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Form CMS-2552-96 Transmittals 22 and 23/24 Cost Reporting Update

NYSICR-2010 Road Shows, April 4-8, 2011

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Form CMS-2552-96 Transmittal 22 – Summary of Significant Revisions

- ◆ **Issued August 2010**
- ◆ **Effective for cost reporting periods ending on or after January 1, 2010**
- ◆ Revised Worksheet S-2 questions on Lines 21.06 and 21.07
- ◆ Worksheet S-7 Part I – general instructions revised to reflect the addition of 23 new RUGs categories effective for services rendered on/after October 1, 2010
- ◆ Worksheet D Part V – instructions revised to indicate that Columns 5.01 and 5.03 may be used for SCH providers with more than 100 beds that straddle the January 1, 2010 effective date and/or December 31, 2010 expiration date in accordance with ACA section 3121. (Further revised in Transmittal 23/24)
- ◆ Worksheet E Part A – addition of Line 24.97
- ◆ Worksheet E Part B – general instructions and Line 1.06 instructions revised to reflect the extension of TOPS through December 31, 2010 for qualifying hospitals. (Further revised in Transmittal 23/24)

Form CMS-2552-96 Transmittal 23 – Summary of Significant Revisions

- ◆ **Issued February 2011**
- ◆ **Effective for cost reporting periods ending on or after November 30, 2010**
- ◆ Worksheet S-2 – Lines 25.07 through 25.09 (and applicable lines 25.10 through 25.59) are added in accordance with the Federal Register, volume 75, number 226, dated Wednesday, November 24, 2010, page 72140 as stipulated by the Patient Protection and Affordable Care Act (ACA) of 2010, Section 5504 to capture the full-time equivalents (FTEs) for intern and resident training at non-provider sites.
- ◆ Worksheet S-2 – Line 64 added for facility to indicate use or non-use of cost center 55.30, “Implantable Devices Charged to Patients”, along with corresponding edits.
- ◆ Worksheet E, Part A - Lines 24.94 through 24.96 - In accordance with ACA of 2010, Sections 3125 and 10314 amends Section 1886(d)(12) of the Act to establish a temporary improvement to the Medicare inpatient hospital payment adjustment for low volume hospitals effective for discharges occurring during Federal fiscal years 2011 and 2012.

Form CMS-2552-96 Transmittal 24 – Summary of Significant Revisions

- ◆ **DRAFT Issued March 2011**
- ◆ **Effective for cost reporting periods ending on or after November 30, 2010**
- ◆ **For automated cost report software purposes, Transmittals 23 and 24 will be merged and implemented simultaneously as “T23/24”.**
- ◆ Worksheet S-2 - Line 21.07 - Is revised to reflect the Patient Protection and Affordable Care Act (ACA) of 2010, Section 3121 as amended by the Medicare and Medicaid Extenders Act (MMEA) of 2010, Section 108 which extends transitional outpatient payments (TOPs) for services rendered January 1, 2010 through December 31, 2011, for sole community hospitals (SCHs) and essential access community hospitals (EACHs), regardless of bed size.
- ◆ Worksheet D, Part V - Line 44 - Is revised to reflect ACA, Section 3122 as amended by the MMEA, Section 109 which extends Medicare reasonable cost payments for certain clinical diagnostic laboratory tests furnished to hospitals patients in certain rural areas for cost reporting periods beginning on or after July 1, 2010, through June 30, 2012.
- ◆ Worksheet D Part V – instructions revised to indicate that Columns 5.01 and 5.03 may be used for SCH providers with more than 100 beds that overlap the January 1, 2010 effective date and/or December 31, 2011 expiration date in accordance with MMEA of 2010, Section 108.
- ◆ Worksheet E, Part B - Line 1.06 - Is revised to reflect ACA, Section 3121 as amended by the MMEA, Section 108 which extends TOPs to include services rendered January 1, 2010 through December 31, 2011, for SCHs and EACHs, regardless of bed size.

Detailed review of significant changes

The following slides will present the cumulative effect of the form and instructional revisions through Transmittal 23/24.

