OMB

Response to Public Comment on Draft 2552-10 Hospital Cost Report

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Comment Number	Entity Submitting Comments	Subject Matter	Summary of Comment	Accept/Deny Change
Substantive Comments				
1	Hospitals, Hospital Associations, Provider Representatives	Eliminating worksheets no longer used for Medicare reimbursement purposes	Commenters expressed concern that eliminating cost report worksheets that are no longer used for Medicare reimbursement purposes, but which are used for Medicaid reimbursement in various states, will cause unnecessary burden to both the hospitals and the states that have relied on the reporting and collection of this information for many years. Commenters urged CMS to examine how the states use the Medicare cost report for Medicaid reimbursement purposes and to retain worksheets that the states use.	We retained Worksheet C, Part II, Calculation of Outpatient Service Cost to Charge Ratios Net of Reductions for Medicaid Only and we retained lines 75 through 85 on Worksheet D-1, Part III to accommodate for the per diem cost for Medicaid.
2	Hospitals, Hospital Associations, Provider Representatives	Creating a self-contained Medicare Disproportionate Share Hospital worksheet	Commenters expressed concern that calculating the disproportionate share hospital (DSH) “off the cost report” obscures the calculation of this hospital reimbursement element and is not fully transparent. Commenters recommended that CMS create a new worksheet to capture the DSH data elements, as well as to provide for a complete calculation of a hospital’s Medicare DSH percentage.	We capture the data that calculates the Medicaid fraction on Worksheet S-2 line 24. The calculation of the payment percentage for DSH data will continue to be handled through the hospital cost report electronic vendors' systems because the factors that are used to calculate DSH are subject to change annually and this information is made available through the change management process.
3	Hospitals, Hospital Associations, Provider Representatives	S-2, Part II - Incorporating FORM CMS-339 into the cost report	Various commenters expressed concern that cost report instructions describing supplemental schedules that may be required as a result of incorporating the FORM CMS-339 in the Medicare cost report could result in data inconsistencies and an increased incidence of cost report rejection. The commenters suggested the supplemental schedules should not be required to be submitted with the cost report but instead allow providers to make the information available to contractors during audit. Alternately, commenters suggested CMS either develop cost reporting forms to collect the data or not eliminate the FORM CMS-339.	We revised the instructions for Worksheet S-2, Part II to require submission of only two additional schedules/exhibits. Exhibit 1 (Allocation of Physician Compensation: Hours) is required only for cost-reimbursed and Tax Equity and Fiscal Responsibility Act (TEFRA) hospitals. Exhibit 2 (Listing of Medicare Bad Debts and Appropriate Supporting Data) is required for all hospitals. As specified in the second paragraph of the instruction pertaining to Exhibit 1 (formerly Exhibit 2 in FORM CMS-339), a hospital may submit computer generated substitutes for Exhibit 1, provided they contain, at a minimum, the same information as in Exhibit l and include the appropriate signatures. CMS has been working to alleviate unnecessary burden and incorporating FORM CMS-339 into the cost report is consistent with that goal. Furthermore, the submission of these schedules/exhibits is required with the cost report as this information is used by the Medicare contractors to determine if an audit is needed and the scope of the audit once the need is determined. We do not envision that including the format and instructions for these schedules/exhibits in the cost report instructions will result in additional discrepancies that were not encountered when these exhibits were in FORM CMS-339. Since there are no edits related to the responses in Worksheet S-2, Part II and related exhibits mentioned in the instructions, a cost report will not be rejected unless the hospital does not complete Worksheet S-2, Part 2. (See 42 CFR 413.24(f)(5).) However, a contractor may request any missing schedule or other required information that is not submitted with the cost report.

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Substantive Comments				
4	Hospitals, Hospital Associations, Provider Representatives	S-2, Part II - Incorporating FORM CMS-339 into the cost report	Although not included in CMS' proposed cost report changes, commenters recommended that the FORM CMS-339 bad debt exhibit be handled in a manner similar to the intern and resident information system (IRIS) diskette. Commenters suggested this exhibit remain separate from the cost report. Commenters expressed concern that describing the exhibit in the cost report instructions and not including it in the cost report forms will lead to an inconsistent review and approval of bad debt reimbursement by the auditors.	Medicare auditors can request additional information to substantiate a provider's claim for reimbursement for bad debts. In accordance with 42 CFR 413.24, "Providers receiving payment on the basis of reimbursable cost must provide adequate cost data…which must be capable of verification by qualified auditors." Furthermore, 42 CFR 412.52 specifies that "All hospitals participating in the prospective payment systems must meet the recordkeeping and cost reporting requirements of §§413.20 and 413.24 of this chapter." Therefore, a Medicare auditor may request any additional information that is necessary to determine whether the hospital's bad debts are allowable.
