Medicare | **Department of Health and Human Services (DHHS)**

Provider Reimbursement Manual | **Centers for Medicare and Medicaid Services (CMS)**
Part 2, Provider Cost Reporting Forms and Instructions, Chapter 40, Form CMS-2552-10

Transmittal 4 | **Date: September 2013**

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
4000 - 4000 (Cont.)	40-7 - 40-8 (2pp.)	40-7 - 40-8 (2pp.)
4004.1 (Cont.) - 4004.1 (Cont.)	40-31 - 40-38.2 (12pp.)	40-31 - 40-38.2 (10 pp.)
4004.2 (Cont.) - 4004.2 (Cont.)	40-41 - 40-42 (2pp.)	40-41 - 40-42 (2pp.)
4005 - 4005.4 (Cont.)	40-55 - 40-65.1 (16 pp.)	40-55 - 40-65.1 (10 pp.)
4007 - 4007 (Cont.)	40-69 - 40-70.2 (4 pp.)	40-69 - 40-70 (2 pp.)
4012 (Cont.) - 4013 (Cont.)	40-79 - 40-82 (4 pp.)	40-79 - 40-82 (4 pp.)
4013 (Cont.) - 4013 (Cont.)	40-87 - 40-88 (2 pp.)	40-87 - 40-88 (2 pp.)
4013 (Cont.) - 4013 (Cont.)	40-91 - 40-94 (4 pp.)	40-91 - 40-94 (4 pp.)
4014 - 4014 (Cont.)	40-99 - 40-100 (2 pp.)	40-99 - 40-100 (2 pp.)
4016 (Cont.) - 4016 (Cont.)	40-105 - 40-106 (2 pp.)	40-105- 40-106 (2 pp.)
4021 (Cont.) - 4022	40-125 - 40-126 (2 pp.)	40-125 - 40-126 (2 pp.)
4024.4 - 4024.5 (Cont.)	40-135 - 40-136 (2 pp.)	40-135 - 40-136 (2 pp.)
4025.1 (Cont.) - 4025.1 (Cont.)	40-143 - 40-146 (4 pp.)	40-143 - 40-146 (4 pp.)
4030.1 - 4030.1 (Cont.)	40-169 - 40-176.8 (18 pp.)	40-169 - 40-176.8 (17 pp.)
4030.2 (Cont.) - 4031.1	40-178.1 - 40-182 (6 pp.)	40-178.1 - 40-182 (6 pp.)
4031.2 (Cont.) - 4033.4 (Cont.)	40-185 - 40-202 (18 pp.)	40-185 - 40-202 (18 pp.)
4033.5 (Cont.) - 4033.7	40-205 - 40-208 (4 pp.)	40-205 - 40-208 (4 pp.)
4033.7 (Cont.) - 4034 (Cont.)	40-211 - 40-216.2 (8 pp.)	40-211 - 40-216.2 (8 pp.)
4045.2 - 4045.2 (Cont.)	40-241 - 40-242 (2 pp.)	40-241 - 40-242 (2 pp.)
4050 - 4052 (Cont.)	40-249 - 40-252 (8 pp.)	40-249 - 40-252 (4 pp.)
4055 (Cont.) - 4056	40-257 - 40-258 (2 pp.)	40-257 - 40-258 (2 pp.)
4066 (Cont.) - 4069	40-281 - 40-286 (8 pp.)	40-283 - 40-286 (7 pp.)
4090	40-503 - 40-508 (6 pp.)	40-503 - 40-508 (6 pp.)
	40-511 - 40-514 (4 pp.)	40-511 - 40-514 (4 pp.)
	40-517 - 40-518 (2 pp.)	40-517 - 40-518 (2 pp.)
	40-521 - 40-524 (4 pp.)	40-521 - 40-524 (4 pp.)
	40-529 - 40-530 (2 pp.)	40-529 - 40-530 (2 pp.)
	40-535 - 40-538 (4 pp.)	40-535 - 40-538 (4 pp.)
	40-541 - 40-550 (10 pp.)	40-541 - 40-550 (10 pp.)
	40-553 - 40-556 (4 pp.)	40-553 - 40-556 (4 pp.)
	40-559 - 40-562 (4 pp.)	40-559 - 40-562 (4 pp.)
	40-569 - 40-570 (2 pp.)	40-569 - 40-570 (2 pp.)
	40-581 - 40-586 (6 pp.)	40-581 - 40-586 (6 pp.)
	40-589 - 40-598 (10 pp.)	40-589 - 40-598 (10 pp.)
	40-607 - 40-612 (6 pp.)	40-607 - 40-612 (6 pp.)
	40-615 - 40-622 (8 pp.)	40-615 - 40-622 (8 pp.)
	40-625 - 40-626 (2 pp.)	40-625 - 40-626 (2 pp.)
	40-629 - 40-630 (2 pp.)	40-629 - 40-630 (2 pp.)
	40-635 - 40-638 (4 pp.)	40-635 - 40-638 (4 pp.)
	40-641 - 40-642 (2pp.)	40-641 - 40-642 (2pp.)
	40-647 - 40-650 (4 pp.)	40-647 - 40-650 (4 pp.)
	40-653 - 40-654 (2 pp.)	40-653 - 40-654 (2 pp.)
	40-661 - 40-663 (3 pp.)	40-661 - 40-663 (3 pp.)

