85.00
*  3A800000   1     1     B
   3A810000   3     1                  1.00
   3A810000   3     3     CAT SCANS
   3A810000   3     4                 13352
   3A810000   3     5                 11122
*  3A820010   4     1                 41.01
   3A820010   4     2     DR. B
   3A820010   4     3                126292
   3A820010   4     4                 94719
   3A820010   4     5                 31573
   3A820010   4     6                124900
   3A820010   4     7                   741
   3A820010   4     12                 6860
   3A820010   4     14                12000
*  3A820010   5     1                 41.01
   3A820010   5     2     DR. C
   3A820010   5     3                189439
   3A820010   5     4                142079
   3A820010   5     5                 47360
   3A820010   5     6                124900
   3A820010   5     7                   333
   3A820010   5     12                 5750
   3A820010   5     14                18900
```

RECORD NAME: TYPE 4 RECORDS
File Encryption and Date and Time Stamp

These type 4 records consist of three records: 1, 1.01, and 1.02. These records are created at the point in which the ECR file has been completed and saved to a disk, CD or flash drive to ensure the integrity of the file.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 2 - WORKSHEET INDICATORS

This table contains the worksheet indicators that are used for electronic cost reporting. A worksheet indicator is provided only for those worksheets from which data are to be provided.

The worksheet indicator consists of seven characters in positions 2 through 8 of the record identifier. The first two characters of the worksheet indicator (positions 2 and 3 of the record identifier) always show the worksheet. The third character of the worksheet indicator (position 4 of the record identifier) is used in several ways. First, it may be used to identify worksheets for multiple hospital-based components, such as subproviders (e.g., S-8; S-9; M series; and O series) or, to identify various types of hospital services such as kidney, heart, lung, or liver acquisitions. Alternatively, it may be used as part of the worksheet, e.g., A81, S10, and S11. The fourth character of the worksheet indicator (position 5 of the record identifier) is used in several ways. First, it may be used to represent the type of provider, by using the key below. Alternatively, it may also be used to identify multiple hospital-based components (e.g., S-11, Parts I and III; and N series) or it may be used in conjunction with the fifth character of the worksheet indicator (position 6 of the record identifier) to identify multiple consolidated FQHCs (e.g., S-11, Part II). Except for Worksheet A-6 (to handle multiple worksheets) and Worksheet I-4 (to handle multiple payment rates), the fifth and sixth characters of the worksheet indicator (positions 6 and 7 of the record identifier) identify worksheets required by a Federal program (18 = title XVIII, 05 = title V, or 19 = title XIX) or worksheet required for the facility (00 = Universal). The seventh character of the worksheet indicator (position 8 of the record identifier) represents the worksheet part.

Provider (or Service) Type - Fourth Digit of the Worksheet Identifier

Universal	0 (Zero)
Hospital	A
IPF	B
IRF	C
Subprovider (Other)	D
SNF	E
Swing-Bed SNF	F
NF	G
Swing-Bed NF	H
CMHC	I
ICF/IID	J
CORF	K
OPT	L
OSP	M
OOT	N
FQHC	Q
RHC	R
PARHM Demonstration	S
PARHM CAH Swing-Bed SNF	T
RHC (continued)	U

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 2 - WORKSHEET INDICATORS

Worksheets Which Apply to the Hospital Complex

Worksheet	Worksheet Indicator
S, Part I	S000001
S, Part II	S000002
S, Part III	S000003
S-2, Part I	S200001
S-2, Part II	S200002
S-3, Part I	S300001
S-3, Part II	S300002
S-3, Part III	S300003
S-3, Part IV	S300004
S-3, Part V	S300005
S-4	S400000 (a)
S-5	S500000
S-6	S61?000 (a) (b)
S-7	S700000
S-8	S81?000 (l)
S-9, Parts I through IV	S900000 (a) (d)
S-10	S100000 (o)
S-10, Part I	S100001 (o)
S-10, Part II	S100002 (o)
S-11, Part I	S111001 (l)
S-11, Part II	S110102 (l)
S-11, Part III	S111003 (l)
S-12	*S120000*
A	A000000
A-6	A600?A0 (f)
A-7, Part I	A700001
A-7, Part II	A700002
A-7, Part III	A700003
A-8	A800000
A-8-1	A810000
A-8-2	A820010 (c)
A-8-3	A83P000 (d) (k) A83R000 (d) (k) A83O000 (d) (k) A83S000 (d) (k)
B, Part I	B000001
B, Part II	B000002
B-1 (For use in column headings)	B10000* (m)
B-1	B100000
B-2	B200010 (c)
C, Part I	C000001

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 2 - WORKSHEET INDICATORS

Worksheets Which Vary by Program

Worksheet	Title V	Title XVIII	Title XIX
C, Part II:			
Hospital	C000052	*	C000192
D, Part III:			
Hospital	D00A053	D00A183	D00A193
PARHM Demonstration	*	D00S183 (n)	*
D, Part IV:			
Hospital	D00A054	D00A184	D00A194
IPF	D00B054	D00B184	D00B194
IRF	D00C054	D00C184	D00C194
Subprovider (other)	D01D054 (e)	*	D01D194 (e)
SNF	D00E054	D00E184	D00E194
Swing-Bed SNF	*	D00F184	*
NF	D00G054	*	D00G194
ICF/IID	D00J054	*	D00J194
PARHM Demonstration	*	D00S184 (n)	*
PARHM CAH Swing-Bed SNF	*	D00T184 (n)	*
D, Part V:			
Hospital	D00A055	D00A185	D00A195
IPF	D00B055	D00B185	D00B195
IRF	D00C055	D00C185	D00C195
Subprovider (Other)	D01D055 (e)	*	D01D195 (e)
SNF	D00E055	D00E185	D00E195
Swing-Bed SNF	D00F055	D00F185	D00F195
NF	D00G055	*	D00G195
Swing-Bed NF	D00H055	*	D00H195
ICF/IID	D00J055	*	D00J195
PARHM Demonstration	*	D00S185 (n)	*
PARHM CAH Swing-Bed SNF	*	D00T185 (n)	*
D-1, Parts I through IV: (d)			
Hospital	D10A051	D10A181	D10A191
IPF	D10B051	D10B181	D10B191
IRF	D10C051	D10C181	D10C191
Subprovider (Other)	D11D051 (e)	*	D11D191 (e)
SNF	D10E051	D10E181	D10E191
NF	D10G051	*	D10G191
ICF/IID	D10J051	*	D10J191
PARHM Demonstration	*	D10S181 (n)	*

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 2 - WORKSHEET INDICATORS

Worksheets Which Apply to the Hospital Complex (Cont.)

Worksheet	Worksheet Indicator
D-2, Parts I & II	D200000 (d)

Worksheets Which Vary by Program

Worksheet	Title V	Title XVIII	Title XIX
D-3:			
Hospital	D30A050	D30A180	D30A190
IPF	D30B050	D30B180	D30B190
IRF	D30C050	D30C180	D30C190
Subprovider (Other)	D31D050 (e)	*	D31D190 (e)
SNF	D30E050	D30E180	D30E190
Swing-Bed SNF	D30F050	D30F180	D30F190
NF	D30G050	*	D30G190
Swing-Bed NF	D30H050	*	D30H190
ICF/IID	D30J050	*	D30J190
PARHM Demonstration	*	D30S180 (n)	*
PARHM CAH Swing-Bed SNF	*	D30T180 (n)	*

Worksheets Which Apply to the Hospital Complex

Worksheet	Worksheet Indicator
D-4, Part I, II and IV:	D4K0000 (d) (h)
	D4H0000 (d) (h)
	D4L0000 (d) (h)
	D4P0000 (d) (h)
	D4N0000 (d) (h)
	D4I0000 (d) (h)
	D4S0000 (d) (h)
	D4O0000 (d) (h)
D-5, Part I:	D5H0001 (i)
	D5M0001 (i)

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 2 - WORKSHEET INDICATORS

Worksheets Which Vary by Component

Worksheet D-5, Part II:	Worksheet Indicator
Hospital	D50A002
IPF	D50B002
IRF	D50C002

Worksheets Which Apply to the Hospital Complex

Worksheet	Worksheet Indicator
D-5, Part III	D500003

Worksheets Which Vary by Component

Worksheet D-5, Part IV:	Worksheet Indicator
Hospital	D50A004
IPF	D50B004
IRF	D50C004

Worksheets Which Apply to the Hospital Complex

Worksheet	Worksheet Indicator
D-6, Part I	D6H0001 (p)
D-6, Part II	D6H0002 (p)
D-6, Part III	D6H0003 (p)
D-6, Part IV	D6H0004 (p)

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 2 - WORKSHEET INDICATORS

Worksheets Which Vary by Component and/or Program

Worksheet	Title V	Title XVIII	Title XIX
E, Part A:			
Hospital	*	E00A18A	*
PARHM Demonstration	*	E00S18A (n)	*
E, Part B:			
Hospital	*	E00A18B	*
IPF	*	E00B18B	*
IRF	*	E00C18B	*
Subprovider	*	E01D18B (e)	*
SNF	*	E00E18B	*
PARHM Demonstration	*	E00S18B (n)	*
E-1, Part I:			
Hospital	*	E10A181	*
IPF	*	E10B181	*
IRF	*	E10C181	*
Subprovider	*	E11D181 (e)	*
SNF	*	E10E181	*
Swing-Bed SNF	*	E10F181	*
PARHM Demonstration	*	E10S181 (n)	*
PARHM CAH Swing-Bed SNF	*	E10T181 (n)	*
E-1, Part II:			
Hospital	*	E10A182	*
E-2:			
Swing-Bed SNF	E20F050	E20F180	E20F190
Swing-Bed NF	E20H050	*	E20H190
PARHM CAH Swing-Bed SNF	*	E20T180 (n)	*
E-3, Part I:			
Hospital	*	E30A181	*

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 2 - WORKSHEET INDICATORS

Worksheets Which Vary by Component and/or Program (Cont.)

Worksheet	Title V	Title XVIII	Title XIX
E-3, Part II:			
Hospital	*	E30A182	*
IPF	*	E30B182	*
E-3, Part III:			
Hospital	*	E30A183	*
IRF	*	E30C183	*
E-3, Part IV:			
Hospital	*	E30A184	*
E-3, Part V:			
Hospital (cost reimbursed)	*	E30A185	*
PARHM Demonstration	*	E30S185 (n)	*

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 2 - WORKSHEET INDICATORS

Worksheets Which Vary by Component and/or Program (Cont.)

Worksheet	Title V	Title XVIII	Title XIX
E-3, Part VI:			
SNF	*	E30E186	*

NOTE: Refer to Table 3 for instructions on the reporting of data for a hospital-based SNF reimbursed prospectively under title XVIII.

E-3, Part VII:			
Hospital	E30A057	*	E30A197
IPF	E30B057	*	E30B197
IRF	E30C057	*	E30C197
SNF	E30E057	*	E30E197
NF	E30G057	*	E30G197
ICF/IID	E30J057	*	E30J197
E-4:			
Hospital	E40A050	E40A180	E40A190
PARHM	*	E40S180 (n)	*
Demonstration			
CAH-Based IPF	*	E40B180	*
CAH-Based IRF	*	E40C180	*

Worksheets Which Apply to the Hospital

Worksheet	Worksheet Indicator
E-5	E500000
E-90, Part I	E900001
E-90, Part II	E900002
E-95, Part I	E950001
E-95, Part II	E950002
E-95, Part III	E950003

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 2 - WORKSHEET INDICATORS

Worksheets Which Apply to the Hospital Complex

Worksheet	Worksheet Indicator
G	G000000
G-1	G100000
G-2, Parts I & II (d)	G200000
G-3	G300000
H	H010000 (a)
H-1, Part I	H110001 (a)
H-1, Part II (For use in column headings)	H11002* (a) (m)
H-1, Part II	H110002 (a)
H-2, Part I	H210001 (a)
H-2, Part II	H210002 (a)

Worksheets Which Vary by Program

Worksheet	Title V	Title XVIII	Title XIX
H-3, Part I	H310051 (a)	H310181 (a)	H310191 (a)
H-3, Part II	H310052 (a)	H310182 (a)	H310192 (a)
H-4, Part I	H410051 (a)	H410181 (a)	H410191 (a)
H-4, Part II	H410052 (a)	H410182 (a)	H410192 (a)

Worksheets Which Apply to the Hospital Complex

Worksheet	Worksheet Indicator
H-5	H510000 (a)
I-1 (Use for statistical basis label)	I1D000* (j) (m) I1H000* (j) (m)
I-1	I1D0000 (j) I1H0000 (j)
I-2	I2D0000 (j) I2H0000 (j)
I-3	I3D0000 (j) I3H0000 (j)
I-4	I4D0010 (j) I4H0010 (j)
I-5	I500000
J-1, Part I	J11I001 (a)
J-1, Part II	J11I002 (a)
J-2	J21I000 (a)
J-4	J41I000 (a)

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 2 - WORKSHEET INDICATORS

Worksheets Which Apply to the Hospital Complex (Cont.)

Worksheet	Worksheet Indicator
K	K010000 (a)
K-1	K110000 (a)
K-2	K210000 (a)
K-3	K310000 (a)
K-4, Part I	K410000 (a)
K-4, Part II	K410002 (a)
K-5, Part I	K510001 (a)
K-5, Part II	K510002 (a)
K-5, Part III	K510003 (a)
L-1, Part I	L100001
M-1	M11?000 (l)
M-2	M21?000 (l)
N-1	N101000 (l)
N-2	N201000 (l)
N-3	N301000 (l)
N-4	N401000 (l)
N-5	N501000 (l)
O	O010000 (a)
O-1	O110000 (a)
O-2	O210000 (a)
O-3	O310000 (a)
O-4	O410000 (a)
O-6, Part I	O610001 (a)
O-6, Part II (For use in column headings)	O61002* (a) (m)
O-6, Part II	O610002 (a)
O-7	O710000 (a)

Worksheets Which Vary by Component and/or Program (Cont.)

Worksheet	Title V	Title XVIII	Title XIX
J-3:	J31I050 (b)	J31I180 (b)	J31I190 (b)
L, Part I:			
Hospital	L00A051	L00A181	L00A191
PARHM Demonstration	*	L00S181 (n)	*

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 2 - WORKSHEET INDICATORS

Worksheets Which Vary by Component and/or Program (Cont.)

Worksheet	Title V	Title XVIII	Title XIX
L, Part II:			
Hospital	L00A052	L00A182	L00A192
L-1, Part II:			
Universal (0)	L100052	L100182	L100192

Worksheet	Title V	Title XVIII	Title XIX
M-3	M31?050 (l)	M31?180 (l)	M31?190 (l)
M-4	M41?050 (l)	M41?180 (l)	M41?190 (l)
M-5	*	M51?180 (l)	*

FOOTNOTES:

(a) Multiple Hospital-Based HHAs, CMHCs, and Hospices

The third digit of the worksheet indicator (position 4 of the record) is numeric from 1 to 0 to accommodate multiple hospital-based HHAs and CMHCs, and 1 through 5 for hospital-based hospices. If there is only one of the components, the default is 1. This affects the H, J, K, and O series worksheets including Worksheets S-4, S-6, and S-9. For CMHCs, the fourth character of the worksheet indicator (position 5 of the record) is I.

(b) Multiple Outpatient Rehabilitation Providers

The third digit of the worksheet indicator (position 4 of the record) is numeric from 1 to 0 to accommodate multiple providers. If there is only one outpatient provider type, the default is 1. The fourth character of the worksheet indicator (position 5 of the record) indicates the outpatient rehabilitation provider as listed below. These affect Worksheet S-6.

I = CMHC K = CORF L = OPT M = OOT N = OSP

(c) Multiple Worksheets for Reclassification and Adjustments Before and After Step-down

The fifth and sixth digits of the worksheet indicator (positions 6 and 7 of the record) are numeric from 01 to 99 to accommodate reports with more lines on Worksheets A-8-2, and/or B-2. For reports which do not need additional worksheets, the default is 01. For reports which do need additional worksheets, the first page of each worksheet is numbered 01. The number for each additional page of each worksheet is incremented by 1.

(d) Worksheets With Multiple Parts Using Identical Worksheet Indicator

Although this worksheet has several parts, the lines are numbered sequentially. This worksheet identifier is used with all lines from this worksheet regardless of the worksheet part. This differs from the Table 3 presentation which still identifies each worksheet and part as they appear on the printed cost report. This affects Worksheets S-9, A-8-3, D-1, D-2, D-4, G-2, H-5, I-5, and J-2.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 2 - WORKSHEET INDICATORS

FOOTNOTES (Cont.):

(e) Multiple Subproviders

The third digit of the worksheet indicator (position 4 of the record) is a numeric from 1 to 0 to accommodate facilities with two or more subproviders. If there is only one subprovider, the default is 1. This affects Worksheets D, Parts III through V; D-1; D-3; D-5, Part II; E, Parts A and B; E-1; and E-3, Parts II and III.

(f) Worksheet A-6

For Worksheet A-6, include in the worksheet identifier the reclassification code as the fifth and sixth digits (positions six and seven in the ECR file). For example, 3A6000A0 or 3A6000B0, 3A6000C0, 3A600AA0, 3A600AB0, 3A600AC0, or 3A600ZZ0.

(g) To be used at a later date.

(h) Worksheet D-4

The third digit of the worksheet indicator (position 4 of the record) must be K for kidney acquisitions, H for heart acquisitions, L for liver acquisitions, N for pancreas acquisitions, P for lung acquisitions, I for intestine, S for islet, or O for other.

(i) Worksheet D-5, Part I

The third digit of the worksheet indicator (position 4 of the record) must be either H for hospital staff data or M for medical staff data.

(j) Renal Dialysis

The third digit of the worksheet indicator (position 4 of the record) must contain either D for renal dialysis department or H for home program dialysis. This applies to Worksheets I-1, I-2, I-3, and I-4.

(k) Multiple Worksheet A-8-3

This worksheet is used for either physical or respiratory therapy services furnished by outside suppliers. The fourth digit of the worksheet indicator (position 5 of the record) is an alpha character of either P for physical therapy, R for respiratory therapy services, O for occupational therapy or S for speech pathology.

(l) Multiple Health Clinic Providers

The third digit of the worksheet indicator (position 4 of the record) is numeric from 1 to 0 to accommodate multiple hospital-based providers. To accommodate hospital-based providers 11 through 36, use alpha characters A through Z. If there is only one hospital-based health clinic provider type, the default is 1. This applies to Worksheet S-8, and the M series worksheets.

The fourth digit of the worksheet indicator (position 5 of the record) indicates the hospital-based health clinic provider type and accommodates the continuation of multiple hospital-based RHCs. Q indicates FQHC and R indicates RHC. U indicates a continuation of multiple hospital-based RHCs 37 through 50 by using the third digit of the worksheet indicator (position 4 of the record) (1 through 0, and A through D) for hospital-based RHCs 37 through 50 in conjunction with the fourth digit of the worksheet indicator (position 5 of

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 2 - WORKSHEET INDICATORS

FOOTNOTES (Cont.):

(l) Multiple Health Clinic Providers (Cont.)

the record) (U) to identify the 37th through 50th hospital-based RHCs. This applies to Worksheet S-8, and the M series worksheets.

Example:

3M31R180 - Represents RHC 1
3M34R180 - Represents RHC 4
3M3ZR180 - Represents RHC 36
3M31U180 - Represents RHC 37
3M34U180 - Represents RHC 40
3M3DU180 - Represents RHC 50 (D would be the limit for the RHC identified by U)

The fourth digit of the worksheet indicator (position 5 of the record) is numeric from 1 to 0 to accommodate multiple hospital-based FQHCs. To accommodate hospital-based FQHCs 11 through 36, use alpha characters A through Z. If there is only one hospital-based FQHC, or one hospital-based FQHC with one or more consolidated FQHCs, the default is 1. This applies to Worksheets S-11, Parts I and III (for multiple hospital-based FQHCs or the primary consolidated FQHC); and the N series worksheets (separate N series for each hospital-based FQHC or one N series for all consolidated FQHCs).

The fourth and fifth digits of the worksheet indicator (positions 5 and 6 of the record) are numeric from 01 to 99 to accommodate multiple consolidated FQHCs affiliated with the one primary hospital-based FQHC. If the facility has only one consolidated FQHC, the default is 01. This applies to Worksheet S-11, Part II (for individual consolidated FQHCs, excluding the primary FQHC).

(m) Type 2 Records for Use in Column Headings

The asterisk (*) in position 7 of the worksheet indicator (position 8 of the record) indicates the data is a type 2 record identifying the column heading and statistical basis.

(n) PARHM Demonstration

The fourth digit of the worksheet indicator (position 5 of the record) identifies worksheets completed for participation in the PARHM demonstration. This applies to Worksheets D, Parts I through V; D-1, Parts I and II ; D-3; E, Part A; E, Part B; E-1, Part I; E-2; E-3, Part V; E-4; and L, Part I.

(o) Worksheet S-10

The seventh digit of the worksheet indicator (position 8 of the record) identifies the Worksheet S-10 for a cost reporting period beginning before October 1, 2022. For cost reporting periods beginning on or after October 1, 2022, a “1” in the seventh digit of the worksheet indicator (position 8 of the record) identifies the worksheet as Worksheet S-10, Part I; and a “2” identifies the worksheet as Worksheet S-10, Part II.

(p) Worksheet D-6

The third digit of the worksheet indicator (position 4 of the record) must be H for HSCT.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10 TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

INTRODUCTION

This table identifies those data elements necessary to calculate a hospital cost report. It also identifies some figures from a completed cost report. These calculated fields (e.g., Worksheet B, column 26) are needed to verify the mathematical accuracy of the raw data elements and to isolate differences between the file submitted by the hospital complex and the report produced by the contractor. Where an adjustment is made, the record must be present in the electronic data file. For explanations of the adjustment(s) required, refer to the cost report instructions.

Table 3 "Usage" column specifies the format of each data item as follows:

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

Consistency in line numbering (and column numbering for general service cost centers) for each cost center is essential. The sequence of some cost centers does change among worksheets. The special care units are the most likely to cause errors. Table 3E provides an example with a chart of special care unit line numbers for reference. Refer to Table 4 for line and column numbering conventions for use with complexes which have more components than appear on the preprinted Form CMS-2552-10.

Table 3 refers to the data elements needed from a standard cost report. When a standard line is subscripted, the subscripted lines must be numbered sequentially with the first subline number displayed as "01" or "1" in field locations 14 through 15. It is unacceptable to format in series of 10, 20, or skip subline numbers (i.e., 01, 03, except for skipping subline numbers for prior year cost center(s) deleted in the current period or initially created cost center(s) no longer in existence after cost finding). Exceptions are specified in this manual. For "Other (specify)" lines (i.e., Worksheets S-4, S-6, S-8, settlement series) and any other non-cost center lines, all subscripted lines must be in sequence and consecutively numbered beginning with subscripted subline "01". Subscripts of lines and columns are based on the format (line or column (as applicable), field size, and usage) of the primary/parent line or column where the specifications in Table 3 do not specifically identify line or column designations. Automated systems should reorder these numbers where the provider skips or deletes a line number in the series.

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

All numeric values are presumed positive. Leading minus signs may only appear in data with values less than zero which are specified in Table 3 with a usage of "-9".

Italic script within this table denotes adjustments which are not displayed in the print image or hard copy of the cost report, but are contained in the ECR file. Examples of these type entries are Worksheets D-2, Part I; D, Part III; and D, Part IV.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET S				
Part I - Cost Report Status				
Provider Use Only				
Electronically prepared cost report	1	1	1	X
Manually prepared cost report	2	1	1	X
If this is an amended report enter the number of times the provider resubmitted this cost report	3	1	1	9
Medicare Utilization: enter "F' for full, "L" for low, or "N" for no	4	1	1	X
Contractor Use Only				
Cost Report Status: Enter the cost report status code: 1 for as submitted, 2 for settled without audit, 3 settled with audit, 4 reopened, or 5 amended	5	1	1	X
Date received (mm/dd/yyyy)	6	2	10	X
Contractor Number	7	2	5	X
Initial report for this Provider CCN	8	2	1	X
Final report for this Provider CCN	9	2	1	X
Notice of Program Reimbursement (NPR) date (mm/dd/yyyy)	10	3	10	X
Enter Contractor's vendor code (ADR)	11	3	1	X
If line 5, column 1 is 4: enter the number of times reopened = 0-9	12	3	1	9
Part II - Certification by a Chief Financial Officer or Administrator of Provider(s)				
Signature of chief financial officer or administrator	1	1	36	X
Checkbox (enter "Y" if electronic signature; otherwise, leave blank)	1	2	1	X
Printed Name	2	1	36	X
Title	3	1	36	X
Signature date (mm/dd/yyyy)	4	1	10	X
Part III - Settlement Summary				
Balances due provider or program:				
Title V	1-3, 5-12	1	11	-9
Title XVIII, Part A	1-3, 5, 7, 9	2	11	-9
Title XVIII, Part B	1-3, 5, 7, 9-12	3	11	-9
HIT	1	4	11	-9
Title XIX	1-3, 5-12	5	11	-9
Providers as assigned	13-199	1-3, 5	11	-9
In total	200	1-5	11	-9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET S-2, Part I				
Hospital and Hospital Health Care Complex Address (for the hospital only):				
Street	1	1	36	X
P.O. Box	1	2	9	X
City	2	1	36	X
State	2	2	2	X
ZIP Code	2	3	10	X
County	2	4	36	X
Hospital and Hospital-Based Component Identification:				
Component name	3-19	1	36	X
CMS Certification number (xxxxxx)	3-5, 7-10, 12-19	2	6	X
CBSA number (xxxxx)	3-5, 7-10, 12-19	3	5	X
Type of hospital/subprovider (see Table 3B)	3-5	4	2	9
Certification date (mm/dd/yyyy)	3-5. 7-10, 12-19	5	10	X
Title V payment system (see Table 3D)	3-5, 7-10, 12-13, 15-17	6	1	X
Title XVII payment system (see Table 3D)	3-5,7, 9, 12-13, 15-17	7	1	X
Title XIX payment system (see Table 3D)	3-5, 7-10, 12-13, 15-17	8	1	X
Cost reporting period beginning date (mm/dd/yyyy)	20	1	10	X
Cost reporting period ending date (mm/dd/yyyy)	20	2	10	X
Type of Control (see Table 3B)	21	1	2	X

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET S-2, Part I (Cont.)				
Inpatient PPS Information				
Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR 412.106? (Y/N)	22	1	1	X
Is this facility subject to 42 CFR 412.106(c)(2) (Pickle amendment hospital)? Enter in column 2 (Y/N).	22	2	1	X
Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1 (Y/N) for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 (Y/N) for the portion of the cost reporting period occurring on or after October 1.	22.01	1, 2	1	X
Is this a newly merged hospital that requires a final UCP to be determined at cost report settlement? Enter in column 1, (Y/N) for the portion of the cost reporting period prior to October 1. Enter in column 2, (Y/N) for the portion of the cost reporting period on or after October 1.	22.02	1, 2	1	X
Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY 2015? Enter in column 1, (Y/N) for the portion of the cost reporting period prior to October 1. Enter in column 2, (Y/N) for the portion of the cost reporting period occurring on or after October 1.	22.03	1, 2	1	X
Does this hospital contain at least 100, but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? (Y/N) (see instructions)	22.03	3	1	X
Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB standards for delineating statistical areas adopted by CMS in FY 2021? Enter in column 1, (Y/N) for the portion of the cost reporting period prior to October 1. Enter in column 2, (Y/N) for the portion of the cost reporting period occurring on or after October 1.	22.04	1, 2	1	X
Does this hospital contain at least 100, but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? (Y/N) (see instructions)	22.04	3	1	X
Did this hospital receive a geographic reclassification from urban to rural in accordance with 42 CFR 412.103? Enter in column 1, “Y” for yes or “N” for no.	22.05	1	1	X
If column 1 is Y, enter the effective date of the geographic reclassification in column 2. (mm/dd/yyyy)	22.05	2	10	X

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET S-2, Part I (Cont.)				
Which method is used to determine Medicaid days on lines 24 and/or 25 of this worksheet? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge.	23	1	1	9
Is the method for identifying the days in the current cost reporting period different from the method used in the prior cost reporting period? Enter in column 2 (Y/N).	23	2	1	X
If line 22 is "Y", enter the in-state Medicaid paid days in column 1.	24	1	9	9
If line 22 is "Y" enter the in-state Medicaid eligible unpaid days in column 2.	24	2	9	9
If line 22 is "Y", enter out of state Medicaid paid days in column 3.	24	3	9	9
If line 22 is "Y", enter out of state Medicaid eligible unpaid days in column 4.	24	4	9	9
If line 22 is "Y", enter Medicaid HMO paid , and eligible but unpaid days in column 5	24	5	9	9
If line 22 is "Y", enter Other Medicaid days in column 6.	24	6	9	9
If line 22 is "Y" and this provider is an IRF, enter the in-state Medicaid paid days in column 1	25	1	9	9
If line 22 is "Y" and this provider is an IRF, enter the in-state Medicaid eligible unpaid days in column 2.	25	2	9	9
If line 22 is "Y" and this provider is an IRF, enter out-of-state Medicaid paid days in column 3.	25	3	9	9
If line 22 is "Y" and this provider is an IRF, enter out-of-state Medicaid eligible unpaid days in column 4.	25	4	9	9
If line 22 is "Y" and this provider is an IRF, enter Medicaid HMO days in column 5.	25	5	9	9
If line 22 is "Y" and this provider is an IRF, enter Other Medicaid days in column 6.	25	6	9	9
For standard Geographic classification (not wage), what is your status at the beginning of the cost reporting period? Enter 1 for urban or 2 for rural.	26	1	1	9
For standard Geographic classification (not wage), what is your status at the end of the cost reporting period? (Enter 1 for urban or 2 for rural.	27	1	1	9
If applicable enter the effective date of geographic reclassification in column 2 (mm/dd/yyyy).	27	2	10	X
If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	35	1	1	9
Beginning date SCH status applies in this period (mm/dd/yyyy).	36	1	10	X
Ending date SCH status applies in this period (mm/dd/yyyy).	36	2	10	X
If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	37	1	1	9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET S-2, Part I (Cont.)				
Is this hospital a former MDH that is eligible for the MDH transitional payment? (Y/N)	37.01	1	1	X
Ending date MDH status applies in this period (mm/dd/yyyy).	38	2	10	X
Does this facility qualify for the inpatient hospital adjustment for low volume hospitals in accordance with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column 1 (Y/N).	39	1	1	X
Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column 2 (Y/N).	39	2	1	X
Is this hospital subject to the HAC program reduction adjustment? Enter (Y/N) in column 1, for discharges prior to October 1. Enter (Y/N) in column 2, for discharges on or after October 1.	40	1, 2	1	X
Prospective Payment System (PPS) - Capital				
Does your facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR 412.320? (Y/N)	45	1-3	1	X
Is this facility eligible for the additional payment exception for extraordinary circumstances pursuant to 42 CFR 412.348(f)? (Y/N)	46	1-3	1	X
Is this a new hospital under 42 CFR 412.300(b) PPS capital? (Y/N)	47	1-3	1	X
Is the facility electing full federal capital payment? (Y/N)	48	1-3	1	X
Teaching Hospital				
Is this hospital involved in training residents in an approved GME program(s)? (Y/N)	56	1	1	X
If line 56, column 1, is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, are you impacted by CR 11642 (or subsequent CR), MA payment reduction? (Y/N)	56	2	1	X
If line 56 is "Y", is this the first cost reporting period during which residents in approved GME programs trained at this facility? (Y/N)	57	1	1	X
If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter (Y/N) in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheets D, Parts III and IV; and D-2, Part II, if applicable.	57	2	1	X

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET S-2, Part I (Cont.)				
If line 56 is "Y", did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, §2148? (Y/N). If "Y" complete Worksheet D-5.	58	1	1	X
Are you claiming costs on line 100 of Worksheet A? If "Y", complete Worksheet D-2, Part I.	59	1	1	X
Are you claiming nursing and allied health education (NAHE) costs for any programs that meets the criteria under 42 CFR 413.85? (Y/N) (see instructions)	60	1	1	X
If line 60, column 1, is "Y", are you impacted by CR 11642 (or subsequent CR), NAHE MA payment adjustment? Enter (Y/N) in column 2.	60	2	1	X
Enter the Worksheet A line number.	60.01-60.70	2	6	9(3).99
Enter the pass-through qualification criterion code. (see Table 3B)	60.01-60.70	3	1	X
Did the hospital receive FTE slots under §5503 of the ACA? (Y/N)	61	1	1	X
If yes, complete columns 4 and 5. Enter the number of IME §5503 slots awarded in column 4.	61	4	9	9(6).99
Enter the number of GME §5503 slots awarded in column 5.	61	5	9	9(6).99
Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)	61.01	2, 3	9	9(6).99
Enter the current year's total unweighted primary care FTE count (excluding OB/GYN, general surgery and primary care FTEs added as a result of §5503 of ACA). (see instructions)	61.02	2, 3	9	9(6).99
Enter the base line FTE count for primary care and/or general surgery residents, which are used for determining compliance with the 75% test. (see instructions)	61.03	2, 3	9	9(6).99
Enter the number of unweighted primary care and/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions)	61.04	2, 3	9	9(6).99
Enter the difference between the baseline primary and/or general surgery FTE count and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)	61.05	2, 3	9	9(6).99
Enter the amount of ACA under §5503 awards that is being used for cap relief and/or FTEs that are non-primary care or general surgery. (see instructions)	61.06	2, 3	9	9(6).99

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET S-2, Part I (Cont.)				
Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter program name in column 1. (Subscript line 61.10 as necessary)	61.10	1	36	X
Enter program code in column 2. (Subscript line 61.10 as necessary)	61.10	2	10	X
Enter the unweighted IME FTE count in column 3.	61.10	3	9	9(6).99
Enter the unweighted direct GME FTE count in column 4.	61.10	4	9	9(6).99
Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter program name in column 1. (Subscript line 61.20 as necessary)	61.20	1	36	X
Enter Program code	61.20	2	10	X
Enter the unweighted IME FTE count	61.20	3	9	9(6).99
Enter the unweighted direct GME FTE count	61.20	4	9	9(6).99
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)				
Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding. (see instructions)	62	1	9	9(6).99
Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during this cost reporting period of HRSA THC program (see instructions)	62.01	1	9	9(6).99
Teaching Hospitals that Claim Residents in Nonprovider Settings				
Has your facility trained residents in nonprovider settings during this cost reporting period? (Y/N) If yes, complete lines 64 through 67 (see instructions)	63	1	1	X
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings				
If line 63 is "Y", or your facility trained residents in the base year period, enter the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings.	64	1	9	9(6).99
If line 63 is "Y", or your facility trained residents in the base year period, enter the number of unweighted non-primary care resident FTEs that trained in your hospital.	64	2	9	9(6).99

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET S-2, Part I (Cont.)				
Enter Program name (subscript line 65 as necessary) (see instructions)	65	1	36	X
Enter Program code	65	2	10	X
Enter the unweighted primary care FTEs attributable to rotations occurring in all nonprovider settings (see instructions)	65	3	9	9(6).99
Enter the unweighted primary care FTEs that trained in your hospital	65	4	9	9(6).99
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings				
If line 63 is "Y", enter the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings in the current year.	66	1	9	9(6).99
If line 63 is "Y", enter the number of unweighted non-primary care resident FTEs that trained in your hospital in the current year.	66	2	9	9(6).99
Enter Program name in column 1. (subscript line 67 as necessary) (see instructions)	67	1	36	X
Enter Program code in column 2.	67	2	10	X
Enter the unweighted primary care FTEs attributable to rotations occurring in all nonprovider settings in column 3.	67	3	9	9(6).99
Enter the unweighted primary care FTEs that trained in the hospital in column 4.	67	4	9	9(6).99
Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)				
For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula that is effective October 1, 2022, in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)? (Y/N)	68	1	1	X
Inpatient Psychiatric Facility PPS				
Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? (Y/N)	70	1	1	X
If line 70 column 1 is "Y", did the facility have a teaching program in the most recent cost report filed on or before November 14, 2004? (Y/N)	71	1	1	X
Did the facility train residents in a new teaching program in accordance with 42 CFR 412.424(d)(1)(iii)(D)? (Y/N)	71	2	1	X
If column 2 is "Y", indicate which program year began during this cost reporting period. (see instructions)	71	3	1	9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET S-2, Part I (Cont.)				
Inpatient Rehabilitation Facility PPS				
Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? (Y/N)	75	1	1	X
If line 75, column 1 is "Y", did the facility have a teaching program in the most recent cost report filed on or before November 14, 2004? (Y/N)	76	1	1	X
Did this facility train residents in a new teaching program in accordance with 42 CFR 412.242(d)(1)(iii)(D)? (Y/N)	76	2	1	X
If column 2 is "Y", indicate which program year began during this cost reporting period. (see instructions)	76	3	1	9
Long Term Care Hospital PPS				
Is this a long term care hospital (LTCH)? (Y/N)	80	1	1	X
Is this a LTCH co-located within another hospital for part or all of the cost reporting period? (Y/N)	81	1	1	X
TEFRA Providers				
Is this a new hospital under 42 CFR 413.40(f)(1)(i) TEFRA? (Y/N)	85	1	1	X
Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? (Y/N)	87	1	1	X
Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? (Y/N) If yes, complete col. 2 and line 89. (see instructions)	88	1	1	X
Enter the number of approved permanent adjustments.	88	2	9	9
If line 88, col. 1, is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based.	89	1	6	9(3).99
Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge.	89	2	10	X
Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.	89	3	9	9(6).99

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET S-2, Part I (Cont.)				
