

# **New IPPS Regulations & Cost Report Forms (2552-10)**

**Hospital Finance & Reimbursement Workshop**

**Columbia, SC**

**November 15, 2011**

# Disclaimer

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# IPPS New Information & Revisions to Hospital Cost Report Forms

## Objectives:

- Understand new regulations included in the Medicare Inpatient PPS FY 12 Final Rule effective October 1, 2011.
- Develop an understanding of key changes in the new cost report form 2552-10, including Worksheet S-10 and charity care.
- Identify new information that may be required to complete the cost report.
- Understand significant impacts to the cost report preparation process.

# FY 2012 Inpatient PPS Final Rule

# FY 2012 IPPS Final Rule

- Hospital Value-Based Purchasing Program
  - Effective beginning FY 2013
  - Final rule issued April 29, 2011, additional clarifications included in FY 12 IPPS final rule and CY 2012 OPSS proposed rule
  - Initial reductions to base operating DRG rate:
    - FY 13 – 1.00%
    - FY 14 – 1.25%
    - FY 15 – 1.50%
    - FY 16 – 1.75%
    - FY 17 and after – 2.00%
  - Hospitals will initially be scored in two domains
    - Clinical process of care – 12 clinical measures (70% of total score)
    - Patient experience of care – HCAHPS survey (30%)

# FY 2012 IPPS Final Rule

- Hospital Value-Based Purchasing Program (cont.)
  - Hospital performance from 7/1/11-3/31/12 will be compared to performance measured from 7/1/09-3/31/10
  - Hospital will be scored on both achievement compared to others and on improvement compared to its own baseline
  - New domains for FY 2014 per FY 12 IPPS final rule
    - Efficiency domain
      - Based on Medicare Spending Per Beneficiary measure
    - Outcomes domain
      - 13 initial outcome measures
  - Proposed weighting effective FY 2104:
    - Clinical process of care – 20%
    - Outcomes – 30%
    - Patient experience – 30%
    - Efficiency – 20%

# FY 2012 IPPS Final Rule

- Hospital Readmissions Reduction Program
  - Effective beginning FY 2013
  - Certain aspects have been addressed in FY 12 final rule:
    - Three conditions to be used:
      - Acute Myocardial Infarction [AMI] 30-day Risk Standardized Readmission Measure (NQF # 0505)
      - Heart Failure [HF] 30-day Risk Standardized Readmission Measure (NQF # 0330)
      - Pneumonia [PN] 30-day Risk Standardized Readmission Measure (NQF # 0506)

# FY 2012 IPPS Final Rule

- Hospital Readmissions Reduction Program (cont.)

- Defines readmission:

*“...the definition of readmission as occurring when a patient is discharged from the applicable hospital and then is admitted to the same or another acute care hospital within a specified time period from the time of discharge from the index hospitalization.”*

- Will reflect readmissions within 30 days from date of initial discharge
- Provides specific exclusions based on a variety of factors such as patients discharged against medical advice or patients with scheduled readmissions

# FY 2012 IPPS Final Rule

- Changes for reporting of pension costs
  - Included in FY 2012 IPPS final rule
  - Treatment for cost finding is different than for wage survey
  - Treatment for wage survey:
    - “...the pension cost to be included in the wage index equals a hospital’s average cash contributions deposited to its defined benefit pension plan over a 3-year period, or number of years that the hospital has sponsored a defined benefit plan if less than 3 years.”
    - “Any reversion or other withdrawal of assets from the pension fund or trust is treated as a negative contribution for purposes of measuring the 3-year average.”

# FY 2012 IPPS Final Rule

- Changes for reporting of pension costs (cont.)
  - Treatment for wage survey (cont.):
    - “The 3-year average is centered on the base cost reporting period for the wage index. For example, the FY 2013 wage index will be based on Medicare cost reporting periods beginning during FFY 2009 and will reflect the average pension contributions made in hospitals’ cost reporting periods beginning during FFYs 2008, 2009, and 2010.”
    - Hospitals may “determine a “prefunding balance” based on pension contributions made but not reflected in the wage index during certain prior periods.”

# FY 2012 IPPS Final Rule

- Changes for reporting of pension costs (cont.)
  - Treatment for wage survey (cont.):
    - This prefunding balance is “equal to (A) minus (B), where (A) is the sum of cash contributions made during a period of consecutive provider cost reporting periods commencing no earlier than October 1, 2002 (the cost reporting period applicable for the FY 2007 wage index), and ending with the cost reporting period applicable for the FY 2012 wage index, and (B) is the sum of pension costs actually reflected in the wage index for the same cost reporting periods.”
    - “The transition policy permits a hospital to include 1/10th of the prefunding balance in the wage index pension cost each year commencing with the FY 2013 wage index and ending with the FY 2022 wage index, that is, in 10 equal prefunding installments.”

# FY 2012 IPPS Final Rule

- Changes for reporting of pension costs (cont.)
  - Treatment for cost finding:
    - Would be effective for cost report periods beginning on or after 10/1/11
    - Allowable pension costs are based on the amount funded during the cost reporting period, on a cash basis, plus any carry forward amounts, subject to a limitation
    - Carry forward balance = “... any contributions made prior to the effective date of the new policy (on a cash basis) that were not reflected as pension costs in a prior period. The carry forward balance must then be updated annually to reflect any increases (current period contributions in excess of the reportable amount) or decreases (carry forward balances which are recognized as a current period pension cost).”

# FY 2012 IPPS Final Rule

- Changes for reporting of pension costs (cont.)
  - Treatment for cost finding (cont.):
    - Limit = “...150 percent of the average contributions made during the three consecutive reporting periods out of the five most recent reporting periods which produce the highest average.”
    - “... the 150-percent limit will be based on the actual pension plan contributions made by a provider as shown on statements provided by the pension plan trustee or insurance carrier, or as reflected on Schedule B or SB of IRS Form 5500.”

# FY 2012 IPPS Final Rule

- Changes for reporting of pension costs (cont.)
  - Treatment for cost finding (cont.):
    - “The historical contributions used to determine the 150-percent limit would be the actual cash contributions made by the provider to the pension plan, without regard to the 150-percent limit applicable to any prior period.”
    - “...pension contributions up to the 150-percent limit will not be subject to actuarial requirements under ERISA, GAAP or otherwise.”
    - “... a provider with costs in excess of the limit will have the option to submit actuarial data to demonstrate that those costs are reasonable and necessary for the current cost reporting period and should therefore be included as current period pension costs.”

