Medicare
Provider Reimbursement Manual -
Part 2, Provider Cost Reporting Forms and Instructions, Chapter 36, Form CMS-2552-96

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

Transmittal 25 **Date: April 2011**

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
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NEW/REVISED MATERIAL--EFFECTIVE DATE:

This transmittal updates Chapter 36, Hospital and Hospital Health Care Complex Cost Report (Form CMS-2552-96). This transmittal also reflects further clarification to existing instructions and incorporates select Federal Register provisions. The effective dates for instructional changes will vary due to various implementation dates.

Significant Revisions:

- Worksheet S-2 - Line 21.06 - Is revised to clarify and reflect the Patient Protection and Affordable Care Act (ACA) of 2010, §3121 as amended by the Medicare and Medicaid Extenders Act (MMEA) of 2010, §108 which extends transitional outpatient payments (TOPs) for services rendered January 1, 2010 through December 31, 2011, for sole community hospitals (SCHs) and essential access community hospitals (EACHs), regardless of bed size and small (100 or fewer beds) rural hospitals paid under the inpatient perspective system.
- Worksheet E, Part A - Line 24.97 - Is revised to reflect the rescission and elimination of the instructions associated with §1109 payments in accordance with the Health Care and Education Reconciliation Act (HCERA) of 2010 as such payments will be funded by a separate appropriation unrelated to Part A of the Medicare trust fund and accordingly are not to be included in the Medicare cost report. Correspondingly, the instructions indicating the use of Worksheet E-1, Part I, line 3.49, column 2 for the corresponding interim payment are also eliminated. Additionally, the corresponding edit 1096E is rescinded and eliminated.
- Worksheet E, Part B - Line 1.06 - Is revised to clarify the implementation of ACA, §3121 as amended by the MMEA, §108 which extends TOPs to include services rendered January 1, 2010 through December 31, 2011, for SCHs and EACHs, regardless of bed size and small (100 or fewer beds) rural hospitals paid under the inpatient perspective system.

REVISED ELECTRONIC SPECIFICATIONS EFFECTIVE DATE: Changes to the electronic reporting specifications are effective for cost reporting periods ending on or after November 30, 2010.

For automated cost report software purposes transmittals 23, 24 and 25 will be merged and implemented simultaneously.

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

for the three year transition of hold harmless payments *(or applicable extensions)* for small rural hospitals under the prospective payment system for hospital outpatient department services, under DRA, section 5105, MIPPA, section 147, *and the Patient Protection and Affordable Care Act (ACA), section 3121 as amended by the Medicare and Medicaid Extenders Act (MMEA) of 2010, section 108* effective for services rendered from January 1, 2009, through December 31, *2011*? Enter "Y" for yes or "N" for no. Also see CR 4367, transmittal 877, dated February 24, 2006 and CR 6320, transmittal 1657, dated December 31, 2008, as applicable. (1/1/2006s) This response impacts the TOPs calculation on worksheet E, Part B, line 1.06.

Line 21.07--Effective for services rendered from January 1, 2009, through December 31, 2009, does the hospital qualify as a SCH with 100 or fewer beds reimbursed under the prospective payment system for hospital outpatient department services, under MIPPA section 147? Enter "Y" for yes or "N" for no in column 1. Also see CR 6320, transmittal 1657, dated December 31, 2008. This response impacts the TOPs calculation on worksheet E, Part B, line 1.06. (1/1/2009s) Effective for services rendered from January 1, 2010, through December 31, 2011, does the hospital qualify as an SCH or essential access community hospital (EACH), regardless of bed size, under the outpatient hold harmless provision in *ACA,* section 3121 as amended by the *MMEA* of 2010, section 108? Enter "Y" for yes or "N" for no in column 2. This response impacts the TOPs calculation on Worksheet E, Part B, line 1.06. (1/1/2010s)

Line 21.08--Indicate in column 1 the method used to capture Medicaid (title XIX) days reported on Worksheet S-3, Part I, line 29, column 5 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 the 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. (10/1/2009b)

Line 22--Are you classified as a referral center? Enter "Y" for yes and "N" for no. See 42 CFR 412.96.

Line 23--Does your facility operate a transplant center? If yes, enter the certification dates below.