Title V and Title XIX Inpatient Services				
Does this facility have title V and/or XIX inpatient hospital services?	90	1, 2	1	X
Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part (Y/N)	91	1, 2	1	X
Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (Y/N) (see instructions)	92	2	1	X
Does this facility operate an ICF/IID facility for purposes of title V and XIX (Y/N)	93	1, 2	1	X
Does title V and/or title XIX reduce capital cost? (Y/N)	94	1, 2	1	X
If line 94 is "Y", by what percentage?	95	1, 2	9	9.9(4)
Does title V or title XIX reduce operating cost? (Y/N)	96	1, 2	1	X
If line 96 is "Y", enter the reduction percentage?	97	1, 2	9	9.9(4)
Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? (Y/N)	98	1, 2	1	X
Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? (Y/N)	98.01	1, 2	1	X
Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? (Y/N)	98.02	1, 2	1	X
Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? (Y/N)	98.03	1, 2	1	X
Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? (Y/N)	98.04	1, 2	1	X
Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? (Y/N)	98.05	1, 2	1	X
Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? (Y/N)	98.06	1, 2	1	X

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET S-2, Part I (Cont.)				
Rural Providers				
Does this facility qualify as a CAH? (Y/N)	105	1	1	X
If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (Y/N)	106	1	1	X
If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? (Y/N)	107	1	1	X
If this facility is a REH (line 3, column 4 is "12"), is it eligible for cost reimbursement for I&R training programs? (Y/N)	107.01	1	1	X
Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR 412.113(c) (Y/N)	108	1	1	X
If this hospital qualifies as a CAH or a cost provider, are therapy services provided by an outside supplier? Enter "Y" for yes, or "N" for no, for the type of therapy as follows: physical therapy in column 1, occupational therapy in column 2, speech therapy in column 3, and respiratory therapy in column 4.	109	1-4	1	X
Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? (Y/N)	110	1	1	X
Did this CAH participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? (Y/N)	111	1	1	X
If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	111	2	3	X
Did this facility participate in the PARHM demonstration for any portion of the current cost reporting period? (Y/N)	112	1	1	X
If yes, enter in column 2, the date the hospital began participating in the PARHM demonstration. (mm/dd/yyyy)	112	2	10	X
In column 3, enter the date the hospital ended participation in the PARHM demonstration, if applicable. (mm/dd/yyyy)	112	3	10	X

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET S-2, Part I (Cont.)				
Miscellaneous Cost Reporting Information				
Is this an all-inclusive provider? (Y/N)	115	1	1	X
If column 1 is "Y", enter the method used (A, B or E only)	115	2	1	X
If column 2 is "E", enter in column 3, either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS Pub. 15-1, chapter 22, §2208.1.	115	3	9	9.9(2)
Are you classified as a referral center? (Y/N)	116	1	1	X
Are you legally required to carry malpractice insurance? (Y/N)	117	1	1	X

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET S-2, Part I (Cont.)				
Is the malpractice insurance a claims-made or occurrence policy? If the policy is claims-made enter 1. If the policy is occurrence, enter 2.	118	1	1	9
List malpractice premiums in column 1, paid losses in column 2, and self-insurance in column 3.	118.01	1-3	11	9
Are malpractice premiums and paid losses reported in other than the Administrative and General cost center? (Y/N) If yes, submit supporting schedule listing cost centers and amounts.	118.02	1	1	X
What is the liability limit for the malpractice insurance policy? Enter in column 1, the monetary limit per lawsuit.	119	1	11	9
Enter in column 2, the monetary limit per policy year.	119	2	11	9
Note: Question 119, columns 1 and 2 are eliminated and replaced with questions 118.01 and 118.02.				
Is this a SCH or EACH that qualifies for the outpatient hold harmless provision found in §3121 of the ACA? (Y/N)	120	1	1	X
Is this a rural hospital with $\leq$100 beds which qualifies for the outpatient hold harmless provision in §3121 of the ACA? (Y/N)	120	2	1	X
Did this facility incur and report costs for high cost implantable devices charged to patients? (Y/N)	121	1	1	X
Does the cost report contain health care related taxes as defined in §1903(w)(3) of the Act? (Y/N)	122	1	1	X
If the answer in column 1 is “Y”, enter in column 2 the Worksheet A line number where these taxes are included.	122	2	6	9(3).99
Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? (Y/N)	123	1	1	X
If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? (Y/N)	123	2	1	X
Did the hospital incur cost, either directly or through a contract with an outside supplier, to establish and maintain access to no less than a 6-month buffer stock of one or more essential medicines according to 42 CFR 412.113(g)? (Y/N)	124	1	1	X

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET S-2, Part I (Cont.)				
Certified Transplant Center Information				
Does this facility operate a Medicare-certified transplant center? (Y/N)	125	1	1	X
If this is a Medicare certified kidney transplant program, enter the certification date (mm/dd/yyyy) and the termination date if applicable (mm/dd/yyyy).	126	1-2	10	X
If this is a Medicare certified heart transplant program, enter the certification date (mm/dd/yyyy) and the termination date, if applicable (mm/dd/yyyy).	127	1-2	10	X
If this is a Medicare certified liver transplant program, enter the certification date (mm/dd/yyyy) and the termination date, if applicable (mm/dd/yyyy).	128	1-2	10	X

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET S-2, Part I (Cont.)				
If this is a Medicare certified lung transplant program, enter the certification date (mm/dd/yyyy) and the termination date, if applicable (mm/dd/yyyy).	129	1-2	10	X
If this is a Medicare certified pancreas transplant program, enter the certification date (mm/dd/yyyy) and the termination date, if applicable (mm/dd/yyyy).	130	1-2	10	X
If this is a Medicare certified intestinal transplant program, enter the certification date (mm/dd/yyyy) and the termination date, if applicable (mm/dd/yyyy).	131	1-2	10	X
If this is a Medicare certified islet transplant program, enter the certification date (mm/dd/yyyy) and the termination date, if applicable (mm/dd/yyyy).	132	1-2	10	X
If this is a Medicare certified other transplant program, enter the certification date (mm/dd/yyyy) and the termination date, if applicable (mm/dd/yyyy).	133	1-2	10	X
If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2. (mm/dd/yyyy)	134 134	1 2	6 10	X X
All Providers				
Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10?	140	1	1	X
If yes, and home office costs are claimed, enter the home office chain number.	140	2	6	X
Name	141	1	36	X
Contractor's Name	141	2	36	X
Contractor's Number	141	3	5	X
Street	142	1	36	X
P.O. Box	142	2	9	X
City	143	1	36	X
State	143	2	2	X
ZIP Code	143	3	10	X
Are provider based physicians' costs included in Worksheet A? (Y/N)	144	1	1	X
If you are claiming cost for renal services on Worksheet A, are the costs for inpatient services only? (Y/N)	145	1	1	X
If column 1 is "N", are you a no Medicare utilization provider for ESRD services? (Y/N)	145	2	1	X

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET S-2, Part I (Cont.)				
Have you changed your cost allocation methodology from the previously filed cost report? See §4020. (Y/N)	146	1	1	X
If yes, enter the approval date (mm/dd/yyyy).	146	2	10	X
Was there a change in the statistical basis? (Y/N)	147	1	1	X
Was there a change in the order of allocation? (Y/N)	148	1	1	X
Was there a change to the simplified cost finding method? (Y/N)	149	1	1	X
If exempt from LCC, enter "Y" for each component and type of service. Enter "N" if not exempt. (See 42 CFR 413.13)				
Hospital	155	1-4	1	X
Subprovider – IPF	156	2-4	1	X
Subprovider – IRF	157	2-4	1	X
SNF	159	2-4	1	X
HHA	160	1-4	1	X
Outpatient Rehab. Providers	161	2-4	1	X
Multicampus				
Is this hospital part of a multicampus hospital that has one or more campuses in different CBSAs? (Y/N)	165	1	1	X
If line 165 is "Y", enter the name in column 0.	166	0	36	X
If line 165 is "Y", enter county in column 1.	166	1	36	X
If line 165 is "Y", enter state in column 1	166	2	2	X
If line 165 is "Y", enter ZIP code in column 3.	166	3	10	X
If line 165 is "Y", enter CBSA in column 4.	166	4	5	X
If line 165 is "Y", enter FTE count/campus in column 5. (see instructions)	166	5	1	9(6).99
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act				
Is this provider a meaningful user under §1886 (n)? (Y/N)	167	1	1	X
If this provider is a CAH (line 105 is "Y"), and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the purchase of certified HIT technology.	168	1	11	9
If this provider is a CAH (line 105 is "Y") and is not a meaningful user (line 167 is "N"), does this provider qualify for a hardship exception under 42 CFR 413.70(a)(6)(ii)? (Y/N)	168.01	1	1	X

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET S-2, Part I (Cont.)				
If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	169	1	9	9.9(2)
Enter the EHR reporting period beginning date (mm/dd/yyyy) in column 1 and the ending date in column 2 (mm/dd/yyyy). (see instructions)	170	1-2	10	X
Does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6. (Y/N) (see instructions)	171	1	1	X
If column 1 is yes, enter the section 1876 Medicare days in column 2.	171	2	9	9
WORKSHEET S-2, Part II				
COMPLETED BY ALL HOSPITALS, PROVIDERS AND OPERATIONS				
For all column 1 responses, enter in column 1 (Y/N). For all date responses, the format is (mm/dd/yyyy)				
Provider Organization and Operation				
Has the provider changed ownership? (Y/N) (see instructions)	1	1	1	X
If column 1 is yes, enter in column 2, the date of the change in column 2 (mm/dd/yyyy).	1	2	10	X
Has the provider terminated participation in the Medicare program? (Y/N)	2	1	1	X
If column 1 is yes, enter in column 2, the date of termination (mm/dd/yyyy).	2	2	10	X
If column 1 is yes, enter in column 3, "V" for voluntary and "I" for involuntary.	2	3	1	X
Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home office, drug or medical supply company) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (Y/N) (see instructions)	3	1	1	X

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET S-2, Part II (Cont.)				
Financial Data Report				
Were the financial statements prepared by a certified public accountant? (Y/N)	4	1	1	X
If col. 1 is "Y", enter in col. 2, A, C or R. (see instructions)	4	2	1	X
Submit complete copies or enter data available (mm/dd/yyyy). (see instructions)	4	3	10	X
Are the cost report total expenses and total revenues different from those on the filed financial statements? (Y/N) (see instructions)	5	1	1	X
Approved Educational Activities				
Are costs claimed for a nursing program? (Y/N)	6	1	1	X
If column 1 is "Y", is the provider the legal operator of the program? (Y/N)	6	2	1	X
Are costs claimed for allied health programs? (Y/N)	7	1	1	X
Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? (Y/N)	8	1	1	X
Are costs claimed for Intern-Resident programs claimed on the current cost report? (Y/N)	9	1	1	X
Was an Intern-Resident program initiated or renewed in the current cost reporting period (Y/N)	10	1	1	X
Are GME costs directly assigned to costs centers other than I&R in an approved teaching program on Worksheet A? (Y/N)	11	1	1	X
Bad Debt				
Is the provider seeking reimbursement for bad debts? (Y/N) If "Y", see instructions.	12	1	1	X
If line 12 is "Y", did the provider's bad debt collection policy change during this cost reporting period? (Y/N) If "Y", submit a copy to your contractor.	13	1	1	X
If line 12 is "Y", are patient deductibles and/or coinsurance amounts waived? (Y/N) If "Y", see instructions.	14	1	1	X
Bed Compliment				
Did total beds available change from the prior cost reporting period? (Y/N) If "Y", see instructions.	15	1	1	X

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET S-2, Part II (Cont.)				
PS&R Data				
Was the cost report prepared using the PS&R data only? (Y/N)	16	1, 3	1	X
If line 16, either col. 1 or 3 is "Y", in columns 2 and 4, enter the "Paid Claims Verified Current As Of" date from the PS&R used to prepare this cost report, if present; otherwise, enter the "Paid Dates" from the PS&R used (mm/dd/yyyy). (see instructions)	16	2, 4	10	X
Was the cost report prepared using the PS&R for totals and the provider's record for allocations? (Y/N)	17	1, 3	1	X
If line 17, either cols. 1 or 3 is "Y", in columns 2 and 4, enter the "Paid Claims Verified Current As Of" date from the PS&R used to prepare this cost report, if present; otherwise, enter the "Paid Dates" from the PS&R used (mm/dd/yyyy). (see instructions)	17	2, 4	10	X
If line 16 or 17 is "Y", were adjustments made to the PS&R data for additional claims that have been billed but are not included on the PS&R to file this cost report? (Y/N) If "Y", see instructions.	18	1, 3	1	X
If line 16 or 17 is "Y", were adjustments made to the PS&R data for correction of other PS&R information? (Y/N) If "Y", see instructions.	19	1, 3	1	X
If line 16 or 17 is "Y", describe adjustments made to PS&R data for other.	20	0	36	X
If line 16 or 17 is "Y", were adjustments made to PS&R data for other. (Y/N)	20	1, 3	1	X
Was the cost report prepared only using the provider's records? (Y/N) If "Y", see instructions.	21	1, 3	1	X
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY				
Capital Related Cost				
Have assets been re-lifed for Medicare purposes? (Y/N) If "Y", see instructions.	22	1	1	X
Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period (Y/N) If "Y", see instructions.	23	1	1	X
Were new leases and/or amendments to existing leases entered into during this cost reporting period? (Y/N) If "Y", see instructions.	24	1	1	X

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET S-2, Part II (Cont.)				
Have there been new capitalized leases entered into during the cost reporting period? (Y/N) If "Y", see instructions.	25	1	1	X
Were assets subject to §2314 of DEFRA acquired during the cost reporting period? (Y/N) If "Y", see instructions.	26	1	1	X
Has the provider's capitalization policy changed during the cost reporting period? (Y/N) If "Y", see instructions.	27	1	1	X
Interest Expense				
Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? (Y/N) If "Y", see instructions.	28	1	1	X
Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? (Y/N) If "Y", see instructions.	29	1	1	X
Has existing debt been replaced prior to its scheduled maturity with new debt? (Y/N) If "Y", see instructions.	30	1	1	X
Has debt been recalled before scheduled maturity without issuance of new debt? (Y/N) If "Y", see instructions.	31	1	1	X
Purchased Services				
Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? (Y/N) If "Y", see instructions.	32	1	1	X
If line 32 is "Y", then were requirements of §2135.2 applied pertaining to competitive bidding? (Y/N) If "N", see instructions.	33	1	1	X
Provider-Based Physicians				
Are services furnished at the provider facility under an arrangement with provider-based physicians? (Y/N) If "Y", see instructions.	34	1	1	X
If line 34 is "Y", were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? (Y/N) If "Y", see instructions.	35	1	1	X

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET S-2, Part II (Cont.)				
Home Office Costs				
Are home office costs claimed on the cost report? (Y/N)	36	1	1	X
If line 36 is "Y", has a home office cost statement been prepared by the home office? (Y/N) If "Y", see instructions.	37	1	1	X
If line 36 is "Y", is the fiscal year end of the home office different from that of the provider? (Y/N)	38	1	1	X
If column 1 is "Y", enter in column 2 the fiscal year end of the home office (mm/dd/yyyy).	38	2	10	X
If line 36 is "Y", does the provider render services to other chain components? (Y/N) If "Y", see instructions.	39	1	1	X
If line 36 is "Y", does the provider render services to the home office? (Y/N) If "Y", see instructions.	40	1	1	X
Cost Report Preparer Contact Information				
Enter the preparer's information:				
Enter in column 1, first name.	41	1	36	X
Enter in column 2, last name.	41	2	36	X
Enter in column 3, title.	41	3	36	X
Enter in column 1, employer.	42	1	36	X
Enter in column 1, phone number.	43	1	36	X
Enter in column 2, e-mail address.	43	2	36	X
WORKSHEET S-3, PART I				
For hospital adults and pediatrics (excluding swing beds, et al.), swing-bed SNF, swing-bed NF, adults and pediatrics in total, each special care unit, the nursery, in total for the hospital, each subprovider, the hospital-based SNF, and in total for the facility, enter:				
Worksheet A line number	1, 8-13, 16-26, 34	1	9	9
Number of beds	1, 7-12, 14, 16-21, 24, 27, 32, 34	2	9	9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET S-3, Part I (Cont.)				
Bed days available	1, 7-12, 14, 16-21, 24, 32, 34	3	9	9
Number of hours for CAH/REH patients	1, 7-12, 14, 15.10	4	11	9(8).99
Title V inpatient days/visits	1, 5-20, 22, 25, 26, 28, 34	5	9	9
Title XVIII inpatient days/visits/trips	1-5, 7-12, 14-19, 22, 24, 25, 26, 29, 32, 33, 33.01, 34	6	11	9
Title XIX inpatient days/visits/trips	1-20, 22, 24, 25, 26, 28, 32, 34	7	11	9
Total inpatient days/visits	1, 5-22, 24-26, 28, 30-32.01, 34	8	11	9
Total Interns & Residents	14, 16-27	9	9	9(6).99
Employees on Payroll	14, 16-27	10	11	9(8).99
Nonpaid workers	14, 16-27	11	11	9(8).99
Title V discharges	1, 14, 16-18	12	11	9
Title XVIII discharges	1, 2, 14, 16-18, 33, 33.01	13	11	9
Title XIX discharges	1, 2-4, 14, 16-18	14	11	9
Total discharges	1, 14, 16-18, 21	15	11	9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET S-3, PART II				
Worksheet A line reference	1, 7, 9	1	11	9
Reported salaries	1-43	2	11	9
Reclassification of salaries from Worksheet A-6	1-43	3	11	-9
Paid hours related to salary in column 4	1-16, 26-43	5	11	9(8).99
WORKSHEET S-3, PART III				
Wage Index Summary:				
Cost	6	2	11	9
Reclassification	6	3	11	-9
Paid hours	6	5	11	9(8).99
Total overhead:				
Cost	7	2	11	9
Reclassification	7	3	11	-9
Paid hours	7	5	11	9(8).99
WORKSHEET S-3, PART IV				
Wage Related Costs:				
Core List	1-23	1	11	-9
Total	24	1	11	-9
Other than core related cost	25	0	36	X
Other than core related cost	25	1	11	-9
WORKSHEET S-3, PART V				
Contract Labor Cost:				
Total facility's contract labor	1	1	11	-9
Total facility's benefit cost	1	2	11	-9
Component specific contract labor cost	2-9, 11-18	1	11	-9
Component specific benefit cost	2-9, 11-18	2	11	-9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET S-4				
County	0	1	36	X
Home health aide hours:				
Titles as appropriate	1	1-4	11	9
Totals	1	5	11	9
Unduplicated census count:				
Titles as appropriate	2	1-4	11	9(8).99
Totals	2	5	11	9(8).99
Number of hours in a normal work week	3	0	6	9(3).99
Other (specify)	18	0	36	X
Number of full-time equivalent employees:				
Staff	3-18	1	6	9(3).99
Contract staff and consultants	3-18	2	6	9(3).99
Total	3-18	3	6	9(3).99
How many CBSAs did you provide services during this cost reporting period?	19	1	2	9
List those CBSA code(s) serviced this period	20	1	5	X
PPS Activity Data	21-38	1-4	11	9
Total	21-38	5	11	9
WORKSHEET S-5				
Renal Dialysis Statistics				
Number of patients in program at end of cost reporting period	1	1-6	6	9
Number of times per week patient receives dialysis	2	1-6	5	9(2).99
Average patient dialysis time including setup	3	1-4	5	9(2).99
CAPD/CCPD exchanges per day	4	4, 6	5	9(2).99
Number of days in year dialysis furnished	5	1, 2	3	9
Number of stations	6	1-4	3	9
Treatment capacity per day per station	7	1, 2	1	9
Utilization (see instructions)	8	1, 2	6	9(3).99
Average times dialyzers reused	9	1, 2	6	9(3).99
Percentage of patients reusing dialyzers	10	1, 2	6	9(3).99

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET S-5 (Cont.)				
Is the dialysis facility approved as a low volume facility for this cost reporting period? (Y/N) (see instructions)	10.01	1	1	X
Did your facility elect 100% PPS effective January 1, 2011? (Y/N) (see instructions for "new" providers)	10.02	1	1	X
If you responded "N" to line 10.02, enter in column 1 the year of transition for the period prior to January 1.	10.03	1	1	X
If you responded "N" to line 10.02, enter in column 2 the year of transition for the period after December 31. (see instructions)	10.03	2	1	X
Transplant Information				
Number of patients on transplant list	11	1	1	9
Number of patients transplanted during the cost reporting period	12	1	1	9
Epoetin (EPO)				
Net costs of EPO furnished to all maintenance dialysis patients by the provider.	13	1	11	9
EPO amount from Worksheet A for home dialysis. (see instructions)	14	1	11	9
Number of EPO units furnished relating to the renal dialysis department.	15	1	11	9
Number of EPO units furnished relating to the home dialysis department.	16	1	11	9
Aranesp				
Net cost of Aranesp furnished to all maintenance dialysis patients by the provider.	17	1	11	9
Aranesp amount from Worksheet A for home dialysis. (see instructions)	18	1	11	9
Number of Aranesp units furnished relating to the renal dialysis department.	19	1	11	9
Number of Aranesp units furnished relating to the home dialysis department.	20	1	11	9
Physician payment method. (enter "X" if applicable)				
MCP	21	1	1	X
Initial Method	21	2	1	X

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET S-5 (Cont.)				
Erythropoiesis-Stimulating Agents (ESA) Statistics				
Enter in column 1 the ESA description	22	1	36	X
Enter in column 2, the net cost of ESA units furnished to all renal dialysis patients	22	2	11	9
Enter in column 3, the net cost of ESA units furnished to all home dialysis program patients.	22	3	11	9
Enter in column 4, the number of ESA units furnished to all renal dialysis department patients.	22	4	11	9
Enter in column 5, the number of ESA units furnished to all home dialysis program patients.	22	5	11	9
List each renal dialysis facility listed on Worksheet S-2, Part I, line 18, and its subscripts, in column 1.	23	1	6	X
Enter the total treatments for each CCN in column 2. (see instructions)	23	2	11	9
WORKSHEET S-6				
Number of hours in a normal week	0	1	6	9(3).99
Other (specify)	18	0	36	X
Number of full-time equivalent employees on payroll	1-18	1	6	9(3).99
Number of full-time equivalent contract personnel	1-18	2	6	9(3).99
Total	1-18	3	6	9(3).99
WORKSHEET S-7				
If this facility contains a hospital-based SNF, are all patients under managed care or was there no Medicare utilization? (Y/N) If "Y", do not complete the rest of this worksheet.	1	1	1	X
Does this facility have an agreement under either §1883 or §1913 of the Act for swing beds?	2	1	1	X
If yes, enter the agreement date (mm/dd/yyyy)	2	2	10	X
Prospective Payment for SNF Statistical Data				
Days (see instructions)	3-199	2, 3	9	9
Total	3-199	4	9	9
Total	200	2-4	9	9
Enter in column 1 the SNF CBSA code or five-character code if rural based facility, in effect at the beginning of the cost reporting period.	201	1	5	X

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET S-7 (Cont.)				
Enter in column 2, the code in effect on or after October 1, of the cost reporting period (if applicable).	201	2	5	X
Enter the amount of the expense for each of the following categories:				
Staffing	202	1	11	9
Recruitment	203	1	11	9
Retention of employees	204	1	11	9
Training	205	1	11	9
Other	206	1	11	9
Enter the percentage of total expenses to total SNF revenue for each of the following categories:				
Staffing	202	2	6	9(3).99
Recruitment	203	2	6	9(3).99
Retention of employees	204	2	6	9(3).99
Training	205	2	6	9(3).99
Other	206	2	6	9(3).99
Is the increased spending associated with direct patient care and related spending reflected in each of the following categories: (Y/N)				
Staffing	202	3	1	X
Recruitment	203	3	1	X
Retention of employees	204	3	1	X
Training	205	3	1	X
Other	206	3	1	X
Other (Specify)	206	0	36	X
Total SNF revenue from inpatient care	207	1	11	9
WORKSHEET S-8				
RHC/FQHC identification:				
Street	1	1	36	X
City	2	1	36	X
State	2	2	2	X
ZIP Code	2	3	10	X
County	2	4	36	X
Designation (for FQHCs only) – “R” for rural or “U” for urban	3	1	1	X
Source of Federal Funds:				
Amount of Federal Funds	4-9	1	20	X
Award Date (mm/dd/yyyy)	4-9	2	10	X
Other (specify)	9	0	36	X

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET S-8 (Cont.)				
Does this facility operate as other than an RHC or FQHC?	10	1	1	X
Indicate number of other operations	10	2	2	9
Type of operation	11	0	36	X
Facility hours of operations: from/to*	11	1-14	4	9
Have you received an approval for an exception to the productivity standards?	12	1	1	X
Is this a consolidated cost report as defined in CMS Pub. 100-02, chapter 13, §80.2?	13	1	1	X
Enter the number of providers included in this report.	13	2	2	9
Enter G or N to identify the grouping as grandfathered or non-grandfathered.	13	3	1	X
Removed and reserved	13.01	1, 2		
Provider name	14	1	36	X
CCN number	14	2	6	X
Have you provided all or substantially all GME costs? (Y/N)	15	1	1	X
Number of program visits performed by Interns & Residents	15	2, 3, 4	11	9
Total number of visits performed by Interns & Residents (see instructions)	15	5	11	9
WORKSHEET S-9				
Part I - Enrollment Days for Cost Reporting Periods Beginning Before October 1, 2015				
Hospice Continuous Home Care	1	1-5	11	9
Hospice Routine Home Care	2	1-5	11	9
Hospice Inpatient Respite Care	3	1-5	11	9
Hospice General Inpatient Care	4	1-5	11	9
Total Hospice Days	5	1-5	11	9
Part II - Census Data for Cost Reporting Periods Beginning Before October 1, 2015				
Number of Patients Receiving Hospice	6	1-5	11	9
Unduplicated Continuous Medicare Hours	7	1, 3	11	9(8).99
Average Length of Stay (line 5/line 6)	8	1-5	11	9(8).99
Unduplicated Census Count	9	1-5	11	9
Total	1-9	6	11	9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET S-9 (Cont.)				
Part III - Enrollment Days for Cost Reporting Periods Beginning on or After October 1, 2015				
Hospice Continuous Home Care	10	1-3	11	9
Hospice Routine Home Care	11	1-3	11	9
Hospice Inpatient Respite Care	12	1-3	11	9
Hospice General Inpatient Care	13	1-3	11	9
Total Hospice Days	14	1-3	11	9
Part IV - Contracted Statistical Data for Cost Reporting Periods Beginning on or After October 1, 2015				
Hospice Inpatient Respite Care	15	1-3	11	9
Hospice General Inpatient Care	16	1-3	11	9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET S-10				
Part I - Hospital and Hospital Complex Data				
Uncompensated and indigent care cost to charge ratio				
Cost to charge ratio	1	1	6	9.9(6)
Net Revenue from Medicaid	2	1	11	9
Did you receive DSH or supplemental payments from Medicaid? (Y/N)	3	1	1	X
If line 3 is "Y", does line 2 include all DSH and/or supplemental payments from Medicaid? (Y/N)	4	1	1	X
If line 4 is "N", then enter DSH and/or supplemental payments from Medicaid.	5	1	11	9
Medicaid Charges	6	1	11	9
Net revenue from stand-alone CHIP	9	1	11	9
Stand-alone CHIP charges	10	1	11	9
Net revenue from state or local indigent care program. (see instructions)	13	1	11	9
Charges for patients covered under state or local indigent care program. (see instructions)	14	1	11	9
Private grants, donations, or endowment income restricted to funding charity care. (see instructions)	17	1	11	9
Government grants, appropriations, or transfers for support of hospital operations. (see instructions)	18	1	11	9
Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	19	1	11	9
Charity care charges and uninsured discounts (see instructions)	20	1, 2	11	9
Cost of patients approved for charity care and uninsured discounts (see instructions)	21	1, 2	11	9
Payments received from patients for amounts previously written off as charity care	22	1, 2	11	9
Does the amount in line 20, col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? (Y/N)	24	1	1	X
If line 24 is yes, enter charges for patient days beyond the indigent care program's length-of-stay limit	25	1	11	9
Charges for insured patients' liability	25.01	1	11	9
Bad debt amount (see instructions)	26	1	11	9
Medicare reimbursable bad debts (see instructions)	27	1	11	9
Medicare allowable bad debts (see instructions)	27.01	1	11	9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET S-10				
Part II - Hospital Data				
Uncompensated and indigent care cost to charge ratio				
Cost to charge ratio	1	1	6	9.9(6)
Charity care charges and uninsured discounts (see instructions)	20	1, 2	11	9
Cost of patients approved for charity care and uninsured discounts (see instructions)	21	1, 2	11	9
Payments received from patients for amounts previously written off as charity care	22	1, 2	11	9
Does the amount in line 20, col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? (Y/N)	24	1	1	X
If line 24 is yes, enter charges for patient days beyond the indigent care program's length-of-stay limit	25	1	11	9
Charges for insured patients' liability	25.01	1	11	9
Bad debt amount (see instructions)	26	1	11	9
Medicare reimbursable bad debts (see instructions)	27	1	11	9
Medicare allowable bad debts (see instructions)	27.01	1	11	9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET S-11, PART I				
Hospital and Hospital Health Care Complex Address (for the hospital only):				
Site Name	1	1	36	X
Type of Control	1	2	2	X
Date Decertified (mm/dd/yyyy)	1	3	10	X
V/I Decertification	1	4	1	X
Date of CHOW (mm/dd/yyyy)	1	5	10	X
Street	2	1	36	X
P.O. Box	2	2	9	X
City	3	1	36	X
State	3	2	2	X
ZIP Code	3	3	10	X
County	3	4	36	X
Designation (Enter “R” for rural or “U” for urban)	3	5	1	X
Is this hospital-based FQHC part of an entity that owns, leases or controls multiple FQHCs? Enter “Y” for yes or “N” for no. If yes, enter the entity’s information below.	4	1	1	X
Name of Entity	5	1	36	X
Street	6	1	36	X
P.O. Box	6	2	9	X

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET S-11, PART I (Cont.)				
HRSA Award Number	6	3	20	X
City	7	1	36	X
State	7	2	2	X
Zip Code	7	3	10	X
Is this hospital-based FQHC filing a consolidated cost report per CMS Pub. 100-02, chapter 13, §80.2? (Y/N)	8	1	1	X
Date Requested (mm/dd/yyyy)	8	2	10	X
Date Approved (mm/dd/yyyy)	8	3	10	X
Number of FQHCs	8	4	2	9
Site Name	9.01-9.99	1	36	X
CCN (xxxxxx)	9.01-9.99	2	6	X
CBSA (xxxxx)	9.01-9.99	3	5	X
Date Requested (mm/dd/yyyy)	9.01-9.99	4	10	X
Date Approved (mm/dd/yyyy)	9.01-9.99	5	10	X
What type of organization is this hospital-based FQHC? Enter "1", "2", or "3" (see instructions)	10	1	1	X
If column 1 is "1" or "3", enter any or all of the applicable alpha characters in column 2. (see instructions)	10	2	4	X
Did this hospital-based FQHC receive a grant under§330 of the PHS Act during this cost reporting period? If this is a consolidated cost report, did the hospital-based FQHC on line 1, column 1 receive a grant under §330 of the PHS Act during this cost reporting period? (Y/N)	11	1	1	X
If the response to line 11 is yes, indicate in column 1, the type of HRSA grant that was awarded (see instructions).	12	1	1	X
Enter the date of the grant award in column 2. (mm/dd/yyyy)	12	2	10	X
Enter the grant award number in column 3. If you received more than one grant subscript this line accordingly.	12	3	20	X

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET S-11, PART I (Cont.)				
Did this hospital-based FQHC submit an initial deeming or annual redeeming application for medical malpractice coverage under the FTCA with HRSA? (Y/N)	13	1	1	X
If column 1 is yes, enter the effective date of coverage in column 2. (mm/dd/yyyy)	13	2	10	X
Did the hospital-based FQHC receive a Teaching Health Center development grant authorized under Part C of Title VII of the PHS Act from HRSA? (Y/N)	14	1	1	X
If yes, enter in column 2 the number of FTE residents that the hospital-based FQHC trained and received funding through your THC grant in the cost reporting period.	14	2	9	9(6).99
If yes, enter in column 3 the number of visits performed by such residents during this cost reporting period.	14	3	11	9
WORKSHEET S-11, PART II				
Site Name	1	1	36	X
Date Certified (mm/dd/yyyy)	1	2	10	X
Type of Control	1	3	2	X
Date Decertified (mm/dd/yyyy)	1	4	10	X
V/I Decertification	1	5	1	X
Date of CHOW (mm/dd/yyyy)	1	6	10	X
Street	2	1	36	X
P.O. Box	2	2	9	X
City	3	1	36	X
State	3	2	2	X
ZIP Code	3	3	10	X
County	3	4	36	X
Designation (Enter "R" for rural or "U" for urban)	3	5	1	X
What type of organization is this hospital-based FQHC? Enter “1”, “2”, or “3” (see instructions)	4	1	1	X
If column 1 is “1” or “3”, enter any or all of the applicable alpha characters in column 2. (see instructions)	4	2	4	X
Did this hospital-based FQHC receive a grant under§330 of the PHS Act during this cost reporting period? (Y/N)	5	1	1	X

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET S-11, PART II (Cont.)				
If the response to line 5 is yes, indicate in column 1, the type of HRSA grant that was awarded. (see instructions)	6	1	1	X
Enter the date of the grant award in column 2. (mm/dd/yyyy)	6	2	10	X
Enter the grant award number in column 3. If you received more than one grant subscript this line accordingly.	6	3	20	X
Did this hospital-based FQHC submit an initial deeming or annual redeeming application for medical malpractice coverage under the FTCA with HRSA? (Y/N)	7	1	1	X
If column 1 is yes, enter the effective date of coverage in column 2. (mm/dd/yyyy)	7	2	10	X
Did the hospital-based FQHC receive a Teaching Health Center development grant authorized under Part C of Title VII of the PHS Act from HRSA? (Y/N)	8	1	1	X
If yes, enter in column 2 the number of FTE residents that the hospital-based FQHC trained and received funding through your THC grant in the cost reporting period.	8	2	9	9(6).99
If yes, enter in column 3 the number of visits performed by such residents during this cost reporting period.	8	3	11	9
WORKSHEET S-11, PART III				
Use this column only when filing a consolidated cost report to identify each FQHC listed on Worksheet S-11, Part I, Line 9, and subscripts in the exact same order.	1, 3, & 5	0	6	X
Medical Visits	1	1-4	11	9
Total Medical Visits	2	1-4	11	9
Mental Health Visits	3	1-4	11	9
Total Mental Health Visits	4	1-4	11	9
IOP Visits	5	1-4	11	9
Total IOP Visits	6	1-4	11	9
Total FQHC Visits	7	1-4	11	9
WORKSHEET S-12				
Medicare Severity Diagnosis-Related Group (MS-DRG) Title	*1-997*	*1*	*11*	*9(8).99*

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET A				
Direct salaries by department	4-23, 30-46, 50-60, 62-78, 88-91, 92.01-102, 105-112, 114-117, 190-194	1	11	-9
Total direct salaries	200	1	11	9
Other direct costs by department	1-23, 30-46, 50-78, 88-91, 92.01, 93-102, 105-117, 190-194	2	11	-9
Total other direct costs	200	2	11	9
Net expenses for allocation by department	1, 2, 4-23, 30-46, 50-78, 88-91, 92.01, 93-102, 105-112, 115-117, 190-194	7	11	-9
Total expenses for allocation	200	7	11	9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET A-6				
For each expense reclassification:				
Explanation	1-499	0	36	X
Adjustment letter (s)	1-499	1	2	X
Increases:				
Worksheet A line number	1-499	3	6	9(3).99
Reclassification salary amount	1-499	4	11	9
Reclassification other amount	1-499	5	11	9
Decreases:				
Worksheet A line number	1-499	7	6	9(3).99
Reclassification salary amount	1-499	8	11	9
Reclassification other amount	1-499	9	11	9
Worksheet A-7 column reference	1-499	10	2	9
Total	500	4-5, 8-9	11	9
WORKSHEET A-7				
For land, land improvements, buildings and fixtures, building improvements, fixed and movable equipment, and in total:				
Part I - Analysis of changes in capital asset balances				
Beginning balance	1-10	1	11	9
Purchases	1-10	2	11	9
Donations	1-10	3	11	9
Disposals and retirements	1-10	5	11	9
Fully depreciated assets	1-10	7	11	9
Part II - Reconciliation of capital cost centers from Worksheet A				
Summary of capital depreciation, lease, interest, insurance, taxes, and other capital-related costs	1-2	9-14	11	-9
Part III - Reconciliation of capital cost centers				
Gross assets and capitalized leases	1-2	1, 2	11	9
Ratio	1-2	4	8	9.9(6)
Insurance, taxes, and other capital-related costs	1-3	5, 6, 7	11	9
Summary of capital				
Depreciation, lease, interest, insurance, taxes, and other capital-related costs	1-2	9-14	11	-9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET A-8				
Description of adjustment	32-49	0	36	X
Basis (A or B)*	1-9, 11, 13-22, 25-29, 30.99, 32-49	1	1	X
Amount*	1-50	2	11	-9
Worksheet A line number+	3-9, 11, 13-22, 29, 32-49	4	6	9(3).99
Worksheet A-7 column reference	1-22, 26-27, 29, 32-49	5	2	9

*These include subscripts of lines 1, 2, and 26 through 27 requiring records for columns 1 and 2. These subscripts should occur based on Worksheet A layout.
+Do not include preprinted lines (i.e., lines 1, 2, 23 through 28, and 30 through 32). Include only subscripts of those lines, if activated by an entry in either of columns 1 or 2.

