Medicare

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 and Medicaid Services (CMS)

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NEW/REVISED MATERIAL--EFFECTIVE DATE: Cost Reporting Periods Beginning on or After October 1, 2015.

This transmittal updates Chapter 40, Hospital and Hospital Health Care Complex Cost Report, (Form CMS-2552-10) to clarify and correct the existing instructions and incorporate statutory and regulatory changes. Effective dates will vary.

Revisions include:

- Worksheet S-2, Part I:
    - Added question 37.01 to identify former Medicare-Dependent, Small Rural Hospitals (MDH) eligible for the transitional hospital-specific payment.
    - Added question 122 to identify providers reporting state health or other taxes.
    - Clarified instructions for line 169.

- Worksheet S-3, Part I:
    - Shaded line 18, columns 6 & 13.

- Worksheet S-3, Part II:
    - Clarified instructions for capitalized labor costs and general instructions for contract labor.

- Worksheet S-10:
    - Clarified instructions for line 26 for bad debt write offs.

- Worksheet E, Part A:
    - Revised CFR citation in instructions for line 20.
    - Modified instructions for lines 48, 49, and 100 through 104 for former MDHs.
    - Added line 70.88 to report volume decrease adjustments for Sole Community Hospitals (SCH) and MDHs.

- Worksheet D-1, Part IV:
    - Revised the worksheet line reference in column 2 and the corresponding instruction.

- Worksheet D-2, Part II:
    Corrected the worksheet line references for line 37.

- Worksheet E-1:
    - Modified instructions for line 1, total interim payments paid, to include the amounts related to the volume decrease adjustment for SCHs and MDHs.

- Worksheet I-1:
    - Modified instructions for lines 10 through 16, 25 and 27 related to Erythropoiesis stimulating agents (ESA) costs.

- Worksheet I-2:
    - Clarified instructions for lines 14, 15, 17 and 19 to include all ESA costs on line 14 for cost reporting periods ending on or after October 1, 2015.

- Worksheet L:
    - Added CFR citation references for lines 1 and 1.01.

REVISED ELECTRONIC SPECIFICATIONS EFFECTIVE DATE: Changes to the electronic reporting specifications are effective for cost reporting periods beginning on or after October 1, 2015.

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.

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 by the type of question.

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 17--Enter on the appropriate lines and columns indicated the component names, CMS certification numbers (CCN), core based statistical area (CBSA) codes (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). The "TEFRA" payment system includes long term care hospitals (LTCH) classified under subclause (II) of subsection (d)(1)(B)(iv) of the Act (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 Island, 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
2 = General Long Term
3 = Cancer
4 = Psychiatric
5 = Rehabilitation
6 = Religious Non-Medical Health Care Institution
7 = Children
8 = Alcohol and Drug
9 = Other

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. If you are not one of the hospital types described in items 1 through 8 above, indicate 9 for "Other".

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 general 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. (See 42 CFR 412.25.)

Line 5--The distinct part IRF is a portion of a general 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. (See 42 CFR 412.25)

Line 6--This is a portion of a general hospital defined as non-Medicare certified not included in lines 4 through 18 which offers a clearly different type of service from the remainder of the hospital. The data on this line cannot be used for Medicare reimbursement.

Line 7--Medicare swing-bed services are paid under the 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. This is a rural hospital with fewer than 100 beds that has a Medicare swing-bed agreement approved by CMS and that is 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. This is authorized by §1913 of the Act.

Line 9--This is a distinct part skilled nursing facility that has been issued an SNF identification number and which meets the requirements of §1819 of the Act. For cost reporting periods beginning on or after October 1, 1996, a complex cannot contain more than one hospital-based SNF or hospital-based NF. *(See 42 CFR 483.5(b)(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 non-reimbursable 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.

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 columns.

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 Medicaid HMO paid and 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 1, 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 Medicaid HMO paid and 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.

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)(ii)? 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)(2) provides for a temporary change in the low-volume adjustment for qualifying hospitals for federal fiscal years (FFYs) 2011 through 2017:

- 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.

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 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 state health or similar taxes? 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.

Lines *123* through 124--Reserved for future use.

Line 125--Does your facility operate a transplant center(s)? Enter "Y" for yes or "N" for no in column 1. If yes, enter the certification dates and termination dates, if applicable, on lines 126 through 133.

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

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

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

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

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

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

Line 133--Use this line if your facility contains a Medicare certified transplant center not specifically identified on lines 126 through 132. Enter the certification date in column 1, and termination date in column 2, if applicable. Subscript this line as applicable; however, do not complete a separate Worksheet D-4 for each Medicare certified transplant center type. For organs identified on this line, enter the corresponding cost on Worksheet A, line 112, and subscripts as applicable.

Line 134--If this is an organ procurement organization (OPO), enter the OPO CCN number 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. 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? 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).

