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

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4000. GENERAL

The Paperwork Reduction Act of 1995 requires that you be informed why information is collected and what the information is used for by the government. Section 1886(f)(1) of the Act requires the Secretary to maintain a system of cost reporting for Prospective Payment System (PPS) hospitals, which includes a standardized electronic format. In accordance with §§1815(a), 1833(e), and 1861(v)(1)(A) of the Act, providers of service participating in the Medicare program are required to submit annual information to achieve settlement of costs for health care services rendered to Medicare beneficiaries. Also, 42 CFR 413.20(b) requires cost reports on an annual basis. In accordance with these provisions, all hospital and health care complexes to determine program payment must complete Form-CMS-2552-10 with a valid OMB control number. In addition to determining program payment, the data submitted on the cost report support management of the Federal programs, e.g., data extraction in developing cost limits, data extraction in developing and updating various prospective payment systems. The information reported on Form CMS-2552-10 must conform to the requirements and principles set forth in 42 CFR, Part 412, 42 CFR, Part 413, and in the Provider Reimbursement Manual, Part I. The filing of the cost report is mandatory and failure to do so results in all payments to be deemed overpayment and a withhold up to 100 percent until the cost report is received. (See PRM-2, §100.) Except for the compensation information the cost report information is considered public record under the freedom of information act 45 CFR Part 5. The instructions contained in this chapter are effective for hospitals and hospital health care complexes with cost reporting periods beginning on or after May 1, 2010.

NOTE: This form is not used by freestanding skilled nursing facilities.

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

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

NOTE: Public reporting burden for this collection of information is estimated to average 106 hours per response, and record keeping burden is estimated to average 551 hours per response. This includes time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to:

- Center for Medicare and Medicaid Services
  7500 Security Boulevard
  Mail Stop C5-03-03
  Baltimore, MD 21244-1855
- The Office of Information and Regulatory Affairs
  Office of Management and Budget
  Washington, DC 20503

Section 4007(b) of OBRA 1987 states that effective with cost reporting periods beginning on or after October 1, 1989, you are required to submit your cost report electronically unless you receive an exemption from CMS. The legislation allows CMS to delay or waiver implementation if the electronic submission results in financial hardship (in particular for providers with only a small percentage of Medicare volume). Exemptions are granted on a case-by-case basis. (See §130.3 for electronically prepared cost reports and requirements.)

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

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

The cost report is designed to accommodate a health care complex with multiple entities. If a health care complex has more than one entity reporting (except skilled nursing facilities and nursing facilities which cannot exceed more than one hospital-based facility), add additional lines for each entity by subscripting the line designation. For example, subprovider, line 4, Worksheet S, Part III is subscripted 4.00 for subprovider I and 4.01 for subprovider II.

NOTE: Follow this sequence of numbering for subscripting lines throughout the cost report.

Similarly, add lines 42.00 and 42.01 to Worksheets A; B, Parts I and II; B-1; C; D, Parts I and III; and Worksheet L-1, Parts I and II. For multiple use worksheets such as Worksheet D-1, add subprovider II to the existing designations in the headings and the corresponding component number.

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

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

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

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

3. Round to 4 decimal places:
   a. Wage adjustment factor
   b. Medicare SSI ratio

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

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

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

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

A&G	-	Administrative and General
AHSEA	-	Adjusted Hourly Salary Equivalency Amount
ARRA	-	American Recovery and Reinvestment Act of 2009
ASC	-	Ambulatory Surgical Center
BBA	-	Balanced Budget Act
BBRA	-	Balanced Budget Reform Act
BIPA	-	Benefits Improvement and Protection Act
CAH	-	Critical Access Hospitals
CAPD	-	Continuous Ambulatory Peritoneal Dialysis
CAP-REL	-	Capital-Related
CBSA	-	Core Based Statistical Areas
CCN	-	CMS Certification Number (formerly known as a provider number)
CCPD	-	Continuous Cycling Peritoneal Dialysis
CCU	-	Coronary Care Unit
CFR	-	Code of Federal Regulations
CMHC	-	Community Mental Health Center
CMS	-	Center for Medicare and Medicaid Services
COL	-	Column
CORF	-	Comprehensive Outpatient Rehabilitation Facility
CRNA	-	Certified Registered Nurse Anesthetist
CT	-	Computer Tomography
CTC	-	Certified Transplant Center
DEFRA	-	Deficit Reduction Act of 1984
DPP	-	Disproportionate Patient Percentage
DRA	-	Deficit Reduction Act of 2005
DRG	-	Diagnostic Related Group
DSH	-	Disproportionate Share
EACH	-	Essential Access Community Hospital
ECR	-	Electronic Cost Report
EHR	-	Electronic Health Records
ESRD	-	End Stage Renal Disease
FQHC	-	Federally Qualified Health Center

FR	-	Federal Register
FTE	-	Full Time Equivalent
GME	-	Graduate Medical Education
HHA	-	Home Health Agency
HIT	-	Health Information Technology
HMO	-	Health Maintenance Organization
HSR	-	Hospital Specific Rate
I & Rs	-	Interns and Residents
ICF/MR	-	Intermediate Care Facility for the Mentally Retarded
ICU	-	Intensive Care Unit
IME	-	Indirect Medical Education
INPT	-	Inpatient
IOM	-	Internet Only Manual
IPF	-	Inpatient Psychiatric Facility
IPPS	-	Inpatient Prospective Payment System
IRF	-	Inpatient Rehabilitation Facility
LDP	-	Labor, Delivery and Postpartum
LIP	-	Low Income Patient
LOS	-	Length of Stay
LCC	-	Lesser of Reasonable Cost or Customary Charges
LTCH	-	Long Term Care Hospital
MA	-	Medicare Advantage (previously known as M+C)
M+C	-	Medicare + Choice (also known as Medicare Part C, Medicare Advantage and Medicare HMO)
MCP	-	Monthly Capitation Payment
MDH	-	Medicare Dependent Hospital
MED-ED	-	Medical Education
MIPPA	-	Medicare Improvements for Patients and Providers Act of 2008
MMA	-	Medicare Prescription Drug Improvement and Modernization Act of 2003
MRI	-	Magnetic Resonance Imaging
MS-DRG	-	Medicare Severity Diagnosis-Related Group
MSP	-	Medicare Secondary Payer
NF	-	Nursing Facility
NPI	-	National Provider Identifier
OBRA	-	Omnibus Budget Reconciliation Act
OLTC	-	Other Long Term Care
OOT	-	Outpatient Occupational Therapy
OPD	-	Outpatient Department
OPO	-	Organ Procurement Organization
OPPS	-	Outpatient Prospective Payment System
OPT	-	Outpatient Physical Therapy
OSP	-	Outpatient Speech Pathology
ORF	-	Outpatient Rehabilitation Facility
PPACA	-	Patient Protection and Affordable Care Act of 2010
PBP	-	Provider-Based Physician
PPS	-	Prospective Payment System
PRM	-	Provider Reimbursement Manual
PRO	-	Professional Review Organization
PRA	-	Per Resident Amount
PS&R	-	Provider Statistical and Reimbursement Report (or System)
PT	-	Physical Therapy
PTO	-	Paid Time Off
RCE	-	Reasonable Compensation Equivalent
RHC	-	Rural Health Clinic
RPCH	-	Rural Primary Care Hospitals
RT	-	Respiratory Therapy