Line 23.01--If this is a Medicare certified kidney transplant center, enter the certification date in column 2 and termination date in column 3. Also complete Worksheet D-6.

Line 23.02--If this is a Medicare certified heart transplant center, enter the certification date in column 2 and termination date in column 3. Also complete Worksheet D-6.

Line 23.03--If this is a Medicare certified liver transplant center, enter the certification date in column 2 and termination date in column 3. Also complete Worksheet D-6.

Line 23.04--If this is a Medicare certified lung transplant center, enter the certification date in column 2 and termination date in column 3. Also, complete Worksheet D-6.

Line 23.05--If Medicare pancreas transplants are performed, enter the more recent date of July 1, 1999 (coverage of pancreas transplants) or the certification dates for kidney transplants and termination date in column 3. Also, complete Worksheet D-6.

Line 23.06--If this is a Medicare certified intestinal transplant center, for services rendered on or after October 1, 2001, enter the certification date in column 2 and termination date in column 3. Also, complete Worksheet D-6.

Line 23.07--If this is a Medicare certified islet transplant center, with an effective date for discharges on or after October 1, 2004, enter the certification date in column 2 and termination date in column 3. Also, complete Worksheet D-6.

Line 24--If this is an organ procurement organization (OPO), enter the OPO number in column 2, the termination date in column 3.

Line 24.01--If this is a Medicare transplant center; enter the CCN (provider number) in column 2, the certification date or recertification date (after December 26, 2007) in column 3.

Line 25--Is this a teaching hospital or is your facility affiliated with a teaching hospital and

receiving payment for I&R? Enter "Y" for yes and "N" for no.

Line 25.01--Is this a teaching program approved in accordance with CMS Pub. 15-I, chapter 4? Enter "Y" for yes and "N" for no.

Line 25.02--If line 25.01 is yes, was Medicare participation and approved teaching program status in effect during the first month of the cost reporting period? Enter "Y" for yes and complete Worksheet E-3, Part IV or "N" for no and complete Worksheets D, Parts III and IV and D-2, Part II, if applicable.

NOTE: CAHs complete question 30.04 in lieu of questions 25, 25.01, and 25.02

Line 25.03--As a teaching hospital, did you elect cost reimbursement for teaching physicians as defined in CMS Pub. 15-I, §2148? Enter "Y" for yes, "N" for no. If yes, complete Worksheet D-9.

Line 25.04--Are you claiming costs on line 70, column 7, of Worksheet A? Enter "Y" for yes and "N" for no. If yes, complete worksheet D-2, Part I.

Line 25.05--Has your facility's direct GME FTE cap (column 1), or IME FTE cap (column 2), been reduced under 42 CFR 413.79(c)(3) or 42 CFR 412.105(f)(1)(iv)(B)? Enter "Y" for yes or "N" for no in the applicable column. (Impacts Worksheet E, Part A; E-3, Part IV; and E-3 Part VI.)

Line 25.06--Has your facility received additional direct GME (column 1) resident cap slots or IME (column 2) resident cap slots under 42 CFR 413.79(c)(4) or 42 CFR 412.105(f)(1)(iv)(C)? Enter "Y" for yes or "N" for no in the applicable column. (Impacts Worksheet E, Part A; E-3, Part IV; and E-3, Part VI.)

Line 25.07--Has your facility trained residents in non-provider settings during the cost reporting period? Enter "Y" for yes or "N" for no in column 1. See Federal Register, Vol. 75, number 226, dated November 24, 2010, page 72139. Complete lines 25.07 through 25.09 (and applicable subscripts) for IME effective for discharges occurring on or after July 1, 2010 and for GME effective for cost reporting periods beginning on or after July 1, 2010.

Line 25.08--If line 25.07 is yes, enter in column 1 the unweighted number of non-primary care FTE residents attributable to rotations occurring in all non-provider settings.

Line 25.09--If line 25.07 is yes, enter the unweighted number of primary care FTE residents attributable to rotations occurring in all non-provider settings for each primary care specialty program in which you train residents. Use lines 25.09 through 25.59 as necessary to identify the program name in column 1, the program code in column 2 and the number of unweighted primary care resident FTEs in that program in column 3.