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. This line is not applicable for cost reporting periods beginning on or after October 1, 2016.*

See 75 FR 44458-44460 (July 28, 2010). The transition factor equals:

If a hospital first becomes a meaningful EHR user in fiscal year 2011, 2012 or 2013:
- 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 hospital first becomes a meaningful EHR user in fiscal year 2014:
- 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 hospital first becomes a meaningful EHR user in fiscal year 2015:
- 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.

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.

Line 12--Indicate whether you are seeking reimbursement for bad debts resulting from Medicare deductible and coinsurance amounts which are uncollectible from Medicare beneficiaries. (See 42 CFR §413.89ff and CMS Pub. 15-1, chapter 3, §§306-324, for the criteria for an allowable bad debt.) Enter "Y" for yes or "N" for no in column 1. If you answer "Y" in column 1, submit a completed Exhibit 2 or internal schedules duplicating the documentation requested on Exhibit 2 to support the bad debts claimed. If you are claiming bad debts for inpatient and outpatient services, complete a separate Exhibit 2 or internal schedule for each category.

Exhibit 2 requires the following documentation:

Columns 1, 2, 3 - Patient Names, Health Insurance Claim (HIC) Number, 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 and dates of service that correlate to the filed bad debt. (See CMS Pub. 15-1, chapter 3, §314, and 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 CMS Pub. 15-1, chapter 3, §§312 and 322, and 42 CFR §413.89 for guidance on the billing requirements for indigent and *Medicaid beneficiaries*.

Columns 5 & 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 dates 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), and CMS Pub. 15-1, chapter 3, §§308, 310 and 314.)

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 & 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.

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 are waived. Enter "Y" for yes or "N" for no in column 1. If you answer "Y" in column 1, ensure that they are not included on the bad debt listings (i.e., Exhibit 2 or your internal schedules) submitted with the cost report.

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 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., Pub. 15-2, chapter 40, §4005.1, and 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" enter the paid-through date of the PS&R in columns 2 and/or 4. 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" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and/or 4. 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.

EXHIBIT 1

Allocation of Physician Compensation: Hours

Provider Name: _____

Provider Number:_____
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.	Sub-Total - Provider Administrative Services (Lines 1, 1A, 1B, 1C).	_____
2.	Physician Services: Medical and Surgical Services to Individual Patients	_____
3.	Non-Reimbursable Activities: Research, Teaching of I/R's 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

EXHIBIT 2
LISTING OF MEDICARE BAD DEBTS AND APPROPRIATE SUPPORTING DATA

PROVIDER _____
NUMBER _____
FYE _____

PREPARED BY _____
DATE PREPARED _____
INPATIENT _____ OUTPATIENT _____

(1) Patient Name	(2) HIC. NO.	(3) DATES OF SERVICE		(4) INDIGENCY & *MEDICAID BENEFICIARY* (CK IF APPL)		(5) DATE FIRST BILL SENT TO BENEFICIARY	(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

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 1, 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, etc. 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--See instructions for columns 5 through 7 of this worksheet.

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.

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 and should not be included 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 and should not be included 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. 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 contract 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), which are included in line 1. Also do not include intern and resident (I & R) salary on this line. Report I & R salary on line 7. Subscript this line and report salaries for Part A teaching physicians on line 4.01.

Lines 5 and 6--Enter the total physician, physician assistant, nurse practitioner and clinical nurse specialist salaries billed under Part B that are included in line 1. Under Medicare, these services are related to patient care and billed separately under Part B. Also include physician salaries for patient care services reported for rural health clinics (RHC) and federally qualified health centers (FQHC) included on Worksheet A, column 1, lines 88 and/or 89 as applicable. Report on line 6 the non-physician 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 these lines amounts that are included on lines 9 and 10 for the SNF or excluded area salaries.

Do not include physician assistants, clinical nurse specialists, nurse practitioners, and nurse midwives.

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 intern 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 chain or other related organization as defined in CMS Pub. 15-1, chapter 21, §2150, enter from your records, the wages and salaries for home office related organization personnel that are included in line 1.

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 *l*ine 10.

General Instructions for Contract Labor:

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, then other documentation is necessary, such as a representative sample of invoices which specify the wage costs, hours, and non-labor costs or a signed declaration from the vendor in conjunction with a sample of invoices. 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.

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). Include on this line contract pharmacy and laboratory wage costs as defined below.

Direct patient care services include 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 services are furnished under contract, rather than by employees. 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.

Contract laboratory services are furnished under contract, rather than by employees. 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).

Line 14--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 figure must be based on recognized methods of allocating an individual's home office/related organization salary to the 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.

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.

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. 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.

Line 15--Enter from your records the salaries and wage-related costs for Part A physician services - administrative, excluding teaching physician Part A services from the home office allocation and/or related organizations.

Line 16--Enter from your records the salaries and wage-related costs for Part A teaching physicians' from the home office allocation and/or related organizations. Also report on this line Part A teaching physicians' salaries under contract.

Lines 17 through 25--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.

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, 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 personnel. (See lines 14, 15, and 20 through 25.)

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 nonemployees.) 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.

    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.