RUG	-	Resource Utilization Group
SCH	-	Sole Community Hospitals
SCHIP	-	State Children's Health Insurance Program
SNF	-	Skilled Nursing Facility
SSI	-	Supplemental Security Income
TEFRA	-	Tax Equity and Fiscal Responsibility Act of 1982
TOPPS	-	Transitional Corridor Payment for Outpatient Prospective Payment System
UPIN	-	Unique Physician Identification Number
WKST	-	Worksheet

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

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

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

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

Part I - Statistics, Departmental Cost Adjustments and Cost Allocations

Step	Worksheet	Instructions
1	S-2, Parts I & II	Read §4004. Complete entire worksheet.
2	S-3, Parts I - V	Read §4005 - 4005.5. Complete entire worksheets.
3 if	S-4	Read §4006. Complete entire worksheet, applicable.
4 if	S-5	Read §4007. Complete entire worksheet, applicable.
5 if	S-6	Read §4008. Complete entire worksheet, applicable.
6 if	S-7	Read §4009. Complete entire worksheet, applicable.
7 if	S-8	Read §4010. Complete entire worksheet, applicable.
8 if	S-9	Read §4011. Complete entire worksheet, applicable.
9	A	Read §4013. Complete columns 1-3, lines 1-200.
10	A-6	Read §4014. Complete, if applicable.
11	A	Read §4013. Complete columns 4 and 5, lines 1-200.
12	A-7	Read §4015. Complete entire worksheet.
13	A-8-1	Read §4017. Complete Part A. If the answer to Part A is yes, complete Parts B and C.
14	A-8-2	Read §4018. Complete, if applicable.
15	A-8-3, Parts I - VI	Read §§4019 - 4019.6. Complete, if applicable.

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

Part II - Departmental Cost Distribution and Cost Apportionment

Step	Worksheet	Instructions
1	C	Read §4023 - 4023.1. Complete entire worksheet.
2	D, Part I	Read §§4024 and 4024.1. Complete entire worksheet.
3	D, Part III	Read §§4024 and 4021.3. Complete entire worksheet.
4	L-1, Part II	Read §4065.2. Complete, if applicable.
5	D-1, Parts I & IV	Read §§4025, 4025.1 and 4025.4. Complete both worksheets.
6	D, Part II	Read §§4024 and 4024.2. Complete entire worksheet. A separate worksheet must be completed for each applicable healthcare program for each hospital and subprovider subject to PPS or TEFRA provisions.
7	D, Part IV	Read §§4024 and 4024.4. Complete entire worksheet. A separate worksheet must be completed for each applicable health care program for each hospital and subprovider subject to PPS or TEFRA provisions.
8	L-1, Part III	Read §4065.3. Complete, if applicable.
9	D, Part V	Read §§4024 and 4024.5. Complete entire worksheet. A separate worksheet must be completed for each applicable health care program for each applicable provider component.
10	D-3	Read §4027. Complete entire worksheet. A separate copy of this worksheet must be completed for each applicable health care program for each applicable provider component.
11	D-1, Parts I & II	Read §§4025, 4025.1 and 4025.2. All providers must complete Part I. The hospital and subprovider(s) must complete Part II, lines 39-48 and lines 65-70.

Step	Worksheet	Instructions
12	D-1, Parts III & IV	Read §§4025, 4025.3 and 4025.4. Only the hospital-based SNF and hospital-based NF must complete Part III, lines 71-85. All providers must complete Part IV.
13	D-2, Parts I - III	Read §§4026 - 4026.3. Complete only those parts that are applicable. Do not complete Part III unless both Parts I and II are completed.
14	L	Read §4064.3. Complete applicable sections.
15	D-5, Parts I & II	Read §§4029 - 4029.2. Complete entire worksheet, if applicable.
16	D-4, Parts I - IV	Read §§4028 - 4028.4. Complete only if hospital is a certified transplant center.
17	E-4	Read §§4034. Complete entire worksheet, if applicable.

Part III - Calculation and Apportionment of Hospital-Based Facilities

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

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

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

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

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

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

D. Title XVIII Only - For Home Health Agency.--

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

E. Title XVIII- For ESRD.--

14	I-1	Read §§4047 - 4048. Complete a separate worksheet for renal dialysis department(s) and a separate worksheet for home program dialysis department(s), if applicable.
15	I-2	Read §4049. Complete a separate worksheet for renal dialysis department(s) and a separate worksheet for home program dialysis department(s), if applicable.
16	I-3	Read §4050. Complete a separate worksheet for renal dialysis department(s) and a separate worksheet for home program dialysis department(s), if applicable.
17	I-4	Read §4051. Complete a separate worksheet for renal dialysis department(s) and a separate worksheet for home program dialysis department(s), if applicable.

18	I-5	Read §4052. Complete only one worksheet combining all renal dialysis departments and home program dialysis departments, if applicable.

F. Title XVIII - For CMHC.--

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

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

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

H. Titles V, XVIII, and XIX - For Rural Health Clinics/Federally Qualified Health Clinics.--

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

Part IV - Calculation of Reimbursement Settlement

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

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

Part V - Additional Data

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

4002. SEQUENCE OF ASSEMBLY

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

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

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

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

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

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

4003.1 Part I - Cost Report Status.--This section is to be completed by the fiscal intermediary (FI)/contractor only (hereafter referred to as contactor).

The contractor should indicate in the appropriate box whether this is the initial cost report (first cost report for the provider number, for this contractor), final report due to termination, or if this is a reopening. If it is a reopening, indicate the number of times the cost report has been reopened. The FI/contractor should also indicate in HCRIS on line 1, column 3 of worksheet S the following codes that correspond to the filing status of the cost report: 1=As submitted; 2=Amended; 3=Settled ; and 4=Reopened.

The contractor indicates general information about this cost report. This data is submitted as alpha-numeric data in the ECR file as follows:

Line 1, Column 1--Enter the cost report status code of 1 for as submitted, 2 for amended, 3 for settled, and 4 for reopened. (Refer to section 10.3 of Chapter 8 of Office of Financial Management settled Manual Pub. 100-06.)

Line 1, Column 2--If this is a reopened cost report, enter the number of times the cost report has been reopened. This field should only be completed if the cost report status code in line 1, column 1 is 4.

Line 2, Column 1--Enter the date (mm/dd/yyyy) an accepted cost report was received from the provider.

Line 2, Column 2--Enter the 5 position Contractor Number.

Line 2, Column 3-- Enter I for initial, enter F for final, or enter N for neither. An initial report is the very first cost report the FI submits for a particular provider number. It may not be the first cost report ever for this provider number which may have been handled by a previous FI, but it would be the initial cost report for the new FI/contractor.

A final report is the terminating cost report for a particular provider number. If, for example, the provider terminated in 2004, but the 1998 cost report was reopened and submitted after the submission of the 2004 report, the 2004 report is still considered the final report for the provider.

If a provider does have a cost report that is both an initial and final report for a particular year then this field should contain an I if the cost report is an as submitted report, and an F if the cost report is a settled report.

Line 2, Column 4--Enter the Notice of Program Reimbursement (NPR) date (mm/dd/yyyy). The NPR date must be present if the cost report status code is 3 or 4.

4003.2 Part II - Certification by Officer or Administrator of Provider(s).--This certification is read, prepared, and signed after the cost report has been completed in its entirety.

Check the appropriate box to indicate whether you are filing electronically or manually. For electronic filing, indicate on the appropriate line the date and time corresponding to the creation of the electronic file. This date and time remains as an identifier for the file by the intermediary and is archived accordingly. This file is your original submission and is not to be modified.