5	Hospitals, Hospital Associations, Provider Representatives	S-2, Part I - Hospital health care complex identification data	Commenters noted the proposed hospital cost report instructions for reporting Medicaid days on Worksheet S-2, Part I, lines 22 and 23 (Medicaid days) and Worksheet S-3, Columns 5 through 7 do not provide consistent definitions of Medicaid days. The commenters requested that CMS provide a consistent definition of Medicaid days between the two worksheets. Commenters also suggested that CMS clarify the purpose of adding lines 21 and 22 to collect Medicaid days on Worksheet S-2, Part I to define the potential relationship to the DSH calculation.	We clarified instructions for Worksheet S-3, Part I, column 7 to explain that a provider is to report the provider's paid in-state Medicaid days for purposes of Medicaid cost finding and settlement through the cost report where applicable. We clarified instructions for Worksheet S-2, lines 22 and 23 to explain that the provider is to report Medicaid days to be used in the Medicare DSH and low income patients (LIP) calculation. We clarified the instructions to Worksheet E, Part A and E-3, Part III to reflect the use of the days on Worksheet S-2, lines 22 and 23 for the DSH and LIP computations respectively.
6	Hospitals, Hospital Associations, Provider Representatives	Hospital wage index information - Worksheet S-3, Part II	Commenters expressed concern that the proposed addition to the instruction for Worksheet S-3, Part II, line 28 to clarify that home office contract labor cannot be added to contract administrative and general costs for the wage index will unduly penalize hospitals with home office costs, as they will not be able to claim legal, consulting and similar fees paid by the home office. The commenters requested that CMS remove this proposed new instruction from the cost report.	Beginning with the FY 2008 wage index, we expanded our definition of contract costs for the wage index to include the following line items: administrative and general, housekeeping, and dietary services; however, we did not include the costs for contract home office services (see FY 2008 IPPS final rule, 72 FR 47315, August 22, 2007). There are many other line items on Worksheet S-3 for which contract services are excluded from the wage index (for example, maintenance, plant operation, laundry and linen, cafeteria, central services and supply). Despite the fact that CMS had not issued guidance for including contract home office services in the wage index, we are now aware that many hospitals believed that the costs were allowed and have been including the costs on Worksheet S-3. Some hospitals have included these contract services on the home office line, while others have included them in cost centers associated with where the services were performed (such as, in the Administrative and General cost center). Due to the concerns raised by the commenters and our need for more time to evaluate and determine the most appropriate handling of these costs for the wage index, we agree to retract the added instruction from Line 28 of this transmittal of the cost report. We will address the cost in future rulemaking. In the meantime, we have broadly instructed the Medicare contractors to allow hospitals to include contract home office cost on the hospital's cost report if the cost is related specifically to the hospital and is allocated directly to the hospital.

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7	Hospitals, Hospital Associations, Provider Representatives	New contract labor and benefit cost worksheet - Worksheet S-3, Part V	Commenters expressed concern that collecting information from contractors for the proposed Worksheet S-3, Part V will be impossible as contractors are paid a flat rate. Commenters stated the information does not affect the allowable costs reported on the cost report and urged that CMS to eliminate this proposed worksheet.	We acknowledge that it may be difficult for some providers to disaggregate their benefit and contract labor costs by department, however, at a minimum, we need to collect total benefit and contract labor costs for actuarial purposes.
8	Hospitals, Hospital Associations, Provider Representatives	Home Health Agency statistical data - Worksheet S-4	Commenters recommended that CMS eliminate columns 5 and 6 under the "PPS Activity Data" section that begins on line 21 due to significant change in condition (SCIC) episode types that were eliminated when the home health PPS was revised as of January 1, 2008.	We eliminated columns 5 and 6 on Worksheet S-4 on the revision of the 2552-10.