WORKSHEET A-8-1				
Part A - For costs incurred and adjustments required as a result of transactions with related organization(s):				
Worksheet A line number	1-4	1	6	9(3).99
Expense item(s)	1-4	3	36	X
Amount allowable in reimbursable cost	1-4	4	11	-9
Amount included in Worksheet A	1-4	5	11	-9
Net Adjustment	1-4	6	11	-9
Worksheet A-7, Part II, column reference (9 through 14 only)	1-4	7	2	9
Total	5	4-6	11	-9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET A-8-1				
Part B - For each related organization:				
Type of interrelationship (A through G)	6-10	1	1	X
If type is G, description of relationship must be included.	6-10	0	36	X
Name of individual or partnership with interest in provider and related organization	6-10	2	15	X
Percent of ownership in provider	6-10	3	6	9(3).99
Name of related organization	6-10	4	15	X
Percent of ownership of related organization	6-10	5	6	9(3).99
Type of business	6-10	6	15	X
WORKSHEET A-8-2				
By each cost center or Physician:				
Worksheet A line number	1-199	1	6	9(3).99
Physician identifier and aggregate only	1-199	2	36	X
Total Physicians' remuneration	1-199	3	11	9
Physician's remuneration - Professional component	1-199	4	11	9
Physician's remuneration - Provider component	1-199	5	11	9
RCE amount	1-199	6	11	9
Number of Physicians' hours – Provider component	1-199	7	11	9
Costs of memberships and continuing education	1-199	12	11	9
Physician cost of malpractice insurance	1-199	14	11	9
In total for the facility (sum of lines 1 through 199):				
Total Physicians' remuneration	200	3	11	9
Physicians' remuneration - Professional component	200	4	11	9
Physician's remuneration - Provider component	200	5	11	9
Number of Physicians' hours - Provider component	200	7	11	9
Cost of memberships and continuing education	200	12	11	9
Physician cost of malpractice insurance	200	14	11	9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET A-8-3				
Total number of weeks worked during which outside suppliers worked	1	1	11	9
Number of unduplicated days on which supervisor or therapist was on provider site (see instructions)	3	1	11	9
Number of unduplicated days on which therapy assistant was on provider site, but neither supervisor nor therapist was on provider site. (see instructions)	4	1	11	9
Number of unduplicated offsite visits – supervisors or therapist	5	1	11	9
Number of unduplicated offside visits – therapy assistants (include only visits made by a therapy assistant when the supervisor and/or therapist was not present during the visit (s)) (see instructions)	6	1	11	9
Standard travel expense rate	7	1	5	99.99
Optional travel expense rate per mile	8	1	3	.99
Total hours worked by discipline	9	1-5	11	9(8).99
AHSEA by discipline	10	1-5	5	99.99
Number of travel hours by discipline	12	1-3	11	9
Number of miles driven by discipline	13	1-3	11	9
Travel allowance and expense – include only one	33, 34, 35	1	11	9
Travel allowance and expense – include only one	44, 45, 46	1	11	9
Overtime hours worked during period by discipline (see instructions)	47	1-4	11	9(8).99
Allocation of provider's standard work year for one full-time employee times the percentage on line 50 (see instructions)	51	5	7	9(4).99
Equipment cost (see instructions)	61	1	11	9
Supplies (see instructions)	62	1	11	9
Total cost of outside supplier services (from your records)	64	1	11	9
Excess over limitation (line 64 minus line 63; if negative, enter zero)	65	1	11	9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEETS B-1; H-1, PART II; J-1, PART II; and O-6, PART II HEADINGS*				
Column heading (cost center name)	1-3*	1-4, 5-23	10	X
Statistical basis	4, 5*	1-4, 5-23	10	X
WORKSHEET B, PART I				
Total adjustments after cost finding	202	25	11	-9
Costs after cost finding and post step-down adjustments by department	30-46, 50-60, 62-78, 88-91, 92.01-102, 105- 117, 190-194, & 201	26	11	-9
Total costs after cost finding and post step-down adjustments	202	26	11	9

*Refer to Table 1 for specifications and Table 2 for the worksheet identifier for column headings. There may be up to five type 2 records (three for cost center name and two for the statistical basis) for each column. However, for any column which has less than five type 2 record entries, blank records or the word "blank" is not required to maximize each column record count.

WORKSHEET B, PART II				
Directly assigned capital related costs by department	4-23, 30-46, 50-60, 62-78, 88-91, 92.01-102, 105-117, 190-194	0	11	9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET B, PART II (Cont.)				
Total directly assigned capital related costs	202	0	11	9
Total adjustments after cost finding	202	25	11	-9
Total capital related costs after cost finding by department	30-46, 50-60, 62-78, 88-91, 93-102, 105-117, 190-194	26	11	-9
Total capital related costs after cost finding in total	202	26	11	9
WORKSHEET B-1				
For each cost allocation using accumulated costs as the statistic, include a record containing an X.	0	5-23	1	X
All cost allocation statistics	1-23, 30-46, 50-60, 62-78, 88-91, 92.01-102, 105-117, 190-194	1-23*	11	9
Reconciliation	4-23, 30-46, 50-78, 88-91, 93-102, 105-117, 190-194	5A-23A	11	-9
Costs to be allocated	202	1-23+	11	9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET B-1 (Cont.)				
* In any column using accumulated costs as the statistical basis for allocating costs, identify any cost center that is not to receive an allocation either by entering a negative 1 (-1) on the appropriate line in the accumulated cost column, or by entering the total accumulated cost as a negative amount on the appropriate line in the reconciliation column. Cost centers that are not to receive an allocation cannot have entries in both the reconciliation and accumulated cost columns when the accumulated cost statistic is offset to zero.				
For those cost centers that are to receive partial allocation of costs, enter only the cost to be excluded from the statistic as a negative amount on the appropriate line in the reconciliation column. This will result in entries in both the reconciliation column and accumulated column simultaneously on the same line where a partial accumulated cost statistic is offset.				
If line 5 is fragmented, make no entries on line 5 but enter any accumulated cost statistic adjustments on the subscripts of line 5.				
+ Include any column that uses accumulated cost as its basis for allocation.				
WORKSHEET B-2				
For post step-down adjustment:				
Adjustment for EPO costs in Renal Dialysis	1	1	36	X
Worksheet Code indicator	1	2	1	X
Worksheet A line number	1	3	6	9(3).99
Amount of adjustment	1	4	11	-9
Adjustment for EPO costs for in Home Program	2	1	36	X
Worksheet Code indicator	2	2	1	X
Worksheet A line number	2	3	6	9(3).99
Amount of adjustment	2	4	11	-9
Adjustment for ARANESP costs in Renal Dialysis	3	1	36	X
Worksheet Code indicator	3	2	1	X
Worksheet A line number	3	3	6	9(3).99
Amount of adjustment	3	4	11	-9
Adjustment for ARANESP costs for in Home Program	4	1	36	X
Worksheet Code indicator	4	2	1	X
Worksheet A line number	4	3	6	9(3).99
Amount of adjustment	4	4	11	-9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET B-2 (Cont.)				
Amount for ESA costs in Renal Dialysis	5	1	36	X
Worksheet B Code indicator	5	2	1	X
Worksheet A line number	5	3	6	9(3).99
Amount of adjustment	5	4	11	-9
Adjustment for ESA costs for in Home Program	6	1	36	X
Worksheet Code indicator	6	2	1	X
Worksheet A line number	6	3	6	9(3).99
Amount of adjustment	6	4	11	-9
Explanation	7-59	1	36	X
Worksheet Code indicator (1=B, Part I; 2=B, Part II; and 3=L-1, 4=D, Part III; and D, Part IV	7-59	2	1	X
Worksheet A line number	7-59	3	6	9(3).99
Amount of adjustment	7-59	4	11	-9
WORKSHEET C, PART I				
Observation bed cost (see instructions)	92	1	11	9
Total cost (line 200 minus line 201)	202	1	11	9
Total charges by department (inpatient)	30-46	6	11	9
Total charges by department (inpatient/outpatient)	50-102, 105-117	6-7	11	9
Total charges (inpatient/outpatient)	200	6-7	11	9
WORKSHEET C, PART II				
Total capital and outpatient reductions	202	4-5	11	-9

NOTE: On Worksheet B-2, if there are more than 59 lines needed, use multiple worksheets. (Refer to the footnote to this worksheet in Table 2.)

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET D, PART III				
Apportionment of inpatient routine service other pass through costs				
Nursing program post-stepdown adjustment	30-35, 40-45	1A	11	-9
Nursing program post-stepdown adjustment total	200	1A	11	-9
Nursing program	30-35, 40-45	1	11	-9
Nursing program total	200	1	11	-9
Allied health (paramedical education) post-stepdown adjustment	30-35, 40-45	2A	11	-9
Allied health (paramedical education) post-stepdown adjustment total	200	2A	11	-9
Allied health (paramedical education) cost	30-35, 40-45	2	11	-9
Allied health (paramedical education) total	200	2	11	-9
Other medical educational cost	30-35, 40-45	3	11	-9
Other medical education total	200	3	11	-9
Total inpatient program pass-through cost	200	9	11	-9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET D, PART IV				
Apportionment of inpatient ancillary service other pass through costs				
Where post step-down adjustments affecting either non-physician anesthetists or direct medical education costs are made, furnish only the net change for each cost center.				
Non-physician anesthetist charge by department	50-60, 62-78, 88-93, 94-98	1	11	-9
Nursing program post-stepdown adjustment	50-60, 62-78, 88-93, 94-98	2A	11	-9
Nursing program post-stepdown adjustment total	200	2A	11	-9
Nursing program	50-60, 62-78, 88-93, 94-98	2	11	-9
Allied health (paramedical education) post-stepdown adjustment	50-60, 62-78, 88-93, 94-98	3A	11	-9
Allied health (paramedical education) post-stepdown adjustment total	200	3A	11	-9
Allied health (paramedical education) cost	50-60, 62-78, 88-93, 94-98	3	11	-9
Other medical education cost	50-60, 62-78, 88-93, 94-98	4	11	-9
Total program pass-through costs and charges	200	1-4, 11, 13	11	-9

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ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET D, PART V				
Apportionment of medical and other health service costs				
PPS Reimbursed Services (see instructions)	50-98	2	11	9
Cost reimbursed services subject to deductible and coinsurance. (see instructions)	50-98	3	11	9
Cost reimbursed services not subject to deductible and coinsurance. (see instructions)	50-98	4	11	9
Ambulance	95	6	11	9
Subtotal program charges	200	2-4, 7	11	9
CRNA charges	201	3-4, 7	11	-9
Net program costs	202	5-7	11	9

NOTE: If Worksheet A, line 19, is subscripted and the provider qualifies for the exception as described in §4010, for non-physician anesthetist services, include the combined charges of those lines on Worksheet D, Part V, line 202, column 2.

WORKSHEET D-1				
Part I - All Provider Components				
Inpatient days (including private room days and swing-bed days, excluding newborn)	1	1	11	9
Inpatient days (including private room days, excluding swing-bed and newborn days)	2	1	11	9
Total private room days	3	1	11	9
Total semi-private room days	4	1	11	9
Swing-bed SNF type inpatient days through 12/31*	5	1	11	9
Swing-bed SNF type inpatient days after 12/31*	6	1	11	9
Swing-bed NF type inpatient days through 12/31*	7	1	11	9
Swing-bed NF type inpatient days after 12/31*	8	1	11	9
Inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	9	1	11	9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET D-1 (Cont.)				
Swing-bed SNF days through 12/31 (title XVIII)*	10	1	11	9
Swing-bed SNF days after 12/31 (title XVIII)*	11	1	11	9
Swing-bed NF days through 12/31 (titles V and XIX)*	12	1	11	9
Swing-bed NF days after 12/31 (titles V and XIX)*	13	1	11	9
Medically necessary private room program days	14	1	11	9
Medicare rate for:				
Swing-bed services through 12/31	17	1	7	9(4).99
Swing-bed services after 12/31	18	1	7	9(4).99
Non-Medicare rate for:				
Swing-bed NF services through 12/31	19	1	7	9(4).99
Swing-bed NF services after 12/31	20	1	7	9(4).99
General inpatient routine service charges	28	1	11	9
Private room charges	29	1	11	9
Semi-private room charges	30	1	11	9
* Hospital or subprovider only				
Part II -- Hospital and Subproviders Only				
Program overflow days by each special care unit for hospital and subproviders only (This data is added to program routine days from Worksheet S-3, Part I, line 1, column 5 through 7, as appropriate.) See CMS Pub. 15-2, §4022	43-47	4	11	9
Total program inpatient costs	49	1	11	9
TEFRA target amount per discharge	55	1	9	9(6).99
TEFRA target amount per discharge	55.01	1	9	9(6).99
TEFRA target amount per discharge	55.02	1	9	9(6).99
CAR T-cell amount paid as an interim payment	55.03	1	9	9
Bonus payment (see instructions)	58	1	11	9
Trended costs	59	1	11	9(8).99
Expected costs	60	1	11	9(8).99
Continuous improvement bonus payment	61	1	11	9
Relief Payment (see instructions)	62	1	11	9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET D-1 (Cont.)				
Part III - Skilled Nursing Facility, Nursing Facility and ICF/IID only				
Aggregate charges to beneficiaries for excess costs	79	1	11	9
Inpatient routine service cost per diem limitation	81	1	7	9(4).99
Utilization review - physicians' compensation	85	1	11	9
Total program inpatient operating costs	86	1	11	9
Part IV - Computation of Observation Bed Cost Hospital Only				
Total observation beds days (see instructions)	87	1	11	9
Observation bed cost (title XVIII only)	89	1	11	9
WORKSHEET D-2				
Part I				
Percent of assigned time of interns and residents (not in approved programs)	2-8, 10-19, 21-26	1	6	9(3).99
Title XVIII, Part B inpatient days (Part A adjustment only)(1)	2-7, 10-13	6	11	-9
Title XVIII, Part A only charges (see note below)	21-26	6	11	-9
Subtotal (sum of lines 2 through 8)	9	8-10	11	-9
Subtotal (sum of lines 21 through 26)	27	8-10	11	-9
Part II				
Title XVIII, Part B inpatient days	29-30, 32-36, 48-41	6	11	9

(1) Display only the Part A coverage days adjustment, negative amount, in the ECR record(s). See §4026.1 for proper submission of reconciliation of these days.

Note: For Part A only charges, the amount reported is only the title XVIII Part B ancillary charges. These will be used to reduce ancillary charges from Worksheet D-3, column 2, and Worksheet D, Part III, sum of columns 1 through 4, in order to properly calculate the Part B ancillary charges.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET D-3				
For each component under titles V, XVIII, and XIX, except for SNFs under title XVIII:				
Inpatient Part A ancillary charges by department	30-43, 50-78, 88-94, 96-98	2	11	9
Total program charges (sum of lines 50 through 94 and 90 through 98)	200	2	11	9
Inpatient program costs by department	50-78, 88-94, 96-98	3	11	9
Total program costs (sum of lines 50 through 94 and 90 through 98)	200	3	11	9
WORKSHEET D-4				
Part I				
Inpatient routine service charges for organ acquisition	1-6	1	11	9
Medicare organ acquisition days	1-6	3	11	9(8).99
Part A inpatient ancillary organ acquisition charges	8-40	2	11	9
Part III				
Provider charges for interns and residents services only where the provider charges separately	57, 58	3	11	9
Total charges applicable to costs in column 1 only where the provider has a schedule of charges for the various direct organ acquisition costs	59	3	11	9
Cost of physicians' services in a teaching hospital	60	3	11	9
Total	61	3	11	9
Total usable organs	62	2	11	9
Medicare usable organs	63	2	11	9
Revenue for organs sold	66	1, 3	11	9
Partial primary payor amounts applicable to organ acquisition	66.01	1, 3	11	9
Partial primary payor amounts applicable to transplants (informational only)	66.02	1, 3	11	9
Organ acquisition charges billed to Medicare under Part B	68	1-4	11	9
Net Organ acquisition cost and charges	69	1-4	11	-9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET D-4 (Cont.)				
Part IV				
Organs excised at provider	70	1, 2	11	9
Organs purchased from other transplant hospitals	71	1, 2	11	9
Organs purchased from non-transplant hospitals	72	1, 2	11	9
Organs purchased from OPOs	73	2	11	9
Organs transplanted	75	1, 2	11	9
Organs transplanted into Medicare beneficiaries	75.01	1, 2	11	9
Kidneys transplanted into MA beneficiaries	75.02	1, 2	11	9
Organs transplanted, Medicare secondary payer	75.03	1, 2, 3	11	9
Organs transplanted, Other	75.04	1, 2	11	9
Organs sold to other hospitals	76	1, 2, 3	11	9
Organs sold to OPOs	77	1, 2, 3	11	9
Organs sold to transplant hospitals	78	1, 2, 3	11	9
Organs sold to MRTC without an agreement or VA hospitals	79	1, 2, 3	11	9
Kidneys sold to MRTC with an agreement	79.01	1, 2, 3	11	9
Organs sold outside the U.S.	80	1, 2, 3	11	9
Organs sent outside the U.S. (no revenue)	81	1, 2	11	9
Organs used for research	82	1, 2, 3	11	9
Unusable or discarded organs	83	1, 2	11	9
WORKSHEET D-5				
Part I				
Physicians' remuneration - in total	1-11	3	11	9
Physicians' remuneration - professional component	1-11	4	11	9
RCE amount	1-11	5	11	9
Number of physicians' hours - professional component	1-11	6	11	9
Cost of memberships and continuing education	1-11	11	11	9
Cost of physician malpractice insurance	1-11	13	11	9
Part II				
Total inpatient days and outpatient visit days	2	1	11	9
Patient days (The same days and visit days are used for both the hospital staff and medical staff costs.)				
Title V inpatient days	4	1	11	9
Title V outpatient visit days	5	1	11	9
Title XVIII inpatient days (Part A)	6	1	11	9
Title XVIII outpatient visit days (Part B)	7	1	11	9
Title XIX inpatient days	8	1	11	9
Title XIX outpatient visit days	9	1	11	9
Total kidney acquisition days and outpatient visit days	10	1	11	9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET D-5 (Cont.)				
Part II (Cont.)				
Total liver acquisition days and outpatient visit days	11	1	11	9
Total heart acquisition days and outpatient visit days	12	1	11	9
Total lung acquisition days and outpatient visit days	13	1	11	9
Total pancreas acquisition days and outpatient visit days	14	1	11	9
Total intestinal acquisition days and outpatient visit days	15	1	11	9
Total islet acquisition days and outpatient visits days	16	1	11	9
Other Organ Acquisition	17	0	36	X
Other Organ Acquisition	17	1	11	9
Part III				
Number of physicians' hours - professional component	1-200	6	11	9
Part IV				
For the hospital and each subprovider:				
Total inpatient days and outpatient visit days	2	1	11	9
Title V inpatient days	4	1	11	9
Title V outpatient visit days	5	1	11	9
Title XVIII inpatient days (Part A)	6	1	11	9
Title XVIII outpatient visit days (Part B)	7	1	11	9
Title XIX inpatient days	8	1	11	9
Title XIX outpatient visit days	9	1	11	9
Title XIX outpatient visit days	9	1	11	9
Total kidney acquisition days and outpatient visit days	10	1	11	9(8).99
Total liver acquisition days and outpatient visit days	11	1	11	9(8).99
Total heart acquisition days and outpatient visit days	12	1	11	9(8).99
Total lung acquisition days and outpatient visit days	13	1	11	9(8).99
Total pancreas acquisition days and outpatient visit days	14	1	11	9(8).99
Total intestinal acquisition days and outpatient visit days	15	1	11	9(8).99
Total islet acquisition days and outpatient visits days	16	1	11	9(8).99
Inpatient allogeneic HSCT acquisition	17.01	1	11	9
Outpatient allogeneic HSCT acquisition	17.02	1	11	9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET D-6				
Part I				
Inpatient routine service charges for acquisition/cost	1, 2, 5, 6, 7	1, 4	11	9
Per Diem Costs	1, 2, 5, 6	2	9	9(6).99
Inpatient acquisition days	1, 2, 5, 6, 7	3	11	9
Inpatient ancillary service acquisition charges/cost	8, 9, 11-28	2, 4	11	9
Outpatient ancillary service acquisition charges/cost	8, 9, 11-28	3, 5	11	9
Part II				
Average Cost Per Day	1, 2, 5, 6	1	9	9(6).99
Inpatient Acquisition Days	1, 2, 5, 6, 7	2	11	9
Inpatient Part B Acquisition Costs	1, 2, 5, 6, 7	3	11	9
Part III				
Acquisition costs	1	1	11	9
Routine and ancillary	2	1, 2	11	9
Interns and residents	3	2	11	9
Apportionment of acquisition costs	4	1, 2	11	9
Cost of physicians in a teaching hospital	5	1, 2	11	9
Total acquisition cost	6	1, 2	11	9
Total transplants	7	1, 2, 3	11	9
Medicare transplants	8	1, 2	11	9
Medicare ratio	9	1, 2	8	9.9(6)
Medicare cost	10	1, 2	11	9
Part IV				
Number of recipients intended for allogeneic HSCT where the acquisition cost was incurred but the transplant did not occur	1	1	11	9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET E, PART A				
For the hospital and subprovider(s):				
DRG amounts - other than outlier payments	1	1	11	9
DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	1.01	1	11	9
DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	1.02	1	11	9
DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	1.03	1	11	9
DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	1.04	1	11	9
Outlier payments for discharges	2	1	11	9
Outlier reconciliation amount	2.01	1	11	9
Outlier payment for discharges for Model 4 BPCI (see instructions)	2.02	1	11	9
Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	1	11	9
Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	1	11	9
Managed Care Simulated Payments	3	1	11	9
Bed days available divided by number of days in cost reporting period (see instructions)	4	1	9	9(6).99

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET E, PART A (Cont.)				
Indirect Medical Education Adjustment Calculation for Hospitals				
FTE count for allopathic and osteopathic programs before December 31, 1996	5	1	9	9(6).99
FTE cap adjustment for qualifying hospitals under §131 of the CAA 2021	5.01	1	9	9(6).99
FTE count for allopathic and osteopathic add-on to cap for new programs	6	1	9	9(6).99
Rural track program FTE cap limitation adjustment after the cap-building window has closed under §127 of the CAA 2021	6.26-6.49	1	9	9(6).99
MMA §422 reduction amount to the IME cap as specified under 42 CFR 412.105(f)(1)(iv)(B)(1)	7	1	9	9(6).99
ACA §5503 reduction amount to the IME cap as specified under 42 CFR 412.105(f)(1)(iv)(B)(2)	7.01	1	9	9(6).99
Adjustment to the rural track program FTE limitation for rural track programs with a rural track Medicare GME affiliation agreement	7.02	1	9	9(6).99
Adjustment to FTE count for allopathic and osteopathic programs for affiliated programs	8	1	9	9(6).99
The amount of increase if the hospital was awarded FTE cap slots under §5503 of the ACA.	8.01	1	9	9(6).99
The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under §5506 of the ACA.	8.02-8.20	1	9	9(6).99
The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021	8.21-8.27	1	9	9(6).99
The amount of increase if the hospital was awarded FTE cap slots under §4122 of the CAA 2023	8.28	1	9	9(6).99
FTE count for allopathic and osteopathic programs in the current year	10	1	9	9(6).99
FTE count for residents in dental and podiatric programs in the current year.	11	1	9	9(6).99
Current year allowable FTEs	12	1	9	9(6).99
Total allowable FTE count for prior year	13	1	9	9(6).99
Total allowable FTE count for the penultimate year if that year ended on or after 9/30/1997, otherwise enter zero.	14	1	9	9(6).99
Sum of lines 12 through 14 divided by 3	15	1	9	9(6).99
Adjustment for residents in the initial years of the program	16	1	9	9(6).99
Adjustment for residents displaced by program or hospital closure	17	1	9	9(6).99
Adjusted rolling average FTE count	18	1	9	9(6).99

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET E, PART A (Cont.)				
Indirect Medical Education Adjustment for Add-on for Section 422 of the MMA				
Current year resident to bed ratio (see instructions)	19	1	8	9.9(6)
Prior year resident to bed ratio	20	1	8	9.9(6)
IME payment adjustment amount (see instructions)	22	1	11	9
IME payment adjustment - Managed Care (see instructions)	22.01	1	11	9
Current year resident to bed ratio (see instructions)	19	1	8	9.9(6)
Prior year resident to bed ratio	20	1	8	9.9(6)
IME payment adjustment amount (see instructions)	22	1	11	9
Number of additional allopathic and osteopathic IME FTE resident cap slots	23	1	9	9(6).99
Indirect medical education adjustment:				
IME payments adjustment factor (see instructions)	27	1	8	9.9(6)
IME add-on adjustment amount (see instructions)	28	1	11	9
IME add-on adjustment amount - Managed Care (see instructions)	28.01	1	11	9
Total IME payment (sum of lines 22 and 28)	29	1	11	9
Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	29.01	1	11	9
DSH adjustment:				
Percentage of SSI recipient patient days to Medicare Part A patient days	30	1	6	9.9(4)
Percentage of Medicaid patient days to total days	31	1	6	9.9(4)
Enter the sum of lines 30 and 31	32	1	6	9.9(4)
Allowable DSH percentage (see instructions)	33	1	6	9.9(4)
DSH adjustment amount	34	1	11	9
Uncompensated Care Payment Adjustment				
Total uncompensated care amount (see instructions)	35	1, 2	11	9
Factor 3 (see instructions)	35.01	1, 2	11	9.9(9)
Hospital UCP, including supplemental UCP (If line 34 is zero, enter zero on this line) (see instructions)	35.02	1, 2	11	9
Pro rata share of the hospital UCP, including supplemental UCP (see instructions)	35.03	1, 2	11	9
Pro rata share of the MDH's UCP, including supplemental UCPs (see instructions)	35.04	1, 2	11	9
Pro rata share of the SCH's UCP, including supplemental UCPs (see instructions)	35.05	1, 2	11	9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET E, PART A (Cont.)				
Additional Payment for High Percentage of ESRD Beneficiary Discharges (lines 40 through 46):				
Total Medicare discharges excluding discharges for MS-DRGs 652, 682, 683, 684 and 685	40	1	11	9
Total Medicare ESRD discharges excluding MS-DRGs 652, 682, 683, 684 and 685	41	1	11	9
Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684, and 685 (see instructions)	41.01	1	11	9
ESRD Medicare discharges to total Medicare Discharges	42	1	9	9(6).99
Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685	43	1	11	9
Average weekly cost for dialysis treatments (see instructions)	45	1	9	9(6).99
Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only)	48	1	11	9
Nursing and allied health managed care	53	1	11	9
Special Add-on payment for new technologies	54	1	11	9
Islet isolation add-on payment	54.01	1	11	9
Net organ acquisition cost	55	1	11	9
Cellular therapy acquisition cost	55.01	1	11	9
Cost of physicians' services in a teaching hospital (see instructions)	56	1	11	9
Routine service other pass through costs	57	1	11	9
Ancillary service other pass through costs	58	1	11	9
Primary payer payments (see instructions)	60	1	11	9
Deductibles billed to Program beneficiaries	62	1	11	9
Coinsurance billed to Program beneficiaries	63	1	11	9
Allowable bad debts (see instructions)	64	1	11	-9
Adjusted reimbursable bad debts (see instructions)	65	1	11	-9
Allowable bad debts for dual eligible beneficiaries (see instructions)	66	1	11	9
Credits received from manufacturers for replaced devices for applicable MS-DRGs (see instructions)	68	1	11	9
Outlier payments reconciliation	69	1	11	-9
Other adjustments (specify) (see instructions)	70	0	36	X
Other adjustments (specify) (see instructions)	70	1	11	-9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET E, PART A (Cont.)				
Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)	70.50	1	11	-9
N95 respirator payment adjustment amount	70.75	1	11	9
Essential medicines payment adjustment amount	70.76	1	11	9
Demonstration payment adjustment amount before sequestration	70.87	1	11	-9
Volume decrease adjustment (to be completed by SCH and MDH, small rural hospitals only)	70.88	1	11	9
Pioneer ACO demonstration payment adjustment (see instructions)	70.89	1	11	-9
HSP bonus payment HVBP adjustment amount (see instructions)	70.90	1	11	-9
HSP bonus payment HRR adjustment amount (see instructions)	70.91	1	11	-9
Bundled Model 1 discount amount (see instructions)	70.92	1	11	-9
HVBP payment adjustment (see instructions)	70.93	1	11	-9
HRR adjustment amount (see instructions)	70.94	1	11	-9
Recovery of excess depreciation	70.95	1	11	9
Low volume adjustment for federal fiscal year (yyyy)	70.96	0	4	X
Low volume adjustment amount	70.96	1	11	9
Low volume adjustment for federal fiscal year (yyyy)	70.97	0	4	X
Low volume adjustment amount	70.97	1	11	9
HAC adjustment amount (see instructions)	70.99	1	11	-9
Low volume adjustment for federal fiscal year (yyyy)	70.98	0	4	X
Low volume adjustment amount	70.98	1	11	9
Sequestration adjustment amount (see instructions)	71.01	1	11	9
Demonstration payment adjustment amount after sequestration	71.02	1	11	-9
Sequestration adjustment PARHM	71.03	1	11	9
Balance due provider/program PARHM	74.01	1	11	-9
Protested amount	75	1	11	-9
To be Completed by Contractor (lines 90 through 96):				
Operating outlier amount	90	1	11	-9
Capital outlier amount	91	1	11	-9
Operating outlier reconciliation amount	92	1	11	-9
Capital outlier reconciliation amount	93	1	11	-9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET E, PART A (Cont.)				
The rate used to calculate the time value of money	94	1	11	9(8).99
Operating time value of money	95	1	11	-9
Capital time value of money	96	1	11	-9
HSP Bonus Payment Amount				
HSP bonus payment (see instructions)	100	1, 2	11	-9
HVBP Adjustment for HSP Bonus Payment				
HVBP adjustment factor (see instructions)	101	1, 2	12	9(1).9(10)
HVBP adjustment amount for HSP bonus payment (see instructions)	102	1, 2	11	-9
HRR Adjustment for HSP Bonus Payment				
HRR adjustment factor (see instructions)	103	1, 2	6	9(1).9(4)
HRR adjustment amount for HSP bonus payment (see instructions)	104	1, 2	11	-9
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment				
Is this the first year of the current 5-year demonstration period?	200	1	1	X
Cost Reimbursement				
Medicare inpatient service costs	201	1	11	9
Medicare discharges	202	1	11	9
Case-mix adjustment factor	203	1	6	9.9(4)
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
Medicare target amount	204	1	11	9
Case-mix adjusted target amount	205	1	11	9
Medicare inpatient routine cost cap	206	1	11	9
Adjustment to Medicare Part A Inpatient Reimbursement				
Program reimbursement under the §410A Demonstration	207	1	11	9
Medicare Part A inpatient service costs	208	1	11	9
Adjustment to Medicare IPPS payments	209	1	11	-9
Reserved for future use	210	1	11	-9
Total adjustment to Medicare IPPS payments	211	1	11	-9
Comparison of PPS versus Cost Reimbursement				
Total adjustment to Medicare Part A IPPS payments	212	1	11	-9
Low-volume adjustment payments	213	1	11	9
Net Medicare Part A IPPS adjustment	218	1	11	9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Column 1 can be subscripted for the following items: Transitional Corridor, Geographic Reclassification and SCH/MDH elections. See §4030 for the applicable lines.

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET E, PART B				
For the hospital, each subprovider and SNF (title XVIII only)				
OPPS or REH Payments	3	1	11	9
Outlier payment	4	1	11	9
Outlier reconciliation amount	4.01	1	11	9
Hospital specific payment to cost ratio	5	1	5	9.9(3)
Transitional corridor payment (see instructions)	8	1	11	9
Ancillary service charges for physicians' professional services (see note below *)	12	1	11	-9
Aggregate amount collected from beneficiaries	15	1	11	9
Amounts collectible	16	1	11	9
Interns and residents (see instructions)	22	1	11	9
Cost of physicians' services in a teaching hospital (see instructions)	23	1	11	9
Deductibles and coinsurance (see instructions)	25	1	11	9
Deductible and coinsurance related to amount on line 24 (see instructions)	26	1	11	9
REH facility payment amount	28.50	1	11	9
Primary payer payments	31	1	11	9
Allowable bad debts (see instructions)	34	1	11	-9
Reimbursable bad debts for dual eligible beneficiaries (see instructions)	36	1	11	9
MSP-LCC reconciliation amount from PS&R	38	1	11	9
Other adjustments (specify) (see instructions)	39	0	36	X
Other adjustments (specify) (see instructions)	39	1	11	-9
Pioneer ACO demonstration payment adjustment (see instructions)	39.50	1	11	-9
N95 respirator payment adjustment amount (see instructions)	39.75	1	11	9
Demonstration payment adjustment amount before sequestration	39.97	1	11	-9
Partial or full credits received from manufacturers for replaced devices (see instructions)	39.98	1	11	-9
Recovery of Accelerated depreciation	39.99	1	11	-9
Sequestration adjustment (see instructions)	40.01	1	11	9
Demonstration payment adjustment amount after sequestration	40.02	1	11	-9
Sequestration adjustment-PARHM	40.03	1	11	9
Balance due provider/program-PARHM	43.01	1	11	-9
Protested amounts	44	1	11	-9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET E, PART B (Cont.)				
To be Completed by Contractor				
Original outlier amount (see instructions)	90	1	11	-9
Outlier reconciliation amount (see instructions)	91	1	11	-9
The rate used to calculate the Time Value of Money	92	1	11	9(8).99
Time Value of Money (see instructions)	93	1	11	-9
Total (sum of lines 91 and 93)	94	1	11	-9

* - For ancillary service charges, the amount reported is the sum of (1) the program ancillary service charges attributable to physicians' professional services included in total charges on Worksheet C, Part I; (2) program charges applicable to excess cost of luxury items; and, (3) your charges to beneficiaries for excess costs. This sum is used to reduce ancillary service charges from Worksheet D-3 or Worksheet D, Part V, in order to properly calculate the lower of cost or charges on Worksheet E, Part B, and Worksheet E-3, Parts V and VI.

Column 1 can be subscripted for the following items: Transitional Corridor, Geographic Reclassification and SCH/MDH elections. See §4030 for applicable lines.

WORKSHEET E-1, PART I				
For each hospital, each subprovider, SNF and swing-bed SNF - Title XVIII only:				
Total interim payments paid to provider	1	2, 4	11	9
Interim payments payable	2	2, 4	11	9
Date of each retroactive lump sum adjustment (mm/dd/yyyy)	3.01-3.98	1, 3	10	X

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET E-1, PART I (Cont.)				
Amount of each retroactive lump sum adjustment:				
Program to provider	3.01-3.49	2, 4	11	9
Provider to Program	3.50-3.98	2, 4	11	9
Enter the date of the tentative payment from Program to Provider (mm/dd/yyyy)	5.01-5.49	1, 3	10	X
Enter the amount of the tentative payment from Program to provider	5.01-5.49	2, 4	11	9
Enter the date of the tentative payment from provider to Program (mm/dd/yyyy)	5.50-5.98	1, 3	10	X
Enter the amount of the tentative payment from provider to Program	5.50-5.98	2, 4	11	9
Enter name of the Contractor	8	0	36	X
Enter Contractor's number	8	1	5	X
Enter the date of the NPR	8	2	10	X
WORKSHEET E-1, PART II				
Health Information Technology Data Collection and Calculation				
Total hospital discharges as defined in ARRA §4102 (Wkst. S-3, Pt. I, col. 15, line 14)	1	1	11	9
Medicare days	2	1	11	9
Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)	3	1	11	9
Total inpatient days	4	1	11	9
Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	5	1	11	9
Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	6	1	11	9
CAH only- The reasonable cost incurred for the purchase of certified HIT technology, Wkst. S-2, Pt. I, line 168)	7	1	11	9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET E-1, PART II (Cont.)				
Calculation of HIT incentive payment (see instructions)	8	1	11	-9
Sequestration adjustment (see instructions)	9	1	11	9
Calculation of the HIT incentive payment after sequestration (see instructions)	10	1	11	9
Inpatient Hospital Services Under PPS & CAH				
Initial/interim HIT payment(s)	30	1	11	9
Initial/interim HIT payment adjustment (see instructions)	31	1	11	-9
Balance due provider (line 8, or line 10, minus lines 30 and 31) (see instructions)	32	1	11	9
WORKSHEET E-2				
Inpatient routine services - swing-bed SNF	1	1	11	9
Title XVIII, Part B swing-bed days	5	2	11	9
Utilization review - physician compensation for SNF optional method only	7	1	11	9
Amounts paid/payable under workmen's compensation or other primary payers	9	1, 2	11	9
Deductibles, excluding any billed for the professional component of provider based physicians' services	11	1, 2	11	9
Coinsurance, excluding any billed for the professional component of provider based physicians' services	13	1, 2	11	9
Other adjustments (specify) (see instructions)	16	0	36	X
Other adjustments (specify) (see instructions)	16	1, 2	11	-9
Pioneer ACO demonstration payment adjustment (see instructions)	16.50	1, 2	11	-9
Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	16.55	1	11	-9
Demonstration payment adjustment amount before sequestration	16.99	1, 2	11	-9
Allowable bad debts	17	1, 2	11	-9
Adjusted reimbursable bad debt (see instructions)	17.01	1, 2	11	-9
Allowable bad debts for dual eligible beneficiaries (see instructions)	18	1, 2	11	9
Sequestration adjustment (see instructions)	19.01	1, 2	11	9
Demonstration payment adjustment amount after sequestration	19.02	1, 2	11	-9
Sequestration adjustment-PARHM	19.03	1, 2	11	9
Sequestration for non-claims-based amounts	19.25	1, 2	11	9
Interim payments (title V and title XIX only)	20	1, 2	11	9
Balance due provider/program-PARHM	22.01	1, 2	11	-9
Protested amounts	23	1, 2	11	-9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET E-2, (Cont.)				