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

	FROM				
Hospital/ Hospital Component	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX
Hospital	Wkst. E-3, Part VII, line 34	Wkst. E, Part A, line 74 or Wkst. E-3, Part I, line 21 or Wkst. E-3, Part IV, line 25 or Wkst. E-3, Part V, line 33	Wkst. E, Part B, line 43	Wkst. E-1, Part II, line 34	Wkst. E-3, Part VII, line 34
Subprovider-IPF	Wkst. E-3, Part VII, line 34	Wkst. E-3, Part II, line 34	Wkst. E Part B, line 43		Wkst. E-3, Part VII, line 34
Subprovider-IRF	Wkst. E-3 Part VII, line 34	Wkst. E-3, Part III, line 35	Wkst. E Part B, line 43		Wkst E-3, Part VII line 34
Subprovider-Other	Wkst. E series as applicable.				
Swing Bed - SNF	Wkst. E-2, col. 1, line 22	Wkst. E-2, col. 1, line 22	Wkst. E-2, col. 2, line 22		Wkst. E-2, col. 1, line 22
Swing Bed - NF	Wkst. E-2, col. 1, line 22	N/A	N/A		Wkst. E-2 col. 1, line 22
SNF	Wkst. E-3, Part VII, Line 34	Wkst. E-3, Part VI, line 18	Wkst. E, Part B, line 43		Wkst. E-3, Part VII, line 34
NF, ICF/MR	Wkst. E-3, Part VII, Line 34	N/A	N/A		Wkst. E-3, Part VII line 34

	FROM			
Hospital/ Hospital Component	Title V	Title XVIII Part A	Title XVIII Part B	Title XIX
Home Health Agency	Wkst. H-4, Part II, sum of cols. 1&2, line 38	Wkst. H-4, Part II, col. 1, line 38	Wkst. H-4, Part II, col. 2, line 38	Wkst. H-4, Part I, sum of cols. 1 & 2, line 38
Outpatient Rehabilitation Providers	Wkst. J-3, line 29	N/A	Wkst. J-3, line 29	Wkst. J-3, line 29
Rural Health Clinic/ Federally Qualified Health Clinic	Wkst. M-3 line 29	N/A	Wkst. M-3 line 29	Wkst. M-3 line 29

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) number, 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 (CAHs or cost reimbursement), or NOT APPLICABLE, respectively.

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
7 = Children
4 = Psychiatric
8 = Alcohol and Drug
5 = Rehabilitation
9 = Other
6 = Religious Non-Medical Health Care Institution

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

NOTE: Long term care hospitals are hospitals organized to provide long term treatment programs with lengths of stay greater than 25 days. Some hospitals may be certified as other than long term care hospitals, but also have 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 inpatient psychiatric facility (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 CMS Pub. 15-1, chapter 23, for a complete explanation of separate cost entities in

multiple facility hospitals. While an excluded unit (excluded from IPPS) in a hospital subject to IPPS may not meet the definition of a subprovider, treat it as a subprovider for cost reporting purposes.

Line 5--The distinct part inpatient rehabilitation facility (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 CMS Pub. 15-1, chapter 23, for a complete explanation of separate cost entities in multiple facility hospitals. While an excluded unit (excluded from IPPS) in a hospital subject to IPPS may not meet the definition of a subprovider, treat it as a subprovider for cost reporting purposes.

Line 6--This 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. See CMS Pub. 15-1, chapter 23, for a complete explanation of separate cost entities in multiple facility hospitals. While an excluded unit (excluded from IPPS)in a hospital subject to IPPS may not meet the definition of a subprovider, treat it as a subprovider for cost reporting purposes. If you have more than one subprovider, subscript this line.

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. This is authorized by §1883 of the Act. (See CMS Pub. 15-1, §§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.

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 442.300 and 42 CFR 442.400 for standards for other nursing facilities, for other than facilities for the mentally retarded, and for facilities for the mentally retarded.) 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/Mental Retarded (ICF/MR) 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/MR.

Line 11--This is any other hospital-based facility not listed above. The beds in this unit are not

certified for titles V, XVIII, or XIX.

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

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

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

Lines 15 and 16--Enter the applicable information for rural health clinics (RHCs) on line 15 and for federally qualified health clinics (FQHCs) on line 16. These lines are used by RHCs and/or FQHCs which have been issued a provider number and meet the requirements of §1861(aa) of the Act. If you have more than one RHC, report them on subscripts of line 15. If you have more than one FQHC, report them on subscripts of line 16. Report the required information in the appropriate column for each. (See Exhibit 2, Table 4) RHCs and FQHCs may elect to file a consolidated cost report pursuant to CMS Pub. 100-4, chapter 9, §30.8. Do not subscript this line if you elect to file under the consolidated cost reporting method. See section 4008.2 for further instructions.

Line 17--This line is used by hospital-based community mental health centers (CMHCs). Subscript this line as necessary to accommodate multiple CMHCs. (See Exhibit 2, Table 4, Part III)

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

Line 19--For any component type not identified on lines 3 through 19, enter the required information in the appropriate column. This includes, but is not limited to comprehensive outpatient rehabilitation facilities (CORFs), outpatient physical therapy (OPT) providers , outpatient occupation therapy (OOT) providers, and/or outpatient speech pathology (OSP) clinics.

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

Line 21--Indicate the type of control or auspices under which the hospital is conducted as indicated:

1 = Voluntary Nonprofit, Church	8 = Governmental, City-County
2 = Voluntary Nonprofit, Other	9 = Governmental, County
3 = Proprietary, Individual	10 = Governmental, State
4 = Proprietary, Corporation	11 = Governmental, Hospital District

5 = Proprietary, Partnership
6 = Proprietary, Other
7 = Governmental, Federal
12 = Governmental, City
13 = Governmental, Other

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

Line 23--Indicate in column 1 the method used to capture Medicaid (title XIX) days reported on Worksheet S-3, Part I, line 32, column 7 during the cost reporting period by entering a "1" if days are based on the date of admission, "2" if days are based on census days (also referred to as the day count), or "3" if the days are based on the date of discharge. Is the method of identifying the days in the current cost reporting period different from the method used in the prior cost reporting period? Enter in column 2 "Y" for yes or "N" for no.

Line 24--If the response to line 22 is "yes", and this provider is an IPPS, enter the in-state Medicaid paid days in column 1, the in state Medicaid eligible days in column 2, the out of state Medicaid paid days in column 3, the out of state Medicaid eligible days in column 4, Medicaid HMO days in column 5, and other Medicaid days in column 6.

Line 25--If the response to line 22 is "yes", and this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in state Medicaid eligible days in column 2, the out of state Medicaid paid days in column 3, the out of state Medicaid eligible days in column 4, Medicaid HMO days in column 5, and other Medicaid days in column 6.

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.

Lines 28 - 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. Enter the beginning and ending dates of SCH status on line 36. Subscript line 36 if more than 1 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 1/1/2010-6/30/2010 and 9/1/2010-12/31/2010.

Line 37--If this is a Medicare dependent hospital (MDH), enter the number of periods within this cost reporting period that MDH status was in effect. Enter the beginning and ending dates of MDH status on line 38. Subscript line 38 if more than 1 period is identified for this cost reporting period and enter multiple dates.

Line 39--Does your facility qualify for additional prospective payment in accordance with 42 CFR 412.107. Enter "Y" for yes or "N" for no.

Lines 40 - 44--Reserved for future use.

Line 45--Does your facility qualify and receive capital payments for disproportionate share in

accordance with 42 CFR 412.320? Enter "Y" for yes and "N" for no. If you are eligible as a result of the Pickle amendment, enter "P" instead of "Y." Only new providers certified prior to October 1, 2001 shall complete this line.