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 wage-related costs that are considered an exception to the core list. (See note below for costs that are not to be included on line 18.) In order for a wage-related cost to be considered an exception, it must meet all of the following tests:

a. The cost is not listed on Worksheet S-3, Part IV,

b. The wage-related cost has not been furnished for the convenience of the provider,

c. The wage-related cost is a fringe benefit as defined by the Internal Revenue Service and, where required, has been reported as wages to IRS (e.g., the unrecovered cost of employee meals, education costs, auto allowances), and

d. The total cost of the particular wage-related cost for employees whose services are paid under IPPS exceeds 1 percent of total salaries after the direct excluded salaries are removed (Worksheet S-3, Part III, column 4, line 3). Wage-related cost exceptions to the core list are not to include those wage-related costs that are required to be reported to the Internal Revenue Service as salary or wages (i.e., loan forgiveness, sick pay accruals). Include these costs in total salaries reported on line 1 of this worksheet.

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--Enter from your records the wage-related costs for each category of employee listed. The costs are the core wage related costs plus the other wage-related costs. 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.

Lines 26 through 43--Enter the direct salary and wages with related salary amounts for paid vacation, holiday, sick, other paid-time-off (PTO), severance, and bonus pay from Worksheet A column 1 for the appropriate cost center identified on lines 26 through 43, column 2.

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. These lines are completed by all hospitals if the ratio of Part II, column 5, sum of lines 9 and 10 divided by the result of column 5, line 1 minus the sum of lines 2, 3, 4.01, 5, 6, 7, 7.01 and 8 equals or exceeds a threshold of 15 percent. However, all hospitals with a ratio greater than 5 percent must complete line 7 of Part III for all columns. Calculate the percent to two decimal places for purposes of rounding.

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 instructions for contract labor above), rather than by employees, for administrative and general, 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.

Line 28--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, column 2 ("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). 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.

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 must reflect any change reported in column 3; For employees who work a regular work schedule, on call hours are not to be included in the total paid hours (on call hours should only relate to hours associated to a regular work schedule; 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.

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.

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).

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.

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. 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. CAHs, as well as §1886(d) hospitals, are required to complete this worksheet. Note that this worksheet does not produce the estimate of the cost of treating uninsured patients required for disproportionate share payments under the Medicaid program.

Definitions:

Uncompensated care--Defined as charity care and bad debt which includes non-Medicare bad debt and non-reimbursable Medicare bad debt. Uncompensated care does not include courtesy allowances or discounts given to patients.

Charity care--Health services for which a hospital demonstrates that the patient is unable to pay. Charity care results from a hospital's policy to provide all or a portion of services free of charge to patients who meet certain financial criteria. For Medicare purposes, charity care is not reimbursable and unpaid amounts associated with charity care are not considered as an allowable Medicare bad debt. (Additional guidance provided in the instruction for line 20.)

Non-Medicare bad debt--Health services for which a hospital determines the non-Medicare patient has the financial capacity to pay, but the non-Medicare patient is unwilling to settle the claim. (Additional guidance provided in the instruction for line 25.)

Non-reimbursable Medicare bad debt--The amount of allowable Medicare coinsurance and deductibles considered to be uncollectible but are **not** reimbursed by Medicare under the requirements of §413.89 of the regulations and of CMS Pub. 15-1, chapter 3. (Additional guidance provided in the instruction for line 25.)

Net revenue--Actual payments received or expected to be received from a payer (including co-insurance 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.)

Instructions:

Cost-to-charge ratio:

Line 1--Enter the cost-to-charge ratio 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

NOTE: The amount on line 18 should not include the amounts on lines 2 and 5. That is, the amounts on lines 2 and 5 are mutually exclusive from the amount on line 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 SCHIP program, which 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 should be 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 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 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 should relate to the services for which payments were reported on line 2.

Line 7--Calculate the Medicaid cost by multiplying line 1 times 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.

State Children's Health Insurance Program:

Line 9--Enter all payments received or expected for services delivered during this cost reporting period that were covered by a stand-alone SCHIP program. Stand-alone SCHIP 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 SCHIP 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 SCHIP program. These charges should relate to the services for which payments were reported on line 9.

Line 11--Calculate the stand-alone SCHIP cost by multiplying line 1 times line 10.

Line 12--Enter the difference between net revenue and costs for stand-alone SCHIP 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:

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 SCHIP), 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 times 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.

Uncompensated care:

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, SCHIP and state and local indigent care programs by entering the sum of lines 8, 12 and 16.

Line 20--Enter the total initial payment obligation of patients who are given a full or partial discount based on the hospital's charity care criteria (measured at full charges), for care delivered during this cost reporting period for the entire facility. For uninsured patients, including patients with coverage from an entity that does not have a contractual relationship with the provider (column 1), this is the patient's total charges. For patients covered by a public program or private insurer with which the provider has a contractual relationship (column 2), these are the deductible and coinsurance payments required by the payer. Include charity care for all services except physician and other professional services. Do not include charges for either uninsured patients given discounts without meeting the hospital's charity care criteria or patients given courtesy discounts. Charges for non-covered services provided to patients eligible for Medicaid or other indigent care program (including charges for days exceeding a length of stay limit) can be included, if such inclusion is specified in the hospital's charity care policy and the patient meets the hospital's charity care criteria.