Line 26--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. Enter the beginning and ending dates of SCH status on line 26.01. Use line 26.02 if more than 1 period is identified for this cost reporting period and enter multiple dates. Note: Worksheet C Part II must be completed for the period not classified as SCH (9/96). 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 1/1/00-6/30/00 and 9/1/00-12/31/00.

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 primary payer payments credited toward the beneficiary's deductible and coinsurance on line 17.

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-6, Part III, line 58.

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 17 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 19--Enter from the PS&R or your records the deductibles billed to program patients.

Line 20--Enter from the PS&R or your records the coinsurance billed to program patients.

Line 21--Enter the program reimbursable bad debts, reduced by the bad debt recoveries. If recoveries exceed the current year's bad debts, line 21 and 21.01 will be negative.

Line 21.01--Enter line 21 (including negative amounts) times 100 percent for cost reporting periods beginning on or after October 1, 1996; 75 percent for October 1, 1997; 60 percent for October 1, 1998; 55 percent for October 1, 1999, and 70 percent for October 1, 2000 and thereafter.

Line 21.02--Enter the gross reimbursable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. These amounts must also be reported on line 21. (4/1/2004b)

Line 22--Enter the sum of lines 18 and 21.01 minus the sum of lines 19 and 20.

Line 23--Enter the programs share of any recovery of accelerated depreciation applicable to prior periods paid under reasonable cost or the hold harmless methodology under capital PPS resulting from your termination or a decrease in Medicare utilization. (See CMS Pub. 15-I, §§136 - 136.16.)

Line 24--Enter any other adjustments. For example, enter an adjustment resulting from changing the recording of vacation pay from cash basis to accrual basis. (See CMS Pub. 15-I, §2146.4.) Specify the adjustment in the space provided.

Effective for Federal fiscal years 2011 and 2012 (October 1, 2010, through September 30, 2011, and October 1, 2011, through September 30, 2012, respectively), temporary improved/changed payments are mandated by §§3125 and 10314 ACA of 2010, as addressed in 42 CFR 412.101 for discharges occurring during Federal fiscal years 2011 and 2012. For cost reporting periods which begin before May 1, 2010, and overlap October 1, 2010, enter on lines 24.94 (and if necessary, lines 24.95 and 24.96) the Medicare inpatient payment adjustment for low volume hospitals as applicable in accordance with the instructions in a forthcoming Change Request (CR). The forthcoming CR will provide instructions regarding the source(s) from which the entered amounts can be obtained and will specify in which situations line 24.95 (and if necessary line 24.96) must be completed. Identify the line label on each line as "Low Volume Adjustment Payment." Where difference low volume adjustment percentages apply during the cost reporting period, identify the label on each line as "Low Volume Adjustment Payment-1" increasing the number by one for each additional payment that applies. The low volume adjustment payment

must also be recorded on Worksheet E-1 as part of an interim payment. The adjustment will not be separately or specifically identified, but will be part of the overall interim payment and therefore will not be placed on a specific line on Worksheet E-1.

***NOTE**: The immediately preceding transmittal 24 indicated the use of line 24.97 for the additional payment in accordance with the Health Care and Education Reconciliation Act (HCERA) of 2010, section 1109 which established an additional payment effective for cost reporting periods which end during Federal fiscal years 2011 and 2012 (one payment for each year) for qualifying providers under section 1886(d) of the Act and also indicated the use of Worksheet E-1, Part I, line 3.49, column 2 for the corresponding interim payment. Such instructions are hereby rescinded and eliminated as section 1109 payments will be funded by a separate appropriation unrelated to Part A of the Medicare trust fund and are accordingly excluded from the Medicare cost report.*

Effective for discharges occurring on or after October 1, 2008, enter on line 24.98 the partial or full credits received from manufacturers for replaced devices applicable to MS-DRGs listed in Change Request 5860, transmittal 1509, dated May 9, 2008.

Only FI/contractors complete line 24.99 by entering the sum of lines 52, 53, 55, and 56.