Worksheet S-2, Lines 21.06 and 21.07

21.06	Does hospital qualify for the 3-year transition of hold harmless payments for small rural hospital under OPPIs under DRA Section 5105 or MIPPA Section 147 and ACA, section 3132? (SEE INSTRUCTIONS) (Y/N)	N	
21.07	Does this hospital qualify as a SCH with 100 or fewer beds under MIPPA Section 147? Enter Y or N in Column 1. For services from 1/1/2010 thru 12/31/2011, does the hospital qualify as SCH or EACH, regardless of bed size, under the O/P hold harmless provision in ACA Section 3121 or MMEA 108? Enter Y or N in Column 2. (SEE INSTRUCTIONS)	N	N

Instructions as revised through Transmittal 23/24:

- Line 21.06**--Effective for services rendered after December 31, 2005, does the hospital qualify for the three year transition of hold harmless payments for small rural hospitals under the prospective payment system for hospital outpatient department services, under DRA, section 5105 or the extension of this provision under MIPPA, section 147, and ACA, section 3132 effective for services rendered from January 1, 2009, through December 31, 2010? Enter "Y" for yes or "N" for no. Also see CR 4367, transmittal 877, dated February 24, 2006 and CR 6320, transmittal 1657, dated December 31, 2008, as applicable. (1/1/2006s) This response impacts the TOPs calculation on worksheet E, Part B, line 1.06.
- Line 21.07**--Effective for services rendered from January 1, 2009, through December 31, 2009, does the hospital qualify as a SCH with 100 or fewer beds reimbursed under the prospective payment system for hospital outpatient department services, under MIPPA *section* 147? Enter "Y" for yes or "N" for no *in column 1*. Also see CR 6320, transmittal 1657, dated December 31, 2008. This response impacts the TOPs calculation on worksheet E, Part B, line 1.06. (1/1/2009s) *Effective for services rendered from January 1, 2010, through December 31, 2011, does the hospital qualify as an SCH or essential access community hospital (EACH), regardless of bed size, under the outpatient hold harmless provision in the Patient Protection and Affordable Care Act (ACA), section 3121 as amended by the Medicare and Medicaid Extenders Act (MMEA) of 2010, section 108. Enter "Y" for yes or "N" for no in column 2. This response impacts the TOPs calculation on worksheet E, Part B, line 1.06. (1/1/2010s)*

Worksheet S-2, Lines 25.07, 25.08, 25.09-25.59

25.07	Has your facility trained residents in non-provider settings during the cost reporting period? Enter Y or N in Column 1. Complete lines 25.07, 25.08, 25.09-25.59 (as necessary) for IME effective for dischs on/after 7/1/2010 and GME effective for cost reporting periods beginning on/after 7/1/2010.	Y	
25.08	If line 25.07 is yes, enter in column 1 the UNWEIGHTED number of non-primary care FTE residents attributable to rotations occurring in all non-provider settings.	11.00	
	If line 25.07 is yes, use lines 25.09-25.59 as necessary to identify the program name in Col 1, program code in Col 2 and number of unweighted primary care resident FTEs b program in Col 3 for each primary care specialty program in which residents are trained (SEE INSTRUCTIONS)	Program Code (2)	Resident FTEs (3)
25.09	FAMILY MEDICINE	1350	1.10
25.10	PREVENTIVE MEDICINE	5400	1.90
25.11	FAMILY PRACTICE	3600	7.00

Instructions appear on next slide

Worksheet S-2, Lines 25.07, 25.08, 25.09-25.59 (continued)

Instructions as revised through Transmittal 23/24:

- ◆ Line 25.07--Has your facility trained residents in non-provider settings during the cost reporting period? Enter "Y" for yes or "N" for no in column 1. See Federal Register, Vol. 75, number 226, dated November 24, 2010, page 72139. Complete lines 25.07 through 25.09 (and applicable subscripts) for IME effective for discharges occurring on or after July 1, 2010 and for GME effective for cost reporting periods beginning on or after July 1, 2010.
- ◆ Line 25.08--If line 25.07 is yes, enter in column 1 the unweighted number of non-primary care FTE residents attributable to rotations occurring in all non-provider settings.
- ◆ Line 25.09--If line 25.07 is yes, enter the unweighted number of primary care FTE residents attributable to rotations occurring in all non-provider settings for each primary care specialty program in which you train residents. Use lines 25.09 through 25.59 as necessary to identify the program name in column 1, the program code in column 2 and the number of unweighted primary care resident FTEs in that program in column 3.