9	Hospitals, Hospital Associations, Provider Representatives	Provider-based RHC/FQHC provider statistical data - Worksheet S-8	Commenters noted the proposed Worksheet S-8 form and instructions are not consistent from lines 10 and forward. Commenters recommended that CMS align the form and instructions for this worksheet.	We aligned Worksheet S-8 with the applicable instructions.
10	Hospitals, Hospital Associations, Provider Representatives, Government	Worksheet S-10	Several commenters expressed concern that CMS removed the unreimbursed costs of state and local indigent care programs, Medicaid State Children's Health Insurance Program (SCHIP) and Medicaid, from the "bottom line" of Worksheet S-10.	We added a new line, line 19, to capture unreimbursed costs for Medicaid SCHIP and state and local indigent care programs and renumbered the subsequent lines of the worksheet.
11	Hospitals, Hospital Associations, Provider Representatives, Government	Worksheet S-10	Commenters urged CMS to add a line on Worksheet S-10 to report the hospital's total unreimbursed and uncompensated costs and would be comprised of all of the subtotal components of program unreimbursed costs (lines 8, 12 and 16), charity care costs (line 23) and bad-debt costs (line 29), that are determined throughout this worksheet.	We recognize the complexity of Worksheet S-10 and agree with the commenters' suggestion. Therefore, we added line 31 to capture total unreimbursed and uncompensated care cost (the new lines 19 plus line 23, and 30).
12	Hospitals, Hospital Associations, Provider Representatives, Government	Worksheet S-10	Commenters urged CMS to add line 1.01 to Worksheet S-10 to calculate a second cost to charge ratio (CCR) that includes a hospital's full costs and would be applied to lines 19 and 28.	We agree that a comprehensive CCR that includes the total hospital costs and charges, including Medicare as well as non-Medicare costs and charges as captured on Worksheet C, Part I, is more appropriate to calculate patient care costs.
13	Hospitals, Hospital Associations, Provider Representatives, Government	Worksheet S-10	Commenters recommended that CMS require Medicaid DSH and supplemental payments be reported separately on Worksheet S-10.	While this comment might seem feasible for large hospitals, the Medicare cost report must accommodate all hospitals. Smaller hospitals may not have detailed accounting and data collection systems required to capture the data as suggested by some commenters and revising their systems would result in undue burden.

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14	Hospitals, Hospital Associations, Provider Representatives, Government	Worksheet S-10	Commenters suggested that CMS modify descriptions on lines 8, 12 and 16 on Worksheet S-10 to indicate the lines are the “difference between net revenues and costs,” and thereby make the lines consistent with line 2, clearly differentiate between payments (net revenues) and charges (gross revenues), and help ensure consistent reporting.	We agree with the commenters' suggestion and modified lines 8, 12 and 16 to include the word “Net.”
15	Hospitals, Hospital Associations, Provider Representatives, Government	Worksheet S-10	Commenters noted the proposed Worksheet S-10 line 13 is labeled as payments from “state or local indigent care programs.” However, the proposed instructions define this line as payments from “state or local government programs.” Commenters suggested CMS specify in the instructions that this line is for payments from “state or local government indigent care programs” to ensure that the correct payments are included.	We agree with the commenters' suggestion and modified line 13 by adding “state or local governmental indigent care programs.”
16	Hospitals, Hospital Associations, Provider Representatives, Government	Worksheet S-10	Some commenters suggested that CMS calculate the cost of charity care by starting with the amount of charges a hospital has written off. Commenters noted that the charity care reported on Internal Revenue Service (IRS) FORM-990, Schedule H, is the amount of charity care charges the hospital has written off. The commenters suggested using the same starting point would streamline and unify charity care reporting across the Federal government, ensure consistency of reporting, and avoid significantly increasing hospitals' administrative burden. Some commenters noted that capturing the data required for Worksheet S-10 proposed lines 19 through 23 would require maintaining a detailed charity-care log for all patients for which charity care has been approved – a task that is extremely difficult and burdensome.	The lines to calculate the cost of charity care, originally proposed as lines 19 through 23, have changed to lines 20 through 23. We incorporated these lines to calculate charity care based on MedPAC and other stakeholder recommendations to capture total uncompensated care, not just charity care charges that have been written off. We believe the approach of using total charity care charges as a starting point rather than the "write off" approach yields data that is more comprehensive and consistent with our objective of using total charity care charges in the calculation of the Health Information Technology (HIT) incentive payment in accordance with the American Recovery and Reinvestment Act of 2009 (ARRA). We cannot use the same starting point as the IRS since our focus regarding charity care is quite different than that of the IRS. MedPAC concurs with our approach. MedPAC noted that calculating charity care costs based on charges a hospital writes off overstates the net charity care cost because any patient care revenues a hospital receives for these cases are ignored. MedPAC further noted that this can lead to situations in which a hospital can claim charity care costs equal to the full cost value of charges written off, even though the patient care payments fully or partially cover the hospital's actual cost of care. Such an overstatement would be inappropriate and uneven among hospitals, especially those that have high charge mark- ups. We are aware of some hospitals that maintain the information required on the revised Worksheet S-10. A hospital should maintain a charity care log and report charity care charges to compute HIT incentive payments in accordance with the ARRA. In fact, to receive Medicare bad debt based on indigency or medical indigency, a hospital must maintain this information on a patient-by-patient basis.