Line 21--Calculate the cost of initial obligation of patients approved for charity care by multiplying line 1 times line 20. Use column 1 for uninsured patients, including patients with coverage from an entity that does not have a contractual relationship with the provider, and use column 2 for patients covered by a public program or private insurer with which the provider has a contractual relationship.

Line 22--Enter payments received or expected from patients who have been approved for partial charity care for services delivered during this cost reporting period. Include such payments for all services except physician or other professional services. Payments from payers should not be included on this line. Use column 1 for uninsured patients, including patients with coverage from an entity that does not have a contractual relationship with the provider, and use column 2 for patients covered by a public program or private insurer with which the provider has a contractual relationship.

Line 23--Calculate the cost of charity care by subtracting line 22 from line 21. Use column 1 for uninsured patients, including patients with coverage from an entity that does not have a contractual relationship with the provider, and use column 2 for patients covered by a public program or private insurer with which the provider has a contractual relationship.

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 in 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 for services delivered during this cost reporting period. The amount must match the amount of such charges included in line 20, column 2.

Line 26--Enter the total facility (entire hospital complex) amount of bad debts written off *during this cost reporting period* on balances owed by patients *regardless of the date of service*. Include such bad debts for all services except physician and other professional services. The amount reported must also include 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; E-3, Part VII, line 34; I-5, line 5 (line 5.05, column 2 for cost reporting periods that overlap or begin on or after or January 1, 2011); J-3, line 21; and M-3, line 23. For privately insured patients, do not include bad debts that were the obligation of the insurer rather than the patient.

Line 27--Enter the total facility (entire hospital complex) Medicare reimbursable (also referred to adjusted) bad debts as the sum of Worksheet 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; J-3, line 21 (line 22 for cost reporting periods that begin on or after October 1, 2012); and M-3, line 23 (line 23.01 for cost reporting periods that begin on or after October 1, 2012).

Line 28--Calculate the non-Medicare and non-reimbursable Medicare bad debt expense by subtracting line 27 from line 26.

Line 29--Calculate the cost of non-Medicare and non-reimbursable Medicare bad debt expense by multiplying line 1 times line 28.

Line 30--Calculate the cost of uncompensated care by entering the sum of lines 23, column 3 and line 29.

Line 31--Calculate the cost of unreimbursed and uncompensated care and by entering the sum of lines 19 and 30.

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. 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

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 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 (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 in 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)).

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 under 42 CFR 413.79(f), and the provider increased its current year FTE cap and current year FTE count due to this affiliation agreement, identify the lower of: a) the difference between the current year numerator and the prior year numerator, and b) the number by which the FTE cap increased per the affiliation agreement, and add the lower of these two numbers to the prior year's numerator (*42 CFR 412.105(a)(1)(i)*). 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

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 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 uncompensated care payment amount 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 uncompensated care payment 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 uncompensated care payments 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 FFY14 uncompensated care payment amount in column 2. The total uncompensated care payment amount for FFY14 is $9,046,380,143 and for FFY15 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 uncompensated care payments 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. In determining Factor 3, the numerator is the current 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 FFY14 the denominator is 36,429,747 and for FFY15 the denominator is 36,484,622 (the denominator represents the total IPPS hospitals' Medicaid days and SSI days for the applicable FFY). *For subsequent fiscal years obtain the denominator from the corresponding federal year IPPS final rule or correction notice, as applicable.* Round Factor 3 to 9 decimal places.

Line 35.02--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 "Y", enter the hospital uncompensated care payment amount determined by CMS for the appropriate FFY in columns 1 and 2. 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 Worksheet S-2, Part I, line 22.01, column 1 or 2 is "N", and Worksheet S-2, Part I, line 22.02, column 1 or 2, is "Y", then CMS did not determine the hospital uncompensated care payment amount for that FFY. Compute this amount by multiplying line 35 times line 35.01, for column 1 and column 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, compute the amount by multiplying line 35 times line 35.01, for column 1 and column 2. If Worksheet S-2, Part I, line 22, column 1, is "N" and/or line 34 above is zero, enter zero on this line.

Line 35.03--Enter the pro rata share of the hospital's uncompensated care payment 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.

For example, 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, this period is prior to FFY 14; enter in column 2, for the period of October 1, 2013 through December 31, 2013 (FFY 14), (92 days/365 days in FFY 14) times line 35.02, column 2.

As another example, 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), (273 days/365 days in FFY 14) times lines 35.02, column 1; enter in column 2, for the period of October 1, 2014 through December 31, 2014 (FFY 15), (92 days/365days in FFY 15) times line 35.02, column 2.

Line 36--Enter the hospital's uncompensated care adjustment amount, (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.

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.

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.

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.