Line 46--Are you eligible for the special exception payment pursuant to 42 CFR 412.348(g)? Enter "Y" for yes or "N" for. If yes, complete Worksheets L, Part III and L-1.

Line 47--Is this a new hospital under 42 CFR 412.300 (PPS capital)? Enter "Y" for yes or "N" for no in column 1. If yes, do you elect full federal capital payments. Enter "Y" for yes or "N" for no in column 2.

Lines 48 - 54--Reserved for future use.

NOTE: CAHs complete question 107 in lieu of questions 55, 56, and 57.

Line 55--Is this a teaching hospital? Enter "Y" for yes or "N" for no.

Line 56--Is this a teaching program approved in accordance with CMS Pub. 15-1, chapter 4? Enter "Y" for yes or "N" for no.

Line 57--If line 56 is yes and this is the first cost reporting period in which you are training residents in approved programs and the residents were on duty during the first month of the cost reporting period? Enter "Y" for yes and complete Worksheet E-4 or "N" for no and complete Worksheets D, Parts III and IV and D-2, Part II, if applicable.

Line 58--As a teaching hospital, did you elect cost reimbursement for teaching physicians as defined in CMS Pub. 15-1, §2148? Enter "Y" for yes or "N" for no. If yes, complete Worksheet D-5.

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

Line 60--Has your facility's direct GME FTE cap (column 1), or IME FTE cap (column 2), been reduced under 42 CFR 413.79(c)(3) or 42 CFR 412.105(f)(1)(iv)(B)? Enter "Y" for yes or "N" for no in the applicable column. (Impacts Worksheet E, Part A; and E-4.)

Line 61--Has your facility received additional direct GME (column 1) resident cap slots or IME (column 2) resident cap slots under 42 CFR 413.79(c)(4) or 42 CFR 412.105(f)(1)(iv)(C)? Enter "Y" for yes or "N" for no in the applicable column. (Impacts Worksheet E-4.)

Line 62--Are you claiming nursing school and allied health costs for a program that meets the provider-operated criteria under 42 CFR 413.85? Enter "Y" for yes or "N" for no. If yes, you must identify such costs in the applicable column(s) of Worksheet D, Parts III and IV to separately identify nursing and allied health (paramedical education) from all other medical education costs.

Lines 63 - 69--Reserved for future use.

Line 70--Are you an IPF or do you contain an IPF subprovider? Enter in column 1 "Y" for yes

or “N” for no.

Line 71--If this facility is an IPF or contains an IPF subprovider (response to line 70, column 1 is “Y” for yes), were residents training in this facility **in the most recent cost report filed on or before November 15, 2004?** Enter in column 1 “Y” for yes or “N” for no. Is the facility training residents in new teaching programs in accordance with §412.424(d)(1)(iii)(D)? Enter in column 2 “Y” for yes or “N” for no. (Note: questions 1 and 2 must have opposite answers, i.e., if column 1 is “Y”, then column 2 must be “N” and vice versa; columns 1 and 2 cannot be “Y” simultaneously, columns 1
and 2 can be “N” simultaneously.) If yes, enter a “1”, “2”, or “3”, respectively, in column 3 to correspond to the I&R academic year in the first 3 program years of the first new program’s existence that begins during the current cost reporting period. If the current cost reporting period

covers the beginning of the fourth academic year of the first new teaching program’s existence, enter the number “4” in column 3. If the current cost reporting period covers the beginning of the fifth or subsequent academic years of the first new teaching program’s existence, enter the number “5” in column 3.

Lines 72 - 74--Reserved for future use.

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

Line 76--If this facility is an IRF or contains an IRF subprovider (response to line 75, column 1 is “Y” for yes), did the facility train residents in teaching programs **in the most recent cost reporting period ending on or before November 15, 2004?** Enter in column 1 “Y” for yes or “N” for no. Is the facility training residents in new teaching programs in accordance with FR, Vol. 70, No. 156, page 47929 dated August 15, 2005? Enter in column 2 “Y” for yes or “N” for no. (Note: questions 1 and 2 must have opposite answers, i.e., if column 1 is “Y”, then column 2 must be “N” and vice versa; columns 1 and 2 cannot be “Y” simultaneously, columns 1 and 2 can be “N” simultaneously.) If yes, enter a “1”, “2”, or “3”, respectively, in column 3 to correspond to the I&R academic year in the first 3 program years of the first new program’s existence that begins during the current cost reporting period. If the current cost reporting period covers the beginning of the fourth academic year of the first new teaching program’s existence, enter the number “4” in column 3. If the current cost reporting period covers the beginning of the fifth or subsequent academic years of the first new teaching program’s existence, enter the number “5” in column 3.

Lines 77 - 79--Reserved for future use.

Line 80--Are you a Long Term Care Hospital (LTCH)? Enter in column 1 “Y” for yes and “N” for no. LTCHs can only exist as independent /freestanding facilities.

Lines 81-84--Reserved for future use.

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

Line 86--Have you established a new “Other” subprovider (excluded unit) under 42 CFR 413.40 (f)(1)(i)? Enter “Y” for yes or "N" for no in column 1. If there is more than one subprovider, subscript this line.

Line 87 - 89--Reserved for future use.

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

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

Line 92--If all of the nursing facility beds are certified for title XIX, and there are also title XVIII certified beds (dual certified), are any of the title XVIII beds occupied by title XIX patients? Enter “Y” for yes or “N” for no. You must complete a separate Worksheet D-1 for title XIX for each level of care.

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

Line 94--Does title XIX reduce capital costs? Enter “Y” for yes or “N” for no in column 2.

Line 95--If line 94 is “Y” for yes, enter the percentage by which capital costs are reduced.

Line 96--Does title XIX reduce operating costs? Enter “Y” for yes or “N” for no in column 2.

Line 97--If line 96 is “Y” for yes, enter the percentage by which operating costs are reduced.

Lines 98 - 104--Reserved for future use.

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

Line 106--If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? Enter “Y” for yes or “N” for no. If yes, an adjustment for the professional component is still required on Worksheet A-8-2.

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

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

If this facility qualifies as a CAH, do I&R in approved medical education programs train in the CAH’s excluded IPF and/or IRF unit? Enter a “Y” for yes or an “N” for no in column 2. If yes, complete Worksheet E-4. CAHs are reimbursed for GME in subproviders on worksheet E-4; and are reimbursed for GME in the rest of the CAH at 101 percent of reasonable cost. The CAH must maintain adequate documentation to support the FTE count and time spent for the excluded IPF and/or IRF units.

Line 108--Is this a rural hospital qualifying for an exception to the certified registered nurse anesthetist (CRNA) fee schedule? (See CFR 412.113(c).) Enter “Y” for yes in column 1.

Otherwise,
enter "N" for no.

Line 109--If this hospital qualifies as a critical access hospital (CAH) (response to line 105 is yes) or is a cost reimbursed provider, are therapy services provided by outside suppliers? Enter "Y" for yes or "N" for no under the corresponding physical, occupational, speech and/or respiratory therapy services as applicable in columns 1 through 4.

Lines 110 - 114--Reserved for future use.

Line 115--If this is an all inclusive rate provider (see instructions in CMS Pub. 15-1, §2208), enter the applicable method (A, B, or E only) in column 2.

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

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

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

Line 119--What is the liability limit for the malpractice insurance policy? Enter in column 1 the monetary limit per lawsuit or enter in column 2 the monetary limit per policy year. A liability limit refers to the maximum sum of money an insurance company will pay per lawsuit and per policy year. For example, a standard liability limit for physician professional liability is $1 million in damages per lawsuit and a total of $3 million for all lawsuits during the policy year (often referred to as $1 million/$3 million).