# FY 2012 IPPS Final Rule

- Changes for reporting of pension costs (cont.)
  - Treatment for cost finding (cont.):
    - “We have not yet finalized the specific procedure to be used when requesting approval of excess contributions. Further details will be provided as soon as possible, after publication of this final rule. Each request will be reviewed on a facts and circumstances basis. We are not setting forth specific criteria for determining whether a pension cost is reasonable and necessary for the current reporting period because that may prevent us from responding to circumstances that we may not have anticipated and recognizing costs that are reasonable for the current period. However, examples of when approval will be likely be granted include excess contributions required to satisfy a funding requirement imposed by law or under a collective bargaining agreement, or to avoid ERISA funding restrictions.”

# Key Changes in 2552-10

# Key Changes in 2552-10

## History and Development of 2552-10

- Current cost report forms - 2552-96 - have been effective for hospital cost reporting since FYE 9/30/96
- There have been 24 subsequent transmittals updating the cost report forms for changes in regulations and other requirements
- In July 2009 CMS published a draft of new cost report forms and instructions – 2552-10 – intended to remove obsolete content and update the remaining forms and instructions
- 2552-10 was originally to be implemented for cost report periods beginning on or after 2/1/10

# Key Changes in 2552-10

## History and Development of 2552-10 (cont.)

- Significant issues with the draft forms were identified by the hospital industry during the initial comment period
- CMS published a new draft 2552-10 in April 2010, and extended the implementation to cost report periods beginning on or after 5/1/2010
- Despite previous indications from CMS that the final 2552-10 would be released in the summer of 2010, it was not published until December 30, 2010 (Transmittal 1)

# Key Changes in 2552-10

## Implementation of 2552-10

- 2552-10 is required for all hospital cost reports for years beginning on or after 5/1/10
- CMS was made aware of a significant number of revisions to 2552-10 that would be necessary before 2552-10 could be implemented
- Transmittal 2 issued August 30, 2011 – changes from Transmittal 1 are noted in red in the transmittal
- HFS version of 2552-10 T2 approved by CMS November 2, 2011

# Key Changes in 2552-10

## Implementation of 2552-10 (cont.)

- CMS has officially extended cost report due dates:

<u>FYE</u>	<u>Original Due Date</u>	<u>Revised Due Date</u>	<u>Extension</u>
4/30/2011	09/30/2011	11/30/2011	60 days
5/31/2011	10/31/2011	11/30/2011	30 days
6/30/2011	11/30/2011	01/31/2012	60 days
7/31/2011	12/31/2011	01/31/2012	30 days
8/31/2011	01/31/2012	02/29/2012	30 days
9/30/2011	02/29/2012	03/31/2012	30 days
10/31/2011	03/31/2012	03/31/2012	none
11/30/2011	04/30/2012	04/30/2012	none

# Key Changes in 2552-10

## Implementation of 2552-10 (cont.)

- From HFS FAQs:

***Can I roll forward a 2552-96 MCR file, rename it, change the FY dates, and use it as a 2552-10?***

*No. The form sets are too different. But we have built in some help to get you started. You MUST create a new 2552-10, MCRX file (FILE New, and select 2552-10 as the File Type). You should use the Template feature option as you create a New File. This will bring forward most of your S-2 info, cost center structure, statistics structure, B-1 square feet, A-8 and A-8-1, S-8 RHC/FQHC statistical data and the new S-2, Part II data (if we find your 339 file, .XPRQ file).*

# Key Changes in 2552-10

## Implementation of 2552-10 (cont.)

- From HFS FAQs:

### ***Why does the HFS data file extension look different?***

*We have switched our data file format from an indexed file (.mcr) to an XML data file (.mcrx) format. Our File Open will display both your .mcr and .mcrx files. This new file format is more dependable and you will not get the old 1520 – Indexed File Error anymore. Our new file includes the data that was stored in our .err, .er1 and .tmp files so you will not see as many associate files as you did in the 2552-96.*

# Key Changes in 2552-10

## Implementation of 2552-10 (cont.)

The HFS 2552-96 MCR (data) files can NOT be rolled forward, renamed, and given new FY dates, and used as a 2552-10.

# Key Changes in 2552-10

## Implementation of 2552-10 (cont.)

From HFS webinar 11/2/11:

- *You should avoid special characters in the Provider Name (S-2 Part I, line 3), as some have caused problems (e.g. &, %, etc.). We think we have this corrected, but better safe than sorry.*
- *CTL X is a “hot key” to delete data (similar to “cut” in Excel). If you have trouble getting rid of a date, or any data cell, use CTL X to delete the data.*
- *Worksheet S-2 FY Dates are now input on S-2 Part I, line 20 (second Tab), instead of on the initial screen. We do NOT display the calendar, but the F4 key, or a double mouse click on the cell, will bring up the calendar.*
- *The CBSA code was S-2 line 21.03, column 5, in the 2552-96 (Hospital component only). It is now S-2 , Part I, column 3, lines 1-19 (all components). Under TOOLS, we have a “Look-Up” table for CBSA codes.*

# Key Changes in 2552-10

## Implementation of 2552-10 (cont.)

From HFS webinar 11/2/11 (cont.):

ECR File Naming

The image shows a file explorer window with three files listed. Red arrows point from callout boxes to specific parts of the file names:

- File 1:** **HFS** icon, **PI140635.11A1.exe**, **C:\MCRIF32**. Callout: "The '11' is the Fiscal Year".
- File 2:** Document icon, **EC140635.11A1**, **C:\MCRIF32**. Callout: "The 'A' indicates that this is the first filing for this FY. Second report with same FY would show a 'B'".
- File 3:** **PDF** icon, **PI140635.11A1.pdf**. Callout: "The '1' means this is an As Submitted Report. A '2' in this position would indicate that this is the first Amended".

# Key Changes in 2552-10

- Worksheet S
  - Part I – provider indicates if this is an electronic or manual cost report, and if this is an amended report, what number amendment it is
  - Additional details for Contractor to reflect

## PART I - COST REPORT STATUS

Provider use only	1. <input type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: _____ Time: _____
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended 6. Date Received: _____ 7. Contractor No.: _____ 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: _____ 11. Contractor's Vendor Code: _____ 12. <input type="checkbox"/> If line 4, column 1 is 4: Enter number of times reopened = 0-9.