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). This amount is subject to change on an annual basis. Consult the appropriate CMS change request for future rates.

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, 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. For new hospital providers established after 1987, do not complete this line. 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, 2017, an MDH can use a FFY 2002 hospital specific rate. The MDH program ends on September 30, 2017.

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, 2017, 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.

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 nursing and allied health managed care payments if applicable.

Line 54--Enter the special add-on payment for new technologies (see 42 CFR 412.87 and 412.88).

Line 55--Enter the net organ acquisition cost from Worksheet(s) D-4, Part III, column 1, line 69.

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 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
- 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.

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 70.88--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 in accordance with ACA 2010, §3022. Obtain this amount from the PS&R.

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 2017 (e.g., standard FFYs: October 1, 2010 through September 30, 2011; October 1, 2011 through September 30, 2012; etc.), temporary improved/changed payments are mandated by §§3125 and 10314 ACA of 2010 and subsequent legislation, as addressed in 42 CFR 412.101. 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 for years 2010 through 2017, 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 70.88, 70.90, 70.91, *70.92,* 70.93, 70.94, and 70.96 through 70.98; minus the sum of lines 68, 70.89, 70.95, and 70.99.

Line 71.01--For cost reporting periods that overlap or begin on or after April 1, 2013, enter the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur during the sequestration period beginning on or after April 1, 2013, divided by total days in the entire cost reporting period, rounded to four decimal places)) times line 71]. Do not apply the sequestration calculation when gross reimbursement is less than zero.

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 74--Enter line 71 minus the sum of lines 71.01, 72, and 73. Transfer to Worksheet S, Part III.

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.

DO NOT COMPLETE THE REMAINDER OF WORKSHEET E, PART A. LINES 90 THROUGH 96 ARE FOR CONTRACTOR USE ONLY.

Line 90--Enter the original operating outlier amount from line 2, sum of all columns of this Worksheet E, Part A, prior to the inclusion of lines 92, 93, 95, and 96, of Worksheet E, Part A.

Line 91--Enter the original capital outlier amount from 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 FFY13. 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 January 1, 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 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.

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.

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.

Instructions for Completing Exhibit 4--

Low-Volume Adjustment Calculation Schedule:

Sections 3125 and 10314 of ACA 2010 and subsequent legislation amended the low-volume hospital adjustment in §1886(d)(12) of the Social Security Act by revising, for FFYs 2011 through 2017 (discharges before October 1, 2017), the definition of a low-volume hospital and the methodology for calculating the low-volume payment adjustment. CMS implemented these changes to the low-volume payment adjustment in the regulations at 42 CFR 412.101 in the FFY 2011 IPPS final rule (75 FR 50238-50275 (March 7, 2013)).

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 uncompensated care payments as follows:

- Enter in column 3, the uncompensated care payment 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 uncompensated care payment 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 uncompensated care payments not eligible for the low-volume payment adjustment (calculated as the total uncompensated care payment, from Worksheet E, Part A, line 35.03, sum of columns 1 and 2, minus the sum of the uncompensated care payments 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, 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, 2017, 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 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 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.

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)--For discharges on or after October 1, 2014, prorate in columns 2 through 4, the amount reported on Worksheet E, Part A, line 55, net organ acquisition costs, 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 55.

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, and 17.

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 through 2017 (discharges before October 1, 2017), 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.

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
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	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

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, 2017, 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.

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)--Prorate in columns 2 and 3, the amount reported on Worksheet E, Part A, line 55, net organ acquisition costs, 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 55.

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, 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, and 17.

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
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	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

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, *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.

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.

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 as follows:

Reimbursement Method	From Column	Transfer To
Part B Payments	4	Wkst. E, Part B, line 41
Part A Payments		
IPPS	2	Wkst. E, Part A, line 72
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
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, respectively.

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.

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
4	Wkst. E, Part B, line 43
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
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.

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 amount on line 71.01; Worksheet E, Part B, line 40, less the amount on line 40.01; Worksheet E-2, line 19, less the amount on line 19.01; Worksheet E-3, Part I, line 18, less the amount on line 18.01; Worksheet E-3, Part II, line 31, less the amount on line 31.01; Worksheet E-3, Part III, line 32, less the amount on line 32.01; Worksheet E-3, Part IV, line 22, less the amount on line 22.01; Worksheet E-3, Part V, line 30, less the amount on line 30.01; and Worksheet E-3, Part VI, line 15, less the amount on line 15.01.

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.

In accordance with the American Recovery and Reinvestment Act (ARRA) of 2009, section 4102, inpatient acute care services under IPPS (providers subject to §1886(d) of the Act) and CAHs are eligible for HIT payments.

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.

Line 7--Include on this line amounts paid to physicians for their administrative services of managing the renal department. These payments are subject to the limitation contained in §2723.3 of CMS Pub. 15-1. Also include payments to physicians for their medical services if the box on line 21 of Worksheet S-5 is marked the initial method. A complete description of the initial method is in CMS Pub. 15-1, §2715. For a renal provider to be paid under the initial method, all renal physicians at the provider must elect the initial method. Under the initial method, renal physicians are paid by the provider for their routine renal medical services and the provider's composite payment rate is increased according to 42 CFR 414.313. 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 non-patient care personnel after reclassifications and adjustments that you report in column 7 of Worksheet A.