Line 120--If this is an SCH (or EACH) that qualifies for the outpatient hold harmless provision in PPACA, section 3121, enter "Y" for yes or "N" for no in column 1. If this is rural hospital with 100 or fewer beds that qualifies for the outpatient hold harmless provision in PPACA, section 3121, enter "Y" for yes or "N" for no in column 2. This response impacts the TOPs calculation on Worksheet E. Part B, line 8.

Lines 121 - 124--Reserved for future use.

Line 125--Does your facility operate a transplant center? Enter "Y" for yes or "N" for no in column 1. If yes, enter the certification dates below.

Line 126--If this is a Medicare certified kidney transplant center, enter the certification date in column 2 and termination date in column 3. Also complete Worksheet D-4.

Line 127--If this is a Medicare certified heart transplant center, enter the certification date in column 2 and termination date in column 3. Also complete Worksheet D-4.

Line 128--If this is a Medicare certified liver transplant center, enter the certification date in

column 2 and termination date in column 3. Also complete Worksheet D-4.

Line 129--If this is a Medicare certified lung transplant center, enter the certification date in column 2 and termination date in column 3. Also, complete Worksheet D-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 dates for kidney transplants and termination date in column 3. Also, complete Worksheet D-4.

Line 131--If this is a Medicare certified intestinal transplant center enter the certification date in column 2 and termination date in column 3. Also, complete Worksheet D-4.

Line 132--If this is a Medicare certified islet transplant center enter the certification date in column 2 and termination date in column 3. 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 2 and termination date in column 3. Subscript this line as applicable and complete a separate Worksheet D-4 for each Medicare certified transplant center type.

Line 134--If this is an organ procurement organization (OPO), enter the OPO number in column 1 Medicare certified transplant center. Enter the certification date in column 2 and termination date in column 3.

Lines 135 - 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 enter the chain name, home office number, FI/contractor number, street address, post office box (if applicable), the city, state, zip code of the home office on lines 141 through 143. Also, enter on line 141, column 2, the FI/contractor name, who receives the Home Office Cost Statement and in column 3, the FI/contractor number. See CMS Pub. 15-1, §2150 for a definition of a chain organization.

Line 141--Enter the name of the Home Office.

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 you are claiming costs for renal services on Worksheet A, are they inpatient services only? Enter "Y" for yes or "N" for no. If yes, do not complete Worksheet S-5 and the Worksheet I series.

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 - 154--Reserved for future use.

Lines 155 - 161--If you are a provider (public or non public) that qualifies for an exemption from the application of the lower of cost or charges as provided in 42 CFR 413.13, indicate the component and/or services 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.

Lines 162 - 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.

Line 166--If you responded "Y" to question 161, 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, CBSA in column 4, and the FTE count for this campus in column 5. If additional campuses exist, subscript this line as necessary.

Line 167--Is this hospital/campus a meaningful user of electronic health record (EHR) technology in accordance section 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.

Line 168--If this provider is a CAH (line 105 is yes) and is also a meaningful EHR technology user (line 167 is yes) in accordance with ARRA 2009, section 4102, enter the applicable adjustment amount for previously acquired HIT assets to the extent that such assets have not been fully depreciated (acquisition cost prior to October 1, 2010, less accumulated depreciation of such assets) as of this cost reporting period; and the applicable adjustment amount where certified HIT assets were fully expensed for Medicare purposes under ARRA, section 4102 enter 100 percent of the acquisition cost where only the current year's HIT depreciation expense is reflected on the provider's books and records.

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

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

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

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

Line Descriptions

Lines 1 through 20 are required to be completed by all hospitals.

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

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

Line 3--Indicate whether the hospital is involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", submit a list of the individuals, the organizations involved, and a description of the transactions with the cost report.

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

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

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

Line 5--Indicate whether the total expenses and total revenues reported on the cost report differ from those on the filed financial statements. Enter "Y" for yes or "N" for no in column 1. If you answer "Y" in column 1, submit a reconciliation with the cost report.

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

Line 7--Indicate whether costs were claimed for Allied Health Programs. Enter "Y" for yes or "N" for no in column 1. If you answer "Y" in column 1, submit a list of the program(s) with the cost report and annotate for each whether the provider is the legal operator of the program.

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

Line 8--Indicate whether approvals and/or renewals were obtained during the cost reporting period for Nursing School and/or Allied Health programs. Enter "Y" for yes or "N" for no in column 1. If you answer "Y" in column 1, submit a list of the program(s), and copies of the approvals and/or renewals with the cost report.

Line 9--Indicate whether Intern-Resident costs were claimed on the current cost report. Enter "Y" for yes or "N" for no in column 1. If you answer "Y" in column 1, submit the current year Intern-Resident Information System (IRIS) on diskette with the cost report.

Line 10--Indicate whether Intern-Resident program(s) have been initiated or renewed during the cost reporting period. Enter "Y" for yes or "N" for no in column 1. If you answer "Y" in column 1, submit copies of the certification(s)/program approval(s) with the cost report. (See 42 CFR §413.79(l) for the definition of a new program.)

Line 11--Indicate whether 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 PRM-1, §§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 5 or internal schedules duplicating the documentation requested on Exhibit 5 to support the bad debts claimed. If you are claiming bad debts for inpatient and outpatient services, complete a separate Exhibit 5 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 PRM-1, §314 and 42 CFR §413.89.)

Column 4--Indigency/Welfare Recipient--If the patient included in column 1 has been deemed indigent, place a check in this column. If the patient in column 1 has a valid Medicaid number, also include this number in this column. See the criteria in PRM-I, §§312 and 322 and 42 CFR §413.89 for guidance on the billing requirements for indigent and welfare recipients.

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 PRM-1, §§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 12--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 13--Indicate whether patient deductibles and/or copayments 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 5 or your internal schedules) submitted with the cost report.

Line 14--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 PRM-1, §2200.2.C., PRM-2, §4005.1, and CFR §412.105(b).)

Line 15--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 16--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 17--If you entered "Y" on either line 15 or 16, 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 18--If you entered "Y" on either line 15 or 16, 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 19--If you entered "Y" on either line 15 or 16, 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 20--Indicate whether the cost report was prepared using provider records only. Enter "Y" for yes or "N" for no in columns 1 and 3. If either column 1 or 3 is "Y", submit detailed documentation of the system used to support the data reported on the cost report. If detail documentation was previously supplied, submit only necessary updated documentation with the cost report.

The minimum requirements are:

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

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

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

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

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

Lines 21 through 22 are required to be completed by cost-reimbursed and TEFRA hospitals only.

Line 21--Indicate whether assets have been relifed for Medicare purposes. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", submit a detailed listing of these specific assets, by class, as shown in the Fixed Asset Register with the cost report.

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

Line 22--Indicate whether changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", submit a copy of the Appraisal Report and Appraisal Summary by class of asset with the cost report.

Line 23--Indicate whether new leases and/or amendments to existing leases were entered into during the cost reporting period. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", submit a listing of the new leases and/or amendments to existing leases if the annual rental cost of each of these leases is $50,000 or greater with the cost report. The listing should include the following information:

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

Note: Providers are required to submit copies of the lease, or significant extracts, upon request from the contractor.

Line 24--Indicate whether new capitalized leases were entered into during the cost reporting period. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", submit a list of the individual assets by class, the department assigned to, and respective dollar amounts if the annual rental cost of these leases is $50,000 or greater with the cost report.