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17	Hospitals, Hospital Associations, Provider Representatives, Government	Worksheet S-10	Commenters recommended CMS exclude from lines 2, 3 and 4 the government grants, appropriations and transfers reported on line 18. Commenters also recommended omitting references to Federal Section 1011 in line 18 instructions.	We agree that lines 2, 3, and 4 should exclude the government grants, appropriations, and transfers reported on line 18 and have revised the instructions accordingly. While Section 1011 of the Medicare Modernization Act of 2003 (MMA 2003) authorized funds for federal fiscal years 2005 through 2008, the statute provides that any unexpended funds that are available after that time period shall remain available until fully expended, even after federal fiscal year 2008. Therefore, the reference to Federal Section 1011 must remain in line 18.
18	Hospitals, Hospital Associations, Provider Representatives, Government	Worksheet A	Commenters noted CMS proposed to redesignate the Other Capital-Related Costs from line 90 to line 3 on Worksheet A. The comments suggested CMS eliminate the cost center and instruct hospitals to include the costs in Worksheet A lines 1 and 2.	While we appreciate the commenters' suggestion, we cannot accommodate the request. Worksheet A-7 provides for the allocation of Other Capital-Related Costs.
19	Hospitals, Hospital Associations, Provider Representatives, Government	Worksheet A	Commenters urged CMS to revise the instructions for allocating costs to the “Medical Supplies Charged to Patients” and “Implantable Devices Charged to Patients” cost centers to provide clarity to hospitals able to directly assign or reclassify costs to those cost centers on Worksheet A and to ensure that auditors understand how the hospital derived information for these cost centers.	We agree that it is appropriate to clarify how hospitals may report the costs of “Medical Supplies Charged to Patients” (cost center 6800) and “Implantable Devices Charged to Patients” (cost center 6900) and we have revised instructions accordingly.
20	Hospitals, Hospital Associations, Provider Representatives, Government	Worksheet A	Commenters recommended CMS add more standard non-reimbursable cost centers such as marketing and fundraising.	While we appreciate the commenters' suggestion to establish additional standard non-reimbursable cost centers, we disagree that the cost centers are required. As the commenters noted, the Medicare cost report permits providers to identify the non-reimbursable cost centers in addition to the established standard non-reimbursable cost centers.
21	Hospitals, Provider Representatives	Reconciliation of capital cost centers - Worksheet A-7	Commenters recommended that CMS eliminate Worksheet A-7 because it is complex, time consuming and no longer provides relevant data in the current reimbursement environment. Alternately, commenters recommended that if Worksheet A-7 is not eliminated, CMS should include Column 10 (which CMS had proposed to eliminate) in Worksheet A-6, because Worksheet A-7 uses the data in that column.	We agree with the commenters' suggestion and retained Column 10 in Worksheet A-6.
22	Hospitals, Hospital Associations, Provider Representatives	Adjustments to expenses - Worksheet A-8	Commenters noted that CMS proposed to incorporate Worksheet A-8-4 into Worksheet A-8-3, but did not eliminate all references to Worksheet A-8-4 that are in Worksheet A-8. The commenters recommended that CMS change all references to Worksheet A-8-4 that are contained in Worksheet A-8 (see lines 23, 24, 30 and 31) to reference Worksheet A-8-3.	We corrected the references to A-8-3 on Worksheet A-8.