# Key Changes in 2552-10

- Worksheet S (cont.)
  - Part III, column 4 is new – reflects EHR incentive payment calculated on the new E-1 Part II

PART III - SETTLEMENT SUMMARY					
		TITLE V 1	TITLE XVIII		HIT 4
			PART A 2	PART B 3	
1	HOSPITAL				

# Key Changes in 2552-10

- Worksheet S-2 Part I (replaces old S-2)
  - Several obsolete questions removed
  - Lines 24 and 25 require breakdown of Medicaid days for DSH and LIP hospitals respectively
  - These days will be the basis for Medicaid % calculation for Medicare DSH on E Part A

*(E Part A) Line 31--Enter the percentage resulting from the calculation of Medicaid patient days (Worksheet S-2, Part I, columns 1 through 6, line 24) to total days reported on Worksheet S-3, Part I, column 8, line 14, plus column 8, line 32, minus the sum of lines 5 and 6, plus employee discount days reported on worksheet S-3, Part I, column 8, line 30.*

		In-State Medicaid paid days	In-State Medicaid eligible days	Out-of State Medicaid paid days	Out-of State Medicaid eligible days	Medicaid HMO days	Other Medicaid days
		1	2	3	4	5	6
24	If line 22 is "yes", and this provider is an IPPS hospital enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible days in col. 2 out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO days in col. 5, and other Medicaid days in col. 6.						
25	If line 22 is "yes", and this provider is an IRF then, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible days in col. 2, out-of-state Medicaid days in col. 3, out-of state Medicaid eligible days in col. 4 Medicaid HMO days in col. 5 and other Medicaid days in col. 6.						

# Key Changes in 2552-10

- Worksheet S-2 Part I (replaces old S-2) (cont.)

24	If line 22 is "yes", and this provider is an IPPS hospital enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible days in col. 2 out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO days in col. 5, and other Medicaid days in col. 6.
25	If line 22 is "yes", and this provider is an IRF then, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible days in col. 2, out-of-state Medicaid days in col. 3, out-of state Medicaid eligible days in col. 4 Medicaid HMO days in col. 5 and other Medicaid days in col. 6.

In-State Medicaid paid days	In-State Medicaid eligible days	Out-of State Medicaid paid days	Out-of State Medicaid eligible days	Medicaid HMO days	Other Medicaid days
1	2	3	4	5	6

# Key Changes in 2552-10

- Worksheet S-2 Part I (replaces old S-2) (cont.)
  - Questions for Teaching Hospitals beginning on new line 56 are now title-specific, allowing for different treatment of medical education between Medicare and Medicaid programs
  - Transmittal 2 includes new IME/GME questions related to PPACA
    - Line 61 – Redistribution of resident FTE slots
    - Lines 63-67 – Resident training in non-provider settings

# Key Changes in 2552-10

- Worksheet S-2 Part I (replaces old S-2) (cont.)
  - New lines 95-97 allows additional details that might be used for Medicaid settlement calculations

Old:

## TITLE XIX INPATIENT SERVICES

38 DO YOU HAVE TITLE XIX INPATIENT HOSPITAL SERVICES?

38.01 IS THIS HOSPITAL REIMBURSED FOR TITLE XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART?

38.02 DOES THE TITLE XIX PROGRAM REDUCE CAPITAL FOLLOWING THE MEDICARE METHODOLOGY?

38.03 ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)?

38.04 DO YOU OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE XIX?

# Key Changes in 2552-10

- Worksheet S-2 Part I (replaces old S-2) (cont.)

New:

## Title V and XIX Inpatient Services

90	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes, and "N" for no in applicable column.
91	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes, and "N" for no in the applicable column.
92	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes, and "N" for no in the applicable column.
93	Does this facility operate an ICFMR facility for purposes of title V and XIX? Enter "Y" for yes, and "N" for no in the applicable column.
94	Does title V or title XIX reduce capital cost? Enter "Y" for yes or "N" for no in the applicable column.
95	If line 94 is "Y", enter the reduction percentage in the applicable column.
96	Does title V or title XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.
97	If line 96 is "Y", enter the reduction percentage in the applicable column.

# Key Changes in 2552-10

- Worksheet S-2 Part I (replaces old S-2) (cont.)
  - New lines 117-119 relate to malpractice insurance

Old:

```
54 LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES:
      PREMIUMS:                                0
      PAID LOSSES:                             0
      AND/OR SELF INSURANCE:                   0
54.01 ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN OTHER THAN THE ADMINISTRATIVE AND
      GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS
      CONTAINED THEREIN.
```

# Key Changes in 2552-10

- Worksheet S-2 Part I (replaces old S-2) (cont.)
  - New lines 117-119 relate to malpractice insurance

New:

117	Is this facility legally-required to carry malpractice insurance?
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.
119	What is the liability limit for the malpractice insurance policy? Enter in column 1 the monetary limit per lawsuit. Enter in column 2 the monetary limit per policy year.

# Key Changes in 2552-10

- Worksheet S-2 Part I (replaces old S-2) (cont.)
  - New lines 167-169 relate to the EHR incentive payment program

## Health Information Technology (HIT) Incentive in the American Recovery and Reinvestment Act

167	Is this provider a meaningful user under §1886 (n)? Enter "Y" for yes or "N" for no.
168	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets.
169	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)

# Key Changes in 2552-10

- **Worksheet S-2 Part II**
  - Replaces old CMS 339 Exhibit 1 questionnaire, and will now be part of the ECR file as opposed to separate hard copy
  - Remaining Exhibits are still hard copy
    - Exhibit 1 – physician hours
    - Exhibit 2 – bad debt logs
  - Questions have been separated into two groups
    - 1-21 – Completed by all hospitals
    - 22-40 – Completed by cost reimbursed and TEFRA hospitals only (except children's hospitals)
  - PS&R paid-through date has been moved to the questionnaire (S-2 question on 2552-96)
  - No significant additional questions
  - Some questions from old 339 have been removed