Line 25--Indicate whether assets subject to §2314 of DEFRA were acquired during the cost reporting period. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", submit a computation of the basis with the cost report.

Line 26--Indicate whether your capitalization policy changed during the cost reporting period. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", submit a copy with the cost report.

Line 27--Indicate whether new loans, mortgage agreements, or letters of credit were entered into during the cost reporting period. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", submit copies of the debt documents and amortization schedules with the cost report. Also, state the purpose of the borrowing.

Line 28--Indicate whether you have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", submit a detailed analysis of the funded depreciation account for the cost reporting period with the cost report. (See PRM-1, §226 and 42 CFR §413.153.)

Line 29--Indicate whether existing debt has been replaced prior to its scheduled maturity with new debt. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", submit a copy of the new debt document and a schedule calculating the allowable cost. (See PRM-I, §233.3 for description of allowable cost.)

Line 30--Indicate whether debt has been recalled before its scheduled maturity without the issuance of new debt. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", submit a detailed analysis supporting the debt cancellation costs and treatment of these expenses on the cost report. (See PRM-1, §215 for description and treatment of debt cancellation costs.)

Line 31--Indicate whether you have entered into new agreements or if changes occurred in patient care services furnished through contractual arrangements with suppliers of service. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", submit copies of the contracts in those instances where the cost of the individual's services exceeds $25,000 per year with the cost report.

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

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

Line 32--If you answered "Y" on line 31, were the requirements of PRM-1, §2135.2 pertaining to competitive bidding applied? Enter "Y" for yes or "N" for no in column 1. If column 1 is "N", submit an explanation with the cost report.

Line 33--Indicate whether Graduate Medical Education costs were directly assigned to cost centers other than the Intern-Resident Services in an Approved Teaching Program on Worksheet A of form CMS-2552-10. Enter "Y" for yes or "N" for no in column 1. If you answer "Y" in column 1, submit a listing of the cost centers and amounts with the cost report.

Line 34--Indicate whether services are furnished at your facility under an arrangement with provider-based physicians. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", submit Exhibit 1, where applicable.

You may submit computer generated substitutes for these schedules provided they contain, at a minimum, the same information as in Exhibit 1. (This includes the signature on a substitute Exhibit 2.)

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

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

Instructions for completing Exhibit 1:

Exhibit 1, Allocation of Physician Compensation Hours:

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

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

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

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

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

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

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

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

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

EXHIBIT 1

Allocation of Physician Compensation: Hours

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)	_____

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_____ _____

Signature: Physician or Physician Department Head Date

EXHIBIT 2
LISTING OF MEDICARE BAD DEBTS AND APPROPRIATE SUPPORTING DATA

PROVIDER _____ PREPARED BY _____

NUMBER _____ DATE PREPARED _____
FYE _____ INPATIENT _____ OUTPATIENT _____

(1) Patient Name	(2) HIC. NO.	(3) DATES OF SERVICE		(4) INDIGENCY & WEL. RECIP. (CK IF APPL)		(5) DATE FIRST BILL SENT TO BENEFICIARY	(6) DATE COLLECTION EFFORTS CEASED	(7) 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/WELFARE RECIPIENT, FOR POSSIBLE EXCEPTION

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Pages 50 through 56 are reserved for future use.

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

This worksheet consists of three parts:

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

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

Column Descriptions

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

Column 2--Refer to 42 CFR 412.105(b) and Vol. 69 of the Federal Register 154, dated August 11, 2004, page 49093 to determine the facility bed count. Indicate the number of beds available for use by patients at the end of the cost reporting period. A bed means an adult bed, pediatric bed, birthing room, or newborn ICU bed (excluding newborn bassinets) maintained in a patient care area for lodging patients in acute, long term, or domiciliary areas of the hospital. Beds in labor room, birthing room, postanesthesia, postoperative recovery rooms, outpatient areas, emergency rooms, ancillary departments, nurses' and other staff residences, and other such areas which are regularly maintained and utilized for only a portion of the stay of patients (primarily for special procedures or not for inpatient lodging) are not termed a bed for these purposes. (See CMS Pub. 15-1, §§2200.2 C and 2205.)

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

Column 4--CAHs accumulate the aggregate number of hours all CAH patients spend in each category on lines 1 and 6 through 10. This data is for informational purposes only.

Columns 5 through 7--Enter the number of inpatient days or visits, where applicable, for each component by program. Do not include HMO days except where required (line 2, columns 6 and 7), organ acquisition, or observation bed days in these columns. Observation bed days are reported in column 8, line 26. For LTCH, enter in column 6 on the applicable line the number of covered Medicare days (from the PS&R) and enter in column 6, line 31 the number of noncovered days (from provider’s books and records) for Medicare patients.

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

NOTE: Section 1886(d)(5)(F) of the Act provides for an additional Medicare payment for hospitals serving a disproportionate share of low income patients. A hospital's eligibility for these additional payments is partially based on its Medicaid utilization. The count of Medicaid days used in the Medicare disproportionate share adjustment computation

includes days for Medicaid recipients who are members of an HMO as well as out of State days, Medicaid secondary payer patient days, Medicaid eligible days for which no payment was received, and baby days after mother's discharge. Medicaid HMO days are reported on line 2 in accordance with CFR 412.106(b)(4)(ii). Therefore, Medicaid patient days reported on line 1, column 7 do not include days for Medicaid patients who are also members of an HMO.

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

Column 9--Enter the number of intern and resident full time equivalents (FTEs) in an approved program determined in accordance with 42 CFR 412.105(f) for the indirect medical education adjustment. The FTE residents reported by an IPF PPS facility or an IRF PPS facility (whether freestanding or a unit reported on line 14 or 15, respectively, of an IPPS hospital's cost report) shall be determined in accordance with 42 CFR 412.424(d)(1)(iii) for IPFs and in accordance with the Federal Register, Vol. 70, number 156, dated August 15, 2005, pages 47929-30 for IRFs.

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

Columns 12 through 14--Enter the number of discharges including deaths (excluding newborn and DOAs) for each component by program. A patient discharge, including death, is a formal release of a patient. (See 42 CFR 412.4.)

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

Line Descriptions

Line 1--In columns 5, 6, 7 and 8, enter the number of adult and pediatric hospital days excluding the SNF and NF swing bed, observation bed, and hospice days. In columns 6 and 7 also exclude HMO days. **Do not include in column 6 Medicare Secondary Payer/Lesser of Reasonable Cost (MSP/LCC) days**. Include these days only in column 8. However, do not include employee discount days in column 8.

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

Line 2--Enter title XVIII M+C and XIX HMO days (columns 6 and 7) and other Medicaid eligible days not included on line 1, columns 6 and 7, respectively.

Line 3--Enter title XVIII M+C and XIX HMO days (columns 6 and 7) for IPF subproviders days not included on line 1, columns 6 and 7, respectively.

Line 4--Enter title XVIII M+C and XIX HMO days (columns 6 and 7) for IRF subproviders days not included on line 1, columns 6 and 7, respectively.

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

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

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

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

Line 14--Enter the sum of lines 7 - 13 for columns 2 - 8, and for columns 12 - 15, enter the amount from line 1. For columns 13 - 15, enter the total for each from your records.

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

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

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

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

Line 18--Enter the applicable data for other than IPF or IRF subproviders. If you have more than one subprovider, subscript this line.

Line 19--If your State recognizes one level of care, complete this line for titles V, XVIII, and XIX, however, do not complete line 18. If you answered yes to line 93 of Worksheet S-2, complete all columns.