Worksheet S-2, Lines 25.09-25.59 – List of Primary Care Program Codes

The ICR-2010 software will permit you to enter each four-digit primary care program code as necessary. If you enter a code that is not on the standard list of codes, a pop-up window will appear so that you can choose the appropriate code from the list provided. This list was developed with CMS guidance.

25.07	Has your facility trained residents reporting period? Enter Y or N in 25.09-25.59 (as necessary) for I and GME effective for cost report
25.08	If line 25.07 is yes, enter in column care FTE residents attributable to settings.
	If line 25.07 is yes, use lines 25.09-25.59 to enter program name in Col 1, program code in Col 2, and number of primary care resident FTEs in Col 3. Enter the program in which residents are trained in Col 4.
25.09	FAMILY MEDICINE
25.10	PREVENTIVE MEDICINE
25.11	FAMILY PRACTICE

Valid Primary Care Residency Codes for S-2 Lines 25.09-25.59

Click on the appropriate residency code below for S-2, Column 2, Line 25.09

- 1350 FAMILY MEDICINE - GENERAL
- 1351 FAMILY MEDICINE - GERIATRIC MEDICINE
- 1400 INTERNAL MEDICINE - GENERAL
- 1408 INTERNAL MEDICINE - GERIATRIC MEDICINE
- 1450 INTERNAL MEDICINE & PEDIATRICS - GENERAL
- 2000 PEDIATRICS - GENERAL
- 2150 PREVENTIVE MEDICINE - GENERAL
- 2153 PREVENTIVE MEDICINE - PUBLIC HEALTH & GEN PREVEN MED
- 2202 GERIATRIC PSYCHIATRY (allopathic)
- 2755 INTERNAL MEDICINE/FAMILY MEDICINE - GENERAL
- 2765 INTERNAL MEDICINE/PREVENTIVE MEDICINE - GENERAL
- 3600 FAMILY PRACTICE - GENERAL
- 3602 FAMILY PRACTICE - GERIATRICS
- 3630 FAM. PRAC. & OST. MANIP. TREATMENT - GENERAL
- 3635 FAM. PRAC. & INTG. OST. MANIP. MED. - GENERAL
- 3900 INTERNAL MEDICINE - GENERAL
- 3904 INTERNAL MEDICINE - GERIATRICS
- 5250 PEDIATRICS - GENERAL
- 5400 PREVENTIVE MEDICINE - GENERAL
- 5425 PUBLIC HEALTH & PREVENTIVE MEDICINE - GENERAL
- 5502 GERIATRIC PSYCHIATRY (osteopathic)
- 6350 INTERNAL MEDICINE/PEDIATRICS - GENERAL

OK 1350 Cancel

When you click on the desired program code, the “OK” button will display it for final confirmation. Note that you will still need to enter the description in Column 1 for the selected code.

Worksheet S-2, Line 64

64	Did this facility incur and report costs in the Implantable Devices Charged to Patients (line 55.30) cost center? Enter in Column 1 Y or N. (SEE INSTRUCTIONS for applicable revenue codes)	Y
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Instructions as revised through Transmittal 23/24:

- ◆ Line 64--Did this facility incur and report costs in the “Implantable Devices Charged to Patients”(line 55.30) cost center as indicated in the Federal Register, Vol. 73, number 161, dated August 19, 2008, page 48462 under the following revenue codes: code 0275 - pacemaker, code 0276 - intraocular lens, code 0278 - other implants and code 0624 - Food and Drug Administration (FDA) investigational devices. Enter “Y” for yes or “N” for no in column 1.
- ◆ RELATED ECR EDIT: *1143S – If Worksheet S-2 line 64 is answered “Y” then there must be an amount greater than 0 on line 55.30, column 27 on worksheet B, Part I and vice versa.[11/30/2010]*

Worksheet S-7, Lines 45, 45.01-45.23

Line	Group (1)		ALL DAYS IN COST REPORTING PERIOD (3.01)	Swing Bed SNF Days (4.06)
44	PA1		206	0
45	AAA		10	4
45.01	ES3		25	5
45.02	ES2		26	0
45.03	ES1		45	0
45.04	HE2		15	5
45.05	HE1		12	0
45.06	HD1		9	0
45.07	HD1		26	5
45.08	HC2		36	0
45.09	HC1		15	0
45.10	HB2		40	5
45.11	HB1		10	0
45.12	LE2		6	5
45.13	LE1		53	0
45.14	LD2		5	0
45.15	LD1		8	5
45.16	LC2		12	0
45.17	LC1		20	0
45.18	LB2		10	0
45.19	LB1		4	0
45.20	CE2		3	0
45.21	CE1		5	0
45.22	CD2		2	0
45.23	CD1		3	0
	TOTALS		3904	156

Effective for services rendered on and after October 1, 2010, twenty-three new RUGs categories are introduced into the reimbursement calculation on Worksheet S-7. Refer to the list at left.