# Key Changes in 2552-10

- Worksheet S-2 Part V – HFS Voluntary Contact Info

S-2, Part V - Voluntary Contact Information											
A	B	C	D	E	F	G	H	I	J	K	
1	VOLUNTARY CONTACT INFORMATION				Provider CCN:	140635	Period	Worksheet S-2, Part V			
2							From:	10/01/2010			
3							To:	09/30/2011			
4											
5									1.00		
6	<b>Cost Report Preparer Contact Information</b>										
7	1.00	First Name							BECKY		1.00
8	2.00	Last Name							DOLIN		2.00
9	3.00	Title							COST REPORT PREPARER		3.00
10	4.00	Employer							HFS		4.00
11	5.00	Phone Number									5.00
12	6.00	E-mail Address									6.00
13	7.00	Department									7.00
14	8.00	Mailing Address 1									8.00
15	9.00	Mailing Address 2									9.00
16	10.00	City									10.00
17	11.00	State									11.00
18	12.00	Zip									12.00
19	<b>Officer or Administrator of Provider Contact Information</b>										
20	13.00	First Name									13.00
21	14.00	Last Name									14.00
22	15.00	Title									15.00
23	16.00	Employer									16.00
24	17.00	Phone Number									17.00
25	18.00	E-mail Address									18.00
26	19.00	Department									19.00
27	20.00	Mailing Address 1									20.00
28	21.00	Mailing Address 2									21.00
29	22.00	City									22.00
30	23.00	State									23.00
31	24.00	Zip									24.00

# Key Changes in 2552-10

- Worksheet S-2 Part V – HFS Voluntary Contact Info
  - From HFS FAQs:

## ***What is this new S-2 Part V and do I need to fill it out?***

*This is a new worksheet that HFS designed and added to the cost report. You are not required to complete the form. However, you should complete the form because you MAC needs your contact information, some of which used to be in the old 339 questionnaire. Any information you enter here will not be part of the regular EC file and will not be added to the HCRIS database.*

# Key Changes in 2552-10

- Worksheet S-3 Part I
  - New column 1 – enter Worksheet A line that corresponds to the various components

Component		Worksheet A Line No.
		1
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	
2	HMO	
3	HMO IPF	
4	HMO IRF	
5	Hospital Adults & Peds. Swing Bed SNF	
6	Hospital Adults & Peds. Swing Bed NF	
7	Total Adults and Peds. (exclude observation beds) (see instructions)	
8	Intensive Care Unit	
9	Coronary Care Unit	
10	Burn Intensive Care Unit	
11	Surgical Intensive Care Unit	
12	Other Special Care	
13	Nursery	
14	Total (see instructions)	

# Key Changes in 2552-10

- Worksheet S-3 Part I (cont.)
  - Separate lines for HMO days for Psych and Rehab

Component		Inpatient Days / Outpatient Visit		
		Title V	Title XVIII	Title XIX
		5	6	7
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)			
2	HMO			
3	HMO IPF			
4	HMO IRF			

# Key Changes in 2552-10

- Worksheet S-3 Part I (cont.)
  - Medicare HMO discharges now entered

Component		Discharges			
		Title V 12	Title XVIII 13	Title XIX 14	Total All Patients 15
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)				
2	HMO				
3	HMO IPF				
4	HMO IRF				

# Key Changes in 2552-10

- Worksheet S-3 Part I (cont.)
  - Observation Admitted and Not Admitted columns have been removed – no longer required

# Key Changes in 2552-10

- Worksheet S-3 Part II
  - New column 1 – enter Worksheet A line that corresponds to Total Salaries, Interns & Residents, and SNF

		Worksheet A Line Number
		1
<b>SALARIES</b>		
1	Total salaries (see instructions)	
2	Non-physician anesthetist Part A	
3	Non-physician anesthetist Part B	
4	Physician-Part A	
5	Physician-Part B	
6	Non-physician-Part B	
7	Interns & residents (in an approved program)	
8	Home office personnel	
9	SNF	

# Key Changes in 2552-10

- Worksheet S-3 Part II (cont.)
  - Data Source no longer reflected – column 6 on old form

Old:

PART II - WAGE DATA	AMOUNT REPORTED 1	RECLASS OF SALARIES 2	ADJUSTED SALARIES 3	PAID HOURS RELATED TO SALARY 4	AVERAGE HOURLY WAGE 5	DATA SOURCE 6
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# Key Changes in 2552-10

- Worksheet S-3 Part II (cont.)
  - Wage Related Costs now come from new S-3 Part IV
  - Previously supported by 339 Exhibit 6

## WAGE-RELATED COSTS

17	Wage-related costs (core) Worksheet S-3, Part IV line 24
18	Wage-related costs (other) Worksheet S-3, Part IV line 25

# Key Changes in 2552-10

- **Worksheet S-3 Part IV**
  - Replaces old 339 Exhibit 6
  - No change in the categories of wage related costs
  - Despite how it currently appears on the cost report forms, line 24 will most likely not go in total to S-3 Part II line 17 – a portion of this amount will be allocated to various excluded lines

# Key Changes in 2552-10

- Worksheet S-3 Part IV (cont.)
  - From HFS FAQs:

***How do I remove the excluded areas on W/S S-3 part IV, Wage Related Costs, Line 24?***

*This is like the old 339 Exhibit 6. Line 24 of S-3 part IV transfers to S-3 part II, line 17, but line 17 is NOT to include the excluded areas, and S-3 part IV has no instruction or means to make these adjustments for excluded areas. We suggested to CMS that they add two columns – column 2 for adjustments, and column 3 for the net (column 1 plus/minus column 2). Then column 3, line 24, would be the transfer to S-3 part II, line 17. If CMS does NOT make this change before you file, you should do a work paper reflecting any adjustments for the excluded areas, and then show the net on S-3 part IV, so that the transfer to S-3 part II, line 17 is correct.*

# Key Changes in 2552-10

- **Worksheet S-3 Part V**

- New worksheet – “Contract Labor and Benefit Cost”
- CMS Instructions:

*This section identifies the contract labor costs and benefit costs for the hospital complex and applicable subproviders and units.*

*Identify the contract labor costs and benefit costs for each component on the applicable line.*

- Instructions do not indicate if any amounts should tie to S-3 Part II
- Based on section in FY 12 IPPS final rule, it appears this worksheet might be used for developing future market basket adjustments for LTCHs, IRFs, and IPFs

# Key Changes in 2552-10

- Worksheet S-3 Part V (cont.)

*Comment: One commenter suggested that, because only a small number of providers (less than 30 percent) reported data for benefits and contract labor on their cost reports, CMS consider requiring all LTCHs to submit this information.*

*Response: ... Form CMS 2552-10 includes a new worksheet (Worksheet S-3, part V) which identifies the contract labor costs and benefit costs for the hospital complex and is applicable to subproviders and units. CMS anticipates that all providers will report these data so we are able to include the data in future market basket rebasings.*

# Key Changes in 2552-10

- Worksheet S-3 Part V (cont.)
  - The cost report instructions for the wage survey appear to suggest that S-3 Part V is completely separate

*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.*

# Key Changes in 2552-10

- Worksheet S-3 Part V (cont.)