Line 20--Enter nursing facility days if you have a separately certified nursing facility for Title XIX or you answered yes to line 93 of Worksheet S-2. Make no entry if your State recognizes only SNF level of care. If you operate an ICF/MR, subscript this line to 20.01 and enter the ICF/MR days. Do not report any nursing facility data on line 20.01.

Line 21--If you have more than one hospital-based other long term care facility, subscript this line.

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

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

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

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

Line 26--Enter the number of outpatient visits for FQHC and RHC. If you have both or multiples of one, subscript the line.

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

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

Line 30--Enter in column 8 the employee discount days if applicable. These days are used on Worksheet E, Part A, line 28 in the calculation of the DSH adjustment and Worksheet E-3, Part III, line 3 in the calculation of the LIP adjustment.

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

Line 32--Indicate in column 7 the count of labor/delivery days for Title XIX and in column 8 the total count of labor/delivery days for the entire facility.

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 PRM-1, section 2205.2). In the case where the maternity patient is in a single multipurpose labor, delivery and postpartum (LDP) 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 (post partum) 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. 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 lines 16 through 18.

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 prospective payment system. 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 this worksheet for IPPS hospitals (see §1886(d)), any hospital with an IPPS subprovider, or any hospital that would be subject to IPPS if not granted a waiver.

NOTE: Any line reference for Worksheets A and A-6 includes all subscripts of that line.

Column 1

Line 1--Enter from Worksheet A, column 1, line 200, the wages and salaries paid to hospital employees increased by amounts paid for vacation, holiday, sick, other paid-time-off (PTO), severance, and bonus pay if not reported in column 1.

NOTE: Bonus pay includes award pay and vacation, holiday, and sick pay conversion (pay in lieu of time off).

NOTE: Capital related salaries, hours, and wage-related costs associated with lines 1 and 2 of Worksheet A must not be included on Worksheet S-3, Parts II and III.

NOTE: Methodology for including vacation/sick/other PTO accruals in the wage index:

PTO salary cost--The required source for costs on Worksheet A is the General Ledger (see Provider Reimbursement Manual, Part II, section 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). Hospitals and FIs/MACs are to include on Worksheet S-3, Part II the current year PTO cost incurred as reflected on the General Ledger; that is, both the current year PTO cost paid and the current year PTO accrual. (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.)

PTO hours--The source for PTO paid hours on Worksheet S-3, Part II is the Payroll Report. Hours are included on the Payroll Report in the period in which the associated PTO expense is paid. Hospitals and FIs/MACs are to include on Worksheet S-3, Part II the PTO hours that are reflected on the current year Payroll Report, which includes hours associated with PTO cost that was expensed in the prior year but paid in the current year. The time period must cover the weeks that best matches the provider's cost reporting period. (Hours associated with PTO cost expensed in the current year but not paid until the subsequent year (current year PTO 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 PTO cost and paid PTO hours for a given year, it should approximate an actual match between cost and hours. Over time, any variances should be minimum.

Lines 2 through 10--The amounts to be 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 7 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 salaries (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 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 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.

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

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

Line 4--Enter the physician Part A 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.

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 and Federally qualified health clinics included on Worksheet A, column 1, line 93. Report on line 6 the non-physician salaries reported for Hospital-based RHC and FQHC services included on Worksheet A, column 1, line 93.

Line 7--Enter from Worksheet A the salaries reported in column 1 of line 21 for interns and residents. Add to this amount the costs for intern and resident services furnished under contract. 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, §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 Line 10.

Line 11--Enter the amount paid for services furnished under contract, rather than by employees, for direct patient care, and top level management services as defined below. DO NOT include cost for equipment, supplies, travel expenses, and other miscellaneous or overhead items (non-labor costs). 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 respectively). Include on this line contract pharmacy and laboratory wage costs as defined below.

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 are 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 or Medicare administrative contractor. A hospital's failure to provide adequate supporting documentation may result in the cost being disallowed for the wage index.

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. Eliminate all supplies, travel expenses, and other miscellaneous items. 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.

Include the amount paid for **top level management services**, as defined below, furnished under contract rather than by employees. Report only those personnel costs associated with the contract. Eliminate all supplies, travel expenses, and other miscellaneous items. 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: other management or administrative services (to be included on lines 12 or 28; see instructions), 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 direct patient care, pharmacy and laboratory contracts, submit to your Medicare contractor the types of services, wages, and associated hours; for top level management contracts, submit the aggregate wages and hours.

If you have no contracts for direct patient care or management services as defined above, enter a zero in column 1. If you are unable to accurately determine the number of hours associated with contracted labor, enter a zero in column 1.

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. DO NOT include costs for equipment, supplies, travel expenses, or other miscellaneous items. Per instructions on Worksheet S-2, Part II, submit to your contractor the following for direct patient care pharmacy contracts: the types of services, wages, and associated hours.

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. DO NOT include costs for equipment, supplies, travel expenses, or other miscellaneous items. Per instructions on Worksheet S-2, Part II, submit to your contractor the following for direct patient care laboratory contracts: the types of services, wages, and associated hours.

Line 12--Enter the amount paid for **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.

Examples of 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 contact. DO NOT include on line 12 any contract labor costs associated with lines 26 through 43 and subscripts for these lines. DO NOT include the costs for contract top level management: chief executive officer, chief operating officer, and nurse administrator; these services are included on line 11. DO NOT include costs for equipment, supplies, travel expenses, or other miscellaneous items.

Line 13--Enter from your records the amount paid under contract (as defined on line 11) for Part A physician services, excluding teaching physician services. Also include Part A teaching physicians under contract on this line. 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). Also, DO NOT include Part A physician contracts for any of the management positions reported on line 11.

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 1. All costs for any related organization 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, excluding teaching physician Part A services from the home office allocation and/or related organizations. Subscript this line and report separately on line 16 the salaries and wage-related costs for Part A teaching physicians from the home office allocation and/or related organizations.

Lines 17 through 25--In general, the amount reported for wage-related costs must meet the “reasonable cost” provisions of Medicare. For example, in developing pension and deferred compensation costs, hospitals must comply with the requirements in 42 CFR 413.100 and the PRM, Part 1, §§ 2140, 2141 and 2142 (see discussion in 73 FR, page 48581, dated August 19, 2008).

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. Hospital are required to complete Worksheet S-3, Part IV, a reconciliation worksheet to aid hospital and intermediaries 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 PRM 15-1, §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 intermediary, the intermediary 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, along with Part A teaching services, and Part B (patient care services) 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. (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:

Hospitals and contractors are not required to remove from domestic claims costs the personnel costs associated with hospital staff who deliver services to employees. Additionally, health related costs, that is, costs for employee physicals and inpatient and outpatient services that are not covered by health insurance but provided to employees at no cost or at a discount, are to be included as a core wage related cost.

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. Include the wage related costs for Part A teaching physicians on line 22. 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, line 93. These wage-related costs are reported separately on line 24.

Lines 26 through 43--Enter the direct wages and salaries from Worksheet A column 1 for the appropriate cost center identified on lines 26 through 43, respectively, increased by the amounts paid for vacation, holiday, sick, and PTO if not reported in column 1 of these lines. 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, 5, 6, 7, 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.

Lines 28, 33, and 35--Enter the amount paid for services performed **under contract**, rather than by employees, for administrative and general, housekeeping, and dietary services, respectively. DO NOT include costs for equipment, supplies, travel expenses, and other miscellaneous or overhead items. Report only personnel costs associated with these contracts. 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 Worksheet S-3, Part II, line 28. Do not include on line 28 the costs for top level management contracts (these costs are reported on line 11).