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment				
Is this the first year of the current 5-year demonstration period?	200	1	1	X
Cost Reimbursement				
Medicare swing-bed SNF inpatient routine service costs	201	1	11	9
Medicare swing-bed SNF inpatient ancillary service costs	202	1	11	9
Total	203	1	11	9
Medicare swing-bed SNF discharges	204	1	11	9
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
Medicare swing-bed SNF target amount	205	1	11	9
Medicare swing-bed SNF inpatient routine cost cap	206	1	11	9
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement				
Program reimbursement under the §410A Demonstration	207	1	11	9
Medicare swing-bed SNF inpatient service costs	208	1	11	9
Adjustment to Medicare swing-bed SNF PPS payments	209	1	11	9
Reserved for future use	210	1	11	-9
Comparison of PPS versus Cost Reimbursement				
Total adjustment to Medicare swing-bed SNF PPS payments	215	1	11	9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET E-3, PART I				
Inpatient hospital services	1	1	11	9
Nursing and allied health managed care payments	1.01	1	11	9
Primary payer payment	5	1	11	9
Deductibles - Part A	7	1	11	9
Coinsurance (see instructions)	9	1	11	9
Allowable bad debts (see instructions)	11	1	11	-9
Allowable bad debts for dual eligible beneficiaries (see instructions)	13	1	11	9
Other adjustment (specify) (see instructions)	17	0	36	X
Other adjustment (specify) (see instructions)	17	1	11	-9
Pioneer ACO demonstration payment adjustment (see instructions)	17.50	1	11	-9
Recovery of Accelerated Depreciation	17.98	1	11	-9
Demonstration payment adjustment amount before sequestration	17.99	1	11	-9
Sequestration adjustment (see instructions)	18.01	1	11	9
Demonstration payment adjustment amount after sequestration	18.02	1	11	9
Interim payments	19	1	11	-9
Protested amounts	22	1	11	-9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET E-3, PART II				
Net Federal IPF PPS Payments (excluding outlier, ECT, stop-loss, and medical education payments)	1	1	11	9
Net IPF PPS Outlier Payments	2	1	11	9
Net IPF PPS ECT Payments	3	1	11	9
Unweighted intern and resident FTE count for the most recent cost report filed on or before November 15, 2004	4	1	9	9(6).99
The temporary FTE cap adjustment for the IPF unweighted residents displaced by program or hospital closure under 42 CFR 412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	4.01	1	9	9(6).99
New teaching program adjustment (see instructions)	5	1	9	9(6).99
Current year's unweighted FTE count of I&R excluding FTE's in the new program growth period of a "new teaching program."	6	1	9	9(6).99
Current years unweighted I&R FTE count for residents within the new program growth period of a "new teaching program."	7	1	9	9(6).99
Intern and resident count for IPF PPS medical education adjustment (see instructions)	8	1	9	9(6).99
Teaching adjustment (see instructions)	11	1	11	9
Nursing and allied health managed care payments	13	1	11	9
Primary payer amounts	17	1	11	9
Deductible - Part A	19	1	11	9
Coinsurance (see instructions)	21	1	11	9
Allowable bad debts (see instructions)	23	1	11	-9
Allowable bad debts for dual eligible beneficiaries (see instructions)	25	1	11	9
Outlier payments reconciliation	29	1	11	9
Other adjustment (specify) (see instructions)	30	0	36	X
Other adjustment (specify) (see instructions)	30	1	11	-9
Pioneer ACO demonstration payment adjustment (see instructions)	30.50	1	11	-9
Recovery of accelerated depreciation	30.98	1	11	-9
Demonstration payment adjustment amount before sequestration	30.99	1	11	-9
Sequestration adjustment (see instructions)	31.01	1	11	9
Demonstration payment adjustment amount after sequestration	31.02	1	11	-9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line (s)	Column (s)	Field Size	Usage
WORKSHEET E-3, PART II				
Interim payments	32	1	11	9
Protested amounts	35	1	11	-9
To be completed by contractor:				
Original outlier amount from Worksheet E-3, Part II, line 2	50	1	11	-9
Outlier reconciliation adjustment amount (see instructions)	51	1	11	-9
The rate used to calculate the Time Value of Money	52	1	11	-9
Time Value of Money (see instructions)	53	1	11	-9
WORKSHEET E-3, PART III				
Net Federal PPS Payment	1	1, 1.01	11	9
Medicare SSI ratio (IRF PPS only) (see instructions)	2	1	9	9.9(4)
IRF LIP Payments	3	1, 1.01	11	9
IRF Outlier Payments	4	1	11	9
Unweighted I&R FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	5	1	9	9(6).99
The temporary FTE cap adjustment for the IRF unweighted residents displaced by program or hospital closure under 42 CFR 412.424(d)(1)(iii)(F)(1) or (2). (see instructions)	5.01	1	9	9(6).99
New Teaching program adjustment (see instructions)	6	1	9	9(6).99
Current year's unweighted FTE count of I&R, excluding FTE's in the new program growth period of a "new teaching program"	7	1	9	9(6).99
Current year unweighted I&R FTE count for residents within the new program growth period of a "new teaching program"	8	1	9	9(6).99
Intern and resident count for IRF PPS medical education adjustment (see instructions)	9	1	9	9(6).99
Teaching adjustment (see instructions)	12	1, 1.01	11	9
Nursing and allied health managed care payments	14	1	11	9
Primary payer payments	18	1	11	9
Deductibles	20	1	11	9
Coinsurance excluding any billed for the professional component of provider based physicians' services	22	1	11	9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET E-3, PART III (Cont.)				
Allowable bad debts (see instructions)	24	1	11	-9
Allowable bad debts for dual eligible beneficiaries (see instructions)	26	1	11	9
Outlier payments reconciliation	30	1	11	9
Other adjustments (specify) (see instructions)	31	0	36	X
Other adjustments (specify) (see instructions)	31	1	11	-9
Pioneer ACO demonstration payment adjustment (see instructions)	31.50	1	11	-9
Recovery of accelerated depreciation	31.98	1	11	-9
Demonstration payment adjustment amount before sequestration	31.99	1	11	-9
Sequestration adjustment (see instructions)	32.01	1	11	9
Demonstration payment adjustment amount after sequestration	32.02	1	11	-9
Interim payments	33	1	11	9
Protested amounts	36	1	11	-9
To be Completed by Contractor:				
Original outlier amount from Worksheet E-3, Part III, line 4	50	1	11	-9
Outlier reconciliation amount (see instructions)	51	1	11	-9
The rate used to calculate the Time Value of Money	52	1	11	-9
Time Value of Money (see instructions)	53	1	11	-9
WORKSHEET E-3, PART IV				
Net federal PPS payment	1	1	11	9
Full standard LTCH PPS payment	1.01	1	11	9
Short stay outlier standard payment amount	1.02	1	11	9
Cost based site neutral payment amount	1.03	1	11	9
LTCH PPS comparable site neutral payment amount	1.04	1	11	9
Outlier Payments	2	1	11	9
Nursing and allied health managed care payments	4	1	11	9
Primary payer payments	8	1	11	9
Deductibles	10	1	11	9
Coinsurance excluding any billed for professional component of provider based physicians' services	12	1	11	9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET E-3, PART IV (Cont.)				
Allowable bad debts (see instructions)	14	1	11	-9
Allowable bad debts for dual eligible beneficiaries (see instructions)	16	1	11	9
Outlier payments reconciliation	20	1	11	9
Other adjustment (specify) (see instructions)	21	0	36	X
Other adjustment (specify) (see instructions)	21	1	11	-9
Pioneer ACO demonstration payment adjustment (see instructions)	21.50	1	11	-9
Recovery of accelerated depreciation	21.98	1	11	-9
Demonstration payment adjustment amount before sequestration	21.99	1	11	-9
Sequestration adjustment (see instructions)	22.01	1	11	9
Demonstration payment adjustment amount after sequestration	22.02	1	11	-9
Interim payments	23	1	11	9
Protested amounts	26	1	11	-9
To be completed by contractor:				
Original outlier amount from Worksheet E-3, Part IV, line 2	50	1	11	-9
Outlier reconciliation amount (see instructions)	51	1	11	-9
The rate used to calculate the Time Value of Money	52	1	11	-9
Time Value of Money (see instructions)	53	1	11	-9
WORKSHEET E-3, PART V				
Inpatient services	1	1	11	9
Nursing and allied health managed care payments	2	1	11	9
Organ acquisition (certified transplant programs only)	3	1	11	9
Cellular therapy acquisition cost	3.01	1	11	9
Primary payer payments	5	1	11	9
Routine service charges	7	1	11	9
Ancillary service charges	8	1	11	9
Aggregate amount actually collected from patients liable for payment for services on a charge basis	11	1	11	9
Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	12	1	11	9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET E-3, PART V (Cont.)				
Deductibles, excluding any billed for the professional component of provider based physicians' services	20	1	11	9
Coinsurance, excluding any billed for the professional component of provider based physicians' services	23	1	11	9
Allowable bad debts (see instructions)	25	1	11	-9
Allowable bad debts for dual eligible beneficiaries (see instructions)	27	1	11	9
Other adjustments (specify) (see instructions)	29	0	36	X
Other adjustments (specify) (see instructions)	29	1	11	-9
Pioneer ACO demonstration payment adjustment (see instructions)	29.50	1	11	-9
Recovery of Accelerated Depreciation	29.98	1	11	-9
Demonstration payment adjustment amount before sequestration	29.99	1	11	-9
Sequestration adjustment (see instructions)	30.01	1	11	9
Demonstration payment adjustment amount after sequestration	30.02	1	11	-9
Sequestration adjustment-PARHM	30.03	1	11	9
Balance due provider/program-PARHM	33.01	1	11	-9
Protested amounts	34	1	11	-9
WORKSHEET E-3, PART VI				
Resource utilization group payment (RUGs)	1	1	11	9
Routine service other pass through costs	2	1	11	9
Ancillary service other pass through costs	3	1	11	9
Deductibles (exclude professional components)	6	1	11	9
Coinsurance, excluding any billed for professional component of provider based physicians' services	7	1	11	9
Allowable bad debts (see instructions)	8	1	11	-9
Reimbursable bad debts for dual eligible beneficiaries (see instructions)	9	1	11	-9
Adjusted reimbursable bad debts (see instructions)	10	1	11	-9
Utilization review	11	1	11	9
Inpatient primary payer amounts	13	1	11	9
Other adjustment (specify) (see instructions)	14	0	36	X
Other adjustment (specify) (see instructions)	14	1	11	-9
Pioneer ACO demonstration payment adjustment (see instructions)	14.50	1	11	-9
Recovery of accelerated depreciation	14.98	1	11	-9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET E-3, PART VI (Cont.)				
Demonstration payment adjustment amount before sequestration	14.99	1	11	-9
Sequestration adjustment (see instructions)	15.01	1	11	9
Demonstration payment adjustment amount after sequestration	15.02	1	11	-9
Sequestration payment adjustment for non-claims-based amounts (see instructions)	15.75	1	11	9
Interim payments	16	1	11	9
Protested amounts	19	1	11	-9
WORKSHEET E-3, PART VII				
Inpatient hospital/SNF/NF services	1	1	11	9
Medical and other services	2	2	11	9
Organ acquisition (certified transplant programs only)	3	1	11	9
Inpatient primary payer payments	5	1	11	9
Outpatient primary payer payments	6	2	11	9
Routine service charges	8	1	11	9
Ancillary service charges for physicians' professional services (see note to Worksheet E, Part B)	9	1, 2	11	9
Amount actually collected from patients liable for payment for services	13	1, 2	11	9
Amount that would have been realized from patient liable for payment for services	14	1, 2	11	9
Interns and residents costs	19	1, 2	11	9
Cost of physicians' services in a teaching hospital (see instructions)	20	1, 2	11	9
Other than outlier payments	22	1, 2	11	9
Outlier payments	23	1, 2	11	9
Customary charges (Title XIX PPS covered services only)	28	1, 2	11	9
Deductibles (exclude professional components)	32	1, 2	11	9
Coinsurance, excluding any billed for the professional component of provider based physicians' services	33	1, 2	11	9
Allowable bad debts (see instructions)	34	1, 2	11	-9
Utilization review	35	1	11	9
Other adjustment (specify) (see instructions)	37	0	36	X
Other adjustment (specify) (see instructions)	37	1, 2	11	-9
Interim payments	41	1, 2	11	9
Protested amounts	43	1, 2	11	-9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET E-4				
Computation of Total Direct GME Amount				
Unweighted resident FTE count for Allopathic and Osteopathic Programs for periods ending on or before December 31, 1996	1	1	9	9(6).99
FTE cap adjustment under §131 of the CAA 2021	1.01	1	9	9(6).99
Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e) (see instructions)	2	1	9	9(6).99
Rural track program FTE cap limitation adjustment under §127 of the CAA 2021	2.26-2.49	1	9	9(6).99
Amount of reduction to Direct GME cap under §422 of the MMA	3	1	9	9(6).99
Direct GME cap reduction amount under §5503 of the ACA in accordance with 42 CFR 413.79(m) (see instructions for cost report periods straddling 7/1/2011)	3.01	1	9	9(6).99
Adjustment (plus or minus) to the hospital's rural track FTE limitation(s) for rural track programs with a rural track Medicare GME affiliation agreement	3.02	1	9	-9(6).99
Adjustment (plus or minus) to the FTE cap for Allopathic and Osteopathic Programs due to a Medicare GME affiliation agreement (42 CFR 413.75(b) and 413.79(f))	4	1	9	-9(6).99
Increase to Direct GME FTE cap under §5503 of the ACA (see instructions for cost reporting period straddling 7/1/2011)	4.01	1	9	9(6).99
Number of additional direct GME FTEs under §5506 of the ACA (see instructions for cost reporting periods straddling 7/1/2011)	4.02-4.20	1	9	9(6).99
Adjustment increase if the hospital was awarded FTE cap slots from §126 of the CAA 2021, effective beginning July 1, 2023	4.21-4.27	1	9	9(6).99
Adjustment increase if the hospital was awarded FTE cap slots from §4122 of the CAA 2023, effective beginning July 1, 2026	4.28	1	9	9(6).99
Unweighted resident FTE count for Allopathic and Osteopathic Programs for current year from your records	6	1	9	9(6).99
Weighted FTE count for primary care physicians in an Allopathic and Osteopathic Program for the current year	8	1	9	9(6).99
Weighted FTE count for all other physicians in an Allopathic and Osteopathic Program for the current year	8	2	9	9(6).99

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET E-4 (Cont.)				
Weighted dental and podiatric resident FTE count for the current year	10	2	9	9(6).99
Unweighted dental and podiatric resident FTE count for the current year	10.01	2	9	9(6).99
Total weighted FTE count	11	1-2	9	9(6).99
Total weighted resident FTE count for the prior cost reporting period. If none, enter 1 here.	12	1-2	9	9(6).99
Total weighted resident FTE count for the penultimate cost reporting period	13	1-2	9	9(6).99
Rolling average FTE count	14	1-2	9	9(6).99
Adjustment for residents in initial years of new programs	15	1-2	9	9(6).99
Unweighted adjustment for residents in initial years of new programs	15.01	1-2	9	9(6).99
Adjustment for residents displaced by program or hospital closure	16	1-2	9	9(6).99
Unweighted adjustment for residents displaced by program or hospital closure	16.01	1-2	9	9(6).99
Adjusted rolling average FTE count	17	1-2	9	9(6).99
Per resident amount	18	1-2	11	9(8).99
Per resident amount under §131 of the CAA 2021	18.01	1-2	11	9(8).99
Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 CFR 413.79(c)(4)	20	1	9	9(6).99
Direct GME FTE unweighted resident count over cap (see instructions)	21	1	9	9(6).99
Adjustment for locality national average per resident amount (see instructions)	23	1	11	9(8).99
Inpatient Program days	26	1-2.01	9	9
Percent reduction for MA DGME	29.01	2-2.01	5	99.99
Medicare outpatient ESRD charges (see instructions)	35	1	11	9
Part A reasonable cost (see instructions)	41	1	11	9
Part B reasonable cost (see instructions)	44	1	11	9
WORKSHEET E-5				
Operating outlier amount	1	1	11	9
Capital outlier amount	2	1	11	9
Operating outlier reconciliation amount	3	1	11	-9
Capital outlier reconciliation amount	4	1	11	-9
The rate used to calculate the time value of money	5	1	11	9(8).99
Operating time value of money	6	1	11	-9
Capital time value of money	7	1	11	-9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET E-90				
Part I				
Cost to establish and maintain buffer stock of essential medicines - directly incurred	1	1	11	9
Cost to establish and maintain buffer stock of essential medicines - contract	2	1	11	9
Total cost to establish and maintain buffer stock of essential medicines	3	1	11	9
Part II				
Medicare routine/ancillary costs	1	1	11	9
Medicare acquisition costs	2	1	11	9
Cost of physicians' services in a teaching hospital	3	1	11	9
Total Medicare reasonable cost	4	1	11	9
Total facility cost	5	1	11	9
Medicare percentage	6	1	8	9(3).99
Essential medicines payment adjustment	7	1	11	9

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ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET E-95				
Part I				
Did the hospital or hospital healthcare complex purchase domestic (column 1) or non-domestic (column 2) respirators?	1	1, 2	1	X
Cost and number of domestic and non-domestic respirators purchased	2	1, 2, 3, 4	11	9
Part II				
Cost and number of domestic and non-domestic respirators purchased	1, 2	1, 2	11	9
Average cost per respirator	3	1, 2	11	9(8).99
Hospital-specific cost differential	4	3	11	9(8).99
Total cost differential	5	3	11	9
Part III				
Medicare routine/ancillary costs	1	1, 2, 3, 4	11	9
Medicare acquisition costs	1.01	1, 2	11	9
Cost of physicians' services in a teaching hospital	1.02	1, 2, 3, 4	11	9
Total Medicare reasonable costs	1.15	1, 2, 3, 4	11	9
Total facility cost	2	5	11	9
Medicare percentage	3	1, 2, 3, 4	8	9.9(6)
N95 respirator payment adjustment	4	1, 2, 3, 4, 5	11	9
WORKSHEET G				
For all hospitals or hospital complexes:				
Balance sheet accounts	1-10, 12-29, 31-34, 37-44, 46-49, 52	1	11	-9
For hospitals or hospital complexes using fund accounting:				
Specific purpose fund account balances	1-10, 12-29, 31-34, 37-41, 43-44, 46-49, 53	2	11	-9
Endowment fund account balances	1-10, 12-29, 31-34, 37-41, 43-44, 46-49, 54-56	3	11	-9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET G (Cont.)				
Plan fund account balances	1-10, 12-29, 31-34, 37-41, 43-44, 46-49, 57-58	4	11	-9
NOTE: All columns for line 6, 14, 16, 18, 20, 22, 24, 26, and 28 should contain negative amounts.				
WORKSHEET G-1				
For hospitals using fund accounting:				
Text as needed for blank lines	4-9, 12-17	0	36	X
Beginning fund balances	1	2, 4, 6, 8	11	-9
Additions and reductions to beginning fund balances	4-9, 12-17	1, 3, 5, 7	11	-9
WORKSHEET G-2				
Part I				
Other patient revenue (specify)	15, 27	0	36	X
Inpatient revenues for routine care by component	1-9	1	11	9
Inpatient revenues for intensive care by special care unit	11-15	1	11	9
Total revenues for routine and special care	17	1	11	9
Ancillary services revenue (inpatient)	18	1	11	9
Outpatient services revenue (associated with admissions)	19	1	11	9
Rural Health Clinic (RHC)	20	1	11	9
Federally Qualified Health Center (FQHC)	21	1	11	9
Ambulance revenue (associated with admissions)	23	1	11	9
ASC revenue	25	1	11	9
Hospice revenue	26	1	11	9
Other patient revenue (specify)	27	1	11	9
Ancillary services revenue (outpatient)	18	2	11	9
Outpatient services revenue	19	2	11	9
Rural Health Clinic (RHC)	20	2	11	9
Federally Qualified Health Center (FQHC)	21	2	11	9
Home health agency revenue	22	2	11	9
Ambulance revenue	23	2	11	9
Outpatient rehabilitation providers	24	2	11	9
ASC revenue	25	2	11	9
Hospice revenue	26	2	11	9
Other outpatient revenue	27	2	11	9
Total inpatient and outpatient revenue	28	1-3	11	9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET G-2 (Cont.)				
Part II				
Text as needed for blank lines	30-35, 37-41	0	36	X
Increases to operating expenses reported on Worksheet A	30-35	1	11	9
Decreases to operating expenses reported on Worksheet A	37-41	1	11	9
Total operating expenses	43	2	11	9
WORKSHEET G-3				
Other (specify)	24, 27	0	36	X
Contractual allowances and discounts on patients' accounts	2	1	11	9
Total operating expenses	4	1	11	9
Other revenues	6-24	1	11	9
COVID-19 PHE Funding	24.50	1	11	9
Other expenses	27	1	11	9
Total other expenses	28	1	11	-9
Net income	29	1	11	-9
WORKSHEET H				
Salaries	3-23	1	11	9
Employee Benefits	3-23	2	11	9
Transportation	1-23	3	11	9
Contracted/Purchased Services	1-23	4	11	9
Other costs	1-23	5	11	9
Reclassifications	1-23	7	11	-9
Adjustments	1-23	9	11	-9
Net expense for allocation	1-23	10	11	9
Total	24	1-5, 7, 9, 10	11	9

Note: Line 23.50 for Worksheets H through H-1, Part II, and line 19.50 for Worksheet H-2 are to be used exclusively for telemedicine, if applicable.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET H-1, PARTS I & II				
Part I				
Total	24	1-5	11	9
Cost allocation	6-23	6	11	9
Part II				
Reconciliation	5-23	5A	11	-9
All cost allocation statistics	1-23	1-4*	11	9
Total	24	1-5	11	9
*See note to Worksheet B-1 for treatment of administrative and general accumulated cost column.				
WORKSHEET H-2, PARTS I & II				
Part I				
Post step down adjustment (including total)	1-20	25	11	-9
Total cost after cost finding	2-19	28	11	9
Total cost	20	0-4, 5-23	11	9
Part II				
Centers - Statistical Basis				
Reconciliation	5-19	4A-23A	11	-9
All cost allocation statistics	1-19	1-23*	11	9
Total	20	1-23	11	9
*See note to Worksheet B-1 for treatment of administrative and general accumulated cost column. Do not include X on line 0 of accumulated cost column since this worksheet is a replica of Worksheet B-1.				
WORKSHEET H-3, PART I				
Part I				
Total visits	1-6	4	11	9
Program visits	1-6	6-7	11	9
Total	7	4, 6, 7	11	9
CBSA numbers	8-13	1	5	X
Program visits by discipline and CBSA	8-13	2, 3	11	9
Total	14	2, 3	11	9
Total charges for medical supplies and drugs	15-16	4	11	9
Program charges for medical supplies	15	6-8	11	9
Charges for drugs	16	7-8	11	9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET H-3, PART II				
Part II				
Total HHA charges	1-5	2	11	9
Total HHA shared ancillary costs	1-5	3	11	9
WORKSHEET H-4, PART I AND II				
Part I				
Total charges for title XVIII – Parts A and B services	2	1-3	11	9
Amount collected from patients	3	1-3	11	9
Amounts collectible from patients	4	1-3	11	9
Primary payer amounts	9	1-3	11	9
Part II				
PPS Payments	11-20	1-2	11	9
Part B deductibles billed to Medicare patients	21	2	11	9
Coinsurance billed to Medicare patients	25	2	11	9
Allowable bad debts	27	2	11	-9
Adjusted reimbursable bad debts	27.01	2	11	-9
Allowable bad debts for dual eligible beneficiaries (see instructions)	28	2	11	9
Other adjustments (specify) (see instructions)	30	0	36	X
Other adjustments (specify) (see instructions)	30	1, 2	11	-9
Pioneer ACO demonstration payment adjustment (see instructions)	30.50	1, 2	11	-9
Demonstration payment adjustment amount before sequestration	30.99	1, 2	11	-9
Sequestration adjustments (see instructions)	31.01	1, 2	11	9
Demonstration payment adjustment amount after sequestration	31.02	1, 2	11	-9
Sequestration adjustment for non-claims-based amounts (see instructions)	31.75	1, 2	11	9
Interim payments (titles V and XIX only)	32	1, 2	11	9
Protested amounts	35	1, 2	11	-9
WORKSHEET H-5				
Total interim payments paid to provider	1	2, 4	11	9
Interim payments payable	2	2, 4	11	9
Date of each retroactive lump sum adjustment (mm/dd/yyyy)	3.01-3.98	1, 3	10	X
Amount of each lump sum adjustment:				
Program to provider	3.01-3.49	2, 4	11	9
Provider to Program	3.50-3.98	2, 4	11	9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET H-5 (Cont.)				
Enter the date of the tentative payment from Program to provider	5.01-5.49	1, 3	10	X
Enter the amount of the tentative payment from Program to provider	5.01-5.49	2, 4	11	9
Enter the date of the tentative payment from provider to Program	5.50-5.98	1, 3	10	X
Enter the amount of the tentative payment from provider to Program	5.50-5.98	2, 4	11	9
Enter the name of the contractor	8	0	36	X
Enter the contractor's number	8	1	5	X
Enter the date of the NPR	8	2	10	X
WORKSHEET I-1				
Total costs by department	1-8, 10-16, 18-26, 28-30	1	11	9
Total cost	31	1	11	9
Statistic	1-6	3	11	9(8).99
FTEs per 2080 hours	1-6	4	11	9(8).99
Charges	28-30	3	11	9
WORKSHEET I-2				
EPO costs (cost reporting periods beginning prior to 10/01/2015). ESAs (cost reporting periods beginning on or after 10/01/2015)	14	6	11	9
ARANESP cost (cost reporting periods beginning prior to 10/01/2015)	15	6	11	9
Totals	1-13, 16, 17	11	11	9
Column totals	17	1-8, 10	11	9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET I-3				
All cost allocation statistics	2-13, 16	1, 5-8	11	9
Percentage of time statistics	2-13, 16	2	6	9(3).99
Hourly statistics	2-13, 16	3, 4	11	9(8).99
Total all cost allocation statistics	17	1, 5-10	11	9
Total percentage of time statistics	17	2	6	9(3).99
Total hourly statistics	17	3, 4	11	9(8).99
Inpatient dialysis treatments	12	0	11	9
WORKSHEET I-4				
Total number of outpatient treatments	1-8, 11	1	11	9
Total CAPD patient weeks	9, 9.01	1	11	9
Total CCPD patient weeks	10, 10.01	1	11	9
Number of outpatient treatments - Medicare	1-8, 11	4	11	9
CAPD patient weeks - Medicare	9	4	11	9
CCPD patient weeks - Medicare	10	4	11	9
Total program payment	1-11	6	11	9
Average payment rates	1-10	7	6	9(3).99
WORKSHEET I-5				
Outlier payments	2.04	1	11	9
Part B deductibles billed	3-3.02	1	11	-9
Part B coinsurance billed	4-4.02	1	11	9
Reimbursable bad debts	5-5.04	1	11	-9
Adjusted reimbursable bad debts (see instructions)	6	1	11	-9
Allowable bad debts for dual eligible beneficiaries (see instructions)	7	1	11	-9
Reimbursable bad debts (see instructions)	11	1	11	-9
Low volume payment amount	15	1	11	9
TDAPA	16	1	11	9
TPNIES	17	1	11	9
CRA TPNIES	18	1	11	9
HDPA	19	1	11	-9
PPA	20	1	11	-9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET J-1, PART I				
General Service Cost Allocation				
Net expenses for cost allocation	1-21	0	11	9
Post step down adjustments (including total)	1-22	25	11	-9
Total (sum of lines 1 through 21)	22	0-4, 5-23	11	9
WORKSHEET J-1, PART II				
General Service Cost Statistics				
Reconciliation	1-21	4A-23A	11	-9
Cost allocation statistics	1-21	1-23*	11	9
Total	22	1-23	11	9
*See note to Worksheet B-1 for treatment of administrative and general accumulated cost column. Do not include X on line 0 of accumulated cost column.				
WORKSHEET J-2, PARTS I AND II				
Part I				
Apportioned Outpatient Rehabilitation Costs				
Total component charges	2-19	2	11	9
Title V charges	2-19	4	11	9
Title XVIII charges	2-19	6	11	9
Title XIX charges	2-19	8	11	9
Title XIX costs	2-19	9	11	9
Total	20	2, 4-9	11	9
Part II				
Charges for Allocation of A&G Costs				
Title V charges	21-27	4	11	9
Title XVIII charges	21-27	6	11	9
Title XIX charges	21-27	8	11	9
Total	28	4-8	11	9
Title XIX costs	21-29	9	11	9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET J-3				
To be completed separately for titles V, XVIII, and XIX (data items apply to titles V, XVIII, and XIX, except as indicated):				
Cost of component services	1	1	11	9
PPS payments received including outliers	2	1	11	9
Outlier payments	3	1	11	9
Primary payer payments	4	1	11	9
Total reasonable cost (see instructions)	5	1	11	9
Total charges for program services	6	1	11	9
Aggregated amount collected	7	1	11	9
Amount collectible	8	1	11	9
Part B deductibles billed	14	1	11	9
Actual coinsurance billed to program patients (from provider records)	19	1	11	9
Allowable bad debts	21	1	11	-9
Adjusted reimbursable bad debts (see instructions)	22	1	11	-9
Allowable bad debts for dual eligible beneficiaries (see instructions)	23	1	11	-9
Other adjustments (specify) (see instructions)	25	0	36	X
Other adjustments (specify) (see instructions)	25	1	11	-9
Pioneer ACO demonstration payment adjustment (see instructions)	25.50	1	11	-9
Demonstration payment adjustment amount before sequestration	25.99	1	11	-9
Sequestration adjustment (see instructions)	26.01	1	11	9
Demonstration payment adjustment amount after sequestration	26.02	1	11	-9
Interim payments (title V and title XIX only)	27	1	11	9
Protested amounts	30	1	11	-9
WORKSHEET J-4				
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
Amount of each retroactive lump sum adjustment: Program to provider	3.01-3.49	2	11	9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET J-4 (Cont.)				
Amount of each retroactive lump sum adjustment: (Cont.)				
Provider to program	3.50-3.98	2	11	9
Enter the date of the tentative payment from Program to provider	5.01-5.49	1	10	X
Enter the amount of the tentative payment from Program to provider	5.01-5.49	2	11	9
Enter the date of the tentative payment from provider to Program	5.50-5.98	1	10	X
Enter the amount of the tentative payment from provider to Program	5.50-5.98	2	11	9
Enter the name of the contractor	8	0	36	X
Enter the contractor's number	8	1	5	X
Enter the date of the NPR (mm/dd/yyyy)	8	2	10	X
WORKSHEET K				
Transportation	1-38	3	11	9
Other costs	1-38	5	11	9
Reclassifications	1-38	7	11	-9
Adjustments	1-38	9	11	-9
Net expense for allocation	39	10	11	9
WORKSHEETS K-1, K-2 AND K-3				
Salaries, benefits & contract services	3-21, 27-38	1-9	11	9
Total	39	1-9	11	9
WORKSHEET K-4, PARTS I AND II				
Part I				
Cost allocation	7-38	7	11	9
Total	39	1-6	11	9
Part II				
Reconciliation	7-38	6A	11	-9
All cost allocation statistics	7-38	1-5*	11	9

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

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET K-5, PARTS I AND II				
Part I				
Post step-down adjustment	1-33	25	11	-9
Total cost after cost finding	2-33	28	11	9
Total cost	34	0-2, 4-23, 28	11	9
Part II				
Centers - Statistical Basis				
Reconciliation	1-33	5A-23A	11	-9
All cost allocation statistics	1-33	1-23*	11	9
* See note to Worksheet B-1 for treatment of administrative and general accumulated cost column. Do not include X on line 0 of accumulated cost column since this is a replica of Worksheet B-1.				
WORKSHEET K-5, PART III				
Total hospice charges (provider's records)	1-10	2	11	9
Hospice share of ancillary costs	1-11	3	11	9
WORKSHEET L				
Part I - Fully Prospective Method				
Capital DRG other than outlier	1	1, 1.01	11	9
Model 4 BPCI Capital DRG other than outlier	1.01	1, 1.01	11	9
Capital DRG outlier payments	2	1	11	9
Model 4 BPCI Capital DRG outlier payments	2.01	1	11	9
Total inpatient days available divided by number of days in cost reporting period	3	1	11	9(8).99
Indirect medical education percentage (see instructions)	5	1	6	9(3).99
Percentage of SSI recipient patient days to Medicare Part A patient days	7	1	6	9.9(4)
Percentage of Medicaid patient days to total days	8	1	6	9.9(4)
Allowable DSH percentage (see instructions)	10	1	6	9.9(4)

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET L (Cont.)				
Part II - Payment Under Reasonable Cost				
Total inpatient program capital cost	5	1	11	9
Part III - Computation of Exception Payments				
Applicable exception percentage (see instructions)	4	1	4	9.99
Percentage adjustment for extraordinary circumstances (see instructions)	6	1	4	9.99
Carryover of accumulated capital minimum payment level over capital payment (prior year Worksheet L, Part II, line 14)	11	1	11	-9
WORKSHEET L-1, PART I				
Extraordinary capital related costs	1-23, 30-46, 50-60, 62-78, 88-91, 92.01-102, 105-117, 190-194	0	11	9
Total extraordinary capital related costs	202	0	11	9
Total adjustments after cost finding	202	25	11	9
Total extraordinary capital related costs after cost finding by department	30-46, 50-60, 62-78, 88-91, 92.01-102, 105-117, 190-194	26	11	9
Total extraordinary capital related costs after cost finding in total	202	26	11	9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET L-1, PART II				
Computation of program inpatient routine service capital cost for extraordinary circumstances				
Swing-bed adjustment	30, 40-42	2	11	9
WORKSHEET M-1				
Hospital-based cost	1-9, 11-13, 15-20, 23-27, 29-30	1, 2, 4, 6-7	11	-9
WORKSHEET M-2				
Number of FTE personnel	1-3, 5-7.02, 7.03, 7.04	1	6	9(3).99
Total visits	1-3, 5-7.02, 7.03, 7.04, 9	2	11	9
Productivity standard*	1-3	3	11	9
Greater of columns 2 or 4	4	5	11	9
Parent provider overhead allocated to facility (see instructions)	15	1	11	9
WORKSHEET M-3				
Adjusted cost per visit	7	1	6	9(3).99
Maximum rate per visit (from contractor records)	8	1-3	6	9(3).99
Rate for Program covered visits	9	1-3	6	9(3).99
Program covered visits excluding mental health services (from contractor records)	10	1-3	11	9
Program covered visits for mental health services (from contractor records)	12	1-3	11	9
Total Program cost (sum of lines 11, 14, and 15, columns 1, 2, and 3)	16	1-3	11	9
Total Program charges (from contractor records) (see instructions)	16.01	1-3	11	9
Total Program preventive charges (from provider's records) (see instructions)	16.02	1-3	11	9
Total Program cost (see instructions)	16.05	1-3	11	9

*Use the standard visits per the instructions as the default. Those standards may change if an approved exception is granted. (See Worksheet S-8 for response to approved exception to the standard productivity visits.)

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET M-3 (Cont.)				
Primary payer payments	17	2	11	9
Beneficiary deductible for RHC only (from contractor records)	18	2	11	9
Beneficiary coinsurance for RHC/FQHC (from contractor records)	19	2	11	9
Total program IOP OPPS payments	21.50	2	11	9
Total program IOP visits and costs	21.55	1, 2	11	9
Program IOP deductible, coinsurance and primary payer amounts	21.60	2	11	9
Allowable bad debts	23	2	11	-9
Adjusted reimbursable bad debts (see instructions)	23.01	2	11	-9
Reimbursable bad debt for dual eligible beneficiaries (see instructions)	24	2	11	-9
Other adjustments (specify) (see instructions)	25	0	36	X
Other adjustments (specify) (see instructions)	25	2	11	-9
Pioneer ACO demonstration payment adjustment (see instructions)	25.50	2	11	-9
Demonstration payment adjustment amount before sequestration	25.99	2	11	-9
Sequestration adjustment (see instructions)	26.01	2	11	9
Demonstration payment adjustment amount after sequestration	26.02	2	11	-9
Interim payments (title V and title XIX only)	27	2	11	9
Protested amounts	30	2	11	9
WORKSHEET M-4				
Ratio of injection/infusion staff time to total health care staff time	2	1-3	8	9.9(6)
Medical supplies cost - injections/infusions	4	1-3	11	9
Total number of injections/infusions	11	1-3	11	9
Number of injections/infusions administered to Medicare beneficiaries	13	1-3	11	9
Number of COVID-19 injections/infusions administered to MA enrollees	13.01	2.01 & 2.02	11	9
Total cost of injections/infusions and their administrative costs	15	2	11	9
Total Medicare cost of injections/infusions and their administrative costs	16	2	11	9
WORKSHEET M-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

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET M-5 (Cont.)				