Part V - Contract Labor and Benefit Cost

Hospital and Hospital-Based Component Identification:

Component		Contract Labor	Benefit Cost
	0	1	2
1	Total facility contract labor and benefit cost		
2	Hospital		
3	Subprovider- IPF		
4	Subprovider- IRF		
5	Subprovider- (Other)		
6	Swing Beds-SNF		
7	Swing Beds-NF		
8	Hospital-Based SNF		
9	Hospital-Based NF		
10	Hospital-Based OLTC		
11	Hospital-Based HHA		
12	Separately Certified ASC		
13	Hospital-Based Hospice		
14	Hospital-Based Health Clinic RHC		
15	Hospital-Based Health Clinic FQHC		
16	Hospital-Based-CMHC		
17	Renal Dialysis		
18	Other		

# Key Changes in 2552-10

- Worksheet S-4 HHA
  - Visits and patient information by discipline have been eliminated
- Worksheet S-7 SNF
  - SNF information previously entered on S-2 has been moved here – lines 201-207
- Worksheet S-8 RHC
  - Physician information no longer included

# Key Changes in 2552-10

- Worksheet S-10
  - Completely redesigned from current S-10
  - Details presented in next section

# Key Changes in 2552-10

- Cost centers have been renumbered
  - Lines 1 – 3 Capital (no longer split between old and new)
  - Previously had been lines 1-4 and 90

1	00100	Capital Related Costs-Buildings and Fixtures
2	00200	Capital Related Costs-Movable Equipment
3	00300	Other Capital Related Costs

# Key Changes in 2552-10

- Cost centers have been renumbered
  - Lines 4 – 23 Other overhead
  - Previously had been lines 5 - 24

4	00400	Employee Benefits
5	00500	Administrative and General
6	00600	Maintenance and Repairs
7	00700	Operation of Plant
8	00800	Laundry and Linen Service
9	00900	Housekeeping
10	01000	Dietary
11	01100	Cafeteria
12	01200	Maintenance of Personnel
13	01300	Nursing Administration
14	01400	Central Services and Supply

# Key Changes in 2552-10

- Cost centers have been renumbered
  - Lines 4 – 23      Other overhead

15	01500	Pharmacy
16	01600	Medical Records & Medical Records Library
17	01700	Social Service
18		Other General Service (specify)
19	01900	Nonphysician Anesthetists
20	02000	Nursing School
21	02100	Intern & Res. Service-Salary & Fringes (Approved)
22	02200	Intern & Res. Other Program Costs (Approved)
23	02300	Paramedical Ed. Program (specify)

# Key Changes in 2552-10

- Cost centers have been renumbered
  - Lines 30 – 46 Routine
  - Previously had been 25 - 36

		<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>
30	03000	Adults and Pediatrics (General Routine Care)
31	03100	Intensive Care Unit
32	03200	Coronary Care Unit
33	03300	Burn Intensive Care Unit
34	03400	Surgical Intensive Care Unit
35		Other Special Care (specify)
40	04000	Subprovider - IPF
41	04100	Subprovider - IRF
42	04200	Subprovider (specify)

# Key Changes in 2552-10

- Cost centers have been renumbered
  - Lines 30 – 46      Routine

43	04300	Nursery
44	04400	Skilled Nursing Facility
45	04500	Nursing Facility
46	04600	Other Long Term Care

# Key Changes in 2552-10

- Cost centers have been renumbered
  - Lines 50 – 93 Ancillary and outpatient services
  - Previously had been lines 37 - 63

		<b>ANCILLARY SERVICE COST CENTERS</b>
50	05000	Operating Room
51	05100	Recovery Room
52	05200	Labor Room and Delivery Room
53	05300	Anesthesiology
54	05400	Radiology-Diagnostic
55	05500	Radiology-Therapeutic
56	05600	Radioisotope
57	05700	Computed Tomography (CT) Scan
58	05800	Magnetic Resonance Imaging (MRI)
59	05900	Cardiac Catheterization
60	06000	Laboratory

# Key Changes in 2552-10

- Cost centers have been renumbered
  - Lines 50 – 93 Ancillary and outpatient services

61	06100	PBP Clinical Laboratory Services-Program Only
62	06200	Whole Blood & Packed Red Blood Cells
63	06300	Blood Storing, Processing, & Trans.
64	06400	Intravenous Therapy
65	06500	Respiratory Therapy
66	06600	Physical Therapy
67	06700	Occupational Therapy
68	06800	Speech Pathology

# Key Changes in 2552-10

- Cost centers have been renumbered
  - Lines 50 – 93 Ancillary and outpatient services

69	06900	Electrocardiology
70	07000	Electroencephalography
71	07100	Medical Supplies Charged to Patients
72	07200	Implantable Devices Charged to Patients
73	07300	Drugs Charged to Patients
74	07400	Renal Dialysis
75	07500	ASC (Non-Distinct Part)
76		Other Ancillary (specify)

# Key Changes in 2552-10

- Cost centers have been renumbered
  - Lines 50 – 93 Ancillary and outpatient services

OUTPATIENT SERVICE COST CENTERS		
88	08800	Rural Health Clinic (RHC)
89	08900	Federally Qualified Health Center (FQHC)
90	09000	Clinic
91	09100	Emergency
92	09200	Observation Beds
93		Other Outpatient Service (specify)

# Key Changes in 2552-10

- Cost centers have been renumbered
  - Lines 94 – 101 Other reimbursable
  - Previously had been lines 64 - 71

		<b>OTHER REIMBURSABLE COST CENTERS</b>
94	09400	Home Program Dialysis
95	09500	Ambulance Services
96	09600	Durable Medical Equipment-Rented
97	09700	Durable Medical Equipment-Sold
98		Other Reimbursable (specify)
99		Outpatient Rehabilitation Provider (specify)
100	10000	Intern-Resident Service (not appvd. techng. prgm.)
101	10100	Home Health Agency

# Key Changes in 2552-10

- Cost centers have been renumbered
  - Lines 105 – 117 Special purpose
  - Previously had been lines 82 - 94

		<b>SPECIAL PURPOSE COST CENTERS</b>
105	10500	Kidney Acquisition
106	10600	Heart Acquisition
107	10700	Liver Acquisition
108	10800	Lung Acquisition
109	10900	Pancreas Acquisition
110	11000	Intestinal Acquisition
111	11100	Islet Acquisition