4095	40-701 - 40-710 (10 pp.)	40-701 - 40-710 (10 pp.)
	40-717 - 40-720 (4 pp.)	40-717 - 40-720 (4 pp.)
	40-725 - 40-732 (10 pp.)	40-725 - 40-732 (8 pp.)
	40-735 - 40-742 (8 pp.)	40-735 - 40-742 (8 pp.)
	40-745 - 40-750 (6 pp.)	40-745 - 40-750 (6 pp.)
	40-753 - 40-760 (6 pp.)	40-753 - 40-760 (6 pp.)
	40-763 - 40-766 (4pp.)	40-763 - 40-766 (4pp.)
	40-769 - 40-770 (2 pp.)	40-769 - 40-770 (2 pp.)
	40-773 - 40-776 (4 pp.)	40-773 - 40-776 (4 pp.)
	40-779 - 40-782 (4 pp.)	40-779 - 40-782 (4 pp.)
	40-785 - 40-802 (20 pp.)	40-785 - 40-802 (20 pp.)
	40-809 - 40-810 (2 pp.)	40-809 - 40-810 (2 pp.)

NEW/REVISED MATERIAL--EFFECTIVE DATE: Cost Reporting Periods Beginning on or After October 1, 2012.

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

Revisions:

- Worksheet S-2, Part I:
  - Added line 39 for low volume eligibility.
  - Added lines 61.01 through 61.06, and 61.10 and 61.20 to collect indirect medical education (IME) and direct graduate medical education (GME) full-time equivalents (FTE) counts in approved teaching programs to ensure compliance with section 5503 of the Patient Protection and Affordable Care Act of 2010 (ACA).
- Worksheet S-3, Part I:
  - Added lines 24.10 (Hospice (non-distinct part)) and 32.01 (Outpatient ancillary labor and delivery days), and revised line 32 (Labor and delivery) to adjust the bed days available to calculate the total number of inpatient beds.
- Worksheet S-3, Part II:
  - Clarified line 1, line 26, and column 2 for reporting direct salaries and wages.
  - Clarified line 17 instructions for health insurance and health-related wage related costs.
- Worksheet S-5:
  - Added lines 10.01 through 10.03 to identify a provider approved for a low volume payment adjustment, ESRD PPS payment election and transition period.
  - Added line 22 and revised lines 13 through 20 to properly report erythropoiesis-stimulating agents (ESA's) for cost reporting periods ending on or after December 31, 2012. (Also impacts Worksheet B-2)
- Worksheet S-10:
  - Clarified lines 26 and 27, total facility bad debt expenses and total facility Medicare reimbursable bad debts, respectively.
- Worksheet A:
  - Clarified line 4 as employee benefit department costs.
- Worksheet A-6:
  - Clarified instructions regarding reclassification of salary amounts paid in addition to direct salaries or wages (such as paid vacation, holiday, sick, other paid-time-off (PTO), severance, and bonus pay) to the same cost center where the direct salaries and wages are reported.
- Worksheet A-8:
  - Added line 30.99 to adjust for amounts received under contractual agreements with hospices.

- Worksheet D, Part IV:

- Reinstated the use of column 1 for certified registered nurse anesthetists (CRNA) services.