Amount 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
Enter the date of the tentative payment from Program to provider	5.01-5.49	1	10	X
Enter the amount of the tentative payment from Program to provider	5.01-5.49	2	11	-9
Enter the date of the tentative payment from provider to Program	5.50-5.98	1	10	X
Enter the amount of the tentative payment from provider to Program	5.50-5.98	2	11	-9
Enter the name of the contractor	8	0	36	X
Enter the contractor's number	8	1	5	X
Enter the date of the NPR	8	2	10	X
WORKSHEET N-1				
Salaries	3-7, 9-12, 23, 25-36, 47, 48, 60-69, 77, 78	1	11	-9
Other Costs	1-7, 9-12, 23-36, 47, 48, 60-69, 77, 78	2	11	-9
Reclassifications	1-7, 9-12, 23-36, 47, 48, 60-69, 77, 78	4	11	-9
Adjustments	1-7, 9-12, 23-36, 47, 48, 60-69, 77, 78	6	11	-9
Net expense for Allocation	1-7, 9-12, 23-36, 47, 48, 60-69, 77, 78	7	11	-9
Total	100	1, 2, 7	11	9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET N-2				
Total medical, mental health, and IOP visits by practitioner	1-10	2	11	9
Total medical visits by practitioner	1-10	7	11	9
Total mental health visits (non IOP visits) by practitioner	1-10	8	11	9
Total IOP visits by practitioner	1-10	8.01	11	9
Title XVIII medical visits provided to beneficiaries by practitioner	1-10	9	11	9
Title XVIII mental health visits (non IOP visits) provided to beneficiaries by practitioner	1-10	10	11	9
Title XVIII IOP visits provided to beneficiaries by practitioner	1-10	10.01	11	9
WORKSHEET N-3				
Ratio of injection/infusion staff time to total health care staff time	2	1-3	8	9.9(6)
Total number of injections/infusions	11	1-3	11	9
Number of injections/infusions administered to Medicare beneficiaries	13	1-3	11	9
Number of COVID-19 injections/infusions administered to MA enrollees	13.01	2.01 & 2.02	11	9
WORKSHEET N-4				
Enter total PPS payments paid for FQHC visits rendered during the cost reporting period	1	1	11	9
Medicare advantage supplemental payments	3	1	11	9
Primary payer payments	5	1	11	9
Coinsurance billed to program beneficiaries	7	1	11	9
Allowable bad debts (see instructions)	9	1	11	-9
Allowable bad debts for dual eligible beneficiaries (see instructions)	11	1	11	-9
Other adjustments (specify) (see instructions)	13	0	36	X
Other adjustments (specify) (see instructions)	13	1	11	-9
Demonstration payment adjustment amount before sequestration	13.99	1	11	-9
Sequestration adjustment (see instructions)	15	1	11	9
Sequestration for non-claims-based amounts	15.25	1	11	9
Demonstration payment adjustment amount after sequestration	16.01	1	11	-9
Protested amounts	20	1	11	-9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET N-5				
Total interim payments paid to FQHC	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
Amount 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
Date of each tentative settlement payment (mm/dd/yyyy)	5.01-5.98	1	10	X
Amount of each tentative settlement payment:				
Program to Provider	5.01-5.49	2	11	9
Provider to Program	5.50-5.98	2	11	9
WORKSHEET O				
Salaries	3-16, 26-39, 40-46, 60-69, 71	1	11	9
Other Costs	1-16, 25-39, 40-46, 60-71	2	11	-9
Reclassifications	1-16, 25-39, 40-46, 60-71	4	11	-9
Adjustments	1-16, 25-39, 40-46, 60-71	6	11	-9
Net Expense for Allocation	1-16, 25-39, 40-46, 60-71	7	11	-9
Total	100	1, 2, 7	11	9
WORKSHEETS O-1 & O-2				
Direct Patient Care Service Cost Centers	26-46	1, 2, 4, 6	11	-9
Total	100	7	11	9
WORKSHEETS O-3 & O-4				
Direct Patient Care Service Cost Centers, Inpatient Care-Contracted	25	2,4,6	11	-9
Direct Patient Care Service Cost Centers	26-46	1, 2, 4, 6	11	-9
Total	100	7	11	9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET O-6, PART II Headings *				
Column heading (cost center name)	1-3*	1-17	10	X
Statistical basis	4, 5*	1-17	10	X
WORKSHEET O-6, PART I				
Costs after cost finding by department	50-53, 60-71, 99	18	11	-9
Total costs after cost finding	100	18	11	9

*Refer to Table 1 for specifications and Table 2 for the worksheet identifier. There may be up to five type 2 records (three for cost center name and two for the statistical basis) for each column. However, for any column with less than five type 2 entries, blank records or the word "blank" is not required to maximize each column record count.

WORKSHEET O-6, PART II				
For each cost allocation using accumulated costs as the statistic, include a record containing X.	0	4-17	1	X
All cost allocation statistics	1-17, 50-53, 60-71	1-17*	11	9
Reconciliation	4-17, 50-53, 60-71	4A	11	-9
Total cost to be allocated	100	1-17+	11	9

*In each column using accumulated cost as the statistical basis for allocating costs, identify each cost center which is to receive no allocation with a negative 1 (-1) placed in the accumulated cost column. Providers may elect to indicate total accumulated cost as a negative amount in the reconciliation column. However, entries must never appear in both the reconciliation column and the accumulated column simultaneously on the same line. For those cost centers that are to receive partial allocation of costs, provide only the cost to be excluded from the statistics as a negative amount on the appropriate line in the reconciliation column.
+Include any column which uses accumulated cost as its basis for allocation.

WORKSHEET O-7				
Charges by Level of Care	1-10	2-5	11	-9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10 TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10

TABLE 3A - WORKSHEETS REQUIRING NO INPUT

WORKSHEET A-8-3, PARTS II & III
WORKSHEET D, PART I & II
WORKSHEET D-1, PART IV
WORKSHEET D-2, PART III
WORKSHEET D-4, PART II
WORKSHEET K-6
WORKSHEET L-1, PART II
WORKSHEET O-5
WORKSHEET O-8

TABLE 3B - TABLES TO WORKSHEET S-2

TABLE I: Type of Control

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

TABLE II: Type of Hospital

1 = General Short Term
2 = General Long Term
3 = Cancer
4 = Psychiatric
5 = Rehabilitation
6 = Religious Nonmedical Health Care Institution
7 = Children's
8 = Reserved for future use
9 = Other
10 = Extended Neoplastic Disease Care
11 = Indian Health Service
12 = Rural Emergency Hospital

TABLE V: Type of Program Operations

1 = NAHE program (42 CFR 413.85(f))
2 = NAHE program (42 CFR 413.85(g)(2))
3 = NAHE program (42 CFR 413.85(g)(3))
4 = NAHE program (42 CFR 413.85(h))

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10

TABLE 3B - TABLES TO WORKSHEETS S-11, PARTS I AND II

TABLE III: Type of Control

1 = Voluntary, Nonprofit, Corporation
2 = Voluntary Nonprofit, Other
3 = Proprietary, Individual
4 = Proprietary, Corporation
5 = Proprietary, Partnership
6 = Proprietary, Other
7 = Governmental, Federal
8 = Governmental, State
9 = Governmental, County
10 = Governmental, City
11 = Governmental, Other

TABLE IV: Types of FQHC organization

1. An organization receiving a grant(s) under §330 of the PHS Act :

   A = Community Health Center (§330(e), PHS Act)
   B = Migrant and Seasonal Agricultural Workers Health Center (§330(g), PHS Act)
   C = Health Care for the Homeless Health Centers (§330(h), PHS Act)
   D = Health Centers for Residents of Public Housing (§330(i), PHS Act)

2. Health Center Program Look-Alikes; Organizations that have been identified by HRSA as meeting the definition of Health Center under §330 of the PHS Act, but not receiving grant funding under §330

3. Outpatient health program/facility operated by:

   A = A tribe or tribal organization under the Indian Self-Determination Act
   B = An urban Indian organization under title V of the Indian Health Care Improvement Act
   C = Other

TABLE VI: Cancer Hospital PCRs

Calendar Year	PCR
2012	0.91
2013	0.91
2014	0.89
2015	0.90
2016	0.92
2017	0.91
2018	0.88
2019	0.88
2020	0.89
2021	0.89
2022	0.89
2023	0.89

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3C - LINES WHICH CANNOT BE SUBSCRIPTED (BEYOND THOSE PREPRINTED)

Worksheet S, Part I: ALL
Worksheet S, Part II: ALL
Worksheet S, Part III: lines 1-3, 5-8, 200
Worksheet S-2, Part I: lines 1-5, 7-11, 20-35, 37, 39, 40, 45-59, 61-64, 66-88, 90-157, 159, 165, and 167-169
Worksheet S-2, Part II: ALL
Worksheet S-3, Part I: lines 1-7, 13-17, 18, 21, and 27-33
Worksheet S-3, Part II: ALL
Worksheet S-3, Part III - IV: ALL
Worksheet S-3, Part IV: ALL, except line 25
Worksheet S-3, Part V: lines 1-4, and 6-8, and 18
Worksheet S-4: lines 1-17, 19, 21-38
Worksheet S-5: lines 1-21
Worksheet S-6: lines 1-17
Worksheet S-7: ALL, except line 206
Worksheet S-8: lines 1-8, 10, 12-13.01, and 15
Worksheet S-9, Part I-IV: ALL
Worksheet S-10: ALL
Worksheet S-10, Part I and II: ALL
Worksheet S-11, Part I: ALL, except lines 9 and 12
Worksheet S-11, Part II: ALL, except line 6
Worksheet S-11, Part III: lines 2 and 4
Worksheet S-12: ALL
Worksheet A: lines 3, 30, 40-44, 46, 74, 77, 78, 94, 95, 100, 102, 105-111, 113, 114, 118, and 200
Worksheet A-6: ALL
Worksheet A-7, Part I: ALL
Worksheet A-7, Part II & III: line 3
Worksheet A-8: lines 1-18, 20-32, and 50
Worksheet A-8-1, Part A: lines 1-2
Worksheet A-8-1, Part B: lines 6-8
Worksheets A-8-2, A-8-3: ALL
Worksheet B, Part I and II: SAME AS WORKSHEET A
Worksheet B-1: SAME AS WORKSHEET A
Worksheet B-2: ALL
Worksheet C, Part I: lines 30, 40, 41, 43- 46, 61, 74, 94, 95, 100,105-111, and 200-202
Worksheet C, Part II: lines 61, 74, and 95
Worksheet D, Part I: lines 30, 40, 41, 43, and 200
Worksheet D, Part II: lines 61, 74, 95, and 200
Worksheet D, Part III: lines 30, 40, 41, 43, 44, and 200
Worksheet D, Part IV: lines 61, 74, 94, and 200
Worksheet D, Part V: lines 61, 74, 94, 95, and 200-202
Worksheet D-1, Part I: ALL
Worksheet D-1, Part II: ALL, except lines 43-47
Worksheet D-1, Part III & IV: ALL
Worksheet D-2, Part I: lines 1-2, 8, 9, 10, 11, 13, 15, 20, 27-31, 37-39, 41-42, 43-47, and 49
Worksheet D-2, Part II: lines 26-28
Worksheet D-3: lines 30, 40-41, 43, 61, 74, 94, 95, and 200-202
Worksheet D-4, Part I: lines 1, 7, 19, 32, and 41
Worksheet D-4, Part II: lines 42, 48, and 55
Worksheet D-4, Part III and IV: ALL

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3C - LINES WHICH CANNOT BE SUBSCRIPTED (BEYOND THOSE PREPRINTED)

Worksheet D-5, Part I and II: ALL, except line 17
Worksheet D-6, Part I: lines 1, 7, 19, and 28
Worksheet D-6, Part II: lines 1 and 7
Worksheet D-6, Part III and IV: ALL
Worksheet E, Part A: ALL, except lines 70
Worksheet E, Part B: ALL, except line 39
Worksheet E-1, Part I: lines 1, 2, 4, 6, and 8
Worksheet E-1, Part II: ALL
Worksheet E-2: ALL, except line 16
Worksheet E-3, Part I: ALL, except line 17
Worksheet E-3, Part II: ALL, except line 30
Worksheet E-3, Part III: ALL, except line 31
Worksheet E-3, Part IV: ALL, except line 21
Worksheet E-3, Part V: ALL, except line 29
Worksheet E-3, Part VI: ALL, except line 14
Worksheet E-3, Part VII: ALL, except line 37
Worksheet E-4: ALL, except line 4
Worksheet E-5: ALL
Worksheet E-90: ALL
Worksheet E-95: ALL
Worksheet G: ALL
Worksheet G-1: lines 1, 3, 10-11, and 18-19
Worksheet G-2, Part I: lines 1-3, 4-7, 9, 10, 16-19, 23, and 25-26
Worksheet G-2, Part II: lines 27, 34, 40 and 41
Worksheet G-3: lines 1-5, 6-23, 25, 26, 28, and 29
Worksheet H (except line 23): ALL
Worksheet H-1, Part I and II: ALL, except line 23
Worksheet H-2, Part I and II: ALL, except line 23
Worksheet H-3, Part I and II: ALL, except lines 8-13
Worksheet H-4, Part I: ALL
Worksheet H-4, Part II: ALL, except line 30
Worksheet H-5, Part I and II: ALL
Worksheet H-6: lines 4, 6, and 8
Worksheet I-1: ALL, except line 30
Worksheets I-2, I-3, I-4, I-5: ALL
Worksheet J-1, Part I and II: ALL
Worksheet J-2, Part I: ALL
Worksheet J-3: ALL, except line 25
Worksheet J-4: lines 1-2, 4, and 6-8
Worksheets K, K-1, K-2, K-3: ALL
Worksheet K-4, Part I: ALL
Worksheet K-4, Part II: ALL
Worksheet K-5, Part I: ALL
Worksheet K-5, Part II: ALL
Worksheet K-5, Part III: ALL
Worksheet K-6: ALL
Worksheet L: ALL
Worksheet L-1, Part I: SAME AS WORKSHEETS A & B
Worksheet L-1, Part II: lines 30, 40, 41, 43, and 200
Worksheets M-1, M-2: ALL

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10 TABLE 3C - LINES WHICH CANNOT BE SUBSCRIPTED (BEYOND THOSE PREPRINTED)

Worksheet M-3: ALL, except line 25
Worksheet M-4: ALL
Worksheet M-5: lines 1-2, 4 and 6-8
Worksheet N-1: ALL
Worksheet N-2: ALL
Worksheet N-3: ALL
Worksheet N-4: ALL, except 13
Worksheet N-5: 1, 2, 4, 6 and 7
Worksheet O: ALL
Worksheet O-1: ALL
Worksheet O-2: ALL
Worksheet O-3: ALL
Worksheet O-4: ALL
Worksheet O-5: ALL
Worksheet O-6, Part I: ALL
Worksheet O-6, Part II: ALL
Worksheet O-7: ALL

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10 TABLE 3D - PERMISSABLE PAYMENT MECHANISMS

P = Prospective Payment T= TEFRA O = Other N= Not applicable

Component	Title V	Title XVIII		Title XIX
Hospital	P, T, or O	P, T, or O	(a)	P, T or O
IPF	P, T, or O	P		P, T, or O
IRF	P, T, or O	P		P, T, or O
Subprovider	P, T, or O	P, T, or O		P, T, or O
Swing-bed SNF	P or O	P or O		P or O
Swing-bed NF	O	*		O
SNF	P or O	P		P or O
NF	P or O	*		P or O
ICF/IID	O	*		O
HHA	P or O	P		P or O
ASC (Distinct Part)	O	O		O
RHC	O	O		O
FQHC	O	O or P	(b)	O
CMHC	O	O or P	(c)	O

(a) For a CAH the payment method should be "O" since they are paid under cost.
(b) Effective for cost reporting periods beginning on or after October 1, 2014, FQHCs must use "P" for payment system.
(c) Effective for cost reporting periods ending on or after September 30, 2016, CMHCs must use "P" for payment system.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3E - LINE NUMBERING FOR SPECIAL CARE UNITS

Cost center integrity for variable worksheets (listed below) must be maintained throughout the cost report. If you use a line designated as "(specify)" or subscript a line, the relative position must flow throughout the cost report.

EXAMPLE: If you add a special care unit after the surgical intensive care unit on line 11 of Worksheet S-3, Part I, it must also be on the first additional special care unit line of Worksheet A (line 35), Worksheet D-1, Part II (line 47), Worksheet D-2, Part I (line 7), etc.

Worksheet	Burn Care	Surgical Care	Lines for Special Care Units	Additional Special Care Units	
			#1	#2	#3
S-3, Part I	10	11	12	12.01	12.02
A	33	34	35	35.01	35.02
B, Parts I-III	33	34	35	35.01	35.02
B-1	33	34	35	35.01	35.02
L-1, Part I	33	34	35	35.01	35.02
C, Part I	33	34	35	35.01	35.02
D, Part I	33	34	35	35.01	35.02
D-1, Part II	45	46	47	47.01	47.02
D-2, Part I	5	6	7	7.01	7.02
D-2, Part II	34	35	36	36.01	36.02
D-4, Part I	4	5	6	6.01	6.02
D-4, Part II	45	46	47	47.01	47.02
G-2, Part I	13	14	15	15.01	15.02

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 4 - NUMBERING CONVENTION FOR MULTIPLE COMPONENTS

This table provides line and column numbering conventions for health care complexes with more than one hospital-based component of the same kind. Table 4 is necessary to ensure that data associated with each component is consistently identified throughout the cost report. This table provides for four additional components. Component II is subline .01, component III is .02, component IV is .03, and component V is .04. The only deviation from this subline numbering is to the CMHC component(s) on Worksheets S-2 and S-3 as listed below. Providers should continue this numbering convention for multiple components in excess of five (5) components.

SUBJECT	WKST	PART	COLUMNS	LINES	SUB LINES

I. For use in facilities with more than one subprovider

This table is no longer applicable

II. For use in facilities with more than one HHA

SUBJECT	WKST	PART	COLUMNS	LINES	SUB LINES
HHA II-X	S	III	1-3, 5	9	1-9
HHA II-X	S-2	I	1-3, 5-8	12	1-9
HHA II-X	S-3	I	1, 5-11	22	1-9
HHA II-X	A		1-2, 7	101	1-9
HHA II-X	A-8-3	I	1	8-9	1-9
HHA II-X	A-8-3	I	4, 8, 9	15-16	1-9
HHA II-X	A-8-3	IV	1	41-51	1-9
HHA II-X	A-8-3	VI-VII	1	64, 72, 75, 77	1-9
HHA II-X	B	I	26	101	1-9
HHA II-X	B	II	0, 26	101	1-9
HHA II-X	B	III	0, 26	101	1-9
HHA II-X	B-1		1-23	101	1-9
HHA II-X	G-2	I	2	20	1-9
HHA II-X	L-1	I	0, 26	101	1-9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 4 - NUMBERING CONVENTION FOR MULTIPLE COMPONENTS

III. For use in facilities with multiple outpatient rehabilitation facilities *

SUBJECT	WKST	PART	COLUMNS	LINES	SUB LINES
O/P Rehab. Provider	S	III	1-3, 5	12	0-49
O/P Rehab. Provider	S-2	I	1-3, 5-8	17	0-49
O/P Rehab. Provider	S-3	I	7-8, 10-11	25	0-49
O/P Rehab. Provider	A		1-2, 7	99	0-49
O/P Rehab. Provider	B	I	26	99	0-49
O/P Rehab. Provider	B	II	0, 26	99	0-49
O/P Rehab. Provider	B	III	0, 26	99	0-49
O/P Rehab. Provider	B-1		1-23	99	0-49
O/P Rehab. Provider	D-2		1	17	0-49
O/P Rehab. Provider	G-2	I	2	22	0-49
O/P Rehab. Provider	L-1	I	0, 27	98	0-49

* Subscripts for this line are CMHC 00-09, CORF 10-19, OPT 20-29, OOT 30-39, and OSP 40-49.

TABLE 5 - COST CENTER CODING
INSTRUCTIONS FOR PROGRAMMERS

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

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

Additional guidelines are:

- Any pre-existing codes for the line must not be allowed to carry over.
- All "Other . . ." lines must not be pre-coded.
- The order of choice is standard first, followed by specific nonstandard, and, lastly, the nonstandard "Other . . ." cost centers.
- When the nonstandard "Other . . ." is chosen, the preparer must be prompted with "Is this the most appropriate choice?" and offered a chance to answer yes or to select another description.
- The cost center coding process must be able to be invoked again for purposes of making corrections.
- A separate list showing the preparer's added cost center names on the left with the chosen standard or nonstandard description and code on the right must be printed for review.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 5 - COST CENTER CODING

- The number of times a description can be selected on a given report must be displayed on the screen next to the description and this number must decrease with each usage to show the remaining numbers available. The numbers are shown on the standard and nonstandard cost center tables.
- Standard cost center lines, descriptions, and codes are not to be changed. The acceptable format for these is displayed in the STANDARD COST CENTER DESCRIPTIONS AND CODES listed on pages 40-807 and 40-810. The proper line number is the first two digits of the cost center code. The only exceptions to the descriptions are: "Paramedical Education Program-(specify)" for which the parenthesis and specify are to be replaced by the program name (i.e., Radiology, Cytotechnology; and "Other Organ Acquisition (specify)") should be changed to specify the acquisition as listed on lines 105 through 111. All "Other" nonstandard lines should be changed to the appropriate cost center name and "Subprovider (specify)" type should be indicated.

INSTRUCTIONS FOR PREPARERS

Coding of Cost Center Labels

Cost center coding is a methodology for standardizing the meaning of cost center labels as used by hospitals on the Medicare cost report. The use of this coding methodology allows providers to continue to use their labels for cost centers that have meaning within the individual institution.

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

Additional cost center descriptions have been identified through analysis of provider labels. The meanings of these additional descriptions were sufficiently different when compared to the Standard labels to warrant their use. These additional descriptions are hereafter referred to as the NONSTANDARD labels. Included with the nonstandard descriptions are "Other . . ." designations to provide for situations where no match in meaning can be found. Refer to Worksheet A, lines 18, 35, 76, 93, 98, 117, and 194. Both the standard and nonstandard cost center descriptions along with their cost center codes are shown on Table 5. The "USE" column on that table indicates the number of times that a given code can be used on one cost report. You are required to compare your added label to the descriptions shown on the standard and nonstandard table for purposes of selecting a code. CMS-approved software provides an automated process to present you with the allowable choices for the line/column being coded and automatically associates the code for the selected matching description with your label.

Additional Guidelines

Categories

You must make your selection from the proper category such as general service descriptions for general service cost center lines, ancillary descriptions for ancillary cost center lines, etc.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 5 - COST CENTER CODING

Additional Hospital-Based Components

The Form CMS-2552-10 provides a preprinted label for one outpatient rehabilitation provider on line 99; however, this designation must be changed to coincide with the specific provider type. Line 99 requires specific cost center code usage depending on the outpatient rehabilitation provider designation (see Table 5). When the hospital needs to report more than one outpatient rehabilitation provider, line 99 must be subscripted in accordance with Table 4.

Intensive Care Cost Centers

When an intensive care type of cost center label is added and it does not closely match the standard or nonstandard cost center descriptions, then a subscript of the intensive care description (code 03100) should be used or a nonstandard code (i.e., 03101 through 03119) and/or one of the nonstandard inpatient routine service cost center codes. There is no "Other Intensive Care" description available.

Use of Cost Center Coding Description More Than Once

Often a description from the standard or nonstandard tables applies to more than one of the labels being added by the preparer. In the past, it was necessary to determine which code was to be used and then increment the code number upwards by one for each subsequent use. This was done to provide a unique code for each cost center label. Now, most CMS-approved software associates the proper code, including increments as required, once a matching description is selected. Remember to use your label. You are matching to CMS's description only for coding purposes.

Cost Center Coding and Line Restrictions

Cost center codes may only be used in designated lines in accordance with the classification of the cost center(s) (i.e., lines 1 through 23) may only contain cost center codes within the general service cost center category of both standard and nonstandard coding. For example, in the general service cost center category for Operation of Plant cost, line 7 and subscripts thereof, should only contain cost center codes of 00700 through 00719 and nonstandard cost center codes. This logic must hold true for all other cost center categories (i.e., ancillary, inpatient routine, outpatient, other reimbursable, special purpose, and nonreimbursable cost centers). There are exceptions, which are contained in Table 6 edits. An example of an exception is A&G cost. Line 5 and subscripts thereof may only contain cost center codes 00500, 00505 through 00539, 00540, 00550, 00560, 00570, 00580, 00590 through 00599, 01080, 01140, and 01160 (standard and nonstandard cost center codes). Other cost center lines contain exceptions that only the standard cost center codes and subscripts (usage) of that code may be used on that line and subscripts of that line. These exceptions are also contained in Table 6.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 5 - STANDARD COST CENTER DESCRIPTIONS AND CODES

GENERAL SERVICE COST CENTERS	CODE	USE
Cap Rel Costs - Bldg & Fixt	00100	(50)
Cap Rel Costs - Mvble Equip	00200	(50)
Other Cap Related Cost	00300	(01)
Employee Benefits Department	00400	(20)
Administrative & General	00500	(01)
Maintenance & Repairs	00600	(20)
Operation of Plant	00700	(20)
Laundry & Linen Service	00800	(20)
Housekeeping	00900	(20)
Dietary	01000	(20)
Cafeteria	01100	(20)
Maintenance of Personnel	01200	(20)
Nursing Administration	01300	(20)
Central Services & Supply	01400	(20)
Pharmacy	01500	(20)
Medical Records & Library	01600	(20)
Social Services	01700	(20)
Non-physician Anesthetists	01900	(20)
Nursing Program	02000	(20)
I&R Services - Salary & Fringes Apprvd	02100	(20)
I&R Services-Other Prgm. Costs Apprv	02200	(20)
INPATIENT ROUTINE SERVICE COST CENTERS		
Adults & Pediatrics	03000	(01)
Intensive Care	03100	(20)
Coronary Care Unit	03200	(20)
Burn Intensive Care	03300	(20)
Surgical Intensive Care	03400	(20)
Subprovider - IPF	04000	(01)
Subprovider - IRF	04100	(01)
Nursery	04300	(01)
Skilled Nursing Facility	04400	(01)
Nursing Facility	04500	(01)
Other Long Term Care	04600	(01)

ANCILLARY SERVICE COST CENTERS	CODE	USE
Operating Room	05000	(30)
Recovery Room	05100	(30)
Delivery Room & Labor Room	05200	(30)
Anesthesiology	05300	(30)
Radiology - Diagnostic	05400	(30)
Radiology - Therapeutic	05500	(30)
Radioisotope	05600	(30)
CT Scan	05700	(30)
MRI	05800	(30)
Cardiac Catheterization	05900	(30)
Laboratory	06000	(30)
PBP Clinical Lab. Service - Prgrm. Only	06100	(01)
Whole Blood & Packed Red Blood Cells	06200	(30)
Blood Storing, Processing & Trans.	06300	(30)
Intravenous Therapy	06400	(30)
Respiratory Therapy	06500	(30)
Physical Therapy	06600	(30)
Occupational Therapy	06700	(30)
Speech Pathology	06800	(30)
Electrocardiology	06900	(30)
Electroencephalography	07000	(30)
Medical Supplies Charged to Patients	07100	(30)
Imp. Dev. Charged to Patients	07200	(30)
Drugs Charged to Patients	07300	(30)
Renal Dialysis	07400	(01)
ASC (Non-Distinct Part)	07500	(30)
Allogeneic Stem HSCT Acquisition	07700	(01)
Car T-Cell Immunotherapy	07800	(01)

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 5 - STANDARD COST CENTER DESCRIPTIONS AND CODES

	CODE	USE
OUTPATIENT SERVICE COST CENTERS		
Rural Health Clinic (RHC)	08800	(50)
Federally Qualified Health Center (FQHC)	08900	(36)
Clinic	09000	(99)
Emergency	09100	(20)
Observation Beds (Non-Distinct Part)	09200	(01)
Partial Hospitalization Program	09399	(01)
OTHER REIMBURSABLE COST CENTERS		
Home Program Dialysis	09400	(01)
Ambulance Services	09500	(01)
Durable Medical Equipment - Rented	09600	(20)
Durable Medical Equipment - Sold	09700	(20)
CMHC	09900	(10)
CORF	09910	(10)
OPT	09920	(10)
OOT	09930	(10)
OSP	09940	(10)
I&R Services - Not Apprvd Prgm	10000	(01)
Home Health Agency	10100	(10)
Opioid Treatment Program	10200	(01)

	CODE	USE
SPECIAL PURPOSE COST CENTERS		
Kidney Acquisition	10500	(01)
Heart Acquisition	10600	(01)
Liver Acquisition	10700	(01)
Lung Acquisition	10800	(01)
Pancreas Acquisition	10900	(01)
Intestinal Acquisition	11000	(01)
Islet Acquisition	11100	(01)
Interest Expense	11300	(01)
Utilization Review - SNF	11400	(01)
Ambulatory Surgical Center (Distinct Part)	11500	(20)
Hospice	11600	(05)
NONREIMBURSABLE COST CENTERS		
Gift, Flower, Coffee Shop & Canteen	19000	(20)
Research	19100	(20)
Physicians' Private Offices	19200	(20)
Nonpaid Workers	19300	(20)

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 5 - NONSTANDARD COST CENTER DESCRIPTIONS AND CODES

GENERAL SERVICE COST CENTERS	CODE	USE
Other Administrative and General (specify)	00505	(35)
Data Processing	00550	(01)
Purchasing, Receiving and Stores	00560	(01)
Admitting	00570	(01)
Cashiering/Accounts Receivable	00580	(01)
Other Administrative and General (specify)	00590	(10)
Inservice Education	01080	(01)
Management Services	01140	(01)
Communications	01160	(01)
Other General Service Cost Center (specify)	01850	(50)
Paramedical Education Program (specify)	02300	(50)
INPATIENT ROUTINE SERVICE COST CENTERS		
Detoxification Intensive Care	02040	(01)
Neonatal Intensive Care Unit	02060	(01)
Pediatric Intensive Care Unit	02080	(01)
Premature Intensive Care	02120	(01)
Psychiatric Intensive Care	02140	(01)
Trauma Intensive Care Unit	02180	(01)
ICF/IID	04510	(01)
Other Special Care (specify)	02400	(50)
Subprovider (specify)	04200	(01)
ANCILLARY SERVICE COST CENTERS		
Acupuncture	03020	(01)
Angiocardiography	03030	(01)
Audiology	03040	(01)
Bacteriology & Microbiology	03050	(01)
Biopsy	03060	(01)
Birthing Center	03070	(01)
Cardiology	03140	(01)
Cardiopulmonary	03160	(01)

ANCILLARY SERVICE COST CENTERS (Cont.)	CODE	USE
Chemistry	03180	(01)
Chemotherapy	03190	(01)
Circumcision	03220	(01)
Cytology	03240	(01)
Dental Services	03250	(01)
Echocardiography	03260	(01)
EKG and EEG	03280	(01)
Electromyography	03290	(01)
Electroshock Therapy	03320	(01)
Endoscopy	03330	(01)
Gastro Intestinal Services	03340	(01)
Hematology	03350	(01)
Histology	03360	(01)
Holter Monitor	03370	(01)
Immunology	03380	(01)
Laboratory - Clinical	03390	(01)
Laboratory - Pathological	03420	(01)
Mammography	03440	(01)
Nuclear Medicine - Diagnostic	03450	(01)
Nuclear Medicine - Therapeutic	03470	(01)
Oncology	03480	(01)
Ophthalmology	03520	(01)
Osteopathic Therapy	03530	(01)
Prosthetic Devices	03540	(01)
Psychiatric/Psychological Services	03550	(01)
Pulmonary Function Testing	03560	(01)
Recreational Therapy	03580	(01)
Sleep Lab	03610	(01)
Stress Test	03620	(01)
Ultra Sound	03630	(01)
Urology	03640	(01)
Vascular Lab	03650	(01)
Other Ancillary Service Cost Centers (specify)	03950	(50)
Blood Clotting Factors for Hemophilia	06250	(01)
Cardiac Rehabilitation	07697	(01)

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 5 - NONSTANDARD COST CENTER DESCRIPTIONS AND CODES

	CODE	USE
ANCILLARY SERVICE COST CENTERS (Cont.)		
Hyperbaric Oxygen Therapy	07698	(01)
Lithotripsy	07699	(01)
OUTPATIENT SERVICE COST CENTERS		
Family Practice	04040	(01)
Telemedicine	04050	(01)
Other Outpatient Service Cost Center (specify)	04950	(50)
Observation Beds (Distinct Part)	09201	(10)
OTHER REIMBURSABLE COST CENTERS		
Other Reimbursable Cost Centers (specify)	09850	(50)
Support Surfaces - Rented	06630	(05)
Support Surfaces - Sold	06730	(05)
SPECIAL PURPOSE COST CENTERS		
Other Special Purpose Cost Centers (specify)	06950	(50)
Other Organ Acquisition (specify)	08600	(20)
NONREIMBURSABLE COST CENTERS		
Other Nonreimbursable Cost Centers (specify)	07950	(50)

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 6 - EDITS

Medicare cost reports submitted electronically must meet a variety of edits. These include mathematical accuracy edits, certain minimum file requirements, and other data edits. Any vendor software which produces an electronic cost report file for Medicare hospitals must automate all of these edits. Failure to properly implement these edits may result in the suspension of a vendor's system certification until corrective action is taken. The vendor's software should provide meaningful error messages to notify the hospital of the cause of every exception. The edit message generated by the vendor systems must contain the related five-digit and one alpha character, where indicated, reject/edit code specified below. Any file submitted by a provider containing a level 1 edit will be rejected by the contractors. Notification must be made to CMS for any exceptions.

The edits are applied at two levels. Level 1 edits (10000 series reject codes) are those which test the format of the data to identify for correction of those error conditions which will result in a cost report rejection. These edits also test for the presence of some critical data elements specified in Table 3. Level 2 edits (20000 series edit codes) identify potential inconsistencies and/or missing data items. These items should be resolved at the provider site and appropriate worksheets and/or data submitted with the cost report. Failure to submit the appropriate data with your cost report may result in payments being withheld pending resolution of the issue(s).

The vendor requirements (above) and the edits (below) reduce both contractors processing time and unnecessary rejections. Vendors should develop their programs to prevent their client hospitals from generating an electronic cost report file where level 1 edit conditions exist. Ample warnings should be given the provider where level 2 edit conditions are violated.

The level 1 edit conditions are to be applied against title XVIII services only. However, any inconsistencies and/or omission which would cause a level 1 condition for non-title XVIII services should be resolved prior to acceptance of the cost report. [05/01/2010b]

Note: The date in brackets [ ] at the end of each edit indicate the effective date of the edit for cost reporting periods ending on or after that date. Dates followed by a “b are for cost reporting periods beginning on or after and dates followed by an "s" are for services rendered on or after the specified date. [05/01/2010b]

I. Level 1 Edits (Minimum File Requirements)

Edit	Condition
10000	The first digit of every record must be either 1, 2, 3, or 4 (encryption code only). [05/01/2010b]
10050	No record may exceed 60 characters. [05/01/2010b]
10100	All alpha characters must be in upper case. This is exclusive of the vendor information, type 1 record, record number 3 and the encryption code, type 4 record, record numbers 1, 1.01, and 1.02. [05/01/2010b]

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 6 - EDITS

Edit	Condition
10150	For micro systems, the end of record indicator must be a carriage return and line feed, in that sequence. [05/01/2010b]
10200	The hospital provider number (record #1, positions 17 through 22) must be valid and numeric. [05/01/2010b]
10225	This edit has been redesignated as 12830S.
10250	All calendar format dates must be edited for 10-character format, e.g., 01/01/2010 (MM/DD/YYYY). [05/01/2010b]
10300	All dates (record #1, positions 23 through 29, 30 through 36, 45 through 51, and 52 through 58) must be in Julian format and a possible date. [05/01/2010b]
10350	The fiscal year beginning date (record #1, positions 23 through 29) must be less than the fiscal year ending date (record #1, positions 30 through 36). [05/01/2010b]
10400	The vendor code (record #1, positions 38 through 40) must be a valid code. [05/01/2010b]
10450	The type 1 record #1 must be correct and the first record in the file. [05/01/2010b]
10500	All record identifiers (positions 1 through 20) must be unique. [05/01/2010b]

NOTE: Contractor's attempt to correct if all record identifiers are not unique in their working copy and continue processing the cost report. If the condition is correctable, notify the provider's vendor and send a copy of the ECR and PI files to the vendor and CMS Central Office. CMS Central Office requires a vendor software update to resolve the condition. [05/01/2010b]

10550	Only a Y or N is valid for fields which require a yes/no response. [05/01/2010b]
10600	Variable columns (Worksheet B, Parts I and II, and Worksheet B-1) must have a corresponding type 2 record (Worksheet A label) with a matching line number. [05/01/2010b]

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 6 - EDITS

Edit	Condition
10650	All line, subline, column, and subcolumn numbers (positions 11-13, 14-15, 16-18, and 19-20, respectively) must be numeric, except as noted below for reconciliation columns. [05/01/2010b]

NOTE: If the administrative and general (A&G) cost center (Worksheet A, line 5) is fragmented into two or more cost centers, then line 5 must be deleted. Fragmented A&G lines must be in sequential order. Any cost center with accumulated costs as its statistic must have its Worksheet B-1 reconciliation column numbered the same as its Worksheet A line number followed by an "A" as part of the line number followed by the subline number.

For example, the following cost centers appear on Worksheet A, lines 5.01 to 5.06.

5.01 Nonpatient telephones	00540
5.02 Data processing	00550
5.03 Purchasing, receiving, and stores	00560
5.04 Admitting	00570
5.05 Cashiering/accounts receivable	00580
5.06 Other administrative and general	00590

If line 5.06, other administrative and general, is allocated based on accumulated cost, then the reconciliation column must be numbered 5A.06. This edit does not require consecutive numbering, only sequential. Line numbers may be skipped but must be in sequential order, e.g., 5.01, 5.02, 5.04, 5A.06. [05/01/2010b]

10655	The cost center code (positions 21 through 25) (type 2 records) must be a code from Table 5, Cost Center Coding, and each cost center code must be unique. [05/01/2010b]

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 6 - EDITS

Edit **Condition**

10700 The following standard cost centers listed below must be reported on the lines as indicated and the corresponding cost center codes may only appear on the lines as indicated. No other cost center codes may be placed on these lines or subscripts of these lines, unless indicated herein. [05/01/2010b]

Cost Center	Line	Code
Cap Rel Costs- Bldg & Fixt	1	00100-00149
Cap Rel Costs- Moveable Equip	2	00200-00249
Other Cap Rel Costs	3	00300
Employee Benefits Department	4	00400-00419
Adults & Pediatrics	30	03000
Subprovider - IPF	40	04000
Subprovider - IRF	41	04100
Subprovider	42	04200*
Nursery	43	04300
Skilled Nursing Facility	44	04400
Nursing Facility	45	04500
ICF/IID	45.01	04510*
Other Long Term Care	46	04600
PBP Clinical Lab Services-Prgm Only	61	06100
Whole Blood & Packed Red Blood Cells	62	06200-06229
Blood Clotting for Hemophiliacs	62.30	06250*
Renal Dialysis	74	07400
Allogeneic HSCT Acquisition	77	07700
CAR T-Cell Immunotherapy	78	07800
Observation Beds (Non-Distinct Part)	92	09200
Observation Beds (Distinct Part)	92.01	09201-09210*
Partial Hospitalization Program	93.99	09399
Home Program Dialysis	94	09400
Ambulance Services	95	09500
I&R Services-Not Apprv Prgm	100	10000
Home Health Agency	101	10100-10109
Opioid Treatment Program	102	10200
Kidney Acquisition	105	10500
Heart Acquisition	106	10600
Liver Acquisition	107	10700
Lung Acquisition	108	10800
Pancreas Acquisition	109	10900
Intestinal Acquisition	110	11000
Islet Acquisition	111	11100
Other Organ Acquisition	112	08600-08619*
Interest Expense	113	11300
Utilization Review- SNF	114	11400
Ambulatory Surgical Center (D.P.)	115	11500-11519
Hospice	116	11600-11604
Gifts, Flower, Coffee Shop & Canteen	190	19000-19019
Research	191	19100-19119
Physicians' Private Offices	192	19200-19219
Nonpaid Workers	193	19300-19319

* Non-standard, indicated for establishing line number and cost center code use.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 6 - EDITS

Edit	Condition
10750	Cost center integrity for variable worksheets must be maintained throughout the cost report. For subscripted lines, the relative position must be consistent throughout the cost report. (See Table 3E.) [05/01/2010b]

EXAMPLE: If you add a neonatal intensive care unit on line 12 of Worksheet S-3, Part I, it must also be on the first other special care unit line of Worksheet A (line 35), Worksheet D-1, Part II (line 47), Worksheet D-2, Part I (line 7), etc.