# Key Changes in 2552-10

- Cost centers have been renumbered
  - Lines 105 – 117 Special purpose

112		Other Organ Acquisition (specify)
113	11300	Interest Expense
114	11400	Utilization Review-SNF
115	11500	Ambulatory Surgical Center (Distinct Part)
116	11600	Hospice
117		Other Special Purpose (specify)

# Key Changes in 2552-10

- Cost centers have been renumbered
  - Lines 190 – 194 Nonreimbursable
  - Previously had been lines 96 - 100

NONREIMBURSABLE COST CENTERS		
190	19000	Gift, Flower, Coffee Shop, & Canteen
191	19100	Research
192	19200	Physicians' Private Offices
193	19300	Nonpaid Workers
194		Other Nonreimbursable (specify)
200		TOTAL (sum of lines 118-199)

# Key Changes in 2552-10

- Standard cost centers for subproviders
  - Line 40 for Psych, 41 for Rehab
  - Subproviders will also have standard lines on settlement worksheets
- New cost centers:
  - Line 57                   CT Scan
  - Line 58                   MRI
  - Line 59                   Cardiac Cath
- Optional cost centers:
  - Line 79.97               Cardiac Rehab
  - Line 79.98               Hyperbaric Oxygen
  - Line 76.99               Lithotripsy

# Key Changes in 2552-10

- Worksheet A-7
  - New line 7 “HIT-designated Assets” – Meaningful Users are to reflect “certified HIT assets”

<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>	
Description	
1	Land
2	Land Improvements
3	Buildings and Fixtures
4	Building Improvements
5	Fixed Equipment
6	Movable Equipment
7	<b>HIT-designated Assets</b>
8	Subtotal (sum of lines 1-7)
9	Reconciling Items
10	Total (line 7 minus line 9)

# Key Changes in 2552-10

- Worksheet A-8
  - New line 32 – only applies to Critical Access Hospitals, which must remove any expense for HIT assets included in the incentive payment program

DESCRIPTION (1)	
32	CAH HIT Adjustment for Depreciation and Interest

# Key Changes in 2552-10

- Worksheet B-1
  - From HFS webinar:
    - More Automated Statistics
      - Patient Days = P
      - Inpatient Charges = I
      - Outpatient Charges = O
    - Still have
      - Gross Salaries = S
      - Total Charges = C
      - Accumulated Cost – Only Use Negative statistic code - # has been retired.

# Key Changes in 2552-10

- **Worksheet C**
  - Now includes Other Reimbursable and Special Purpose cost centers, so charges can be entered for various lines previously excluded from Worksheet C (examples include home health, hospice, organ acquisition)
    - These additional charges impact cost-to-charge calculation used on S-10

# Key Changes in 2552-10

- Worksheet C

Old:

WKST A	COST CENTER DESCRIPTION
LINE NO.	

65	AMBULANCE SERVICES
66	DURABLE MEDICAL EQUIP-REN
67	DURABLE MEDICAL EQUIP-SOL
68	OTHER REIMBURSABLE
101	SUBTOTAL
102	LESS OBSERVATION BEDS
103	TOTAL

# Key Changes in 2552-10

- Worksheet C

New:

COST CENTER DESCRIPTIONS	
97	Durable Medical Equipment-Sold
98	Other Reimbursable (specify)
99	Outpatient Rehabilitation Provider (specify)
100	Intern-Resident Service (not appvd. tchng. prgm.)
101	Home Health Agency
SPECIAL PURPOSE COST CENTERS	
105	Kidney Acquisition
106	Heart Acquisition
107	Liver Acquisition
108	Lung Acquisition
109	Pancreas Acquisition
110	Intestinal Acquisition
111	Islet Acquisition
112	Other Organ Acquisition (specify)
115	Ambulatory Surgical Center (Distinct Part)
116	Hospice
117	Other Special Purpose (specify)
200	Subtotal (sum of lines 30 thru 199)
201	Less Observation Beds
202	Total (line 200 minus line 201)

p

# Key Changes in 2552-10

- **Worksheet C**
  - Initial proposed 2552-10 excluded C Part II, but it has been added back for final version for possible use in Medicaid calculation

# Key Changes in 2552-10

- D series
  - No material changes, mainly just updated and renumbered
  - D Part VI has been eliminated, vaccine charges now to be included on D Part V column 4

# Key Changes in 2552-10

- D series (cont.)
  - D Part V columns 2 and 3 replace old columns 5.01 and 5.02
    - Column 2 can be subscripted if split is necessary

Cost to Charge Ratio from Worksheet C, Part I, col. 9	Program Charges			Program Cost		
	PPS Reimbursed Services (see instructions)	Cost Reimbursed Services Subject to Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject to Ded. & Coins. (see instructions)	PPS Services (see instructions)	Cost Services Subject to Ded. & Coins. (see instructions)	Cost Services Not Subject to Ded. & Coins. (see instructions)
1	2	3	4	5	6	7

# Key Changes in 2552-10

- D series (cont.)
  - Old D-4 now D-3
  - Nursery charges can now be entered on D-3
  - Old D-6 Organ Acquisition now D-4

# Key Changes in 2552-10

- E series
  - E Part A - DRG payments entered on single line, no longer split

Old:

```
PART A - INPATIENT HOSPITAL SERVICES UNDER PPS
                                             HOSPITAL
                                     DESCRIPTION
DRG AMOUNT
1    OTHER THAN OUTLIER PAYMENTS OCCURRING PRIOR TO OCTOBER 1
1.01 OTHER THAN OUTLIER PAYMENTS OCCURRING ON OR AFTER OCTOBER 1
      AND BEFORE JANUARY 1
1.02 OTHER THAN OUTLIER PAYMENTS OCCURRING ON OR AFTER JAN 1
```

# Key Changes in 2552-10

- E series (cont.)
  - E Part A - DRG payments entered on single line, no longer split

New:

## **PART A - INPATIENT HOSPITAL SERVICES UNDER PPS**

1	DRG amounts other than outlier payments
---	---

# Key Changes in 2552-10

- E series (cont.)
  - E Part A – Several new lines related to changes in FTE slots from PPACA provisions
  - E Part A “Other Adjustments”
    - Lines 70.97-70.99 – PPACA Low-Volume Adjustment payments
    - Transmittal 1 indicated that “Section 1109” payment from Reform Reconciliation Act were to be reflected on Line 70.96 as well as on E-1. Transmittal 2 rescinds those instructions – these payments are not to be reflected on the cost report.