Line 25--If you are filing under the fully prospective payment methodology for capital costs or on the basis of 100 percent of the Federal rate under the hold harmless methodology, enter the program's share of the gain or loss applicable to cost reimbursement periods for those assets purchased during a cost reporting period prior to the beginning of your first cost reporting period under capital PPS and disposed of in the current cost reporting period. For assets purchased and disposed of after the onset of capital PPS, make no adjustment. For providers paid under the hold harmless reasonable cost methodology, compute gains or losses on the disposal of old assets in accordance with CMS Pub. 15-1, §§132-134.4. For gains or losses on new capital, enter the program's share of the gain or loss applicable to cost reimbursement periods for those assets purchased during a cost reporting period prior to the beginning of your first cost reporting period under capital PPS and disposed of in the current cost reporting period. For assets purchased and disposed of after the onset of capital PPS, make no adjustment. (See 42 CFR 413.134(f)(1).)

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

Enter the amount of any excess depreciation taken as a negative amount.

Line 26--Enter the amount due you (i.e., the sum of the amounts on line 22 plus or minus lines 24 and 25 minus line 23).

Line 27--Enter the sequestration adjustment amount, if applicable.

Line 28--Enter the total interim payments (received or receivable) from Worksheet E-1, column 2, line 4. For intermediary final settlements, enter the amount reported on line 5.99 on line 28.01. Include in interim payment the amount received as the estimated nursing and allied health managed care payments.

Line 29--Enter line 26 minus the sum of lines 27 and 28. Transfer to Worksheet S, Part II.

Line 30--Enter the program reimbursement effect of protested items. Estimate the reimbursement effect of the nonallowable items by applying reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See §115.2.) Attach a schedule showing the details and computations for this line.

Lines 31 through 49 were intentionally skipped to accommodate future revisions to this worksheet.

DO NOT COMPLETE THE REMAINDER OF WORKSHEET E, PART A. LINES 50 THROUGH 56 ARE FOR CONTRACTOR USE ONLY.

Line 50--Enter the original operating outlier amount from line 2.01 sum of all columns of this worksheet.

Line 51--Enter the original capital outlier amount from worksheet L, part I, line 3.01.

Line 52--Enter the operating outlier reconciliation adjustment in accordance with CMS Pub. 100-04, Chapter 3, §20.1.2.5-§20.1.2.7

Line 53--Enter the capital outlier reconciliation adjustment amount in accordance with CMS Pub. 100-04, Chapter 3, §20.1.2.5 - §20.1.2.7

Line 54--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 55--Enter the operating time value of money for operating related expenses.

Line 56--Enter the capital time value of money for capital related expenses.

NOTE: If a cost report is reopened more than one time, subscript lines 50 through 56, respectively, one time for each time the cost report is reopened.

For all other hospitals enter one of the following:

c. If line 1.05 is = > 90 percent but < 100 percent, enter 60 percent of the result of line 1.04 minus line 1.02.
d. If line 1.05 is < 90 percent, enter 6 percent of line 1.04.

For services rendered on or after January 1, 2004 for cancer or children's hospitals only:

a. If line 1.02 is < line 1.04 and Worksheet S-2, line 19 response is 3 or 7 (cancer or children's hospitals), enter the result of line 1.04 minus line 1.02.

For services rendered January 1, 2004, through December 31, 2005, for small rural hospitals and small rural SCHs:

a. If line 1.02 is < line 1.04, Worksheet S-2, line 21 response is 2 (rural hospitals) or if 21.02 equals "Y" and Worksheet E, Part A, line 3 is =< 100 enter the result of line 1.04 minus line 1.02.
b. If line 1.02 is < line 1.04, Worksheet S-2, line 21 response is 2 (rural hospitals) or if 21.02 equals "Y", and Worksheet E, Part A, line 3 is =< 100, and Worksheet S-2, line 26 is => 1 (sole community hospitals (SCH)) enter the result of line 1.04 minus line 1.02.

For cost reporting periods beginning on or after January 1, 2004, through services rendered on or before December 31, 2005, for rural SCHs:

a. If line 1.02 is < line 1.04 or Worksheet S-2, line 26 response is => 1 (number of periods SCH status in effect) enter the result of line 1.04 minus line 1.02.

NOTE: For purposes of TOPs, a hospital is considered rural if it is geographically rural, classified to rural for wage index purposes, or classified to rural for the standardized amount purposes. For example, a hospital that is geographically rural is always considered rural for TOPs, even if it is reclassified to urban for the wage index and/or standardized amount. A hospital that is geographically urban, but reclassified to rural for the wage index and/or standardized amount, is considered rural for purposes of TOPs.

