

SUPPLEMENTAL TO FORM CMS-2552-10

THIS REPORT IS REQUIRED BY LAW (42 USC 1395g; 42 CFR 413.20(b)). FAILURE TO REPORT CAN RESULT IN ALL INTERIM PAYMENTS MADE SINCE THE BEGINNING OF THE COST REPORTING PERIOD BEING DEEMED OVERPAYMENTS (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-XXXX
EXPIRES XX-XX-XXXX

| | | |
|---|----------------------------|-------------------------------------|
| PAYMENT ADJUSTMENT FOR ESTABLISHING AND MAINTAINING ACCESS TO A BUFFER STOCK OF ESSENTIAL MEDICINES | PROVIDER CCN: _____ | PERIOD: FROM: _____ TO: _____ |
|---|----------------------------|-------------------------------------|

PART I - ESSENTIAL MEDICINES PAYMENT ADJUSTMENT ELIGIBILITY

| | | | |
|---|--|--|---|
| 1 | NUMBER OF BEDS | | 1 |
| 2 | IS THIS AN INDEPENDENT HOSPITAL? | | 2 |
| 3 | DID THE HOSPITAL INCUR COST IN ORDER TO ESTABLISH AND MAINTAIN ACCESS TO A BUFFER SUPPLY OF ESSENTIAL MEDICINES? | | 3 |

PART II - ADDITIONAL RESOURCE COST OF ESSENTIAL MEDICINES

| | | | |
|---|--|--|---|
| 1 | COST TO ESTABLISH AND MAINTAIN BUFFER STOCK OF ESSENTIAL MEDICINES - DIRECTLY INCURRED | | 1 |
| 2 | COST TO ESTABLISH AND MAINTAIN BUFFER STOCK OF ESSENTIAL MEDICINES - CONTRACT | | 2 |
| 3 | TOTAL COST TO ESTABLISH AND MAINTAIN BUFFER STOCK OF ESSENTIAL MEDICINES | | 3 |

PART III - CALCULATION OF MEDICARE PAYMENT ADJUSTMENT FOR ESSENTIAL MEDICINES

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|---|---|--|---|
| 1 | MEDICARE ROUTINE/ANCILLARY COST | | 1 |
| 2 | MEDICARE ACQUISITION COST | | 2 |
| 3 | COST OF PHYSICIANS' SERVICES IN A TEACHING HOSPITAL | | 3 |
| 4 | TOTAL MEDICARE REASONABLE COST | | 4 |
| 5 | TOTAL FACILITY COST | | 5 |
| 6 | MEDICARE PERCENTAGE | | 6 |
| 7 | ESSENTIAL MEDICINES PAYMENT ADJUSTMENT | | 7 |

ACCORDING TO THE PAPERWORK REDUCTION ACT OF 1995, NO PERSONS ARE REQUIRED TO RESPOND TO A COLLECTION OF INFORMATION UNLESS IT DISPLAYS A VALID OMB CONTROL NUMBER. THE VALID OMB CONTROL NUMBER FOR THIS INFORMATION COLLECTION IS 0938-XXXX. THE TIME REQUIRED TO COMPLETE THIS INFORMATION COLLECTION IS ESTIMATED TO BE 1.00 HOURS PER RESPONSE, INCLUDING THE TIME TO REVIEW INSTRUCTIONS, SEARCH EXISTING DATA RESOURCES, GATHER THE DATA NEEDED, AND COMPLETE AND REVIEW THE INFORMATION COLLECTION. IF YOU HAVE COMMENTS CONCERNING THE ACCURACY OF THE TIME ESTIMATE(S), OR SUGGESTIONS FOR IMPROVING THIS FORM, PLEASE WRITE TO: CMS, 7500 SECURITY BOULEVARD, ATTN: PRA REPORT CLEARANCE OFFICER, MAIL STOP C4-26-05, BALTIMORE, MARYLAND 21244-1850. PLEASE DO NOT SEND APPLICATIONS, CLAIMS, PAYMENTS, MEDICAL RECORDS, OR ANY DOCUMENTS CONTAINING SENSITIVE INFORMATION TO THE PRA REPORTS CLEARANCE OFFICE. PLEASE NOTE THAT ANY CORRESPONDENCE NOT PERTAINING TO THE INFORMATION COLLECTION BURDEN APPROVED UNDER THE ASSOCIATED OMB CONTROL NUMBER LISTED ON THIS FORM WILL NOT BE REVIEWED, FORWARDED, OR RETAINED. IF YOU HAVE QUESTIONS OR CONCERNS REGARDING WHERE TO SUBMIT YOUR DOCUMENTS, PLEASE CONTACT 1-800-MEDICARE.