# Key Changes in 2552-10

- E series (cont.)
  - New Worksheet E-4 replaces old E-3 Part IV for GME

# Key Changes in 2552-10

- E series (cont.)
  - Section 422 I&R FTE cap add-on no longer reflected on E-3 Part VI – now incorporated into IME calculation on E Part A and GME calculation on new Worksheet E-4

E Part A:

<b>Indirect Medical Education Adjustment for the Add-on</b> <i>for Section 422 of the MMA</i>	
23	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).
24	IME FTE resident count over cap (see instructions)
25	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)
26	Resident to bed ratio (divide line 25 by line 4)
27	IME payments adjustment (see instructions)
28	IME Adjustment (see instructions)
29	Total IME payment (sum of lines 22 and 28)

# Key Changes in 2552-10

- E series (cont.)
  - Note that E-4 line 3 requires the input of the section 422 reduction
  - Old E-3 Part VI required the input of the reduced FTE cap that resulted from the reduction

**3** *Amount of r* eduction to Direct GME *c* ap *u*nder *s* ection 422 of MMA

# Key Changes in 2552-10

- E series (cont.)
  - Worksheet E-1 Part II “Health Information Technology Data Collection And Calculation”
    - Calculates EHR incentive payment and compares it to initial payment received to determine settlement that is carried forward to Worksheet S

# Key Changes in 2552-10

- E series (cont.)
  - Worksheet E-1 Part II “Health Information Technology Data Collection And Calculation”

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION	
1	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I <i>line 14, column 15</i>
2	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12
3	Medicare HMO days from Wkst S-3, Part I, column 6. line 2
4	Total inpatient bed days from S-3, Part I column 8 sum of lines 1, 8-12
5	Total hospital charges from Wkst C, Part I, column 8 line 200
6	Total hospital charity care charges from Wkst S-10, column 3 line 20
7	CAH only - The reasonable cost incurred for the purchase of certified HIT technology <i>from</i> Worksheet S-2, Part I line <i>168</i>
8	Calcualtion of the HIT incentive payment (see instructions)

# Key Changes in 2552-10

- E series – Settlement Pages
  - E Part A – Hospital IP
  - E Part B – Hospital OP
  - E-2 – Swing Beds
  - E-3 Part I – TEFRA (Children’s and Cancer Hospitals)
  - E-3 Part II – IP Psych
  - E-3 Part III – IP Rehab
  - E-3 Part IV – LTCH
  - E-3 Part V – CAHs
  - E-3 Part VI – SNF
  - E-3 Part VII – All Other Title V or Title XIX

# Key Changes in 2552-10

- G series

- Virtually unchanged, except for addition to Worksheet G balance sheet of lines 27 and 28 HIT Designated Assets and related Accumulated Depreciation

*Line 27--Health Information Technology (HIT) Designated Assets--The amounts included here are the acquisition costs of HIT acquired assets in accordance with ARRA 2009, section 4102. Acute care hospitals are required to depreciate such assets in accordance with their applicable depreciation schedules. CAHs are required to identify such assets on this line, but do not depreciate such assets as they will be fully expensed during the year of acquisition.*

# Key Changes in 2552-10

- G series

FIXED ASSETS	
12	Land
13	Land improvements
14	Accumulated depreciation
15	Buildings
16	Accumulated depreciation
17	Leasehold improvements
18	Accumulated depreciation
19	Fixed equipment
20	Accumulated depreciation
21	Automobiles and trucks
22	Accumulated depreciation
23	Major movable equipment
24	Accumulated depreciation
25	Minor equipment depreciable
26	Accumulated depreciation
27	HIT designated Assets
28	Accumulated depreciation

# Key Changes in 2552-10

- H series
  - Eliminates old H-1, H-2, and H-3 and renames remaining worksheets, but otherwise no significant changes
- I, J, K, L, and M series
  - Virtually the same as 2552-96, except for renumbering of previously subscripted lines and other minor clean-up

# Worksheet S-10 and Charity Care

# Worksheet S-10 and Charity Care

- **Worksheet S-10**
  - Completely revised – will probably be the most significant change from 2552-10 for most hospitals
    - Impacts EHR incentive payment calculation
    - Anticipated to also be used in Medicare DSH calculation beginning in FY 14
  - Will now be required by CAHs
  - Data should exclude physician/professional services

# Worksheet S-10 and Charity Care

- Worksheet S-10 (cont.)

- Revised definitions:

- Uncompensated care

- Old - Defined as charity care and bad debt.*

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

# Worksheet S-10 and Charity Care

- Worksheet S-10 (cont.)

- Revised definitions:

- Charity care

- Old - Health services for which hospital policies determine the patient is unable to pay. Charity care results from a provider's policy to provide health care services free of charge (or where only partial payment is expected not to include contractual allowances for otherwise insured patients) to individuals who meet certain financial criteria. For the purpose of uncompensated care charity care is measured on the basis of revenue forgone, at full-established rates. Charity care does not include contractual write-offs.*

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

# Worksheet S-10 and Charity Care

- Worksheet S-10 (cont.)
  - “Net Revenue” for Medicaid, SCHIP, and other indigent care programs defined as *Actual payments received or expected to be received from a payer (including co-insurance payments from the patient) for services delivered during this cost reporting period. Net revenue will typically be charges (gross revenue) less contractual allowance.*
  - Line 1 - cost-to-charge ratio based on Worksheet C Total Costs / Total Charges

# Worksheet S-10 and Charity Care

- Worksheet S-10 (cont.)
  - Medicaid

Medicaid (see instructions for each line)	
2	Net revenue from Medicaid
3	Did you receive DSH or supplemental payments from Medicaid?
4	If line 3 is yes, does line 2 include all DSH or supplemental payments from Medicaid?
5	If line 4 is no, enter DSH or supplemental payments from Medicaid
6	Medicaid charges
7	Medicaid cost (line 1 times line 6)
8	Difference between net revenue and costs for Medicaid program (line 2 plus line 5 minus line 7)

*If not separately identifiable, disproportionate share (DSH) and supplemental payments should be included in (Line 2). For these payments, report the amount received or expected for the cost reporting period, net of associated provider taxes or assessments.*

# Worksheet S-10 and Charity Care

- Worksheet S-10 (cont.)
  - SCHIP

State Children's Health Insurance Program (SCHIP) (see instructions for each line)	
9	Net revenue from stand-alone SCHIP
10	Stand-alone SCHIP charges
11	Stand-alone SCHIP cost (line 1 times line 10)
12	Difference between net revenue and costs for stand-alone SCHIP (line 9 minus line 11)

# Worksheet S-10 and Charity Care

- Worksheet S-10 (cont.)
  - Other Indigent Care Programs

Other state or local government indigent care program (see instructions for each line)	
13	Net revenue from state or local indigent care program (not included on lines 2, 5 or 9)
14	Charges for patients covered under state or local indigent care program (not included in lines 6 or 10)
15	State or local indigent care program cost (line 1 times line 14)
16	Difference between net revenue and costs for state or local indigent care program (line 13 minus line 15)

# Worksheet S-10 and Charity Care

- Worksheet S-10 (cont.)