10800	For every line used on Worksheets A; B, Part I; C, Part I; D, Parts I through V; and D-2; D-3; D-4; and G-2; there must be a corresponding type 2 record. [05/01/2010b]
10850	Fields requiring numeric data (days, charges, discharges, costs, FTEs, etc.) may not contain any alpha character. [05/01/2010b]
10900	Numeric fields (except unit cost multipliers and HVBP adjustment factors) cannot exceed 11 positions. Unit cost multipliers cannot exceed 13 positions. HVBP adjustment factors cannot exceed 12 positions. [05/01/2010b]
10950	In all cases where the file includes both a total and the parts which comprise that total, each total must equal the sum of its parts. [05/01/2010b]

EXAMPLE: The inpatient departmental charges on Worksheet C, Part I, column 6, sum of lines 30 through 117, must equal total departmental charges as reported on Worksheet C, Part I, column 6, line 200.

11000	All dates must be possible, e.g., no “00”, no “30” or “31” of February, and the date cannot be greater than the current date. [05/01/2010b]
10000S	The hospital street address, city, state, and ZIP code (Worksheet S-2, Part I, line 1, column 1, and line 2, columns 1, 2, and 3) must be present and valid. [05/01/2010b]
10025S	The provider’s CBSA (Worksheet S-2, Part I, column 3, lines 3 through 19) must be a five-position alphanumeric field. [10/01/2012b]
10050S	The cost report beginning date (Worksheet S-2, Part I, column 1, line 20) must be on or after 05/01/2010. [05/01/2010b]
10100S	The type of control (Worksheet S-2, Part I, column 1, line 21) must be present and a valid code of 1 through 13. [05/01/2010b]
10150S	All provider and component numbers displayed on Worksheet S-2, Part I, column 2, lines 3 through 10, lines 12 through 19, and line 140, column 2, must contain six (6) alphanumeric characters. [05/01/2010b]

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 6 - EDITS

Edit	Condition
10200S	The cost report period beginning date (Worksheet S-2, Part I, column 1, line 20) must precede the cost report ending date (Worksheet S-2, column 2, line 20). [05/01/2010b]
10250S	The hospital name, CCN number, CBSA, provider type, certification date, and title XVIII payment mechanism (Worksheet S-2, Part I, line 3, columns 1 through 5, and 7, respectively) must be present and valid. [05/01/2010b]
10300S	If Worksheet S-2, Part I, line 3, column 7, is P, Worksheet S-3, Part II, column 2, sum of lines 2 through 43, must be greater than zero. This edit applies to short term acute care hospitals subject to PPS, but not an LTCH (CCN XX-2000 through XX-2299), an IRF (CCN XX-3025 through XX-3099), or a psychiatric (CCN XX-4000 through XX-4499). [05/01/2010b]
10350S	For each provider name reported (Worksheet S-2, Part I, column 1, lines 3 through 5, 7 through 10, or 12 through 19), there must be corresponding entries made on Worksheet S-2, Part I, lines 3 through 5, 7 through 10, or 12 through 19, for the CCN (column 2), the CBSA (column 3), provider type (column 4), the certification date (column 5), and the payment system for titles V, XVIII, or XIX (columns 6, 7, or 8, respectively, except lines 14, 18, and 19) indicated with a valid code (P, T, O, or N). (See Table 3D.) If there is no component name entered in column 1, then columns 2 through 8 for that line must also be blank. [05/01/2010b]
10400S	If Worksheet S-2, Part I, any of lines 3 through 5, 7 through 10, or 12 through 19, column 2, has a response then column 3 must have a response. [05/01/2010b]
10450S	On Worksheet S-2, Part I, there must be a response for: **Column 1**: lines 21, 22, 26 through 27, 56, 59, 60, 63, 70, 75, 80, 81, 85, 88, 105, 108, 110, 112, 115, 116, 117, 121, 123, 125, 140, 144, 146 through 149, 165, and 167. **Column 1:** Line 68: Do not apply this edit for cost reporting periods beginning on or after October 1, 2022 **Columns 1 and 2**: lines 20, 39, 40, 90, 93 through 94, 96, 120. **Columns 1 and 2**: lines 98, 98.01, 98.02, 98.05, and 98.06. [09/30/2017] **Columns 1 and 2**: lines 22.01 and 22.02. [10/01/2013] **Column 2 only**: lines 45 through 47, and 92. **Columns 1, 2, and 3**: Line 22.03: Do not apply this edit for cost reporting periods beginning on or after October 1, 2016. [10/01/2014] Line 22.04. Do not apply this edit for cost reporting periods beginning on or after October 1, 2022. [10/01/2020] If lines 3 through 5, 9, and/or 12, have a CCN in column 2, then the respective component, lines 155 through 160, columns 1 and 2, must be present. If line 3, column 4, is "12" (provider type is REH), then line 107.01, column 1, must be present. [10/01/2023] If line 17 has a CCN in column 2, then line 161, column 2, must be present.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 6 - EDITS

Edit	Condition
10450S (Cont.)	If line 22, column 1="Y", then line 22, column 2, and line 23, columns 1 and 2, must be present.
	If line 22.05, column 1, is "Y", then line 22.05, column 2, must have a date. [10/01/2023]
	If line 26, column 1, does not equal line 27, column 1, then line 27, column 2, must have a date.
	If line 88, column 1, is "Y", then line 88, column 2, must be greater than zero AND line 89, and subscripts, columns 1, 2, and 3, must be present. [10/01/2022b]
	If line 94, column x (where x = 1 or 2), is "Y", then line 95, column x, must be present.
	If line 96, column x (where x = 1 or 2), is "Y", then line 97, column x, must be present.
	If CAH (line 105="Y") AND line 56="Y", then line 107, column 1, and line 58, column 1, must be present. If CAH (line 105="Y"), then line 106, column 1, must be present. If CAH (line 105="Y"), then line 109, columns 1 through 4, must be present. If NOT CAH (line 105="N"), and the cost reporting period equals 365 or 366 days, and line 167="Y", then line 169, column 1, must be present. Do not apply this edit for cost reporting periods beginning on or after October 1, 2016. If line 47, column 2="Y", then line 48, column 2, must be present. If line 56, column 1="Y" AND not a CAH (line 105="N"), then lines 57 and 58, column 1, must be present. If line 56, column 1="Y", then line 56, column 2, and line 61, column 1, must be present. If line 57, column 1="Y", then line 57, column 2, must be present. Do not apply this edit for cost reporting periods beginning on or after December 27, 2020. If line 60, column 1="Y", then line 60, column 2, must be present. If line 60, column 1="Y", then line 60.01 and subscripts, columns 2 and 3, must be present. [09/30/2017] If line 61, column 1="Y", then columns 4 and/or 5 , must be present. If line 63, column 1="Y", then lines 66 and/or 67 must be present. [07/01/2010b] If line 70="Y", then line 71, column 1, must be present. If line 71, column 1="Y", then line 71, column 2, must be present. If line 75, column 1="Y", then line 76, column 1, must be present. If line 76, column 1="Y", then line 76, column 2, must be present. If line 90, (column x, where x=1 or 2) ="Y", then line 91, column x, must be present. If line 91, column 1 or 2="Y" (title V or XIX), then lines 45 and 46, same respective column 1 or 3 (title V or XIX), must be present. If line 105="Y", then lines 98.03 and 98.04, columns 1 and 2, must be present. [09/30/2017] If line 105="Y" AND line 56, column 1="Y", then line 107, column 1, must be present. [12/31/2019] If line 107, column 1="Y" and either line 70 or 75 is "Y", then line 107, column 2, must be present. [12/31/2019] If line 112, column 1="Y", then line 112, column 2, must be on or after 01/29/2019. If line 115, column 1="Y", then line 115, column 2, must be present. If line 117="Y" then line 118, column 1, line 118.01, column 1 or 3, and line 118.02, column 1, must be present. [06/30/2012] If line 140, column 1="Y", and column 2 is not blank, then lines 141 through 143, all columns except P. O. Box, must be present (i.e. home office info). If line 165="Y", then line 166, columns 0 through 5, must be present. If line 167="Y", then line 171, column 1, must be "Y" or "N". [10/01/2014] NOTE: Except as otherwise noted, the effective date for this edit is 05/01/2010b. [05/01/2010b]

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 6 - EDITS

Edit	Condition
10500S	If this is an IPF or IPF subprovider (Worksheet S-2, Part I, line 3 or 4, column 2, is in the range of XX-4000 to XX-4499, or there is a "S" or "M" in the third position of the provider number), and line 71, column 1, is "N", and column 2, is "Y", then column 3 must be 1, 2, 3, 4, 5, or 6. If there is not an IPF as the provider or subprovider, then Worksheet S-2, Part I, line 70, column 1, must be "N". [05/01/2010b]
10550S	If this is an IRF or IRF subprovider (Worksheet S-2, Part I, line 3 or 5, column 2, is in the range of XX-3025 to XX-3099, or there is a "T" or "R" in the third position of the provider number), and line 76, column 1, is "N", and column 2, is "Y", then column 3 must be 1, 2, 3, 4, 5, or 6. If there is not an IRF as the provider or subprovider, then Worksheet S-2, Part I, line 75, column 1, must be "N". [05/01/2010b]
10600S	For a CAH, if Worksheet S-2, Part I, column 1, line 56, equals "Y", and column 1, line 105, is also "Y", then questions 56 through 59 do not apply and are replaced with question 107. [05/01/2010b]
10650S	If this is an LTCH (Worksheet S-2, Part I, line 3, column 2, is in the range of XX-2000 to XX-2299), Worksheet S-2, Part I, line 80, column 1, must be "Y". If this is not a LTCH, then Worksheet S-2, Part I, line 80, must be "N". [05/01/2010b]
10700S	If Worksheet S-2, Part I, column 7, line 3 is "P", then line 45, column 2, must contain either a "Y", "N" or "P" response. [05/01/2010b]
10710S	If the CCN on Worksheet S-2, Part I, column 2, line 3, is XX-4000 through XX-4499 (freestanding IPF), then Worksheet B, Part I, column 26, lines 60 and 73, must be greater than zero. Do not apply this edit if Worksheet S-2, Part I, line 115, column 1, is "Y". [08/31/2018]
11750S	If Worksheet S-2, Part I, line 56, response is "Y", then line 57 must contain a response "Y" or "N". This edit does not apply if Worksheet S-2, Part I, line 107, is "Y". [05/01/2010b]
12000S	If Worksheet S-2, Part I, line 22, column 2, is "Y", then Worksheet E, Part A, line 33, must be 35 percent. [05/01/2010b]
12005S	If Worksheet S-2, Part I, line 22, column 1, is "Y", and this provider has a CCN of XX-0001 through XX-0879 and Worksheet S-3, Part I, line 1, column 7, is greater than zero, then Worksheet S-2, Part I, line 24, the sum of columns 1 through 6, must be greater than zero. If Worksheet S-2, Part I, line 22, column 1, is "N", do not apply this edit. [06/30/2012]
12008S	If Worksheet S-2, Part I, line 22, column 1, is "Y", and this provider has a CCN of XX-0001 through XX-0879, and line 23, column 1, is "3", then Worksheet S-2, Part I, line 24, the sum of columns 1 through 6, must equal the sum of Worksheet S-3, Part I, lines 1, 2, 8 through 13, and 32, column 7. [06/30/2012]

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 6 - EDITS

Edit **Condition**

12010S If Worksheet S-2, Part I, line 3, column 2 has a CCN of XX-3025 through XX-3099, and Worksheet S-3, Part I, line 1, column 7 is greater than zero, then Worksheet S-2, Part I, line 25, the sum of columns 1 through 6, must be greater than zero. [06/30/2012]

12013S If Worksheet S-2, Part I, any of lines 16.01 through 16.49, column 2, has an FQHC CCN entry, then Worksheet S-11, Part I, line 8, column 1, must be "N" (filing a consolidated cost report), and Worksheet S-11, Part II, must not be completed. [10/01/2014]

12015S If Worksheet S-3, Part I, line 17, column 7 is greater than zero, then Worksheet S-2, Part I, line 25, the sum of columns 1 through 6 must be greater than zero. [06/30/2012]

12030S Worksheet S-2, Part I, column 2, lines as indicated below may only contain those CCNs as indicated for that line. The type of provider is also indicated. [05/01/2010b] This was level 2 edit 20550S. It is now a level 1 rejectable edit to be consistent with HCRIS edits.

Line	CCN (1)	Type Provider
3	0001-0899	Short Term Hospitals
	1225-1299	Medical Assistance Facility
	1300-1399	CAH
	1990-1999	Religious Non-Medical Health Care Institution (Hospital Services)
	2000-2299	Long Term Care Hospitals
	3025-3099	Rehabilitation Hospitals
	3300-3399	Children's Hospitals
	4000-4499	Psychiatric Hospitals
4, 5, 7	3rd digit of CCN is M	Psychiatric unit in a CAH*
	3rd digit of CCN is R	Rehabilitation unit in a CAH*
	3rd digit of CCN is S	Psychiatric unit*
	3rd digit of CCN is T	Rehabilitation unit*
	3rd digit of CCN is U	Swing-bed designation for Short Term Hospital*
	3rd digit of CCN is W	Swing-bed designation for Long Term Care Hospital*
	3rd digit of CCN is Y	Swing-bed designation for Rehabilitation Hospital*
	3rd digit of CCN is Z	Swing-bed designation for a CAH*
	3rd and 4th digit of CCN are:	Psychiatric unit in a LTCH***
	SA	Line 3 CCN range XX-2000 - XX-2099
	SB	Line 3 CCN range XX-2100 - XX-2199
	SC	Line 3 CCN range XX-2200 - XX-2299
	3rd and 4th digit of CCN are:	Rehabilitation unit in a LTCH***
	TA	Line 3 CCN range XX-2000 - XX-2099
	TB	Line 3 CCN range XX-2100 - XX-2199
	TC	Line 3 CCN range XX-2200 - XX-2299
	3rd and 4th digit of CCN are	Psychiatric unit in a Rehabilitation Hospital***
	SD	Line 3 CCN range XX-3025 - XX-3099
	3rd and 4th digit of CCN are	Psychiatric unit in a Children's Hospital***
	SE	Line 3 CCN range XX-3300 - XX-3399
	3rd and 4th digit of CCN are	Rehabilitation unit in a Children's Hospital***
	TE	Line 3 CCN range XX-3300 - XX-3399

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 6 - EDITS

Edit	Condition	
Line	CCN (1)	Type Provider
	3rd and 4th digit of CCN are:	Rehabilitation unit in a Psychiatric Hospital***
	TF	Line 3 CCN range XX-4000 - XX-4099
	TG	Line 3 CCN range XX-4100 - XX-4199
	TH	Line 3 CCN range XX-4200 - XX-4299
	TJ	Line 3 CCN range XX-4300 - XX-4399
	TK	Line 3 CCN range XX-4400 - XX-4499
	0001-0899	Short Term Unit of Non-PPS Hospital
	1300-1399	CAH
	3025-3099	Rehabilitation Hospital as Subprovider
	4000-4499	Psychiatric Hospital as Subprovider
9	5000-6499	Hospital-Based SNF
	6990-6999	Skilled Nursing Facility
10.01	G000-G999	ICF/IID
	H000-H999	ICF/IID
12	3100-3199	Home Health Agency
	7000-8499	Home Health Agency
	9000-9799	Home Health Agency
13	C000-C999	Ambulatory Surgical Center
14	1500-1799	Hospital-Based Hospice
15	3400-3499	Hospital-Based RHC
	3975-3999	Hospital-Based RHC
	8500-8899	Hospital-Based RHC
16	1000-1199	Hospital-Based FQHC
	1800-1989	Hospital-Based FQHC
17	1400-1499	CMHC
	4600-4799	CMHC
	4900-4999	CMHC
	3200-3299	CORF
	4500-4599	CORF
	4800-4899	CORF
	6500-6989	O/P Rehab. Providers (OPT, OOT, OSP)
18	2300-2499	Renal - Hospital Satellite
	3500-3799	Renal - Hospital Satellite
134	3rd digit of CCN is P	Organ Procurement Organization**
134	9800-9899	Transplant Centers

(1) The first two characters of the CCN (not listed here) identify the state. The last four characters (listed above) identify the type of provider.

* These are hospital components (excluded units) whose last three (3) numbers match those last three (3) numbers of the hospital.

** EXCEPTION - Organ procurement organizations (OPOs) are assigned a six-digit CCN. The first two digits identify the State code. The third digit is the alpha character "P." The remaining three digits are a unique facility identifier.

*** Identifies components of edit 12030S that are effective for cost reporting periods beginning on or after 10/01/2019.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 6 - EDITS

Edit	Condition
12040S	If Worksheet S-2, Part I, line 26, column 1, and line 27, column 1, are "2", then Worksheet S-2, Part I, line 45, column 2, must be "N". Do not apply this edit to urban hospitals (Worksheet S-2, Part I, line 3, column 3, is not 999##) for cost reporting periods ending on or after October 1, 2023. [11/30/2020]
12050S	If this hospital qualifies for sole community hospital (SCH) status (see 42 CFR 412.92) and Worksheet S-2, Part I, line 35, is greater than zero, then the beginning and ending dates on line 36 must be present. The number entered on line 35 should agree with the number of times line 36 is being subscripted, and vice versa. The beginning and ending dates, line 36 and any continuation of the subscripts, columns 1 and 2, must be within the parameters of the cost reporting period's beginning and ending dates, and the ending date may not be earlier than the beginning date. Conversely, if there is a date on line 36, then line 35 must be greater than zero. Line 35, column 1, can only have a response of -0-, 1, or 2. [05/01/2010b]
12100S	If this hospital qualifies for medical dependent hospital (MDH) status (see 42 CFR §412.108) and Worksheet S-2, Part I, line 37, is greater than zero, then the beginning and ending dates on line 38 must be present. The beginning and ending dates, line 38 and any continuation of the subscripts, columns 1 and 2, must be within the parameters of the cost reporting period's beginning and ending dates, and the ending date may not be earlier than the beginning date. Conversely, if there is a date on line 38, then line 37 must be greater than zero. [05/01/2010b]
12105S	For cost reporting periods beginning on or after October 1, 2017, Worksheet S-2, Part I, line 37.01, must be blank. [10/01/2015]
12110S	If Worksheet S-2, Part I, line 39, either column 1 or 2, is "N" for no, then Worksheet E, Part A, lines 70.96, 70.97, and 70.98, must be zero; and vice versa. [07/01/2022]
12115S	If Worksheet S-2, Part I, line 40, columns 1 and 2, are "N" for no, then Worksheet E, Part A, line 70.99, must be zero, and vice versa; and, if Worksheet S-2, Part I, line 40, columns 1 or 2, are "Y" for yes, then Worksheet E, Part A, line 70.99, must be greater than zero, and vice versa. [07/01/2022]
12125S	If Worksheet S-2, Part I, column 1, line 20, begins on or after October 1, 2014, and Worksheet A, column 7, line 89, is greater than zero, then Worksheet S-8 and Worksheets M-1 through M-5 must not be completed. However, if Worksheet S-2, Part I, column 1, line 20, begins on or after October 1, 2014, and Worksheet A, column 7, line 89, is greater than zero, then Worksheets S-11, Parts I, III, and Part II for consolidated FQHCs, and Worksheets N-1 through N-5, respectively, must be completed. Only apply this edit if Worksheet S-2, Part I, line 16 (and subscripts), column 7, is "P", and Worksheet S-11, Part III, line 4, column 2, is greater than zero. [10/1/2014b]
12130S	If Worksheet S-2, Part I, line 56, column 1,response is "Y", then Worksheet S-3, Part I, line 27, column 9, must be greater than zero. [12/27/2020b]
12135S	If Worksheet S-2, Part I, line 56, column 1, response is "N", then line 58 must contain a response of "N". [05/01/2010b]
12150S	If Worksheet S-2, Part I, column 1, line 115, equals "Yes", column 2, line 115, must have a designation of A, B, or E. [05/01/2010b]

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 6 - EDITS

Edit	Condition
12160S	If the last four digits of the CCN reported on Worksheet S-2, Part I, line 3, column 2, fall between 4000 through 4499, and Worksheet S-2, Part I, line 115, column 1, equals "Y", the CCN reported on line 3, column 2, must be an approved all-inclusive rate IPF provider. And, if the CCN reported on Worksheet S-2, Part I, line 3, column 2, is not an approved all-inclusive rate IPF provider, line 115, column 1, must equal "N". [10/01/2024b]
12200S	If Worksheet S-2, Part I, line 47, column 2, equals "Y", then line 48, column 2, must have a response for all cost reports. [05/01/2010b]
12300S	If the hospital has rendered title XIX inpatient services (Worksheet S-2, Part I, line 90, column 2, is "Y"), then title XIX hospital days (Worksheet S-3, Part I, column 7, line 2, plus line 14) and title XIX hospital discharges (Worksheet S-3, Part I, column 14, line 2, plus line 14) must both be greater than zero. [05/01/2010b]
12350S	All amounts reported on Worksheet S-3, Part I, must not be less than zero. [05/01/2010b]
12400S	For Worksheet S-3, Part I, the sum of the inpatient days/outpatient visits in columns 5, 6, and 7, for each of lines 1, 5 through 20, 22, 24 through 26, 28, and 30 through 32, must be equal to or less than the total inpatient days/outpatient visits in column 8 for each line. [05/01/2010b]
12410S	If Worksheet S-2, Part II, line 12 equals "N", then the following worksheet amounts must be zero: E, Part A, line 64; E, Part B, line 34; E-2, line *17, columns 1 and 2*; E-3, Part I, line 11; E-3, Part II, line 23; E-3, Part III, line 24; E-3, Part IV, line 14; E-3, Part V, line 25; E-3, Part VI, line 8; E-3, Part VII, line 34, columns 1 and 2; H-4, line 27, column 2; I-5, line 5.05, columns 1 and 2; J-3, line 21; M-3, line 23, column 2; and N-4, line 9. [07/01/2025b]
12411S	If Worksheet S, Part I, line 4, is "L" or "N", then Worksheet S-2, Part II, line 12, must be "N". [07/01/2025b]

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 6 - EDITS

Edit	Condition
12450S	If the hospital is subject to IPPS and has a CCN of XX-0001 through XX-0879 and Worksheet S-2, Part I, line 3, column 7, is "P", then Worksheet S-3, Part II, column 5, lines 1 through 43, must be equal to or greater than zero. Do not apply this edit if Worksheet S-2, Part I, column 4, line 3, is "11" (Indian Health) or "12" (REH). [05/01/2010b]
12500S	For Worksheet S-3, Part I, the sum of the discharges in columns 12, 13, and 14, for each of lines 1, 14, and 16 through 18, must be equal to or less than the total discharges in column 15 for each line indicated. [05/01/2010b]
12535S	If Worksheet S-2, Part I, line 71, columns 1 or 2, is "Y", then Worksheet S-2, Part I, line 56, column 1, must be "Y". If Worksheet S-2, Part I, line 71, columns 1 and 2, are both "N", then Worksheet E-3, Part II, lines 4, 5, and 7, must be zero, and vice versa. [12/31/2019]
12536S	If Worksheet S-2, Part I, line 76, columns 1 or 2, is "Y", then Worksheet S-2, Part I, line 56, column 1, must be "Y". If Worksheet S-2, Part I, line 76, columns 1 and 2, are both "N", then Worksheet E-3, Part III, lines 5, 6, and 8, must be zero, and vice versa. [12/31/2019]
12550S	If Worksheet S-2, Part I, column 1, line 75, equals "Y", then column 7, line 3, for the hospital, or line 5, for the subprovider, must be "P". If column 1, line 75, is "N", then the CCN in column 2, line 3, for the hospital, cannot be in the range of XX-3025 through XX-3099, and line 5, must be blank. [05/01/2010b]
12600S	If this is a LTCH (CCN on Worksheet S-2, Part I, line 3, column 2, is in the range of XX-2000 through XX-2299), then Worksheet S-2, Part I, line 80, column 1, must be "Y." [05/01/2010b]
12650S	If Worksheet S-2, Part I, line 71, column 1, is "Y", then Worksheet S-2, Part I, line 70, column 1, must be "Y". [05/01/2010b]
12655S	If Worksheet S-2, Part I, line 110, is "Y", then line 22, column 1, must be "N". [09/30/2017]

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 6 - EDITS

Edit	Condition
12660S	If Worksheet S-2, Part I, line 120, column 1, is "Y" and the provider's beds on Worksheet E, Part A, line 4, are greater than 100, and the provider's cost report period overlaps March 1, 2012, then Worksheet D, Part V, sum of the charges on lines 50 through 98, column 2.01, must be greater than zero. If Worksheet S-2, Part I, line 120, column 1, is "Y" and the provider's beds on Worksheet E, Part A, line 4, are less than or equal to 100, do not apply this edit. [05/01/2010b]
12800S	If Worksheet S-2, Part I, line 121, is answered "Y" then there must be an amount greater than 0 on line 72, column 26, on worksheet B, Part I, and vice versa. [05/01/2010b]
12810S	If Worksheet S-2, Part I, line 124, is N, then Worksheet E-90 must not be present and Worksheet E Part A, line 70.76 must be zero; and if Worksheet E-90, Part I, line 3, exceeds zero, then Worksheet S-2, Part I, line 124, must be Y. [10/01/2024b]
12830S	If Worksheet S-2, Part I, column 1, line 140, is "Y", and column 2 is not blank, the contractor number must be present on Worksheet S-2, Part I, column 3, line 141, and the contractor number must consist of five digits that are not exclusively zeroes. [12/31/2015]
12840S	If Worksheet A, column 7, line 74, is greater than zero, then Worksheet S-2, Part, I, column 1, line 145, must be "Y" or "N"; and, if Worksheet S-2, Part I, column 1, line 145, is "N", then Worksheet S-2, Part I, column 2, line 145, must be "Y" or "N". [06/30/2015]
12850S	If Worksheet S-2, Part I, line 167, column 1 is "Y", then Worksheet S-2, Part I, line 20, column 1 (cost report beginning date), must be on or after 10/01/2010. [05/01/2010b]
12855S	Worksheet S-3, Part I, column 6, line 2, must be equal to or greater than Worksheet S-2, Part I, line 171, column 2. [10/01/2015b]
12900S	If Worksheet S-7, column 1, line 1 equals "Y", then Worksheet S-3, Part I, column 6, line 19, must equal zero and vice versa. If Worksheet S-7, column 1, line 2, equals "N", then Worksheet S-3, Part I, column 6, line 5, must equal zero. Do not apply this edit to a cost reporting period ending on or after October 1, 2019. [05/01/2010b]
12905S	For cost reporting periods beginning prior to December 27, 2020, for non-CAHs (Worksheet S-2 Part I, line 105, column 1, is "N"), if Worksheet S-2, Part II, column 1, line 9, is "Y", then Worksheet S-2, Part I, column 1, line 56, must also be "Y" and Worksheet A, column 7, sum of lines 21 and 22, must be greater than zero; and if Worksheet S-2, Part I, line 57, column 1, is "N", or columns 1 and 2, are "Y", then Worksheet E-4 for title XVIII must be completed. However, if Worksheet S-2, Part I, line 57, column 1, is "Y" and column 2, is "N", do not complete Worksheet E-4 for title XVIII. For cost reporting periods beginning on or after December 27, 2020, for non-CAHs (Worksheet S-2 Part I, line 105, column 1, is "N"), if Worksheet S-2, Part II, column 1, line 9, is "Y", then Worksheet S-2, Part I, column 1, line 56, must be "Y"; Worksheet A, column 7, sum of lines 21 and 22, must be greater than zero; Worksheet S-2, Part I, line 57, column 1, must be "Y"; and Worksheet E-4 for title XVIII must be completed. [06/30/2012]

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TABLE 6 - EDITS

Edit	Condition

12906S For CAHs (Worksheet S-2, Part I, line 105, column 1 is "Y"), if Worksheet S-2, Part II, column 1, line 9, is "Y", then Worksheet S-2, Part I, column 1, line 56, must also be "Y" and Worksheet A, column 7, sum of lines 21 and 22, must be greater than 0. CAHs do not complete Worksheet E-4. [06/30/2012]

12910S Worksheet S-2, Part II, must have a response in every ECR file for:

Column 1: lines 1 through 12, and line 15.

If line 1, column 1, = "Y", then line 1, column 2, must be present.
If line 2, column 1, = "Y", then line 2, columns 2 and 3, must be present.
If line 4, column 1, = "Y", then line 4, column 2, must be present.
If line 6, column 1, = "Y", then line 6, column 2, must be present.
If line 12, column 1, = "Y", then lines 13 and 14, column 1 must be present.
If line 16, column 1, = "Y", then line 16, column 2, must be present.
If line 16, column 3, = "Y", then line 16, column 4, must be present.
If line 17, column 1, = "Y", then line 17, column 2, must be present.
If line 17, column 3, = "Y", then line 17, column 4, must be present.
If lines 16 or 17, (column x, where x = 1 or 3), is "Y", then line 18, column x, must be present.
If lines 16 or 17, (column x, where x = 1 or 3), is "Y", then line 19, column x, must be present.
If lines 16 or 17, (column x, where x = 1 or 3), is "Y", then line 20, column x, must be present.
If line 20, columns 1 or 3, are "Y", then line 20, column 0, must be present.

Columns 1 and 3: lines 16, 17, and 21. [06/30/2012]

12920S If Worksheet S-2, Part I, line 3, column 7, is "T" or "O" (except for children's hospitals (CCN XX-3300 through XX-3399)), then Worksheet S-2, Part II, must have a response in every ECR file for:

Column 1: lines 22 through 32, 34, and 36.

If line 32, column 1, = "Y", then line 33, column 1, must be present.
If line 34, column 1, = "Y", then line 35, column 1, must be present.
If line 36, column 1, = "Y", then line x (where x = 37, 38, 39, or 40), column 1, must be present.
If line 38, column 1, = "Y", then line 38, column 2, must be present. [06/30/2012]

12930S The cost report preparer information (Worksheet S-2, Part II, lines 41 through 43, all columns) must be valid and present. [06/30/2012]

12950S If Worksheet S-2, Part I, line 167, column 1, is "Y", then line 170, column 1, must have an EHR reporting period beginning date and column 2 must have an EHR reporting period ending date. Effective for cost reporting periods beginning on or after October 1, 2016, apply this edit only to Puerto Rico hospitals. [04/01/2013s]

12951S If Worksheet S-2, Part I, line 171, column 1, is "Y", then column 2 must be greater than zero. [10/01/2015b]

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 6 - EDITS

Edit	Condition
12955S	For Worksheet S-3, Part I, the amount reported in column 13, line 2, must be less than or equal to the amount in column 15, line 1; column 14, line 2, must be less than or equal to the amount in column 15, line 1; column 14, line 3, must be less than or equal to the amount in column 15, line 16; column 14, line 4, must be less than or equal to the amount in column 15, line 17; and the sum of columns 12, 13, and 14, lines 1 and 2, must be less than or equal to the amount in column 15, line 1. [12/31/15]
12975S	For Worksheet S-3, Part I, each of columns 1 through 8, lines 1, 5, and 6 must be zero if Worksheet S-2, Part I, column 4, line 3 is "12" (REH). [01/01/2023b]
12980S	If Worksheet S-3, Part I, column 4, line 15.10, is greater than zero, then column 8, line 15.10, must be greater than zero, and vice versa. [01/01/2023b]
12981S	If Worksheet S-2, Part I, line 3, column 4, is "12" (REH), then Worksheet S-3, Part I, line 28, columns 5, 7 and 8, must be zero. [01/01/2023b]

The following wage index edits are to be applied against PPS short term acute care hospital providers only: edit numbers 13000S, 13050S, 13100S, 13150S, 13200S, 13250S, 13255S, 13260S, 13265S, and 13267S. These edits do apply if the hospital is subject to PPS but not apply to an LTCH (CCN XX-2000 through XX-2299), an IRF (CCN XX-3025 through XX-3099), an IPF (CCN XX-4000 through XX-4499) or if the third digit of the CCN is an "S" or a "T". Nor do they apply if the third digit of the CCN is M (psychiatric unit in a CAH) or the third digit of the CCN is R (rehabilitation unit in a CAH).

13000S	For Worksheet S-3, Part II, sum of columns 2 and 3, each of lines 1 through 43, and subscripts as applicable, must be equal to or greater than zero. [05/01/2010b]
13050S	The amount of salaries reported for Interns and Residents in approved programs, Worksheet S-3, Part II, column 2, line 7, must be equal to the amount on Worksheet A, column 1, line 21 (including subscripts). [05/01/2010b]
13100S	The amount on Worksheet S-3, Part II, sum of columns 2 and 3, line 9, must equal the corresponding amount on Worksheet A, column 1, line 44, plus or minus any related amounts reported on Worksheet A-6, columns 4 and/or 8, for line 44 designation indicated in columns 3 and/or 7. [05/01/2010b]
13150S	The amount on Worksheet S-3, Part II, sum of columns 2 and 3, line 10, must equal the corresponding amount on Worksheet A, column 1, lines 20, 23, 40 through 42, 45 through 46, 94 through 95, 98 through 101, 105 through 112, 113, 115 through 117 and 190 through 194, and subscripts thereof, plus or minus any related amounts reported on Worksheet A-6, columns 4 and/or 8, for lines 20, 23, 40 through 42, 45 through 46, 94 through 95, 98 through 101, 105 through 112, 114, 115 through 117, and 190 through 194 and subscripts thereof, indicated in columns 3 and/or 7. [05/01/2010b]
13200S	Worksheet S-3, Part II, sum of columns 2 and 3, line 17, must be greater than zero. Apply this edit to PPS providers only. Do not apply this edit if Worksheet S-2, Part I, line 3, column 4, is "11" (Indian Health) or "12" (REH). [05/01/2010b]
13250S	If Worksheet S-3, Part II, sum of columns 2 and 3, lines 1 through 16, and 26 through 43, is greater than zero, then the corresponding line for column 5 must be greater than zero. If the sum of column 5, lines 9 and 10, divided by the sum of column 5, line 1, minus lines 2, 3, 5, 6, 7, and 8, is less than 15%, then lines 26 through 43 are not required to be completed. Do not apply this edit if Worksheet S-2, Part I, line 3, column 4, is "11" (Indian Health) or "12" (REH). [05/01/2010b]

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 6 - EDITS

Edit	Condition
13255S	The amount on Worksheet S-3, Part II, line 18, column 4, must equal the sum of Worksheet S-3, Part IV, line 25, and subscripts. Effective for cost reporting periods beginning on or after October 1, 2018, Worksheet S-3, Part II, line 18, column 4; and Worksheet S-3, Part IV, line 25, and subscripts, must equal zero. [09/30/2017]
13260S	For cost reporting period beginning on or after October 1, 2015, Worksheet S-3, Part II, line 14, columns 2, 3, 4, 5, and 6, must equal zero. For cost reporting periods beginning prior to October 1, 2015, Worksheet S-3, Part II, lines 14.01 and 14.02, columns 2, 3, 4, 5, and 6, must equal zero. [09/30/2018]
13262S	For cost reporting period beginning on or after October 1, 2022, Worksheet S-3, Part II, line 15, must equal zero. For cost reporting periods beginning before October 1, 2022, Worksheet S-3, Part II, lines 15.01 and 15.02, must equal zero. [10/01/2024]
13265S	For cost reporting period beginning on or after October 1, 2017, Worksheet S-3, Part II, line 16, must equal zero. For cost reporting periods beginning before October 1, 2017, Worksheet S-3, Part II, lines 16.01 and 16.02, must equal zero. [12/31/2019]
13267S	Worksheet S-3, Part III, line 1, columns 4 and 5, must be greater than zero for IPPS providers. Do not apply this edit if Worksheet S-2, Part I, line 3, column 4, is "11" (Indian Health) or "12" (REH). [09/30/2018]
13270S	For cost reporting period beginning on or after October 1, 2015, Worksheet S-3, Part IV, line 8, must equal zero. For cost reporting periods beginning before October 1, 2015, Worksheet S-3, Part IV, lines 8.01, 8.02, and 8.03, must equal zero. [09/30/2018]
13275S	If Worksheet S-2, Part I, line 3, column 7 is "P", and the CCN is XX-0001 through XX-0899, then the amount on Worksheet S-3, Part IV, line 24, must be greater than zero. Do not apply this edit if Worksheet S-2, Part I, line 3, column 4, is "11" (Indian Health) or "12" (REH). [05/01/2010b]
13300S	Eliminated as of 05/01/2010b
13350S	If Worksheet S-4, line 20, column 1, has data then it must be five alphanumeric digits (CBSA). [05/01/2010b]
13375S	If Worksheet S-5, line 13, is greater than zero, line 15 must be greater than zero (and vice versa). If line 14 is greater than zero, line 16 must be greater than zero (and vice versa). If line 17 is greater than zero, line 19 must be greater than zero (and vice versa). If line 18 is greater than zero, line 20 must be greater than zero (and vice versa). Additionally, if Worksheet S-5, line 13 or 17, is greater than zero, Worksheet A, line 74, column 7, must be greater than zero and if Worksheet S-5, line 14 or 18, is greater than zero, then Worksheet A, line 94, column 7, must be greater than zero. [06/30/2012]
13376S	If Worksheet S-5, line 22 (and subscripts), column 2, is greater than zero, then line 22 (and subscripts), column 4, must be greater than zero (and vice versa). If line 22 (and subscripts), column 3, is greater than zero, then line 22 (and subscripts), column 5, must be greater than zero (and vice versa). Additionally, if sum of Worksheet S-5, line 22 and subscripts, column 2, is greater than zero, then Worksheet A, line 74, column 7, must be greater than zero; and, if the sum of Worksheet S-5, line 22, and subscripts, column 3, is greater than zero, then Worksheet A, line 94, column 7, must be greater than zero. [01/01/2013]

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 6 - EDITS

Edit	Condition
13377S	Worksheet S-5, lines 10.01 and 10.02, must have a "Y" or "N" response. [10/01/2012b]
13380S	If Worksheet S-5, line 10.02, column 1, is "N", then line 10.03, column 2, must be 1, 2, 3, or 4; and if the cost reporting period is not the same as the calendar year, then line 10.03, column 1, must be 1, 2, 3, or 4. [10/01/2012b]
13385S	If Worksheet S-5, line 10.01, is "Y", then the sum of Worksheet S-5, line 23 (and subscripts), column 2, must equal the sum of Worksheet I-4, line 12, column 1, for the renal dialysis department, plus Worksheet I-4, line 12, column 1, for the home program dialysis department. [09/30/2016]
13400S	The sum of Worksheet S-7, column 2, lines 3 through 199, must agree with Worksheet S-3, Part I, column 6, line 19. The sum of Worksheet S-7, column 3, lines 3 through 199, must agree with Worksheet S-3, Part I, column 6 (and 6.01, if applicable), line 5, excluding CAH swing-beds. Do not apply this edit to a cost reporting period ending on or after October 1, 2019. [05/01/2010b]
13450S	If Worksheet S-8, line 13, column 1, is "N", then line 13, column 2, must be blank, and line 14 (and any subscripts), columns 1 and 2, must be blank. [05/01/2010b]
13455S	If Worksheet S-8, line 13, column 1, is "Y", then line 13, column 3, must contain a "G" or "N" response. [10/01/2024b]
13705S	If Worksheet S-9, Part III, column 4, line 10, is greater than zero, then Worksheet O-1, column 7, line 100, must be greater than zero, and vice versa. [10/01/2015b]
13710S	If Worksheet S-9, Part III, column 4, line 11, is greater than zero, then Worksheet O-2, column 7, line 100, must be greater than zero, and vice versa. [10/01/2015b]
13715S	If Worksheet S-9, Part III, column 4, line 12, is greater than zero, then Worksheet O-3, column 7, line 100, must be greater than zero, and vice versa. [10/01/2015b]
13720S	If Worksheet S-9, Part III, column 4, line 13, is greater than zero, then Worksheet O-4, column 7, line 100, must be greater than zero, and vice versa. [10/01/2015b]
13725S	Worksheet S-9, Part IV, line 15, columns 1, 2, or 3, cannot be greater than Worksheet S-9, Part III, line 12, columns 1, 2, or 3, respectively. [10/01/2015b]
13730S	Worksheet S-9, Part IV, line 16, columns 1, 2, or 3, cannot be greater than Worksheet S-9, Part III, line 13, columns 1, 2, or 3, respectively. [10/01/2015b]
13735S	If Worksheet S-9, Part IV, column 4, line 15, is greater than zero, then Worksheet O-3, column 7, line 25, must be greater than zero, and if Worksheet S-9, Part IV, column 4, line 16, is greater than zero, then Worksheet O-4, column 7, line 25, must be greater than zero. [10/01/2015b]

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 6 - EDITS

Edit **Condition**

Worksheet S-10 edits apply only to 1886(d) hospitals and CAHs. The Worksheet S-10 edits do not apply to LTC, IRF, IPF, cancer, or children's hospitals. For 1886(d) hospitals and CAHs, apply the following edits: 14000S, 14005S, 14006S, 14007S, 14008S, 14010S, 14011S, 14013S, 14014S, 14015S, 14016S, 14020S, and 14021S.