The default line is line 45 and the default designation is AAA.

Worksheet D Part V, use of Columns 5.01 and 5.03

Line # / Description	Cost to Charge Ratio from C Pt II Col 8 (1)	Cost to Charge Ratio from C Pt I Col 9 (1.01)	Cost to Charge Ratio from C Pt II Col 9 (1.02)	PPS services (See instructions) (5.01)	All Other (See instructions) (5.02)	PPS services (See instructions) (5.03)	PPS services (Col 1.01 x Col 5.01) (9.01)	All Other (Col 1.01 x Col 5.02) (9.02)	PPS (9.03)
37 Operating Room	0.729229	0.729229	0.729229	5,459	0	6,004	3,981	0	0
38 Recovery Room	0.714600	0.714600	0.714600	0	0	0	0	0	0
39 Delivery Room & Labor Room	1.025953	1.025953	1.025953	0	0	0	0	0	0
40 Anesthesiology	0.670059	0.670059	0.670059	471	0	518	316	0	0
41 Radiology-Diagnostic	0.919055	0.919055	0.919055	22,096	0	24,305	20,307	0	0
42 Radiology-Therapeutic	0.609024	0.609024	0.609024	18,194	0	20,014	11,081	0	0
43 Radioisotope	0.632916	0.632916	0.632916	6,322	0	6,955	4,001	0	0
44 Laboratory	0.599093	0.599093	0.599093	6,240	0	6,863	3,738	0	0
44.01 BLOOD LAB	0.881856	0.881856	0.881856	0	0	0	0	0	0
45 PBP Clinical Lab Services-Prgm Only	0.750300	0.750300	0.750300	0	0	0	0	0	0
46 Whole Blood & Packed Red Blood Cell	0.703489	0.703489	0.703489	2,411	0	2,652	1,696	0	0
46.30 Blood Clotting Factors Admin Costs	0.000000	0.000000	0.000000	0	0	0	0	0	0
47 Blood Storing, Processing & Trans.	0.713722	0.713722	0.713722	0	0	0	0	0	0
48 Intravenous Therapy	0.797463	0.797463	0.797463	0	0	0	0	0	0
49 Respiratory Therapy	0.494598	0.494598	0.494598	1,038	0	1,141	513	0	0

Instructions as revised through Transmittal 23/24:

- In accordance with ACA, section 3121 *as amended by the Medicare and Medicaid Extenders Act (MMEA) of 2010, section 108*, SCHs regardless of bed size, are entitled to hold harmless payments. As such, SCHs with greater than 100 beds whose cost report overlaps January 1, 2010 or December 31, **2011**, (Worksheet S-2, line 21.07, column 2 is “Y” for yes), must enter the applicable charges in columns 5.01 and 5.03 to correspond to the respective portion of the cost reporting period.

Worksheet E Part A, Lines 24.94-24.97

24	Other Adjustments (See instructions) Specify:	2,400
24.94	Low Volume Adjustment Payment-1 (See insts-periods ending in FFY 2011 or FFY 2012 ONLY)	249,400
24.95	Low Volume Adjustment Payment-2 (See insts-periods ending in FFY 2011 or FFY 2012 ONLY)	24,950
24.96	Low Volume Adjustment Payment-3 (See insts-periods ending in FFY 2011 or FFY 2012 ONLY)	2,496
24.97	HCERA Payment (Periods ending in Federal Fiscal Years 2011 or 2012 ONLY)	249,700
24.98	Credits received from manufacturers for replaced devices (SEE INST)	0
25	Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets	250,000

Instructions for Lines 24.94-24.96, as revised through Transmittal 23/24:

- ◆ Effective for Federal fiscal years 2011 and 2012 (October 1, 2010, through September 30, 2011, and October 1, 2011, through September 30, 2012, respectively), temporary improved/changed payments are mandated by Sections 3125 and 10314 ACA of 2010, as addressed in 42 CFR 412.101 for discharges occurring during Federal fiscal years 2011 and 2012. For cost reporting periods which begin before May 1, 2010, and overlap October 1, 2010, enter on lines 24.94 (and if necessary, lines 24.95 and 24.96) the Medicare inpatient payment adjustment for low volume hospitals as applicable in accordance with the instructions in a forthcoming Change Request (CR). The forthcoming CR will provide instructions regarding the source(s) from which the entered amounts can be obtained and will specify in which situations line 24.95 (and if necessary line 24.96) must be completed. Identify the line label on each line as “Low Volume Adjustment Payment.” Where difference low volume adjustment percentages apply during the cost reporting period, identify the label on each line as “Low Volume Adjustment Payment-1” increasing the number by one for each additional payment that applies. *The low volume adjustment payment must also be recorded on Worksheet E-1 as part of an interim payment. The adjustment will not be separately or specifically identified, but will be part of the overall interim payment and therefore will not be placed on a specific line on Worksheet E-1.*

Worksheet E Part A, Lines 24.94-24.97 (continued)

24	Other Adjustments (See instructions) Specify:	2,400
24.94	Low Volume Adjustment Payment-1 (See insts-periods ending in FFY 2011 or FFY 2012 ONLY)	249,400
24.95	Low Volume Adjustment Payment-2 (See insts-periods ending in FFY 2011 or FFY 2012 ONLY)	24,950
24.96	Low Volume Adjustment Payment-3 (See insts-periods ending in FFY 2011 or FFY 2012 ONLY)	2,496
24.97	HCERA Payment (Periods ending in Federal Fiscal Years 2011 or 2012 ONLY)	249,700
24.98	Credits received from manufacturers for replaced devices (SEE INST)	0
25	Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets	250,000

Instructions for Line 24.97, as revised through Transmittal 23/24:

- Effective for cost reporting periods which end during Federal fiscal years 2011 and 2012, enter on line 24.97 the additional payment in accordance with the Health Care and Education Reconciliation Act (HCERA) of 2010, section 1109 which establishes an additional payment (one payment for each year) for qualifying providers under section 1886(d) of the Act. Identify the line label as “HCERA Payment” *on Worksheet E-1, line 3.49, column 2*. This payment must also be recorded on Worksheet E-1 as an interim payment.

Worksheet E Part B, TOPS payments for eligible hospitals

Line # / Description	Services on & after 1/1/2009 (1)	Services on & after 1/1/2010 (1.01)
1 Medical and other services (See Instructions)	2,227	
1.01 Medical and other services rendered on/after 8/1/2000	116,778	116,822
1.02 PPS Payments received including outliers	125,000	68,564
1.03 Enter the 1996 hospital specific payment to cost ratio	0.000	0.850
1.04 Line 1.01 times line 1.03	0	99,299
1.05 Line 1.02 divided by line 1.04	0.0000	0.6905
1.06 Transitional corridor payment	0	26,125
1.07 Enter the amount from Worksheet D Part IV, column 9, line 101	4,579	0

Original Transmittal 22 revision, updated for Transmittal 23/24 changes:

- ◆ SCHs with greater than 100 beds whose cost report overlaps January 1, 2010 and/or December 31, 2011, (Worksheet S-2, line 21.07, column 2 is “Y” for yes) are entitled to hold harmless payments and must use columns 1 and 1.01 to correspond to the respective portion of the cost reporting period for lines 1.01 through 1.06.

Worksheet E Part B, TOPS payments for eligible hospitals (continued)

Instructions for Line 1.06, as revised through Transmittal 23/24:

- ◆ In accordance with ACA 2010, section 3121 *as amended by the Medicare and Medicaid Extenders Act (MMEA) of 2010, section 108* for services rendered January 1, 2010, through December 31, **2011**, SCHs and EACHs, regardless of bed size, are entitled to hold harmless TOPS:
 - ◆ a. For services rendered January 1, 2010, through December 31, **2011**, if Worksheet S-2, Line 21.07, column 2, is “Y”, enter 85 percent of (line 1.04 minus line 1.02).