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23	Hospitals, Hospital Associations, Provider Representatives	Provider-based physician adjustments - Worksheet A-8-2	Commenters recommended that the CMS indicate the Worksheet A-8-2, Column 2 physician identifier should be an alphabetic code (as described in the instructions) to avoid any possibility that the physician might be identified on the worksheet itself.	We agree with the commenters' suggestion and revised the instructions on Worksheet A-8-2 to ask for the alphabetical code physician identifier.
24	Hospitals, Hospital Associations, Provider Representatives	Computation of inpatient operating cost - Worksheet D-1	Commenters expressed concern that proposed changes to Worksheet D-1, line 38 instructions could adversely impact the calculation of Medicare allowable costs, which form the basis for calculating sole community hospital and Medicare-dependent hospital -specific rates, flow into Medicaid calculations in different states, and are used by the CMS and others to calculate Medicare payment adequacy levels. Commenters requested that CMS revert back to the prior instructions for Worksheet D-1 line 38 so that this line equals the sum of lines 36 and 37 divided by the inpatient days reported on line 2. Alternatively, commenters suggested that CMS could eliminate the requirement that PPS hospitals complete lines 28 through 37 and use routine costs on line 27 for the cost-per-diem computation on line 38.	We acknowledge the commenters' concern and revised the instructions for line 38.
25	Hospitals, Hospital Associations, Provider Representative, Government	Hospital financial statements - Worksheet G series	Several commenters recommended that CMS develop a detailed set of instructions for the Worksheet G series since CMS uses this worksheet series to calculate Medicare payment adequacy levels and policy impacts.	We recognize the complex nature of the Worksheet G instructions and revised the instructions to be more comprehensive and explicit.
26	Hospital Associations	Worksheet J-2, Part II	Commenters noted an error on the proposed Worksheet J-2, Part II presenting two cost centers for drugs on lines 27 and 28 that are not listed in other worksheets nor described in the instructions. The commenters recommended that CMS combine the two cost centers into one for "Drugs Charged to Patients."	We revised Worksheet J-2, Part II to include only one cost center for drugs on line 27 labeled "Drugs Charged to Patients."
27	Hospital Associations, Provider Representative	Provider-based hospice costs - Worksheet K series	Commenters recommended that CMS eliminate Worksheet K-1, K-2 and K-3 because additional details in those worksheets are not used for any purpose and the information is contained in Worksheet K.	We appreciate that the commenters want to work with us to ensure that cost report data are aligned with reimbursement methodologies. The CMS Chronic Care Policy Group is planning to reform the hospice payment system in the near future and will be using cost report data during that process. Since hospice services are labor-intensive, having detailed information about the disciplines providing services to hospice patients is critical, whether the data are from paid hospice staff or from contracted care providers. Indeed, these data are needed to ensure that cost report data are aligned with hospice reimbursement methodologies. Therefore, we believe that the detailed information from Worksheets K-1, K-2, and K-3 is critical to future hospice payment reform work, and as such should not be eliminated from the hospital cost report.

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28	Hospital, Provider Representative	Adding an additional cost center to the cost report	Several commenters asked that CMS create a cost center to capture the costs of magnetoencephalography (MEG) rather than including the MEG costs in standard cost center 5400 “Electroencephalography” (EEG). Commenters expressed concern that including the costs for MEG in a cost center with EEG, a much less costly but higher volume service than MEG, creates a CCR for MEG that is estimates lower than actual costs for MEG procedures on hospital outpatient claims and leads to payment rates for MEG under the Medicare hospital outpatient prospective payment system (OPPS).	We appreciate the comment, however, CMS does not believe a separate cost center is required to report costs for MEG, a service for which so few providers furnish so few services in a year. We recognize that our claims data shows only Medicare hospital outpatient billings and that there are likely to be more MEG services that are furnished to Medicare beneficiaries who are in covered inpatient stays and to patients who are not Medicare beneficiaries. However, the extremely low volume of claims for MEG services furnished to Medicare beneficiaries in the hospital outpatient setting and the extremely low number of hospitals that report these codes relative to the volumes we typically have considered in adding both standard and nonstandard cost centers to the cost report lead us to conclude that a specific cost center for MEG is not justified at this time.
29	Hospital	Combining Labor, Delivery, Nursery with Obstetrics	A commenter strongly recommended combining Labor and Delivery, Nursery and Obstetric into one cost center.	We cannot combine these cost centers as the cost of Labor and Delivery must be separately identified for the DSH calculations.