14000S If Worksheet S-10 (or Worksheet S-10, Part I, effective 10/01/2022b), line 3, is "Y" and line 4, is "N", then line 5 must not be zero. [10/01/2014b]

14005S Worksheet S-10 (or Worksheet S-10, Part I, effective 10/01/2022b), line 20, column 3, must be less than Worksheet C, line 200, column 8. If Worksheet S-2, Part I, line 115, column 1, is "Y", do not apply this edit. [10/01/2013b]

14006S Worksheet S-10 (or Worksheet S-10, Part I, effective 10/01/2022b), line 20, column 2, must be greater than or equal to line 25. [10/01/2013b]

14007S Worksheet S-10, Part II, line 20, column 3, must be less than or equal to Worksheet S-10, Part I, line 20, column 3; and Worksheet S-10, Part II, line 20, column 1, must be less than or equal to Worksheet S-10, Part I, line 20, column 1; and Worksheet S-10, Part II, line 20, column 2, must be less than or equal to Worksheet S-10, Part I, line 20, column 2. [10/01/2022b]

14008S Worksheet S-10, Part II, line 20, column 2, must be greater than or equal to line 25. [10/01/2022b]

14010S For each of columns 1 and 2, if Worksheet S-10 (or Worksheet S-10, Part I, effective 10/01/2022b), line 22, is greater than line 21, then line 23 must be zero. [10/01/2013b]

14011S For each of columns 1 and 2, if Worksheet S-10, Part II, line 22, is greater than line 21, then line 23 must be zero. [10/01/2022b]

14013S Worksheet S-10 (or Worksheet S-10, Part I, effective 10/01/2022b), line 24, must have a "Y" or "N" response. If line 24, is "Y", then line 25 must be greater than zero, and if line 25 is greater than zero, then line 24 must be "Y". [10/01/2017b]

14014S Worksheet S-10, Part II, line 24, must have a "Y" or "N" response. If line 24, is "Y", then line 25 must be greater than zero, and if line 25 is greater than zero, then line 24 must be "Y". If this provider is a CAH (Worksheet S-2, Part I, line 105=Y, do not apply this edit. [10/01/2022b]

14015S If Worksheet S-10 (or S-10, Part I, effective 10/01/2022b), line 27.01, is greater than zero, then line 26 must be greater than or equal to line 27.01, and line 27 must be less than 27.01. [10/01/2013b]

14016S If Worksheet S-10, Part II, line 27.01, is greater than zero, then line 26 must be greater than or equal to line 27.01, and line 27 must be less than 27.01. If this provider is a CAH (Worksheet S-2, Part I, line 105=Y, do not apply this edit. [10/01/2022b]

14020S If Worksheet S-10 (or Worksheet S-10, Part I, effective 10/01/2022b), line 26, is zero then line 27.01 must be zero. [10/01/2013b]

14021S If Worksheet S-10, Part II, line 26, is zero then line 27.01 must be zero. If this provider is a CAH (Worksheet S-2, Part I, line 105=Y, do not apply this edit. [10/01/2022b]

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 6 - EDITS

Edit **Condition**

If the Medicare hospital-based FQHC payment mechanism on Worksheet S-2, Part I, column 7, line 16 (and applicable subscripts), is equal to "P", and Worksheet S-11, Part III, line 4, column 2, is greater than zero, then apply the following edits: 15000S, 15050S, 15100S, 15150S, 15200S, 15250S, 15300S, 15350S, 15400S, 15450S, 15500S, 15550S, 15600S, 15650S, 15700S, 15750S, 15800S, 15850S, 15900S, 15950S, 16000S, 16050S, and 16100S.

15000S For each FQHC CCN entry on Worksheet S-2, Part I, column 2, line 16, and its applicable subscripts, the applicable Worksheet S-11, Part I, lines 1 through 3, must contain: the FQHC site name in column 1, line 1; the FQHC street address in column 1, line 2; the FQHC city name in column 1, line 3; the FQHC two-letter state abbreviation in column 2, line 3; the FQHC ZIP code (formatted as XXXXX) or the FQHC ZIP+4 code (formatted as XXXXX-XXXX) in column 3, line 3; the FQHC county name in column 4, line 3; and, an "R" or "U" in column 5, line 3. [10/01/2014b]

15050S If Worksheet S-11, Parts I and III, are present, then Worksheet N-1 must be present. Conversely, if Worksheet N-1 is present, then Worksheet S-11, Parts I and III, must be present. [10/01/2014b]

15100S The FQHC CCN reported on Worksheet S-11, Part I, column 2, line 9, beginning with subscripted line 9.01, must be between XX-1000 through XX-1199, or XX-1800 through XX-1989, where XX corresponds to the two-digit state code. [10/01/2014b]

15150S The type of control reported on Worksheet S-11, Part I, column 2, line 1, must have a value of 1 through 11. (See Table 3B.) [10/01/2014b]

15200S For the FQHC entered on Worksheet S-11, Part I, column 1, line 1, there must be a "Y" or "N" response for:
Column 1: lines 4, 8, 11, 13, and 14. [10/01/2014b]

15250S If Worksheet S-11, Part I, column 3, subscripts of line 9, are completed, it must have a valid five-position alphanumeric CBSA code. [10/01/2014b]

15300S If Worksheet S-11, Part I, line 4, is "Y", then Worksheet S-11, Part I, columns 1, 2, and 3, as applicable, lines 5 through 7, must be present and valid, and vice versa. [10/01/2014b]

15350S The certification dates for the primary FQHC listed on Worksheet S-2, Part I, column 5, line 16, and for each corresponding consolidated FQHC entered on Worksheet S-11, Part II, column 2, line 1, must be present and possible, and must be on or before the cost reporting period beginning date (Worksheet S-2, Part I, column 1, line 20) and after 01/01/1966. [10/01/2014b]

15400S If Worksheet S-11, Part I, column 1, line 8, is "Y", then column 4 must contain a number greater than or equal to one, for the number of consolidated FQHCs other than the primary FQHC, and, if Worksheet S-2, Part I, column 5, line 16, is on or after 10/01/2014, then Worksheet S-11, Part I, column 2, line 8, must contain a date of request, and column 3 must contain the date of approval. If Worksheet S-11, Part I, column 4, line 8, is greater than or equal to 1, then column 1, must be "Y". [10/01/2014b]

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 6 - EDITS

Edit	Condition
15450S	If Worksheet S-11, Part I, column 1, line 8, is "Y", then line 9, beginning with subscripted line 9.01, for each FQHC must contain: the FQHC site name in column 1, the FQHC CCN in column 2, and the CBSA code in column 3. If the applicable Worksheet S-11, Part II, column 2, line 1, is on or after 10/01/2014, then Worksheet S-11, Part I, line 9, beginning with subscripted line 9.01, must contain the date of request in column 4, and the date of approval in column 5. If Worksheet S-11, Part I, column 1, line 8, is "N", then line 9, beginning with subscripted line 9.01, must be blank. [10/01/2014b]
15500S	If Worksheet S-11, Part I, column 1, line 10, is "1" or "3", then column 2 must have only an A, B, C, and/or D, and vice versa. If Worksheet S-11, Part I, column 1, line 10, is "2", then column 2 must be blank, and vice versa. [10/01/2014b]
15550S	If Worksheet S-11, Part I, column 1, line 11, is "Y", then line 12 must contain the type of grant award in column 1 (see Table 3B), the date of the grant award in column 2 (MM/DD/YYYY), and the grant award number in column 3. If Worksheet S-11, Part I, column 1, line 11, is "N", then line 12 must be blank. [10/01/2014b]
15600S	If Worksheet S-11, Part I, column 1, line 13, is "Y", then column 2 must contain a valid date (MM/DD/YYYY), and vice versa. [10/01/2014b]
15650S	If Worksheet S-11, Part I, column 1, line 14, is "Y", then columns 2 and 3 must be greater than zero, and vice versa. [10/01/2014b]
15700S	If Worksheet S-11, Part I, any of lines 9.01 through 9.99, has an entry, then the corresponding Worksheet S-11, Part II, lines 1 through 3, must contain an entry for each FQHC: the FQHC site name in column 1, line 1; the FQHC street address in column 1, line 2; the FQHC city name in column 1, line 3; the FQHC two-letter state abbreviation in column 2, line 3; the FQHC ZIP code (formatted as XXXXX) or the FQHC ZIP+4 code (formatted as XXXXX-XXXX) in column 3, line 3; the FQHC county name in column 4, line 3; and an "R" or "U" in column 5, line 3. [10/01/2014b]
15750S	For each consolidated FQHC entered on Worksheet S-11, Part II, column 1, line 1, there must be a corresponding entry for the type of control in column 3, and must have a value of 1 through 11. (See Table 3B.) [10/01/2014b]
15800S	If Worksheet S-11, Part II, column 1, line 4, is "1" or "3", then column 2 must have only an A, B, C, and/or D, and vice versa. If Worksheet S-11, Part II, column 1, line 4 is "2", then column 2 must be blank, and vice versa. (See Table 3B.) [10/01/2014b]
15850S	If Worksheet S-11, Part I, column 1, line 8, is "Y", then for each consolidated FQHC identified on Worksheet S-11, Part I, column 2, lines 9.01 through 9.99, there must be a "Y" or "N" response on each applicable Worksheet S-11, Part II, for: **Column 1:** lines 5, 7, and 8. [10/01/2014b]
15900S	If Worksheet S-11, Part II, column 1, line 5, is "Y", then line 6 must contain the type of grant award in column 1 (see Table 3B), the date of the grant award in column 2 (MM/DD/YYYY), and the grant award number in column 3. If Worksheet S-11, Part II, column 1, line 5, is "N", then line 6 must be blank. [10/01/2014b]

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 6 - EDITS

Edit	Condition
15950S	If Worksheet S-11, Part II, column 1, line 7, is "Y", then column 2 must contain a valid date (MM/DD/YYYY), and vice versa. [10/01/2014b]
16000S	If Worksheet S-11, Part II, column 1, line 8, is "Y", then both columns 2 and 3 must be greater than zero, and vice versa. [10/01/2014b]
16050S	If Worksheet S-11, Part I, column 1, line 1, contains an entry, then Worksheet S-11, Part III, columns 1 through 4, lines 1 through 4, must be equal to or greater than zero. [10/01/2014b]
16100S	If Worksheet S-11, Part I, column 2, any of lines 9.01 through 9.99, has an FQHC CCN entry, then Worksheet S-11, Part III, column 0, for lines 1.01 through 1.99, 3.01 through 3.99, and 5.01 through 5.99, must contain a corresponding CCN in the exact same order. [10/01/2014b]
10000A	Worksheet A, columns 1 or 2, line 200, must be greater than zero. [05/01/2010b]
10050A	If the hospital is not a rural hospital qualifying for an exception to the CRNA fee schedule (Worksheet S-2, Part I, line 108, column 1, is "N"), then nonphysician anesthetist costs after reclassification and adjustment (Worksheet A, column 7, line 19) must equal zero. [05/01/2010b]
10100A	Other capital-related costs, interest expense, and utilization review-SNF, after reclassification and adjustment (Worksheet A, column 7, lines 3, 113, and 114), must equal zero. [05/01/2010b]
10150A	Worksheet A, line 3, column 7, must be zero for the cost reporting period. [05/01/2010b]
10160A	When Worksheet S-2, Part I, line 3, column 7 is "P" (IPPS provider), if Worksheet A, line 52, column 7, is greater than zero, then Worksheet S-3, Part I, line 32, column 8, must be greater than zero. [09/30/2017]
10200A	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). [05/01/2010b]
10250A	For each line on Worksheet A-6, if there is an entry in column 4 or 5, there must be an entry in columns 1 and 3; and if there is an entry in column 8 or 9, there must be an entry in columns 1 and 7. All entries in column 1 must be capitalized. All entries must be valid; for example, no salary adjustments in column 3 and/or 7, lines 1 through 3 (capital cost centers), 61, 92, and 113. [05/01/2010b]
10300A	If Worksheet S-2, Part I, column 7, any of lines 3 through 6 equals P, and Worksheet S-2, Part I, line 21, equals 1, 2, 3, 4, 5, or 6, then Worksheet A-7, Part I, columns 1 through 3, line 10, minus column 5, line 10, must be greater than zero, and Worksheet A-7, Part III, sum of columns 9 through 14, lines 1 and 2 (and subscripts for each line), must be greater than zero. [05/01/2010b]
10325A	An explanation must be on the first line for each reclassification code, or when there are multiple reclassifications of the same code, if data is present in any of columns 2 through 9 on Worksheet A-6, column zero. [10/01/2011b]

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TABLE 6 - EDITS

Edit	Condition
10350A	Worksheet A-7, Part III, sum of columns 9 through 14, lines 1 and 2 (and subscripts for each line), must equal the corresponding line on Worksheet A, column 7, lines 1 and 2 (and subscripts). [05/01/2010b]
10351A	If Worksheet A-7, Part III, line 3, sum of columns 5, 6, and 7, is greater than zero then Worksheet A-7, Part III, line 3, column 3, must also be greater than zero. [05/01/2010b]
10400A	For Worksheet A-8 adjustments on lines 3 through 9, 11, 13 through 22, 29, and 32, if column 2 has an entry, then columns 1 and 4 must have entries; and for lines 33 through 49 (and subscripts thereof), if column 2 has an entry, then all four columns (0, 1, 2, and 4) for that line must have entries. [05/01/2010b]
10425A	For Worksheet A-8 adjustments on lines 1, 2, 26, and 27, if column 1, 2, or 5, has an entry, then all three columns for that line must have entries. [05/01/2010b]
10450A	If Worksheet A-8-1, Part A, either of columns 4 or 5, lines 1 through 4, does not equal zero, then column 1, the corresponding line must be present. [05/01/2010b]
10500A	If there are any transactions with related organizations or home offices as defined in CMS Pub. 15-1, chapter 10 (Worksheet S-2, Part I, column 1, line 140, is "Y"), Worksheet A-8-1, Part A, columns 4 or 5 (amounts in columns 4 or 5 must have a parallel line number in column 1, and vice versa), sum of lines 1 through 4, must be greater than zero; and Part B, column 1, any one of lines 6 through 10, must contain any one of alpha characters A through G. Conversely, if Worksheet S-2, Part I, column 1, line 140, is "N", Worksheet A-8-1 must not be present. [05/01/2010b]
10540A	This edit has been redesignated as 10540D.
10541A	Worksheet A-8-2, column 1, may only contain Worksheet A line numbers 4 through 41; line 43; lines 50 through 78; line 90 through 99; line 102; lines 105 through 111; and line 115; and subscripts of each as allowed. [05/01/2010b]
10550A	Worksheet A-8-2, column 3, must be equal to or greater than the sum of columns 4 and 5, and columns 6 and 7 must each be greater than zero if column 5 is greater than zero. CAHs are exempt from completing columns 6 and 7. [05/01/2010b]
10600A	Worksheet A-6, column 10, must contain values of 9 through 14 (Worksheet A-7, Part III, column reference) for the corresponding line of column 3 or column 7 which contains a capital-related line number value of 1 or 2, and/or subscripts thereof. [05/01/2010b]
10650A	Worksheet A-8, column 5, must contain a value of 9 through 14 (Worksheet A-7, Part III, column reference) for any line in column 4, including lines 1, 2, 26, and 27, which contain a capital-related line reference of 1 or 2 (and/or subscripts thereof) and has a basis code in column 1 and/or an amount in column 2. [05/01/2010b]
10700A	Worksheet A-8-1, Part A, column 7, lines 1 through 4 (and subscripts thereof), must contain a value of 9 through 14 (Worksheet A-7, Part III, column 7 reference) if column 1, the corresponding line (and/or subscripts thereof), is 1 or 2. [05/01/2010b]
10750A	If Worksheet A-8-3, sum of columns 1 through 4, line 47, is equal to zero, column 5, line 51, must also be equal to zero. Conversely, if Worksheet A-8-3, sum of columns 1 through 4, line 47, is greater than zero, then column 5, line 51, must be greater than the sum of columns 1 through 4, line 47, and equal to or less than 2080 hours. [05/01/2010b]

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 6 - EDITS

Edit	Condition
10755A	If Worksheet A-8-3, line 33, is greater than zero, then line 33 must equal line 28; if line 34 is greater than zero, then line 34 must equal the sum of lines 27 and 31; or, if line 35 is greater than zero, then line 35 must equal the sum of lines 31 and 32. [05/01/2010b]
10760A	If Worksheet A-8-3, line 44, is greater than zero, then line 44 must equal the sum of lines 38 and 39; if line 45 is greater than zero, then line 45 must equal the sum of lines 39 and 42; or, if line 46 is greater than zero, then line 46 must equal the sum of lines 42 and 43. [05/01/2010b]
10800A	If Worksheet S-2, Part I, line 144, equals "Y", then Worksheet A-8-2, column 3, must be greater than zero and vice versa. [05/01/2010b]
10000B	On Worksheet B-1, all statistical amounts must be greater than zero, except for reconciliation columns. [05/01/2010b]
10050B	Worksheet B, Part I, column 26, line 202, must be greater than zero. [05/01/2010b]
10100B	For each general service cost center with a net expense for cost allocation greater than zero (Worksheet B-1, columns 1 through 23, line 202), 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 reconciliation column. [05/01/2010b]
10150B	For any column which uses accumulated cost as its basis of allocation (on Worksheet B-1), if there is a "-1" in the accumulated cost column, then there may not be an amount in the reconciliation column for the same cost center line. [05/01/2010b]
10000C	On Worksheet C, Part I, all amounts must be equal to or greater than zero. [05/01/2010b]
10050C	Worksheet C, Part I, column 1, line 92, must equal the sum of all title XVIII, Worksheets D-1, column 1, line 89, for hospital and subprovider components. [05/01/2010b]
10100C	If Worksheet S-3, Part I, column 8, lines 1, 8 through 12, are greater than zero, the corresponding line (lines 30 through 35) on Worksheet C, Part I, column 6, must also be greater than zero, and vice versa. [05/01/2010b]
10150C	For cost reporting periods beginning on or after October 1, 2022, if Worksheet B, Part I, line 78, column 26, is greater than zero, Worksheet C, Part I, line 78, column 8, must be greater than zero. [10/01/2022b]
10000D	The total outpatient charges on each line of Worksheet C, Part I, column 7, must be greater than or equal to the sum of all Worksheet D, Part V, columns 2 through 4. This edit was previously 20000D. [09/30/2017]
10050D	If Medicare hospital inpatient days (Worksheet S-3, Part I, column 6 (and 6.01, if applicable), line 14) and Medicare hospital inpatient ancillary pass-through costs (Worksheet D, Part IV, column 11, line 200) are greater than zero, and the hospital is not an all-inclusive rate provider (Worksheet S-2, Part I, column 1, line 115, is "N"), then Medicare hospital inpatient ancillary service costs (Worksheet D-3, column 3, line 200) must also be greater than zero. [05/01/2010b]

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TABLE 6 - EDITS

Edit	Condition
10100D	The total inpatient charges on each line of Worksheet C, Part I, column 6, must be greater than or equal to the sum of all Worksheets D-3, column 2, lines as appropriate. [05/01/2010b]
10150D	Worksheet D-1, Part IV, line 87, for title XVIII hospital, must equal Worksheet S-3, Part I, column 8, line 28. [05/01/2010b]
10200D	Worksheet D-1, Part I, column 1, sum of lines 5 and 6, must equal Worksheet S-3, Part I, column 8, line 5, and Worksheet D-1, Part I, column 1, sum of lines 10 and 11, must be equal to or less than Worksheet D-1, Part I, column 1, sum of lines 5 and 6. [05/01/2010b]
10201D	Worksheet D-1, Part I, column 1, sum of lines 7 and 8, must equal Worksheet S-3, Part I, column 8, line 6. [02/28/2022]
10205D	If Worksheet S-2, Part I, line 112, column 1, is "Y", then Worksheet D-1, Part I, title XVIII, column 1, sum of lines 5 and 6, must equal Worksheet S-3, Part I, column 8, line 5; and Worksheet D-1, Part I, title XVIII, column 1, lines 10 and 11, for the PARHM demonstration portion of the cost reporting period ("PARHM Demonstration" box checked), plus the Worksheet D-1, Part I, title XVIII, column 1, lines 10 and 11, for the non-PARHM demonstration portion of the cost reporting period ("Hospital" box checked), must be equal to or less than Worksheet D-1, Part I, title XVIII, column 1, sum of lines 5 and 6. [01/29/2019]
10206D	This edit has been rescinded.
10250D	Worksheet D-1, Part I, title XVIII, sum of lines 10 and 11, must equal Worksheet S-3 Part I, line 5, column 6. [05/01/2010b]
10255D	If Worksheet S-2, Part I, line 112, column 1, is "Y", then Worksheet D-1, Part I, title XVIII, sum of lines 10 and 11, for the PARHM demonstration portion of the cost reporting period ("PARHM Demonstration" box checked) must equal Worksheet S-3, Part I, line 5, column 6.01; and the days on Worksheet D-1, Part I, title XVIII, sum of lines 10 and 11, for the non-PARHM demonstration portion of the cost reporting period ("Hospital" box checked), must equal Worksheet S-3, Part I, line 5, column 6. [01/29/2019]
10256D	This edit has been rescinded.
10300D	If the sum of Worksheet D-2, Part I, column 1, lines 2 through 8, 10 through 19, and 21 through 26, is greater than zero, then line 28, column 1, must equal 100 percent. [05/01/2010b]
10350D	The sum of all Worksheet D-1, column 1, line 85, for all titles for both SNF and/or NF components, plus the sum of all Worksheet(s) E-2, column 1, line 7, must be equal to or less than the absolute value of Worksheet A-8, line 25. [05/01/2010b]
10400D	If any of the hospital's Worksheet D-1, lines 5 through 8, and 17 through 20, are greater than zero, then each Worksheet D-1 with line 21 greater than zero for title V, title XVIII, and title XIX, must have the same rates for lines 5 through 8, and 17 through 20. Do not apply this edit to a CAH. [05/01/2010b]

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TABLE 6 - EDITS

Edit	Condition
10410D	If Worksheet D-1, Part II, line 55.03, is greater than zero, line 55.02 must be zero; and, if Worksheet D-1, Part II, line 55.02, is greater than zero, line 55.03 must be zero. [08/07/2019]
10411D	For cost reporting periods beginning before October 1, 2022, if Worksheet D-1, Part II, line 55.03, is greater than zero, Worksheet B, Part I, line 73.01, column 26, must be greater than zero. [08/07/2019]
10412D	For cost reporting periods beginning on or after October 1, 2022, if Worksheet D-1, Part II, line 55.03, is greater than zero, Worksheet B, Part I, line 78, column 26, must be greater than zero. [10/01/2022b]
10450D	If Worksheet S-3, Part I, column 6, lines 1, 8 through 12 (or lines 16 through 17 for psychiatric or rehabilitation subproviders), are greater than zero, then the corresponding line on Worksheet D-3, column 2, lines 30 through 41, must also be greater than zero, and vice versa. [05/01/2010b]
10451D	If Worksheet S-3, Part I, column 6.01, for PARHM demonstration, lines 1, 8 through 12 (or lines 16 through 17 for psychiatric or rehabilitation subproviders), are greater than zero, then the corresponding line on PARHM demonstration Worksheet D-3, column 2, lines 30 through 41, must also be greater than zero, and vice versa. [01/29/2019]
10452D	This edit has been rescinded.
10460D	For cost reporting periods beginning on or after October 1, 2020, Worksheet D-3, line 77, column 2, must be zero. [10/01/2020b]
10500D	If Worksheet D-4, lines 1 through 6, columns 1 and/or 3, or lines 8 through 40, column 2, have data, then Worksheet S-2, Part I, lines 126 through 132, column 1, must have a corresponding certification date. [06/30/2012]
10505D	If Worksheet D-4, line 62, column 2, is greater than zero, then Worksheet D-4, sum of lines 70 through 73, columns 1 and 2, must be greater than zero. [06/30/2014]
10510D	*For cost reporting periods beginning before January 1, 2023, if Worksheet D-4, Part III, line 62, column 2, is greater than zero, then line 62, column 2, must equal Worksheet D-4, Part IV, line 74, columns 1 and 2, less line 83, columns 1 and 2. For cost reporting periods beginning on or after January 1, 2023, if Worksheet D-4, Part III, line 62, column 2, is greater than zero, then line 62, column 2, must equal Worksheet D-4, Part IV, line 74, columns 1 and 2, less the sum of line 82, columns 1 and 2, and line 83, columns 1 and 2. [01/01/2023b]*
10511D	*If Worksheet D-4, Part III is for kidney, and line 63, column 2, is greater than zero, then line 63, column 2, must equal Worksheet D-4, Part IV, sum of lines 75.01, 75.02, 75.03, 77, 78, and 79.01, columns 1 and 2. If Worksheet D-4, Part III is for organs other than kidney, and line 63, column 2, is greater than zero, then line 63, column 2, must equal Worksheet D-4, Part IV, sum of lines 75.01, 75.03, 77, 78, and 79.01, columns 1 and 2. [10/01/2022b]*
10512D	*For each of columns 1 and 2, Worksheet D-4, Part IV, line 75, must equal the sum of lines 75.01, 75.02, 75.03 and 75.04. [10/01/2022b]*
10513D	*If Worksheet D-4, Part IV, line 75.03, sum of columns 1 and 2, are greater than zero, then Worksheet D-4, Part IV, line 75.03, column 3, must be greater than zero and equal Worksheet D-4, Part III, sum of lines 66.01 and 66.02, column 1. [10/01/2022b]*

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TABLE 6 - EDITS

Edit	Condition
10514D	*Worksheet D-4, Part IV, line 76, columns 1, 2, and 3 must be zero for cost reporting periods beginning on or after October 1, 2022. [10/01/2022b]*
10515D	*Worksheet D-4, Part IV, if the sum of columns 1 and 2 for any of lines 77 through 80, and 82, are greater than zero, then column 3 of the same line must be greater than zero. [10/01/2022b]*
10516D	*If Worksheet D-4, Part IV, sum of columns 1 and 2, lines 77, 78 and 79.01 are greater than zero, Worksheet D-4, Part III, line 66, column 1, must be greater than zero and must equal Worksheet D-4, Part IV, column 3, sum of lines 77, 78, and 79.01. [10/01/2022b]*
10517D	*For each of columns 1 and 2, Worksheet D-4, Part IV, line 74, must equal the sum of lines 75 (not subscripts), and 77 through 83. [10/01/2022b]*
10540D	Worksheet D-5, Part III, column 1, may only contain Worksheet A line numbers 4 through 41, 43, 50 through 78, 90 through 99, 102, 105 through 111, 115, and subscripts as allowed. [05/01/2010b]
10545D	For cost reporting periods beginning on or after December 27, 2020, Worksheet D, Part III, column 3, must be zero; and Worksheet D, Part IV, column 4, must be zero. [12/27/2020b]
10550D	If Worksheet S-2, Part I, line 60, is "N", then Worksheet D, Part III, columns 1 and 2, and Worksheet D, Part IV, columns 2 and 3, must also be zero, and vice versa. [06/30/2012]
10560D	If Worksheet S-2, Part I, line 58, is "N", then Worksheet D-5, Parts I and II, or, for cost reporting periods ending on or after June 30, 2014, Worksheet D-5, Parts III and IV, must not be present. [05/01/2010b]
10600D	Worksheet D-4, Part III, line 62, column 2, must be equal to or greater than Worksheet D-4, Part III, line 63, column 2. [05/01/2010b]
10000E	When Worksheet S-2, Part I, line 112, column 1, is "Y", apply this edit to Worksheets E, Part A, for the IPPS and PARHM components collectively. If Worksheet S-2, Part I, line 22, column 1, is "N", then Worksheet E, Part A, line 34, must be zero, and conversely, if Worksheet S-2, Part I, line 22, column 1, is "Y", and Worksheet S-2, Part I, line 22, column 2, is "N", then Worksheet E, Part A, line 32, must be equal to or greater than 15 percent; and, when the sum of Worksheet E, Part A, lines 1.01 and 1.02, is greater than zero, then Worksheet E, Part A, line 34, must be greater than zero. [05/01/2010b]
10001E	This edit has been rescinded.
10005E	When Worksheet S-2, Part I, line 112, column 1, is "Y", apply this edit to Worksheets E, Part A, for the IPPS and PARHM components collectively. If Worksheet S-2, Part I, line 22, column 1, is "N", then Worksheet E, Part A, line 35.02, columns 1 and 2, and line 36, must be zero. Conversely, if the cost reporting period overlaps October 1, 2013, and Worksheet S-2, Part I, line 22, column 1, is "Y", then Worksheet E, Part A, line 35.02, column 1, must be zero, and line 35.02, column 2, and line 36, must be greater than zero. If the cost reporting period begins on or after October 1, 2013, and Worksheet S-2, Part I, line 22, column 1, is "Y", then Worksheet E, Part A, line 35.02, columns 1 and 2, as applicable, and line 36, must be greater than zero. If the provider's Factor 3 is zero on the Medicare DSH Uncompensated Care Payment Factor 3 table from the applicable IPPS final rule, do not apply this edit. [10/01/2013b]

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 6 - EDITS

Edit	Condition
10006E	This edit has been rescinded.
10010E	If the cost reporting period begins or overlaps October 1, 2013, and Worksheet S-2, Part I, line 22, is "Y", and Worksheet S-2, Part I, line 22.01, columns 1 and/or 2, is "N", then Worksheet E, Part A, lines 35 and 35.01, column 1, must be zero and column 2 must be greater than zero. If the cost reporting period begins after October 1, 2013, and Worksheet S-2, Part I, line 22, is "Y", and Worksheet S-2, Part I, line 22.01, columns 1 and/or 2, is "N", then Worksheet E, Part A, lines 35 and 35.01, columns 1 and 2, must be greater than zero, as applicable. If the provider's Factor 3 is zero on the Medicare DSH Uncompensated Care Payment Factor 3 table from the applicable IPPS final rule, do not apply this edit. [10/01/2013]
10060E	When Worksheet S-2, Part I, line 112, column 1, is "Y", apply this edit to Worksheets E, Part A, for the IPPS and PARHM components collectively. If the cost reporting period ends on or after October 1, 2013, then Worksheet E, Part A, line 1, must be zero, and the sum of lines 1.01 and 1.02 must be greater than zero if Worksheet S-3, Part I, line 14, sum of columns 6 and 6.01, is also greater than zero. [10/01/2013]
10061E	This edit has been rescinded.
10070E	This edit has been eliminated.
10080E	If the cost reporting period overlaps October 1, 2013, then Worksheet E, Part A, column 1, lines 35 through 35.03, must be left blank, and only column 2 is completed. [10/01/2013]
10081E	If Worksheet E, Part A, line 70.75, or Worksheet E, Part B, line 39.75, is greater than zero, then Worksheet S-2, Part I, line 20, column 1, must be on or after January 1, 2023. [12/31/2021]
10100E	Worksheet E, Part A, line 40, column 1, if applicable (for hospital, title XVIII only) must be equal to or less than Worksheet S-3, Part I, column 15, line 14. [05/01/2010b]
10150E	Worksheet E, Part A, line 30, must equal Worksheet L, Part I, line 7, where both amounts are present. [05/01/2010b]
10160E	If Worksheet E, Part A, line 45, is greater than zero, it must equal $435.60 for cost reporting periods beginning on or after January 1, 2013. Do not apply this edit to cost reporting periods beginning on or after October 1, 2024. [06/30/2024]
10161E	If Worksheet E, Part A, line 45, is greater than zero, it must equal $435.60 for cost reporting periods beginning on or after January 1, 2013, when Worksheet S, Part I, line 5, equals 2 or 3. Do not apply this edit to cost reporting periods beginning on or after October 1, 2024. [01/01/2013b]
10162E	If Worksheet E, Part A, line 45, is greater than zero, it must equal $821.46 for cost reporting periods beginning on or after October 1, 2024, when Worksheet S, Part I, line 5, equals 2 or 3. [10/01/2024b]

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Edit	Condition
10170E	When Worksheet S-2, Part I, line 112, column 1, is "Y", apply this edit to Worksheets E, Part A, for the IPPS and PARHM components collectively. If Worksheet E, Part A, line 48, is greater than zero, Worksheet S-2, Part I, line 35 or 37, must be greater than zero (except when Worksheet S-2, Part I, line 37.01, is "Y", then line 37 must be zero), and conversely, if Worksheet S-2, Part I, lines 35 or 37, is greater than zero, then Worksheet E, Part A, line 48, must be greater than zero. If Worksheet S-2, Part I, line 110, is "Y", do not apply this edit. [05/01/2010b]
10171E	This edit has been rescinded.