Worksheet E-1, Line 3.49

DESCRIPTION	1. Inpatient Part A Payment Date	2. Inpatient Part A Payment Amount	3. Part B Payment Date	4. Part B Payment Amount
1 Total interim pmts paid to provider		\$5,950,000		\$473,519
2 Interim pmts payable on individual bills		\$0		\$0
3.01 List separately each .01	11/15/2002	\$80,200	00/00/0000	\$0
3.02 retroactive lump sum Program .02	2/25/2002	\$28,000	00/00/0000	\$0
3.03 adjustment amount based .03	6/15/2002	\$8,500	00/00/0000	\$0
3.04 on subsequent revision .04	00/00/0000	\$0	00/00/0000	\$0
3.05 of the interim rate for to .05	00/00/0000	\$0	00/00/0000	\$0
3.06 the cost reporting .06	00/00/0000	\$0	00/00/0000	\$0
3.07 period. Also show date .07	00/00/0000	\$0	00/00/0000	\$0
3.08 of each payment. Provider .08	00/00/0000	\$0	00/00/0000	\$0
3.09 If none, enter a zero. .09	00/00/0000	\$0	00/00/0000	\$0
3.49 HCERA Payment _____ .49	12/31/2010	\$249,700	00/00/0000	\$0

- ◆ The ICR-2010 software will transfer the amount entered on Worksheet E Part A Line 24.97 to Worksheet E-1, Line 3.49, Column 2. You will still need to enter the payment date in Column 1 of E-1 Line 3.49.

Impact on Form CMS-2552-10

- ◆ The changes that have been implemented in Form CMS-2552-96, Transmittal 23/24, must also be implemented in Form CMS-2552-10, Transmittal 2. The draft for Form CMS-2552-10, Transmittal 2 is still in development at CMS.



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Form CMS-2552-10 Status Update

NYSICR-2010 Road Shows, April 4-8, 2011

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CMS-2552-10

Timeline

- ◆ Form CMS-2552-10, Transmittal #1, issued by CMS December 30, 2010.
- ◆ Transmittal #2 is expected to be released during April – this is to correct issues with the instructions, forms and ECR specs that were incorrect in the initial release. This will also incorporate the changes first implemented with Form CMS-2552-96, Transmittal 23/24.
- ◆ Test case from CMS released to vendors in January. This also has been revised several times since the initial version was released.
- ◆ The CMS approval process usually takes 3 to 5 months, depending on their workload and the volume of issues in the cost report.
- ◆ Effective date: Cost reporting periods beginning on/after May 1, 2010.
- ◆ CMS has granted a 30-day extension for 4/30/2011 year end hospitals. First cost reports (FYE 4/30/2011 and FYE 5/31/2011) will be due October 31, 2011.
- ◆ We expect that short-period cost reports that begin on or after May 1, 2010 that are NOT terminating may use the 2552-96. CMS has not issued anything official in this regard however, but we understand that they plan to.

CMS-2552-10

SUMMARY OF REVISIONS

- ◆ Standardize subscribed lines and renumber forms.
- ◆ Reorganize data on Worksheet S-2.
- ◆ Remove obsolete worksheets.
- ◆ Assign separate settlement worksheets for the following:
 1. Inpatient Psychiatric Facility or subprovider.
 2. Inpatient Rehabilitation Facility or subprovider.
 3. Long Term Care Hospital.

CMS-2552-10

SUMMARY OF REVISIONS (continued)

- ◆ Include Worksheet S-2, Part II to:
 1. Incorporate data previously reported on FORM CMS-339.
 2. Require electronic submission as part of the filing.
 3. Eliminate separate submission of the FORM CMS-339.
- ◆ Include Worksheet S-3, Part IV to collect wage information previously reported on the FORM CMS-339.
- ◆ Include Worksheet S-3, Part V to collect contract labor and benefit costs.
- ◆ Redesign numerous worksheets for more efficient collection of data.
- ◆ Implement HIT (EHR) Revisions
- ◆ Implement GME changes per ACA Section 5504A
- ◆ Worksheet S-10

Worksheet S-10 (Lines 1-16)

12-10

FORM CMS-2552-10

4090 (Cont.)