NOTE: Do not include overhead costs on lines 11 and 12.

Column 3--Enter on each line, as appropriate, the **salary** portion 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 6 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: For workers who are contracted solely for the purpose of providing services on-call, the wages and associated hours must be included on 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, 5, 6, 7, and 8. Add to this amount line: 28, 33, and 35.

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

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

Line 4--From Part II, enter the sum of lines 11, 12, 13, 14, and 15 and subscripts if applicable.

Line 5--From Part II, enter the sum of lines 17, 18, and 22. Enter on this line in column 6 the wage-related cost percentage computed by dividing Part III, column 4, line 5, by Part III, column 4, line 3. Round the result to 2 decimal places.

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

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

4005.4 Part IV--Wage Related Costs.--The hospital must provide the contractor with a complete list of all core wage related costs. This worksheet provides for the identification of such costs.

GAAP is used in reporting wage related costs. In addition, some costs such as payroll taxes, which are reported as a wage related costs on Worksheet S-3, Part IV, are not considered fringe benefits.

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

4005.5 Part V--Contract Labor and Benefit Costs.--This section identifies the contract labor costs and benefit costs for the hospital complex and applicable subproviders and units.

Indentify on the applicable line, the component name, CCN, contract labor costs, and benefit costs.

4006. WORKSHEET S-4 - HOSPITAL-BASED HOME HEALTH AGENCY STATISTICAL DATA

In accordance with 42 CFR 413.20(a), 42 CFR 413.24(a), and 42 CFR 413.24(c), you are required to maintain statistical records for proper determination of costs payable under titles V, XVIII, and XIX. The statistics required on this worksheet pertain to a hospital-based home health agency. The data maintained is dependent upon the services provided by the agency, number of program home health aide hours, total agency home health aide hours, program unduplicated census count, and total unduplicated census count. In addition, FTE data are required by employee staff, contracted staff, and total. Complete a separate S-4 for each hospital-based home health agency.

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

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

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

Enter the number of hours in your normal work week.

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

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

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

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

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

Line 20--Identify each CBSA where the reported HHA visits are performed by entering the 5 digit CBSA code and Non-CBSA (rural) code as applicable. Subscript the lines to accommodate the number of CBSAs you service. Rural CBSA codes are assembled by placing the digits "999" in front of the two digit State code, e.g., for the state of Maryland the rural CBSA code is 99921.

PPS Activity Data--Applicable for Medicare Services.

In accordance with 42 CFR §413.20 and §1895 of the Social Security Act, home health agencies transitioned from a cost based reimbursement system to a prospective payment system (PPS) effective for home health services rendered on or after October 1, 2000.

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

HHA Visits--See PRM-2, chapter 32, §3205, page 32-13 for the definition of an HHA visit.

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

Less than a full Episode of Care--When 4 or fewer visits are provided by the HHA in a 60 day episode period, the result is a low utilization payment adjustment (LUPA). In this instance the HHA will be reimbursed based on a standardized per visit payment.

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

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

When an episode of care is initiated in one fiscal year and concludes in the subsequent fiscal year, all statistical data (i.e., cost, charges, counts, etc…) associated with that episode of care will appear on the PS&R of the fiscal year in which the episode of care is concluded. Similarly, all data required in the cost report for a given fiscal year must only be associated with services rendered during episodes of care that conclude during the fiscal year. Title XVIII visits reported on this worksheet will not agree with the title XVIII visits reported on Worksheet H-3, sum of columns 6 and 7, line 14.

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

This is true for all episode of care payment categories in columns 1 through 4.

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

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

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

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

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

NOTE: Lines 36 and 37 are mutually exclusive.

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

Column 7--Enter on lines 21 through 37, respectively, the sum total of amounts from columns 1 through 4.

4007. WORKSHEET S-5 - HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA

In accordance with 42 CFR 413.20(a), 42 CFR 413.24(a), and 42 CFR 413.24(c), you are required to maintain statistical records for proper determination of costs payable under the Medicare program. The statistics reported on this worksheet pertain to the renal dialysis department. The data maintained, depending on the services provided by the hospital, includes patient data, the number of treatments, number of stations, and home program data.

If you have more than one renal dialysis department, submit one Worksheet S-5 combining all of the renal dialysis departments' data. You must also have on file (as supporting documentation), a Worksheet S-5 for each renal dialysis department and the appropriate workpapers. File this documentation with exception requests in accordance with CMS Pub. 15-1, §2720. Enter on the combined Worksheet S-5 each renal dialysis provider's satellite number if you are separately certified as a satellite facility.

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

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

Line 13--Enter the direct product cost net of discount and rebates for Epoetin (EPO). Include all EPO cost for patients receiving outpatient, home (method I or II), or training dialysis treatments. This amount includes EPO cost furnished in the renal department or any other department if furnished to an end stage renal disease dialysis patient. Report on this line the amount of EPO cost included in line 74 of Worksheet A.

Line 14--Based on the instructions contained on line 13, enter the amount of Epoetin included on line 94 (home dialysis program) from Worksheet A.

Line 15--Enter the number of EPO units furnished relating to the renal dialysis department.

Line 16--Enter the number of EPO units furnished relating to the home dialysis program.

Line 17--Enter the direct product cost net of discount and rebates for Darbepoetin Alfa (Aranesp) Include all Aranesp cost for patients receiving outpatient, home (method I or II), or training dialysis treatments. This amount includes Aranesp cost furnished in the renal department or any other department if furnished to an end stage renal disease dialysis patient. Report on this line the amount of Aranesp cost included in line 74 of Worksheet A.

Line 18--Based on the instructions contained on line 17, enter the dollar amount of Aranesp included on line 94 (home dialysis program) from Worksheet A.

Line 19--Enter the number of micrograms (mcgrs) of Aranesp furnished relating to the renal dialysis department.

Line 20--Enter the number of micrograms of Aranesp furnished relating to the home dialysis program.

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

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

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

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

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

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

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

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

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

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

4009. WORKSHEET S-7 - PROSPECTIVE PAYMENT FOR SKILLED NURSING FACILITIES

In accordance with 42 CFR 413.60(a), 42 CFR 413.24(a), and 42 CFR 413.40(c), you are required to maintain statistical records for proper determination of costs payable under the Medicare program. Public Law 105-33 (Balanced Budget Act of 1997) requires that all SNFs be reimbursed under PPS for cost reporting periods beginning on and after July 1, 1998.

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

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

Column Descriptions for Lines 3 Through 57

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

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

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

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

Line 58--Enter in column 1, the CBSA code in effect at the beginning of the cost reporting period. Enter in column 2, the CBSA code in effect on or after October 1 of the current cost reporting period, if applicable.

Lines 59 through 64--A notice published in the August 4, 2003, **Federal Register**, Vol. 68, No. 149 provided for an increase in RUG payments to hospital based SNFs for payments on or after October 1, 2003. Congress expects this increase to be used for direct patient care and related expenses. Lines 59 through 64 are idetnified as following: 59 - Staffing, 60 - Recruitment, 61 - Retention of Employees, 62 - Training, and 63 - Other. Enter in column 1 the direct patient care expenses and related expenses in accordance with the above referenced Federal Register citation. Enter in column 2 the ratio, expressed as a percentage, of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. For each line, indicate in column 3 whether the increased RUG payments received reflects increases associated with direct patient care and related expenses by responding "Y" for yes. Indicate "N" for no if there was no increase in spending in any of these areas. If the increased spending is in an area not previously identified in areas one through four, identify on the "Other (Specify)" line(s), the cost center(s) description and the corresponding information as indicated above.