30	Hospitals, Hospital Associations, Provider Representative, Government	Adding additional standard cost centers	Several commenters asked that CMS create cost centers to report the costs of magnetic resonance imaging (MRI), Computed Tomography (CT), nuclear medicine services, cardiac catheterization and drugs that require detailed coding.	We agree that it is appropriate to create standard cost centers for CT Scanning, MRI, and cardiac catheterization. Therefore, we added standard cost centers CT, MRI, and Cardiac Catheterization on the revised Medicare cost report FORM CMS-2552-10. However, we do not believe that creating standard cost centers for nuclear medicine services and for drugs that require detailed coding is appropriate. The Medicare cost report already contains standard cost center “Radioisotope” to capture the costs and charges for nuclear medicine services. Under the regulations defining the departmental method of cost apportionment, a hospital must separately apportion the costs of each ancillary department for which the hospital maintains a separate account in their internal accounting records. We expect hospitals maintaining a separate account for the costs and charges of nuclear medicine services to report these costs and charges under “Radioisotope,” rather than including them in “Diagnostic Radiology.”
31	Hospital	Critical Access Hospitals	A commenter recommended adding an adjustment worksheet to Worksheet C for Critical Access Hospitals, similar to Worksheets A-6 and A-8.	The commenter's proposal is contrary to Medicare principles of reimbursement. The purpose of Worksheet C is to capture gross charges and gross costs subject to the Medicare principles to generate a CCR for each cost center.

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32	Hospital	Health Information Technology incentive in the American Recovery and Reinvestment Act	Commenters suggested including a worksheet to track the ARRA HIT incentive/penalty.	We revised the FORM CMS-2552-10 to capture and track the HIT payments. We added a question on Worksheet S-2, Part I to identify HIT meaningful users. We added a line on Worksheet A-7 to track the equipment purchased with the HIT incentive payments. We added lines on Worksheet G to track the cost and the related accumulated depreciation of HIT assets. We added Worksheet E-1, Part II to report the HIT payments made by contractors. We added a column on Worksheet S, Part II to track the incentive payments in the Settlement Summary.
33	Hospital	Use Revenue codes to drive the cost report	A commenter suggested mapping revenue codes to the charges on Worksheet C. That is the same worksheet used to calculate the cost by applying the CCRs.	While we appreciate the suggestion of tying revenue codes to the charges, we cannot revise Worksheet C to group costs and charges by revenue code and Med PAR charge groupings because we cannot insure a one-to-one correlation between cost center departments and revenue codes. We have no reason to believe that hospitals can report costs by revenue code for all services. Hospitals may use multiple revenue codes to report charges for services reported in a single cost center and not be unable to report costs by revenue code. Similarly, we have no reason to believe that hospitals would be able to report costs by Med PAR grouping. Furthermore, even if hospitals could report costs in that manner, such a reporting structure would not support the calculation of CCRs at the hospital-specific departmental level that is required for OPPS rate setting.

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Clarification Comments (comments not on substantive information within the application; CMS will clarify directly with commenters)				
1	Hospitals, Hospital Associations	Various worksheets	Inconsistencies among worksheets and inconsistencies among the instructions and the worksheets.	The instructions and the forms have been modified and are now in alignment.
2	Hospitals, Hospital Associations	Challenges inherent in the new cost reporting requirements	The commenter believes that it is only fair that hospitals be given a reasonable transition period to develop the capacity to meet new CMS reporting requirements.	CMS is very sensitive to providers needs and that is why the new cost reporting requirements are for a cost reporting period beginning on or after May 1, 2010, allowing providers a whole year to get their accounting system in line with our newly revised instructions.
3	Hospitals, Hospital Associations	Direct graduate medical education (GME) & End Stage Renal Dialysis (ESRD) outpatient direct medical education costs - Worksheet E-4	These commenters recommend that line 38 reference the new Worksheet D-4, rather than Worksheet D-6, as D-6 was renamed as D-4 in the proposed FORM CMS-2552-10.	The reference has been corrected to Worksheet D-4.
4	Hospitals, Hospital Associations	Various worksheets	Inconsistencies among worksheets and inconsistencies among the instructions and the worksheets.	The instructions and the forms have been modified and are now in alignment.