Lines 10 through 16--Include on the appropriate lines costs directly charged to the renal department after reclassifications and adjustments. Report other direct costs on line 16 that cannot be specifically identified on lines 11 through 15. *Line 15 must include all ESA costs.*

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 ESA's* 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--Add lines *17* through 26. This total must agree with the total on Worksheet B, 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 the Medicare Benefit Policy Manual (100-02 IOM), chapter 11 (ESRD), §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 Pub. 15-1, §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--Add the costs from Worksheet I-1, and transfer these amounts to line 1 in the following manner:

Worksheet I-2	Worksheet I-2 Column	Worksheet I-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
Medical Supplies	7	Sum of lines 14 and 24
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 that are paid for under the composite payment rate system. The total costs (column 11) for these individual dialysis services are transferred to Worksheet I-4.

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
Line 2	Line 1
Line 3	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

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.

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 periods ending on or after December 31, 2015, all ESA's should be entered on this line. (e.g. EPO, Aranesp etc.)*

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 periods ending on or after December 31, 2015, this line should not be completed and all amounts should be included 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 column 6, lines 14, *and* 15, should be excluded 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 (EPO) and 15 (Aranesp), 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

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 the final rule for payment of capital-related costs on a PPS pursuant to 42 CFR 412, Subpart M. (See 56 FR 43449 (August 30, 1991).) 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. If your facility experienced a geographic redesignation *(see 42 CFR 412.102 (a) and (b))* from urban to rural, or rural to urban (Worksheet S-2, lines 26 and 27, column 1, are "1" and "2" or "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. Enter in co1umn 1, the capital DRG payments for the portion of the reporting period the hospital is classified as urban, and enter in co1umn 1.01, the capital DRG payments for the portion of the reporting period the hospital is classified as rural.

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(a) and (b)),* 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)),* 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: 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: $\{e^{.2822 \text{ x line } 4/\text{line } 3}\}$-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: $(e^{.2025 \text{ x line } 9})$-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.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 1 - RECORD SPECIFICATIONS

RECORD NAME: Type 1 Records - Record Number 1 (Cont.)

12.	Version Number	3	X	42-44	Version of extract software, e.g., 001=1st, 002=2nd, etc. or 101=1st, 102=2nd. The version number must be incremented by 1 with each recompile and release to client(s).
13.	Creation Date	7	9	45-51	YYYYDDD - Julian date; date on which the file was created (extracted from the cost report)
14.	ECR Spec. Date	7	9	52-58	YYYYDDD - Julian date; date of electronic cost report specifications used in producing each file. Valid for cost reporting periods *beginning* on or after (*10*/*1*/2015) 2015*274*. Prior approvals *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 position 21-60. #4 - The time that the cost report is created. This is represented in military time as alpha numeric. Use position 21-25. 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 1-3) 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 and is recorded as line 5 and only for capital cost centers, columns 1-2 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 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 filed cost report	1	1	1	X
Manually submitted 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 or "L" for low	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 4, column 1 is 4: enter the number of times reopened = 0-9	12	3	1	9
Part III				
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	1	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

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

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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 S-2, Part I (Cont.)				
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
Is this hospital a former MDH that is eligible for the MDH transitional payment? (Y/N)	*37.01*	*1*	*1*	*X*
Beginning date MDH status applies in this period (mm/dd/yyyy).	38	1	10	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)(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)(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
<u>Prospective Payment System (PPS) - Capital</u>				
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 PPS capital? (Y/N)	47	1-3	1	X
Is the facility electing full federal capital payment? (Y/N)	48	1-3	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 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
Enter Program name in column 1. (subscript line 65 as necessary) (see instructions)	65	1	36	X
Enter Program code in column 2.	65	2	10	X
Enter the unweighted primary care FTEs attributable to rotations occurring in all nonprovider settings in column 3. (see instructions)	65	3	9	9(6).99
Enter the unweighted primary care FTEs that trained in your hospital in column 4.	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
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

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.)				
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
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 a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II? (Y/N)	87	1	1	X
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 and/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)

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 critical access hospital (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
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 Demo) for the current cost reporting period? (Y/N)	110	1	1	X
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
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

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.)				
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. Note: Question 119, columns 1 and 2 are eliminated and replaced with questions 118.01 and 118.02.	119	2	11	9
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 ≤ 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 state health or similar taxes? (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*
Transplant Center Information				
Does this facility operate a transplant center? (Y/N)	125	1	1	X
If this is a Medicare certified kidney transplant center, enter the certification date (mm/dd/yyyy) and the termination date if applicable (mm/dd/yyyy).	126	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 B-1 (Continued)

* In each column using accumulated costs as the statistical basis for allocating costs, identify each cost center *that is not* to receive *an* allocation *by placing* a negative 1 (-1) in the accumulated cost column *or p*roviders may elect to indicate total accumulated cost as a negative amount in the reconciliation column. *Cost centers that are not to receive an allocation cannot have* entries in both the reconciliation and accumulated *cost* column*s* simultaneously.