In accordance with DRA 2005, section 5105, MIPPA 2008, section 147, and ACA 2010, section 3121 *as amended by MMEA 2010, section 108* for services rendered January 1, 2006, through December 31, 20*11*, rural hospitals with 100 or fewer beds that are not SCHs are entitled to hold harmless TOPs:

a. For services rendered January 1, 2006, through December 31, 2006, if Worksheet S-2, line 21.06, is "Y", enter 95 percent of (line 1.04 minus line 1.02).

b. For services rendered January 1, 2007, through December 31, 2007, if Worksheet S-2, line 21.06, is "Y", enter 90 percent of (line 1.04 minus line 1.02).

c. For services rendered January 1, 2008, through December 31, 20*11*, if Worksheet S-2, line 21.06, is "Y", enter 85 percent of (line 1.04 minus line 1.02).

In accordance with MIPPA 2008, section 147, for services rendered January 1, 2009, through December 31, 2009, SCHs with 100 or fewer beds are entitled to hold harmless TOPs:

a. For services rendered January 1, 2009, through December 31, 2009, if Worksheet S-2, line 21.07, column 1, is "Y", enter 85 percent of (line 1.04 minus line 1.02).

In accordance with ACA 2010, section 3121 as amended by MMEA 2010, section 108 for services rendered January 1, 2010, through December 31, 2011, SCHs and EACHs, regardless of bed size, are entitled to hold harmless TOPs:

a. For services rendered January 1, 2010, through December 31, 2011, if Worksheet S-2, line 21.07, column 2, is "Y", enter 85 percent of (line 1.04 minus line 1.02).

Line 1.07--Enter the outpatient ancillary pass through amount from worksheet D, Part IV, columns 9, 9.01 and 9.02, line 101.

Line 2--Enter the cost of services rendered by interns and residents as follows from Worksheet D-2.

Provider/Component Facility	Title XVIII Hospital	Title XVIII Subprovider	Title XVIII Skilled Nursing
Hospital	Part I, col. 9, line 9 plus line 24; or Part II, col. 7, line 34; or Part III, col. 6, line 41	Part I, col. 9, line 10; or Part II, col. 7, line 35, or Part III, col. 6, line 42	Part I, col. 9, line 12; or Part II, col. 7, line 37; or Part III, col. 6, line 44

Line 3--If you are an approved CTC, enter the cost of organ acquisition from Worksheet D-6, Part III, column 2, line 61 when Worksheet E 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 4--For hospitals or subproviders that have elected to be reimbursed for the services of teaching physicians on the basis of cost (see 42 CFR 415.160 and CMS Pub. 15-I, §2148), enter the amount from Worksheet D-9, Part II, column 3, line 17.

Line 5--Enter the sum of lines 1 through 4 excluding subscripts in column 1.

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 as defined in 42 CFR 413.13(d) or customary charges as defined in 42 CFR 413.13(e).

NOTE: RPCHs/CAHs are not subject to the computation of the lesser of reasonable costs or customary charges. If the component is an RPCH/CAH, do not complete lines 6 through 16. Instead, enter on line 17 the amount computed on line 5.

Line Descriptions

NOTE: If the medical and other health services reported here qualify for exemption from the application of LCC (see §3630), also enter the total reasonable cost from line 5 directly on line 17. Still complete lines 6 through 16 to insure that you meet one of the criteria for this exemption.

Lines 6 through 10--These lines provide for the accumulation of charges which relate to the reasonable cost on line 5.

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-I, §2104.3) and (2) charges to beneficiaries for excess costs. (See CMS Pub. 15-I, §§2570-2577.)

Line 6--For total charges for medical and other services, enter the sum of Worksheet D, Part V, columns 5 and 5.01 (for hospitals and subproviders with cost reporting periods which overlap October 1, 1997, for ambulance services, and SNFs with cost reporting periods beginning prior to January 1, 1998), line 104 and Worksheet D, Part VI, line 2. For cost reporting periods overlapping 8/1/2000 and after, for hospital and subprovider services, enter the sum of D, Part V, columns 5, 5.02, and 10, line 104, plus D, Part VI, line 2.

For cost reporting periods beginning 1/1/99 for SNF services enter the sum of Worksheet D, Part V, column 5, line 104 and D, Part VI, line 2.