10175E	If Worksheet S-2, Part I, line 3, column 4, is "12" (REH), then Worksheet E, Part B, line 28.50, must be greater than zero, and vice versa. [01/01/2023b]
10180E	The sum of Worksheet E-3, Part IV, lines 1.01 through 1.04, must equal the amount entered on line 1. [08/31/2017]
10191E	If the number of beds calculated in accordance with 42 CFR 412.105(b) on Worksheet E, Part A, line 4, exceeds 100, then Worksheet E-90 must not be present and Worksheet E, Part A, line 70.76, must be zero. [10/01/2024b]
10192E	If Worksheet E-90, Part I, line 1 through line 3; or Part II, line 1 through line 7, contain data, then Worksheet S-2, Part I, line 140, must be "N" for no, and no data entered on Worksheet S-2, Part I, line 141 through line 143; and, if Worksheet S-2, Part I, line 140, is "Y" for yes, or Worksheet S-2, Part I, line 141 through line 143, contains data, then Worksheet E-90 must not be present. [10/01/2024b]
10200E	If Worksheet S-2, Part I, line 3 or 5, column 4, equals "5", and line 75, column 1, equals "Y", and Worksheet S-3, Part I, line 1 or 17, column 6, is greater than zero, then Worksheet E-3, Part III, line 1 must be greater than zero, and vice versa. [05/01/2010b]
10225E	If Worksheet S-2, Part I, line 60, is "N", then Worksheets E, Part A, line 53; E-3, Part I, line 1.01; E-3, Part II, line 13; E-3, Part III, line 14; E-3, Part IV, line 4; and E-3, Part V, line 2; must be zero. [09/30/2018]
10226E	If Worksheet S-2, Part I, line 4, column 2, contains a CCN (IPF subprovider), then Worksheet E-3, Part II, line 13 (NAHE managed care payments), must be zero; and, if Worksheet S-2, Part I, line 5, column 2, contains a CCN (IRF subprovider), then Worksheet E-3, Part III, line 14 (NAHE managed care payments), must be zero. [08/31/2019]
10235E	If Worksheet S-2, Part I, line 56, column 2, is "Y", then Worksheet S-3, Part I, lines 2, 3, and 4, columns 6 and 6.01, must equal Worksheet E-4, line 26, columns 2 and 2.01. [05/01/2010b]
10250E	If Worksheet S-2, Part I, line 76, column 1, is "Y", and column 2, is "N", and Worksheet S-3, Part I, line 1 or 17, column 6, is greater than zero, then Worksheet E-3, Part III, line 5, must have an amount greater than zero, and vice versa. [05/01/2010b]
10300E	If Worksheet S-2, Part I, line 76, column 1, is "N", and column 2, is "Y", and column 3, is 1, 2, 3, 4 or 5, and Worksheet S-3, Part I, line 1 or 17, column 6, is greater than zero, then Worksheet E-3, Part III, line 8, must be greater than zero, and vice versa. [05/01/2010b]

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TABLE 6 - EDITS

Edit	Condition
10350E	If Worksheet S-2, Part I, line 76, column 1, is "Y", column 2, is "N", and Worksheet S-3, Part I, line 1 or 17, column 6, is greater than zero, then Worksheet E-3, Part III, line 8, must be zero. [05/01/2010b]
10400E	Removed and reserved.
10450E	If Worksheet S-2, Part I, line 3, column 4, is "2"; line 80, column 1, is "Y"; line 87, column 1, is "N", and Worksheet S-3, Part I, line 1, column 6, is greater than zero, then Worksheet E-3, Part IV, line 1, for the long term care facility, must be greater than zero, and vice versa. [05/01/2010b]
10455E	If Worksheet S-2, Part I, line 3, column 4, is "10"; line 80, column 1, is "Y"; line 87, column 1, is "Y", and Worksheet S-3, Part I, line 1, column 6, is greater than zero, then Worksheet E-3, Part I, line 1, for the extended neoplastic disease care hospital, must be greater than zero. [10/01/2014b]
10500E	If Worksheet S-2, Part I, lines 3 or 4, column 4, equals "4", and line 70, column 1, is "Y", and Worksheet S-3, Part I, line 1 or 16, column 6, is greater than zero, then Worksheet E-3, Part II, line 1, for the IPF must be greater than zero, and vice versa. [05/01/2010b]
10600E	If Worksheet S-2, Part I, line 71, column 1, is "Y", and column 2, is "N", and Worksheet S-3, Part I, line 1 or 16, column 6, is greater than zero, then Worksheet E-3, Part II, line 4, must have an amount greater than zero. [05/01/2010b]
10650E	If Worksheet S-2, Part I, line 71, column 1, is "N" and column 2, is "Y", and column 3 is 1, 2, 3, 4 or 5, and Worksheet S-3, Part I, line 1 or 16, column 6, is greater than zero, then Worksheet E-3, Part II, line 7, must be greater than zero. [05/01/2010b]
10700E	If Worksheet S-2, Part I, line 71, column 1 is "Y", column 2, is "N", and Worksheet S-3, Part I, line 1 or 16, column 6, is greater than zero, then Worksheet E-3, Part II, line 7, must be zero. [5/01/2010b]
10710E	If Worksheet E-3, Part VI, line 1, is greater than zero, then line 15.01 must be greater than zero. [04/01/2022]
10750E	Removed and reserved.
10800E	Edit has been changed to level 2 edit 20900E. [05/01/2010b]
10825E	If Worksheet E, Part A, line 8.01, or Worksheet E-4, line 4.01, is greater than zero then Worksheet S-2, Part I, line 61, column 1, must be "Y". [05/01/2010b]
10830E	If Worksheet E-4, line 6, or line 8, column 3, is greater than zero, then both lines must be greater than zero, and line 8, column 3, must be less than or equal to line 6. [01/31/2018]
10850E	Edit has been changed to level 2 edit 20850E. [05/01/2010b]
10900E	If Worksheet E, Part A, line 24, is less than or equal to zero, then lines 25 through 28 should be zero. [05/01/2010b]

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TABLE 6 - EDITS

Edit **Condition**

The 10000G series of edits apply to all provider types, except governmental providers. Consequently, do not apply these edits to providers where the response to Worksheet S-2, Part I, line 21, is "7" through "13". This exception applies to the following edits: 10000G, 10050G, 10100G, and 10150G:

10000G Total assets on Worksheet G (sum of each of columns 1 through 4, lines 1 through 10, 12 through 29 (subscripts as indicated), and 31 through 34, must equal total liabilities and fund balance (sum of each of columns 1 through 4, lines 37 through 44, 46 through 49, and 52 through 58). This edit was previously 20000G. [10/31/2020]

10050G Total patient revenue (Worksheet G-2, Part I, column 3, line 28) must equal the sum of inpatient and outpatient revenue (Worksheet G-2, Part I, sum of columns 1 and 2, line 28). This edit was previously 20050G. [10/31/2020]

10100G Net income or loss (Worksheet G-3, column 1, line 29) must not equal zero. This edit was previously 20100G. [10/31/2020]

10160G Worksheet G-3, line 5, must be less than Worksheet G-2, line 28, column 3. [06/30/2024]

10200G If Worksheet G-3, lines 24.51 through 24.60, column 1, has an entry greater than zero, then column 0 for that corresponding line must also contain a line description. [03/31/2023]

10150G Contractual allowances (Worksheet G-3, column 1, line 2) must not be negative. This edit was previously 20150G. [10/31/2020]

10000H Worksheet H-2, Part II, sum of lines 1 through 19, for each of columns 1 through 4, and 5 through 23 (including the reconciliation column and accumulated cost column with negative one (-1) entries only), must equal the corresponding column of Worksheet B-1, line 101, and subscripts, as appropriate. [05/01/2010b]

10050H Worksheet H-2, Part I, columns 0 through 4, 5 through 23, and 25, lines 1 through 19, must agree with the corresponding columns on Worksheet B, Part I, line 101, and subscripts, as applicable. [05/01/2010b]

10100H If Worksheet H-1, Part I, any of columns 1 through 4, line 24, is greater than zero, then Worksheet H-1, Part II, sum of the corresponding columns, must be greater than zero. [05/01/2010b]

10150H Total visits on Worksheet H-3, Part I, sum of column 4, lines 1 through 6, must be equal to or greater than the unduplicated census count, Worksheet S-4, sum of columns 1 through 4, line 2. Do not apply this edit if Worksheet S-4, sum of columns 1 through 3, line 2, equals zero. [05/01/2010b]

10175H If Worksheet H-3, line 7 (sum of columns 6 and 7), is greater than zero, then Worksheet H-4, line 22 (sum of columns 1 and 2), and Worksheet H-5, line 4 (sum of columns 2 and 4), must be greater than zero, and vice versa. [06/30/2012]

10200H Worksheet H, column 10, line 24, must equal Worksheet A, column 7, line 101, and/or subscripts, as applicable. [05/01/2010b]

10250H Worksheet H-3, Part I, sum of lines 1 through 6, column 4, must equal Worksheet S-3, Part I, column 8, line 22, and subscripts, as applicable. [05/01/2010b]

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TABLE 6 - EDITS

Edit	Condition
10300H	Worksheet H-3, Part I, columns 6 and 7, lines 1 through 6, must equal Worksheet S-4, columns 1 through 4, lines 21, 23, 25, 27, 29, and 31, respectively. Also, Worksheet H-3, Part I, lines 8 through 13, sum of columns 2 and 3, for all CBSAs, for each respective discipline, must equal the visits for the same respective discipline, on lines 1 through 6, columns 6 and 7. [05/01/2010b]
10310H	If Worksheet H-4, Part II, sum of lines 11 through 14, column 1, is greater than zero, then line 31.01, column 1, must be greater than zero; and if sum of lines 11 through 14, column 2, is greater than zero, then line 31.01, column 2, must be greater than zero. [04/01/2022]
10000I	Worksheet I-1 (Renal Dialysis), column 1, sum of lines 1 through 8 and 10 through 16, must equal Worksheet A, column 7, line 74. Worksheet I-1 (Home Program), column 1, sum of lines 1 through 8 and 10 through 16, must equal Worksheet A, column 7, line 94. If Worksheet S-2, Part I, line 145, column 1, is "Y", do not apply this edit to the Renal Dialysis department and do not complete the Renal Dialysis department Worksheets I-1 through I-4 for this cost report. If Worksheet S-2, Part I, line 145, column 2, is "N", do not apply this edit to the renal dialysis department. If the Home Program department Worksheet S-5, line 1, columns 1, 2, 3, 4, 5, and 6, are zero, do not apply this edit to the Home Program department. [05/01/2010b]
10050I	Worksheet I-1 (Renal Dialysis), column 1, sum of lines 1 through 8, 10 through 16, and 18 through 26, must equal the amount from Worksheet B, Part I, column 26 (for cost reporting periods beginning on or after 10/1/2015, column 24, minus columns 21 and 22), line 74. Worksheet I-1(Home Program), column 1, sum of lines 1 through 8, 10 through 16, and 18 through 26, must equal the amount from Worksheet B, Part I, column 26 (for cost reporting periods beginning on or after 10/1/2015, column 24, minus columns 21 and 22), line 94. If Worksheet S-2, Part I, line 145, column 1, is "Y", do not apply this edit to the Renal Dialysis department and do not complete the Renal Dialysis department Worksheets I-1 through I-4 for this cost report. If Worksheet S-2, Part I, line 145, column 2, is "N", do not apply this edit to the renal dialysis department. If the Home Program department Worksheet S-5, line 1, columns 1, 2, 3, 4, 5, and 6, are zero, do not apply this edit to the Home Program department. [05/01/2010b]
10100I	If Worksheet B, Part I, line 74, column 26, is greater than zero and Worksheet S-2, Part-I, line 145, column 1, is "N" and Worksheet S-2, Part I, line 145, column 2, is "Y", then Renal Dialysis Worksheets S-5, I-1, I-2, I-3, I-4, and I-5, should be present (containing any data) and Worksheet I-3, line 17, column 3, should be greater than zero and vice versa. Do not apply this edit if Worksheet S-2, Part I, line 145, column 1, is "Y". [05/01/2010b]
10150I	If Worksheet B, Part I, line 94, column 26, is greater than zero, or if Worksheet I-4 (Home Program), line 11, column 4, is greater than zero, then Home Program Worksheets S-5, I-1, I-2, I-3, I-4, and I-5, must be present (containing any data), and vice versa; and Worksheet I-3, line 17, column 3, must be greater than zero. [05/01/2010b]
10200I	If Worksheet I-2, any of columns 1 through 8, line 1, are greater than zero, then Worksheet I-3, for related columns 1 through 8, sum of lines 2 through 16, must be greater than zero. [05/01/2010b]
10250I	If Worksheet S-2, Part I, line 145, column 1, is "N" and Worksheet A, column 7, line 74, is greater than zero, then the I series worksheets must be present for renal dialysis services. Do not apply this edit if Worksheet S-2, Part I, line 145, column 1, is "Y", or if column 2, is "N". [05/01/2010b]

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 6 - EDITS

Edit	Condition
10300I	If Worksheet I-1, column 1, line 31, is greater than zero, then Worksheet I-4, column 1, sum of lines 1 through 10, must also be greater than zero. [05/01/2010b]
10350I	Worksheets I-2 and I-3, column 6, line 15, must be zero, for cost reporting periods beginning on or after October 1, 2015. [10/01/2015b]
10400I	For each line on Worksheet I-4, with treatments in column 1 greater than zero, the cost in the corresponding column 2 must be greater than zero; and vice versa. [01/01/2024]
10401I	Worksheet I-5, line 5, must be zero, for cost reporting periods beginning on or after January 1, 2017. [01/01/2017b].
10402I	Worksheet I-5, lines 5.01, 5.02, and 5.03, must be zero, for cost reporting periods beginning on or after January 1, 2020. [01/01/2020b].
10000J	Worksheet J-1, Part I, sum of columns 0 through 4, 5 through 23, and 25, line 22, must equal Worksheet B, Part I, column 26, line 99, and/or applicable subscripts, and vice versa. [05/01/2010b]
10050J	Worksheet J-1, Part II, sum of lines 1 through 21, for each of columns 1 through 4, and 5 through 23, must equal the corresponding columns of Worksheet B-1, line 99, and/or subscripts as appropriate. Include reconciliation and accumulated cost columns with negative one (-1) entries only. [05/01/2010b]
10000K	For cost reporting periods ending prior to September 30, 2016, the K worksheet series must not be completed. [10/01/2015b]
10000L	If Worksheet S-2, Part I, line 3, column 3, is urban (not 999xx CBSA code), and Worksheet E, Part A, line 4, is less than 100; Worksheet L, Part I, line 11, must be zero and Worksheet S-2, Part I, line 45, column 2, must contain a response of "N". [05/01/2010b]
10050L	If Worksheet S-2, Part I, line 46, is "N", then Worksheet L-1, must not be completed. [05/01/2010b]
10000M	If Worksheet S-8 is present, then Worksheet M-1 must be present. Conversely, if Worksheet M-1 is present, then Worksheet S-8 must be present. [05/01/2010b]
10050M	If Worksheet S-8, line 12, equals "Y", Worksheet M-2, column 3, lines 1, 2, and 3, must each be greater than zero and at least one line must contain a value other than the standard amount. Conversely if Worksheet S-8, line 12, equals "N", Worksheet M-2, column 3, lines 1, 2, and 3, must contain the values 4200, 2100, and 2100, respectively. Apply this edit to both the RHC components, and FQHC components for cost reporting periods beginning prior to October 1, 2014. Do not apply this edit to cost reporting periods ending after December 31, 2024. [05/01/2010b]
10100M	This edit has been eliminated.
10150M	The sum of Worksheet M-1, column 7, lines 1 through 9, 11 through 13, 15 through 19, 23 through 27, and 29 through 30, must equal the amount on Worksheet A, column 7, line 88, for an RHC, and line 89 for an FQHC, for cost reporting periods beginning prior to October 1, 2014. [05/01/2010b]
10155M	*For each line 1 through 8, if Worksheet M-2, column 2 is greater than zero, then each corresponding line in column 1 must be greater than zero. [12/31/2025]*

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 6 - EDITS

Edit	Condition
10250M	The sum of Worksheet M-3, line 16.02, columns 1 and 2, must be less than or equal to the sum of line 16.01, columns 1 and 2. For FQHCs, do not apply this edit for cost reporting periods beginning on or after October 1, 2014. [05/01/2010b]
10255M	If the cost reporting period is within a calendar year on Worksheet S-2, Part I, line 20, columns 1 and 2, then Worksheet M-3, columns 1 and 3 for lines 8 through 16, must be blank. [01/01/2025b]
10300M	Worksheet M-4, line 13.01, columns 2.01 and 2.02, must be zero, for cost reporting periods beginning on or after January 1, 2022. [01/01/2022b]
10305M	Worksheet M-4, lines 1 through 14, columns 1, 2, 2.01, 2.02, and 2.03, must be zero, for cost reporting periods beginning on or after July 1, 2025. [07/01/2025b]

If the Medicare hospital-based FQHC payment mechanism on Worksheet S-2, Part I, column 7, line 16 (and applicable subscripts), is equal to "P" and Worksheet S-11, Part III, column 2, sum of lines 2, 4, and 6, is greater than zero, then apply the following edits 10000N, 10050N, 10150N, 10200N, 10250N, 10300N, and 10305N:

10000N	The sum of Worksheet(s) N-1, column 7, line 100, must equal the sum of the amount(s) on Worksheet A, column 7, line 89 and its subscripts. [10/01/2014b]
10050N	For each amount on Worksheet N-1, column 7, lines 23 through 31, and line 33, that are greater than zero, the corresponding total visits on Worksheet N-2, Part I, column 2, lines 1 through 10, must also be greater than zero. [10/01/2014b]
10150N	Worksheet N-2, column 2, lines 1 through 10, must be equal to the sum of columns 7 , 8, and 8.01, lines 1 through 10, for each line. [10/01/2014b]
10200N	Worksheet N-2, column 2, line 11, must be equal to Worksheet S-11, Part III, column 5, sum of lines 2, 4 and 6. [10/01/2014b]
10250N	Worksheet N-2, column 9, line 11 must, be equal to Worksheet S-11, Part III, column 2, line 2. [10/01/2014b]
10300N	Worksheet N-2, column 10, line 11 must, be equal to Worksheet S-11, Part III, column 2, line 4. [10/01/2014b]
10305N	Worksheet N-2, column 10.01, line 11, must be equal to Worksheet S-11, Part III, column 2, line 6. [01/01/2024]
10350N	Worksheet N-3, line 13.01, columns 2.01 and 2.02, must be zero, for cost reporting periods beginning on or after January 1, 2022. [01/01/2022b]
10360N	Worksheet N-3, lines 1 through 14, columns 1, 2, 2.01, 2.02, and 2.03, must be blank, for cost reporting periods beginning on or after July 1, 2025. [07/01/2025b]
10400N	If Worksheet N-4, line 1, is greater than zero, then line 15 must be greater than zero. [04/01/2022]
10000O	For cost reporting periods ending on or after September 30, 2016, the O worksheet series must be completed when both of the following are true: Worksheet S-2, Part I, columns 2 and 5, line 14 (or applicable subscripts), have entries, and Worksheet A, column 7, line 116 (or applicable subscripts), is greater than zero, and vice versa. [09/30/2016]

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 6 - EDITS

Edit	Condition
10030O	For each hospital-based hospice, if Worksheet A, column 7, line 116 (or applicable subscript), is greater than zero, then Worksheet O, column 7, line 100, must equal Worksheet A, column 7, line 116 (or applicable subscript) and Worksheet S-2, Part I, line 14 (or applicable subscripts), columns 2 and 5, must have an entry. [09/30/2016]
10050O	Worksheet O-5, column 3, line 100, must equal Worksheet B, Part I, column 26, line 116. [09/30/2016]
10090O	For each general service cost center with a net expense for cost allocation greater than zero (Worksheet O-6, Part II, line 100, columns 1 through 17), the corresponding total cost allocation statistic (Worksheet O-6, Part II, column 1, line 1; column 2, line 2, etc.) must also be greater than zero. Exclude from this edit any reconciliation column. [09/30/2010]
10100O	Worksheet O-6 Part II, line 52, columns 6, 8, and 17, the statistic in each column must equal Worksheet S-9, line 12, column 4, minus Worksheet S-9, line 15, column 4. For Worksheet O-6, Part II, for each column 6, 8, and 17, if there is no cost on line 100, do not apply this edit. [09/30/2016]
10150O	Worksheet O-6 Part II, line 53, columns 6, 8, and 17, the statistic in each column must equal Worksheet S-9, line 13, column 4, minus Worksheet S-9, line 16, column 4. For Worksheet O-6, Part II, for each column 6, 8, and 17, if there is no cost on line 100, do not apply this edit. [09/30/2016]
10200O	Worksheet O-6, Part II, line 50, columns 10, 11 and 15, the statistic in each column must equal Worksheet S-9, line 10, column 4. For Worksheet O-6, Part II, for each column 10, 11, and 15, if there is no cost on line 100, do not apply this edit. [09/30/2016]
10250O	Worksheet O-6, Part II, line 51, columns 10, 11 and 15, the statistic in each column must equal Worksheet S-9, line 11, column 4. For Worksheet O-6, Part II, for each column 10, 11, and 15, if there is no cost on line 100, do not apply this edit. [09/30/2016]
10300O	Worksheet O-6, Part II, line 52, columns 10, 11 and 15, the statistic in each column must equal Worksheet S-9, line 12, column 4. For Worksheet O-6, Part II, for each column 10, 11, and 15, if there is no cost on line 100, do not apply this edit. [09/30/2016]
10350O	Worksheet O-6, Part II, line 53, columns 10, 11 and 15, the statistic in each column must equal Worksheet S-9, line 13, column 4. For Worksheet O-6, Part II, for each column 10, 11, and 15, if there is no cost on line 100, do not apply this edit. [09/30/2016]

II. Level 2 Edits (Potential Rejection Errors)

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

Edit	Condition
20000	All type 3 records with numeric fields and a positive usage must have values greater than zero (supporting documentation may be required for negative amounts). [05/01/2010b]

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 6 - EDITS

Edit	Condition
20050	Only elements set forth in Table 3, with subscripts as appropriate, are required in the file. [05/01/2010b]
20100	Moved to level 1 edit 10655.
20150	Standard cost center lines, descriptions, and codes should not be changed. (See Table 5 for standard descriptions and codes.) This edit applies to the standard line only and not subscripts of that code. [05/01/2010b]
20200	All standard cost center codes must be entered on the designated standard cost center line and subscripts thereof as indicated in Table 5. [05/01/2010b]
20250	All nonstandard cost center codes may be placed on any standard subscripted cost center line and or generic cost center line within the cost center category (i.e., only nonstandard cost center codes of the general service cost center may be placed on standard cost center lines of general service cost centers). Exceptions are listed in edit 10700. [05/01/2010b]
20300	The cost to charge ratio on Worksheet C, Part I, column 11, should not be more than 100%, or less than 0.1%. [05/01/2010b]
20350	Administrative and general cost center codes 00500, 00540, 00550, 00560, 00570, 00580, 00590-00599, 01080, 01140, and 01160 (standard and nonstandard) may only appear on line 5 and subscripts of line 5. Other nonstandard descriptions and codes may also appear on subscripts of line 5 but must be within the general services cost center category. [05/01/2010b]
20450	The cost reporting period must be greater than 27 days and less than 459 days. [05/01/2010b]
20500	Bad debts for dual eligible beneficiaries new amounts cannot exceed total bad debts (e.g., for Worksheet E, Part A, line 66, must be less than or equal to line 64). Do not apply this edit if the total bad debt line is negative. This edit applies to the following worksheets: E, Part A, line 66; E, Part B, line 36; E-2, line 18; E-3, Part I, line 13; E-3, Part II, line 25; E-3, Part III, line 26; E-3, Part IV, line 16; E-3, Part V, line 27; E-3, Part VI, line 9; H-4, Part II, line 28; I-5, line 7; J-3, line 23; and, M-3, line 24. [05/01/2010b]
20000S	Worksheet S, Part III, sum of columns 2 and 3, for line 200 (title XVIII), should not equal zero. [05/01/2010b]
20050S	The combined amount due the provider or Program (Worksheet S, Part III, line 200, sum of columns 1 through 5) should not equal zero. [05/01/2010b]
20100S	The hospital certification date (Worksheet S-2, Part I, column 5, line 3 through 5) should be on or before the cost report beginning date (Worksheet S-2, Part I, column 1, line 20). [05/01/2010b]

If the Medicare hospital payment mechanism (Worksheet S-2, Part I, column 7, line 3) is equal to P, then apply the following edits for codes 20200S, 20210S, and 20250S for acute care hospitals:

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 6 - EDITS

Edit	Condition
20200S	When Worksheet S-2, Part I, line 112, column 1, is "Y", apply this edit to Worksheets E, Part A, for the IPPS and PARHM components collectively. The DRG payments other than outlier payments (Worksheet E, Part A, column 1, line 1) should be both greater than zero and greater than the outlier payments (Worksheet E, Part A, column 1, line 2). For cost reporting periods overlapping or beginning on or after October 1, 2013, the DRG payments other than outlier payments (Worksheet E, Part A, column 1, sum of lines 1.01 and 1.02) should be greater than zero and greater than the outlier payments (Worksheet E, Part A, column 1, line 2.) Do not apply this edit if Worksheet S-2, Part I, column 4, line 3, is "12" (REH). [05/01/2010b]
20201S	This edit has been rescinded.
20210S	The DRG payments for federal specific operating payment for Model 4 BPCI (Worksheet E, Part A, column 1, sum of lines 1.03 and 1.04) should be greater than the outlier payment for discharges for Model 4 BPCI (Worksheet E, Part A, column 1, line 2.02). Do not apply this edit if Worksheet E, Part A, column 1, lines 1.03, 1.04, and 2.02, all equal zero. [10/01/2014]
20250S	The cost of Medicare Part A services under TEFRA (Worksheet E-3, Part I, column 1, line 1) should not be present. [05/01/2010b]
20300S	If Worksheet S-2, Part I, lines 26 and 27, differ for standard geographic reclassification (not wage), then lines 26 and 27 must have a response in the ECR File. [05/01/2010b]
20325S	REMOVED AND RESERVED
20350S	A valid code for the type of hospital must be present on Worksheet S-2, Part I, column 4, line 3, as indicated in Table 3B. [05/01/2010b]
20400S	For every valid subprovider on Worksheet S-2, Part I, line 4 through 6 and subscripts thereof, a corresponding line 4 through 6 and subscripts, column 4, as appropriate, must be present with a valid type of hospital code from Table 3B. [05/01/2010b]
20460S	If Worksheet S-2, Part I, line 63, is "Y," then the FTE count should be completed on lines 64, 65, 66, or 67, as applicable. If any of lines 64 through 67 and applicable subscripts, column 1, are completed, all columns for that line must be completed. [05/01/2010b]
20465S	If Worksheet S-2, Part I, line 63 is "Y," then the sum of Worksheet S-2, Part I, line 66, columns 1 and 2, and line 67 and applicable subscripts, columns 3 and 4, must be greater than or equal to the sum of Worksheet E-4, line 6, column 1, and line 10, column 2. [06/30/2012]
20500S	If the provider has a charge structure (Worksheet S-2, Part I, column 1, line 115, is "No"), for each cost center on lines 30 through 40, 43 through 91, 92.01 through 92.10, 99.xx, 101, 102, and 105 through 117, if either total charges (Worksheet C, Part I, sum of columns 6 and 7), or total costs after step down (Worksheet B, Part I, column 26) equal zero, then both should equal zero. [05/01/2010b]

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 6 - EDITS

Edit	Condition
20525S	If Worksheet S-2, Part I, CAH (line 105 = "Y") and line 167 = "Y", then line 168, must be present. Do not apply this edit to a cost reporting period beginning on or after October 1, 2016. [06/30/2012]
20550S	This edit is no longer an applicable level 2 edit. It was changed to level 1 edit 12030S in order to be consistent with the rejectable edits in HCRIS rather than just a warning. [05/01/2010b]
20600S	If Worksheet S-2, Part I, column 1, line 146, response is "Y," providers should ensure that proper documentation has been submitted to their contractor in accordance with CMS Pub. 15-2, §4020. [05/01/2010b]
20650S	If Worksheet S-2, Part I, column 1, line 105 response is "Y," then Worksheet S-3, Part I, column 4, the sum of lines 1, and 7 through 12, should be greater than zero. [05/01/2010b]
20700S	If Worksheet S-2, Part II, columns 1 or 3, line 16, equals "Y," then line 16 the corresponding column 2 or 4 must have a paid through date of the PS&R, after the cost report fiscal year end date. [05/01/2010b]
20750S	Eliminated as of 05/01/2010b. The edit was incorporated into edit 20700S.
21000S	The following statistics from Worksheet S-3, Part I, should be greater than zero (do not apply "a", "b", or "d", if Worksheet S-2, Part I, column 4, line 3, is"12" (REH)): a. Number of beds for the hospital (column 2, line 14) [05/01/2010b]; b. Number of beds for the facility (column 2, sum of lines 14 through 24) [05/01/2010b]; d. Total inpatient days for all patients in the hospital (column 8, line 14) [05/01/2010b]; and e. Total inpatient days/visits and outpatient visits for all patients in the facility (column 8, sum of lines 1 through 13, and 15 through 26). [05/01/2010b]
21050S	If Medicare hospital inpatient days (Worksheet S-3, Part I, column 6 (and 6.01, if applicable), line 14) is greater than zero, then the following fields on Worksheet S-3, Part I, should also be greater than zero. a. Total hospital discharges (column 15, line 14) [05/01/2010b]; b. Medicare hospital discharges (column 13, line 14) [05/01/2010b]; and c. Hospital full time equivalent employees (column 10, line 14). [05/01/2010b]
21100S	Total hospital inpatient days (Worksheet S-3, Part I, column 8, lines 1, 8 through 12, 16 through 21, and 24) should be less than or equal to hospital bed days available (Worksheet S-3, Part I, column 3, lines 1, 8 through 12, 16 through 21, and 24). [05/01/2010b]

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 6 - EDITS

Edit	Condition
21150S	The hospital and each component in a health care complex reporting interns and residents in FTEs (Worksheet S-3, Part I, column 9, lines 14, and 16 through 26) should have corresponding cost allocation statistics for interns and residents (Worksheet B-1, sum of columns 21 and 22, sum of lines 30 through 46, 88 through 89, 94, 99, 115, and 116, respectively) and, conversely, there should be FTEs on the aforementioned Worksheet S-3 if there are statistics on the aforementioned Worksheet B-1. [05/01/2010b]
21200S	For prospective payment system hospital cost reports, where the ratio of Worksheet S-3, Part II, column 5, sum of lines 9 and 10, divided by the result of column 5, line 1, minus the sum of column 5, lines 3, 5, and 8, is equal to or greater than 5 percent, Worksheet S-3, Part III, columns 2 and 5, line 7, must be present. [05/01/2010b]
21250S	For prospective payment system hospital cost reports, where the ratio of Worksheet S-3, Part II, column 5, sum of lines 9 and 10, divided by the result of column 5, line 1, minus the sum of column 5, lines 3, 5, and 8, is equal to or greater than 15 percent, Worksheet S-3, Part II, column 2, lines 26 through 43, must be present, if the corresponding line on Worksheet A, column 1, is greater than zero. [05/01/2010b]
21300S	If Worksheet S-3, Part II, sum of columns 2 and 3, lines 9 and 10, are greater than zero, then the sum of columns 2 and 3, line 19, must also be greater than zero. The provider should submit supporting documentation when the sum of lines 9 and 10 is greater than zero and line 19 equals zero. [05/01/2010b]
21350S	If Worksheet S-2, Part I, column 1, line 12, and subscripts, are present, then Worksheet S-4, column 1, line 19, must be greater than zero and the number of CBSA codes on line 20, and subscripts, must equal the number identified on line 19. [05/01/2010b]
20000A	Worksheet A-6, column 1 (reclassification code), must be an alpha character. [05/01/2010b]
20050A	Worksheet A-7, Part III, column 2, must be less than or equal to column 1 for lines 1 and 2, and subscripts thereof. [05/01/2010b]
20100A	REMOVED AND RESERVED
20150A	If Worksheet A, column 7, either of lines 74 or 94, is greater than zero, then Worksheet S-5, columns 1 or 2, line 21, must contain an X. DO NOT APPLY IF WORKSHEET S-2, Part I, line 145, = "Y." [05/01/2010b]

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 6 - EDITS

Edit	Condition

Column headings (Worksheets B-1, B, Parts I, and II, J-1, Part II, and L-1, Part I) are required as indicated for codes 20000B and 20050B:

20000B At least one cost center description (lines 1 through 3), at least one statistical basis label (lines 4 through 5), and one statistical basis code (line 6) (capital cost center lines only) must be present for each general service cost center with cost greater than zero (Worksheet B-1, columns 1 through 23, line 202). Exclude any reconciliation columns from this edit. [05/01/2010b]

20050B The column numbering among these worksheets must be consistent. For example, data in capital-related costs - buildings and fixtures is identified as coming from column 1 on all applicable worksheets. [05/01/2010b]

20100B Worksheet B, Part II, column 26, sum of lines 30 through 117 and 190 through 194, and subscripts as allowed, must be equal to or greater than zero. Not applicable for CAHs. [05/01/2010b]

20000C If Worksheet C, Part I, column 3, has costs on any line, then column 8 must have charges on the corresponding cost center and vice versa. [10/01/2012b]

20000D This edit has been moved to level 1 edit number 10000D. [05/01/2010b]

20050D If the provider has a charge structure (Worksheet S-2, Part I, line 115, column 2 is not A, B, or E) and total inpatient days (Worksheet D-1, column 1, line 1, for the hospital and all components and all titles) are greater than zero, then general inpatient routine service charges (Worksheet D-1, column 1, line 28, for the hospital and all components and all titles) must also be greater than zero. If there are no private room days, do not apply this edit. [05/01/2010b]

20100D If Worksheet D-4, Part III, column 1, line 66, is greater than zero or Part IV, sum of columns 1 and 2, lines 76 through 80, are greater than zero, then both must be greater than zero. [05/01/2010b]

20125D The number of total usable organs Worksheet D-4, Part III, line 62, must equal Worksheet D-4, Part IV, sum of columns 1 and 2, line 74, minus the sum of columns 1 and 2, line 83. Do not apply this edit to cost reporting periods beginning on or after January 1, 2023. [10/01/2014b]

20126D The number of total usable organs Worksheet D-4, Part III, line 62, must equal Worksheet D-4, Part IV, line 74, sum of columns 1 and 2, minus the sum line 82, column 1 plus column 2, and line 83, sum of column 1 plus column 2. [01/01/2023b]

20150D If Worksheet B, Part I, column 26, lines 105 through 112, as appropriate, are greater than zero or Worksheet D-4, Part IV, sum of columns 1 and 2, lines 70 through 73, are greater than zero, then both should be greater than zero. [05/01/2010b]

20200D Worksheet D-4, Part IV, sum of columns 1 and 2, lines 70 through 73, should equal the sum of columns 1 and 2, lines 75 through 83. [05/01/2010b]

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 6 - EDITS

Edit	Condition
20250D	If Worksheet D-5, Part IV, line 20 or 21, is greater than zero, then Worksheet E-4, line 6, must be greater than zero. [06/30/2014]
20850E	If Worksheet S-2, Part I, line 61, column 1, is "Y", then Worksheet E, Part A, line 8.01, or Worksheet E-4, line 4.01, must be greater than zero and vice versa. [05/01/2010b]
20100E	Worksheet E, Part A, line 40, column 1, if applicable (title XVIII only), must be equal to or less than Worksheet S-3, Part I, column 13, for the sum of lines 2 and 14. [05/01/2010b]
20900E	Worksheet E-3, Part VI, line 9, bad debt for dual eligible beneficiaries, cannot exceed the total bad debt line 8 (e.g., Worksheet E-3, Part I, line 13, cannot exceed line 11; E-3, Part II, line 25, cannot exceed line 23; E-3, Part III, line 26, cannot exceed line 24; E-3, Part IV, line 16, cannot exceed line 14; E-3, Part V, line 27, cannot exceed line 25). Do not apply this edit if total bad debt is negative. [05/01/2010b]
20000G	This edit has been redesignated as 10000G.
20050G	This edit has been redesignated as 10050G.
20100G	This edit has been redesignated as 10100G.
20150G	This edit has been redesignated as 10150G.
20000I	If Worksheet I-1, column 1, lines 1 through 6, have amounts greater than zero, then the corresponding line for columns 3 and 4, must contain amounts which do not equal zero. [05/01/2010b]
20050I	If Worksheet I-1, column1, line 31, is greater than zero, then Worksheet I-4, column 7, including subscripts, and the sum of lines 1 through 10, must be greater than zero, and vice versa. [05/01/2010b]
20100I	Worksheet I-2, column 11, sum of lines 2 through 16, and 18, must equal Worksheet I-1, column 1, sum of lines 1 through 8, 10 through 16, 18 through 26, and 28 through 30. [05/01/2010b and beginning prior to 10/01/2015]
20105I	Worksheet I-2, column 11, line 19, plus column 6, line 14, must equal Worksheet I-1, column 1, line 31. [10/01/2015b]
20150I	If Worksheet I-2, column 11, line 12, is greater than zero, then the treatments reported on Worksheet I-3, column 0, line 12, should also be greater than zero. [05/01/2010b]
20200I	Worksheet I-4, column 4, lines 1 through 10, should be equal to or less than the corresponding amounts in column 1 for each line. [05/01/2010b]

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TABLE 6 - EDITS

Edit	Condition
20250I	If Worksheet I-4, column 1, sum of lines 1 through 10, is greater than zero, then Worksheet I-2, column 11, sum of lines 2 through 11, must also be greater than zero. [05/01/2010b]
20100K	Worksheet K-5, Part I, line 34, the sum of columns 0 through 3, 4 through 22, and 24, plus subscripts, must equal Worksheet B, Part I, column 26, line 116. [05/01/2010b through periods beginning prior to 10/01/2015]

Apply the following K series edits if Worksheet S-2, columns 2 and 5, line 14, are present.

20000K	Worksheet A, column 7, line 116, must be greater than zero. [05/01/2010b through periods beginning prior to 10/01/2015]
20050K	Worksheet K, column 10, line 39, must be equal to Worksheet A, column 7, line 116. [05/01/2010b through periods beginning prior to 10/01/2015]
20000M	Worksheet M-2, sum of column 2, lines 1 through 3, 5 through 7, and 9, should agree with Worksheet S-3, Part I, column 8, line 26, and subscripts as applicable. For FQHCs, do not apply this edit for cost reporting periods beginning on or after 10/1/2014. [05/01/2010b]
20050M	Total FTEs on Worksheet M-2, column 1, sum of lines 1 through 3 and 5 through 7, should be equal to or less than the FTEs on Worksheet S-3, Part I, column 10, line 26, and subscripts as applicable. For FQHCs, do not apply this edit for cost reporting periods beginning on or after 10/1/2014. [05/01/2010b]
20050O	If Worksheet S-2, Part I, columns 2 and 5, line 14, are present, then there must be an entry on Worksheet O, column 7, lines 3, 4, 5, 13, 14, 28, 37, 38, and 41. Do not apply this edit to Worksheet O, column 7, line 5, if Worksheet O-3, column 7, line 100; Worksheet O-4, column 7, line 100; and Worksheet O, column 7, line 66; are all zero. [9/30/2016]

NOTE: CMS reserves the right to require additional edits to correct deficiencies that become evident after processing the data commences and, as needed, to meet user requirements.