For those cost centers which are to receive partial allocation of costs, provide only the cost to be excluded from the statistic as a negative amount on the appropriate line in the reconciliation column. If line 5 is fragmented, line 5 must be deleted and subscripts of line 5 must be used.

+ Include any column which 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 B, Part indicator	1	2	1	9
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 B, Part indicator	2	2	1	9
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 B, Part indicator	3	2	1	9
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 B, Part indicator	4	2	1	9
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 (Continued)				
Amount for ESA costs in Renal Dialysis	5	1	36	X
Worksheet B, Part indicator	5	2	1	9
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 B, Part indicator	6	2	1	9
Worksheet A line number	6	3	6	9(3).99
Amount of adjustment	6	4	11	-9
Explanation	7-59	1	36	X
Worksheet B and L-1, Part numbers (1=B, Part I; 2=B, Part II; and 3=L-1	7-59	2	1	9
Worksheet A line number	7-59	3	6	9(3).99
Amount of adjustment	7-59	4	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.)

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)	50-101, 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

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 III: lines 1-3, 5-8, 200
Worksheet S-2, Part I: lines 1-5, 7-10, 12, 20-35, 37, 45-60, 61-64, 66-85, 90-157, 159, 165, 167-169
Worksheet S-2, Part II: ALL
Worksheet S-3, Part I: lines 1-7, 13-17, 18, 21, 27-33
Worksheet S-3, Part II: ALL, except for line 43
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, 15
Worksheet S-9, Part I and II: ALL
Worksheet S-10: ALL
Worksheet A: lines 3, 30, 43-44, 46, 74, 94, 95-97, 100, 105-111, 113-115, 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 1-32, 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
Worksheet D-5, Part I and II: ALL, except line 17

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-2552-10 TABLE 3C - LINES WHICH CANNOT BE SUBSCRIPTED (BEYOND THOSE PREPRINTED)

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 30
Worksheet E-4: lines 1-2, 6, 8, 11-18, 20, 21, 23
Worksheet G: ALL
Worksheet G-1: lines 1, 3, 10-11, 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, 200
Worksheets M-1, M-2: ALL
Worksheet M-3: ALL, except line 25
Worksheet M-4: ALL
Worksheet M-5: lines 1-2, 4 and 6-8

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 5 digit and 1 alpha character, where indicated, reject/edit code specified below. Any file submitted by a provider containing a level I edit will be rejected by the contractors. Notification must be made to CMS for any exceptions.

The edits are applied at two levels. Level I 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 II 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 I edit conditions exist. Ample warnings should be given the provider where Level II edit conditions are violated.

The Level I edit conditions are to be applied against Title XVIII services only. However, any inconsistencies and/or omission which would cause a Level I condition for non Title XVIII services should be resolved prior to acceptance of the cost report. [05/01/2010b]

Note: The dates in brackets [ ] at the end of each edit indicate effective date of that 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 I 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
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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 17-22) must be valid and numeric. [05/01/2010b]
10225	*The contractor number on Worksheet S, Part I, line 7, must be present, consist of five digits and not exclusively zero's. [12/31/2015]*
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 23-29, 30-36, 45-51, and 52-58) must be in Julian format and a possible date. [05/01/2010b]
10350	The fiscal year beginning date (record #1, positions 23-29) must be less than the fiscal year ending date (record #1, positions 30-36). [05/01/2010b]
10400	The vendor code (record #1, positions 38-40) 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 1-20) 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
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 26, column 1, does not equal line 27 column 1, then line 27, column 2, must have a date. 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, columns 1 and 2, 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 61, column 1, must be present. If line 57, column 1="Y", then line 57, column 2, must be present. 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 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 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, or 5. 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, or 5. 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]
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, 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
	(1) The first two characters of the CCN (not listed here) identify the state. The last 4 characters (listed above) identify the type of provider. (**) EXCEPTION - Organ procurement organizations (OPOs) are assigned a 6-digit CCN. The first 2 digits identify the State code. The third digit is the alpha character "P". The remaining 3 digits are a unique facility identifier.
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]
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, than Worksheet S-8 and Worksheets M-1 through M-5 must not be completed. [10/1/2014b]*
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]
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, 5-20, 22, 24-26, 28, and 30-32, must be equal to or less than the total inpatient days/outpatient visits in column 8 for each line. [05/01/2010b]

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="P", then Worksheet S-3, Part II, column 5, lines 1-43, must be equal to or greater than zero. [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, 16-18 must be equal to or less than the total discharges in column 15 for each line indicated. [05/01/2010b]
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 column 2, line 3, for the hospital, cannot be in the range of 3025-3099, and line 5 must be blank. [05/01/2010b]
12600S	If this is a LTCH (Worksheet S-2, Part I, line 3, column 2, is in the range of 2000-2299), 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]
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 50-98, 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]
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]
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. [05/01/2010b]]