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	PROVIDER NO.:	PERIOD: FROM _____ TO _____	WORKSHEET S-10
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Uncompensated and indigent care cost computation

1	Cost to charge ratio (Worksheet C, Part I line 200 column 3 divided by line 200 column 8)		1
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Medicaid (see instructions for each line)

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

State Children's Health Insurance Program (SCHIP) (see instructions for each line)

9	Net revenue from stand-alone SCHIP		9
10	Stand-alone SCHIP charges		10
11	Stand-alone SCHIP cost (line 1 times line 10)		11
12	Difference between net revenue and costs for stand-alone SCHIP (line 9 minus line 11)		12

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)		13
14	Charges for patients covered under state or local indigent care program (not included in lines 6 or 10)		14
15	State or local indigent care program cost (line 1 times line 14)		15
16	Difference between net revenue and costs for state or local indigent care program (line 13 minus line 15)		16

Worksheet S-10 (Lines 17-31)

Uncompensated care (see instructions for each line)				
17	Private grants, donations, or endowment income restricted to funding charity care			17
18	Government grants, appropriations or transfers for support of hospital operations			18
19	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			19
		Uninsured patients	Insured patients	Total (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			20
21	Cost of initial obligation of patients approved for charity care (line 1 times line 20)			21
22	Partial payment by patients approved for charity care			22
23	Cost of charity care (line 21 minus line 22)			23
24	Does the amount in line 20, column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			24
25	If line 24 is yes, enter charges for patient days beyond an indigent care program's length of stay limit (see instructions)			25
26	Total bad debt expense for the entire facility (see instructions)			26
27	Medicare bad debts for §1886(d) hospitals from Worksheets E, Part A and E, Part B, or for CAHs from Worksheet E-3, Part V			27
28	Non-Medicare and non-reimbursable bad debt expense (line 26 minus line 27)			28
29	Cost of non-Medicare bad debt expense (line 1 times line 28)			29
30	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)			30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			31

Worksheet S-10

- ◆ S-10 will now be meaningful.
- ◆ Data will be used in the calculation of the Electronic Health Record (EHR) Payment.
- ◆ Data will be used in the calculation of DSH “Additional Payment”.
- ◆ Compliance with completing the form correctly and completely is important. Since the data impacts payment, expect to be audited.

Worksheet S-10

- ◆ A Case for Charity Care Logs
 - ◆ Should provide detailed account information not typically available in most hospital accounting systems
 - ◆ Creates documentation audit trail

Worksheet S-10

◆ Charity Care Log – Sample Data Elements

- ◆ Patient name
- ◆ Charity application status (approved, pending, denied)
- ◆ Service from and to dates
- ◆ Patient days
- ◆ Primary/Secondary Payor
- ◆ Total gross charges
- ◆ Contractual adjustments
- ◆ Payments
- ◆ Full or partial charity care
- ◆ Charity care write-off amount
- ◆ Patient amount due after charity discount
- ◆ Patient payment plan: Yes or No
- ◆ Cost of care
- ◆ Cost of charity

2552-96 to 2552-10 cross-references

(separate documents, based on Form CMS-2552-10 Transmittal #1, 12/30/2010)

- ◆ Summary of Changes
- ◆ Worksheet S-2 crosswalk
- ◆ Worksheet A crosswalk
- ◆ Worksheet E Part A crosswalk
- ◆ Worksheet E Part B crosswalk

PLEASE NOTE that these are subject to changes expected in the forthcoming Transmittal #2. In addition, the Worksheet S-2 and Worksheet A crosswalks are based on the standard Medicare forms. These may appear slightly different as NYSICR Exhibits 1 (S-2) and 11 (A) when they are updated for the 2552-10 forms.

Form CMS-2552-10 on the Web

- ◆ Form CMS-2552-10 Transmittal #1 may be downloaded in its entirety from the CMS website. The URL is:
<https://www.cms.gov/Transmittals/2010Trans/list.asp>
- ◆ Look for “R1p240”, which stands for Revision 1 for Provider Reimbursement Manual, Part 2, Chapter 40, which was issued on 12/30/2010.
- ◆ This will allow you to have a complete set of the CMS-2552-10 forms from the beginning. Since this link is in the “Transmittals” section, when Transmittal #2 is released, the posting on the CMS website will consist only of the T-2 changes, replacing the original Transmittal #1 posting.
- ◆ The most recent version of the complete 2552-10 instruction manual and forms is also available at:
<http://www.cms.gov/Manuals/PBM/list.asp> (Select 15-2 and then select chapter 40)

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Questions?