- Uncompensated Care:

- Line 17

- Enter the value of all non-government grants, gifts and investment income received during this cost reporting period that were restricted to funding uncompensated or indigent care. Include interest or other income earned from any endowment fund for which the income is restricted to funding uncompensated or indigent care.*

# Worksheet S-10 and Charity Care

- Worksheet S-10 (cont.)

- Uncompensated Care:

- Line 18

*Enter all grants, appropriations or transfers received or expected from government entities for this cost reporting period for purposes related to operation of the hospital, including funds for general operating support as well as for special purposes (including but not limited to funding uncompensated care). Include funds from the Federal Section 1011 program, if applicable, which helps hospitals finance emergency health services for undocumented aliens. While Federal Section 1011 funds were allotted for federal fiscal years 2005 through 2008, any unexpended funds will remain available after that time period until fully expended even after federal fiscal year 2008. If applicable, report amounts received from charity care pools net of related provider taxes or assessments. Do not include funds from government entities designated for non-operating purposes, such as research or capital projects.*

# Worksheet S-10 and Charity Care

- Worksheet S-10 (cont.)
  - Expanded disclosures for Charity Care:

		Uninsured	Insured	Total
		patients	patients	(col. 1 + col. 2)
		1	2	3
20	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility			
21	Cost of initial obligation of patients approved for charity care (line 1 times line 20)			
22	Partial payment by patients approved for charity care			
23	Cost of charity care (line 21 minus line 22)			

# Worksheet S-10 and Charity Care

- Worksheet S-10 (cont.)

- Line 20 :

- *Enter the total initial payment obligation of patients who are given a full or partial discount based on the hospital's charity care criteria (measured at full charges), for care delivered during this cost reporting period for the entire facility.*
    - *For uninsured patients, including patients with coverage from an entity that does not have a contractual relationship with the provider (column 1), this is the patient's total charges.*
    - *For patients covered by a public program or private insurer with which the provider has a contractual relationship (column 2), these are the deductible and coinsurance payments required by the payer.*

# Worksheet S-10 and Charity Care

- Worksheet S-10 (cont.)
  - Line 20 :
    - *Do not include charges for either uninsured patients given discounts without meeting the hospital's charity care criteria or patients given courtesy discounts. Charges for non-covered services provided to patients eligible for Medicaid or other indigent care program (including charges for days exceeding a length of stay limit) can be included, if such inclusion is specified in the hospital's charity care policy and the patient meets the hospital's charity care criteria.*
    - Note that Line 20 is used in the EHR incentive payment calculation – the higher the number, the higher the calculated payment

# Worksheet S-10 and Charity Care

- Worksheet S-10 (cont.)
  - Line 22 :
    - *Enter payments received or expected from patients who have been approved for partial charity care for services delivered during this cost reporting period. Include such payments for all services except physician or other professional services. Payments from payers should not be included on this line.*

# Worksheet S-10 and Charity Care

**Description: Patient A has insurance and has patient liability of \$1,000. Patient A qualified for a 50% charity care discount based on the hospitals charity care policy.**

Patient Liability	1,000		
Charity Care Discount	50%		
Partial Payment Expected	500		
Charity Care Write-Off	500		
	<b>Correct</b>	<b>Incorrect</b>	
Total Initial Obligation	1,000	500	(Shown as Net)
Overall Hospital RCC	0.40	0.40	
Cost of Initial Obligation	400	200	
Partial Payment	500	-	
Cost of Charity Care	(100)	200	

# Worksheet S-10 and Charity Care

- Worksheet S-10 (cont.)
  - Line 24 :
    - *Enter “Y” for yes if any charges for patient days beyond a length-of-stay limit imposed on patients covered by Medicaid or other indigent care program are included in the amount reported in line 20, column 2, and complete line 25. Otherwise enter “N” for no.*
  - Line 25 :
    - *If you answered yes to question 24, enter charges for patient days beyond a length-of-stay limit imposed on patients covered by Medicaid or other indigent care program for services delivered during this cost reporting period. The amount must match the amount of such charges included in line 20, column 2.*

# Worksheet S-10 and Charity Care

- Worksheet S-10 (cont.)
  - Bad Debts:

26	Total bad debt expense for the entire <b>hospital complex</b> (see instructions)
27	<b>Medicare bad debts for the entire hospital complex</b> (see instructions)
28	Non-Medicare and non-reimbursable bad debt expense (line 26 minus line 27)
29	Cost of non-Medicare bad debt expense (line 1 times line 28)

# Worksheet S-10 and Charity Care

- Worksheet S-10 (cont.)
  - Line 26 :
    - *Enter the total facility (**entire hospital complex**) charges for bad debts (bad debt expense) written off or expected to be written off on balances owed by patients for services delivered during this cost reporting period. Include such charges for all services except physician and other professional services. Include the sum of all Medicare allowable bad debts appearing in the Worksheet E, H, I, J, and M series including: E, Part A, line 64; E, Part B, line 34; E-2, line 17; E-3, Part I, line 11; E-3, Part II, line 23; E-3, Part III, line 24; E-3, Part IV, line 14; E-3, Part V, line 25; E-3, Part VI, line 8; **Part VII, line 34**; H-4, Part II, line 27; I-5, line 5; J-3, line 21; and M-3, line 23. For privately insured patients, do not include bad debts that were the obligation of the insurer rather than the patient.*

# Worksheet S-10 and Charity Care

- Worksheet S-10 (cont.)
  - Line 27 :
    - *Enter the total facility (entire hospital complex) Medicare reimbursable (also referred to as adjusted) bad debts as the sum of Worksheet E, Part A, line 65; E, Part B, line 35; E-2, line 17, columns 1 and 2; E-3, Part I, line 12; E-3, Part II, line 24; E-3, Part III, line 25; E-3, Part IV, line 15; E-3, Part V, line 26; E-3, Part VI, line 10; H-4, Part II, line 27; I-5, line 5; J-3, line 21; and M-3, line 23.*

# Review and Final Questions

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