- Worksheets E, Part A; E, Part B; E-1, Part II; E-2; E-3, Parts I - VI; H-4, Part II; J-3; and M-3:
  - Added a line for the sequestration adjustment amount reducing payments by 2 percent in accordance with the Executive Order effective for portions of cost reporting periods that overlap or begin on or after April 1, 2013 pursuant to Section 251A of the Balanced Budget and Emergency Deficit Control Act of 1985, as amended by the Budget Control Act of 2011.
- Worksheets E, Part A; E, Part B; E-2; E-3, Parts I - VI; H-4, Part II; I-5; J-3; and M-3:
  - Revised the bad debt instructions in accordance with section 3201 of the Middle Class Tax Relief and Job Creation Act of 2012.
- Worksheet E, Part A:
  - Revised line 4 to adjust for non-distinct part hospice days, outpatient ancillary labor and delivery days, and total labor and delivery room days.
  - Revised lines 40 and 41 for the calculation of the ESRD add-on payment in accordance with FR 160, Vol. 76, dated August 18, 2011, page 51693.
  - Revised lines 48 and 49 to reflect the extension of the Medicare-dependent hospital program through September 30, 2013 in accordance with section 606 of the American Taxpayer Relief Act of 2012.
  - Added line 70.92 to reflect the Model 1 bundled payment initiative in accordance with ACA 2010, section 3023 effective for discharges occurring on or after October 1, 2013.
  - Added line 70.93 to reflect the payment adjustment amount for the Hospital Value-Based Purchasing (HVBP) program in accordance with ACA 2010, section 3001 effective for discharges occurring on or after October 1, 2012.
  - Added line 70.94 to reflect the payment adjustment amount for the Hospital Readmissions Reduction program in accordance with ACA 2010, section 3025 effective for discharges occurring on or after October 1, 2012.
  - Revised the instructions for lines 70.96 through 70.98 to reflect the extension of the low volume adjustment through federal fiscal year 2013 in accordance with section 605 of the American Taxpayer Relief Act of 2012.
- Worksheet E, Part B:
  - Clarified line 27 to appropriately calculate costs for cost reimbursed providers exempt from the lower of reasonable costs or customary charges.
- Worksheet E-1, Part II:
  - Added lines 9 and 10 and revised line 32 for the sequestration adjustment impacting the electronic health record incentive payment.
- Worksheet I-4 and I-5:
  - Revised the instruction for services furnished on or after January 1, 2011, to calculate reimbursable bad debts and a facility-specific composite cost percentage under ERSD PPS.

REVISED ELECTRONIC SPECIFICATIONS EFFECTIVE DATE: Changes to the electronic reporting specifications are effective for cost reporting periods beginning on or after October 1, 2012.

DISCLAIMER: The revision date and transmittal number apply to the red *italicized material* only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

Line 15--Calculate the costs for patients covered by a state or local government program by multiplying line 1 times line 14.

Line 16--Calculate the difference between net revenue and costs for patients covered by a state or local government program by subtracting line 13 from line 15. If line 15 is less than line 13, then enter zero.

Uncompensated care:

Line 17--Enter the value of all non-government grants, gifts and investment income received during this cost reporting period that were restricted to funding uncompensated or indigent care. Include interest or other income earned from any endowment fund for which the income is restricted to funding uncompensated or indigent care.

Line 18--Enter all grants, appropriations or transfers received or expected from government entities for this cost reporting period for purposes related to operation of the hospital, including funds for general operating support as well as for special purposes (including but not limited to funding uncompensated care). Include funds from the Federal Section 1011 program, if applicable, which helps hospitals finance emergency health services for undocumented aliens. While Federal Section 1011 funds were allotted for federal fiscal years 2005 through 2008, any unexpended funds will remain available after that time period until fully expended even after federal fiscal year 2008. If applicable, report amounts received from charity care pools net of related provider taxes or assessments. Do not include funds from government entities designated for non-operating purposes, such as research or capital projects.

Line 19--Calculate the total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs by entering the sum of lines 8, 12 and 16.

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

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

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

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

Line 24--Enter "Y" for yes if any charges for patient days beyond a length-of-stay limit imposed on patients covered by Medicaid or other indigent care program are included in the amount reported in line 20, column 2, and complete line 25. Otherwise enter "N" for no.

Line 25--If you answered yes to question 24, enter charges for patient days beyond a length-of-stay limit imposed on patients covered by Medicaid or other indigent care program for services delivered during this cost reporting period. The amount must match the amount of such charges included in line 20, column 2.

Line 26--Enter the total facility (entire hospital complex) *amount of* bad debts written off *on balances owed by patients* during this cost reporting period. Include such *bad debts* for all services except physician and other professional services. *The amount reported must also include the amounts reported on* Worksheets: E, Part A, line 64; E, Part B, line 34; E-2, line 17, *columns 1 and 2*; E-3, Part I, line 11; E-3, Part II, line 23; E-3, Part III, line 24; E-3, Part IV, line 14; E-3, Part V, line 25; E-3, Part VI, line 8; *E-3,* Part VII, line 34; *I-5, line 5 (line 5.05, column 2 for cost reporting periods that overlap or begin on or after or January 1, 2011)*; J-3, line 21; and M-3, line 23. For privately insured patients, do not include bad debts that were the obligation of the insurer rather than the patient.

Line 27--Enter the total facility (entire hospital complex) Medicare reimbursable (also referred to adjusted) bad debts as the sum of Worksheet E, Part A, line 65; E, Part B, line 35; E-2, line 17, columns 1 and 2 *(line 17.01, columns 1 and 2 for cost reporting periods that begin on or after October 1, 2012)*; E-3, Part I, line 12; E-3, Part II, line 24; E-3, Part III, line 25; E-3, Part IV, line 15; E-3, Part V, line 26; E-3, Part VI, line 10; I-5, line *11*; J-3, line 21 *(line 22 for cost reporting periods that begin on or after October 1, 2012)*; and M-3, line 23 *(line 23.01 for cost reporting periods that begin on or after October 1, 2012)*.

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

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

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

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