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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 1-12, and 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 thru XX-3399)), then Worksheet S-2, Part II must have a response in every ECR file for:

Column 1: lines 22-32, 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 41-43, all columns) must be valid and present. [06/30/2012]

12950S If Worksheet S-2, Part 1, 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. [04/01/2013s]

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 and 13250S. These edits do apply if the hospital is subject to PPS but not an LTCH (Provider number 2000-2299), an IRF (Provider number

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 2552-10
TABLE 6 - EDITS

3025-3099), a Psychiatric Hospital (Provider number 4000-4499) or if the third digit of the provider number is an "S" or a "T". Nor do they apply if the third digit of provider number is M (Psychiatric unit in Critical Access Hospital) or the third digit of provider number is R (Rehabilitation unit in Critical Access Hospital).

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; and column 14, line 4, must be less than or equal to the amount in column 15, line 17. [12/31/15]*
13000S	For Worksheet S-3, Part II, sum of columns 2 and 3, each of lines 1-43 and subscripts as applicable must be equal to or greater than zero. [05/01/2010b]
13050S	The amount of salaries reported for Interns & Residents in approved programs, Worksheet S-3, Part II, column 1, 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 & 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 & 3, line 10 must equal the corresponding amount on Worksheet A, column 1, lines 20, 23, 40-42, 45-46, 94-95, 98-101, 105-112, 113, 115-117 and 190-194, and subscripts thereof, plus or minus any related amounts reported on Worksheet A-6, columns 4 and/or 8 for lines 20, 23, 40-42, 45-46, 94-95, 98-101, 105-112, 114, 115-117 and 190-194 and subscripts thereof, indicated in columns 3 and/or 7. [05/01/2010b]
13200S	Worksheet S-3, Part II, sum of columns 2 & 3, line 17 must be greater than zero. Apply this edit to PPS providers only. [05/01/2010b]
13250S	If Worksheet S-3, Part II, sum of columns 2 and 3, lines 1-16 and 26-43 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 26-43 are not required to be completed. [05/01/2010b]
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.[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]

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Edit	Condition
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]
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 column which uses accumulated cost as its basis for allocation and any reconciliation column. [05/01/2010b]

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Edit	Condition
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]
10050D	If Medicare hospital inpatient days (Worksheet S-3, Part I, column 6, 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]
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, column 1, sum of lines 5 and 6, must equal Worksheet S-3, Part I, column 8, line 5, and Worksheet D-1, column 1, sum of lines 10 and 11, must be equal to or less than Worksheet D-1, column 1, sum of lines 5 and 6. [05/01/2010b]
10250D	Worksheet D-1, title XVIII, sum of lines 10 and 11, must equal Worksheet S-3 Part I, line 5, column 6. [05/01/2010b]
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, must be equal to or less than the absolute value of Worksheet A-8, line 25. If Worksheet S-7, line 2, column 1, equals "Y", add Worksheet(s) E-2, column 1, line 7, to Worksheet D-1 for the comparison of 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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Edit	Condition
10400E	If Worksheet S-2, Part I, line 76, column 1, is "N", column 2, is "N", Worksheet S-3, part I, line 1 or 17, column 6, is greater than zero and Worksheet E-3, Part III, line 7 is greater than zero, then Worksheet E-3, Part III, lines 6 must be greater than zero. [05/01/2010b]
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 "2"; 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 "subclause (II)" LTCH, 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]

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Edit	Condition
10750E	If Worksheet S-2, Part I, line 71, column 1, is "N", column 2, is "N", and Worksheet S-3, Part I, line 1 or 16, column 6, is greater than zero, and Worksheet E-3, Part II, line 6 is greater than zero, then Worksheet E-3, Part II, line 5, must be greater than zero. [05/01/2010b]
10800E	Edit has been changed to Level II 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]
10850E	Edit has been changed to Level II 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]
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 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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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]
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, 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, 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 Worksheet I series 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]
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]

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Edit	Condition
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 entries only. [05/01/2010b]
10000L	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" 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; except when Worksheet S-2, Part I, line 26, is "1" and Worksheet S-2, Part I, line 27, column *1*, is "2", and Worksheet S-2, Part I, line 3, column 3, is 999xx (CBSA is rural). [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. [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]
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 10/1/2014.* [05/01/2010b]

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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]
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	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). [05/01/2010b]
20050G	Total patient revenue (Worksheet G-2, Part I, column 3, line 28) should equal the sum of inpatient and outpatient revenue (Worksheet G-2, Part I, sum of columns 1 and 2, line 28). [05/01/2010b]
20150G	Contractual allowances (Worksheet G-3, column 1, line 2) should not be negative. [10/01/2012b]
20100G	Net income or loss (Worksheet G-3, column 1, line 29) should not equal zero. [05/01/2010b]
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]
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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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]
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]

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.