

Cost Report Transmittal Update

2552-96 T-20 /2552-96 T-21/2552-10

Marc Levy
Senior Manager,
Baker Newman & Noyes

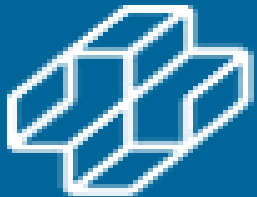


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- Worksheet S-2 - Question 21.06 (Test Case Page 2)
 - Effective for services rendered after December 31, 2005, does the hospital qualify for the three year transition of hold harmless payments for small rural hospitals under the prospective payment system for hospital outpatient department services, under DRA, **section 5105 or the extension of this provision under MIPPA, section 147 effective for services rendered from January 1, 2009 through December 31, 2009?** 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



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- Worksheet S-2 - Question 21.07 (Test Case Page 2)
 - 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 147? Enter "Y" for yes or "N" for no. 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)



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- Worksheet S-2 - Questions 61-62.01 (Test Case Page 6)
 - Line 61--Is the hospital part of a multi-campus **hospital that has one or more campuses in different CBSAs?** Enter "Y" for yes, "N" for no. (4/30/2008)

MULTICAMPUS

61.00 IS THIS FACILITY PART OF A MULTICAMPUS HOSPITAL THAT HAS ONE OR MORE CAMPUSES IN DIFFERENT CBSA? Y
ENTER "Y" FOR YES AND "N" FOR NO.

IF LINE 61 IS YES, ENTER THE NAME IN COL. 0, COUNTY IN COL. 1, STATE IN COL.2, ZIP IN COL 3,
CBSA IN COL. 4 AND FTE/CAMPUS IN COL. 5.

NAME	COUNTY	STATE	ZIP CODE	CBSA	FTE/CAMPUS
62.00 CAMPUS A	COOK	IL	60053	16974	3,000.00
62.01 CAMPUS B	PEORIA	IL	60148	37900	2,820.00
62.02					0.00
62.03					0.00
62.04					0.00
62.05					0.00
62.06					0.00
62.07					0.00
62.08					0.00
62.09					0.00



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- Worksheet S-8 - Questions 9-10 (Test Case Page 17)
 - Line 9--Subscript line 9 as needed to list all physicians furnishing services at the RHC/FQHC. Enter the physician's name in column 1, and the physician's Medicare billing number in column 2. **This line is not applicable for cost reporting periods ending on or after May 31, 2009.**
 - Line 10--Subscript line 10 as needed to list all supervisory physicians. Enter the physician's name in column 1, and the number of hours the physician spent in supervision in column 2. **This line is not applicable for cost reporting periods ending on or after May 31, 2009.**

PHYSICIAN INFORMATION:		PHYSICIAN NAME	BILLING NUMBER
9	PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT	JOHN BROWN	185393
9.01	PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT	MICHAEL TIPPER	112735
9.02	PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT	JOAN SMITH	114567
		PHYSICIAN NAME	HOURS OF SUPERVISION
10	SUPERVISORY PHYSICIAN(S) AND HOURS OF SUPERVISION DURING PERIOD	JOAN SMITH	750.00

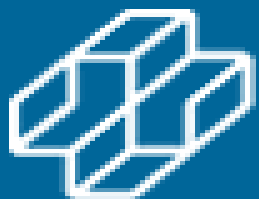


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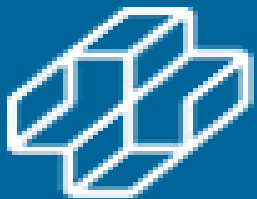
- Worksheet A - Implantable Devices
 - Line 55--Include the expense of medical supplies charged to patients. These items are low cost medical supplies generally not traceable to individual patients. Do not include high cost implantable devices on this line. This amount is generally not input on Worksheet A, but rather allocated to this cost center on Worksheet B from cost center 15 (central service and supply) based on the recommended statistic of charges requisitioned.



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- Worksheet A - Implantable Devices continued
 - Line 55.30--Include the expense of implantable devices charged to patients. The types of items includable on this line are high cost implantable devices chargeable and traceable to individual patients. Do not include low cost medical supplies on this line. When determining what costs are reported in this cost center, providers should use costs associated with implantable devices bearing revenue codes identified in the FR, Vol. 73, No. 161, page 48462, dated August 19, 2008. This amount is generally not input on Worksheet A, but rather allocated to this cost center on Worksheet B from cost center 15 (central service and supply) based on the recommended statistic of charges requisitioned. Identify this line with the appropriate cost center code according to Table 5 of the electronic reporting specifications. This cost center is effective for cost reporting periods beginning on or after May 1, 2009.



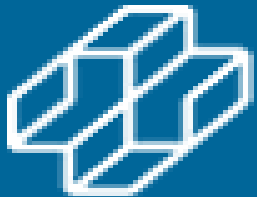
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- **Worksheet A - Implantable Devices continued**
- Hospitals Must Identify Expense and Revenue of Medical Supplies Implanted and Still in the Patient at the Time of Discharge
- Per the FY 2009 Medicare Inpatient Final Rules published on August 19, 2008:
- "In considering how to instruct hospitals on what to report in the cost center for medical supplies and the cost center for devices, we looked at the existing criteria for the type of device that qualifies for payment as a transitional pass-through device category in the OPPS. (There are no such existing criteria for devices under the IPPS.) The provisions of the regulations under §419.66(b) state that for a medical device to be eligible for pass-through payment under the OPPS, the medical device must meet the following criteria:
 - a. If required by the FDA, the device must have received FDA approval or clearance (except for a device that has received an FDA investigational device exemption (IDE) and has been classified as a Category B device by the FDA in accordance with §§405.203 through 405.207 and 405.211 through 405.215 of the regulations) or another appropriate FDA exemption.



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- Worksheet A - Implantable Devices continued
 - b. The device is determined to be reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body part (as required by section 1862(a)(1)(A) of the Act).
 - c. The device is an integral and subordinate part of the service furnished, is used for one patient only, comes in contact with human tissues, and is surgically implanted or inserted whether or not it remains with the patient when the patient is released from the hospital.
 - d. The device is not any of the following:
 - Equipment, an instrument, apparatus, implement, or item of this type for which depreciation and financing expenses are recovered as depreciable assets as defined in Chapter 1 of the Medicare Provider Reimbursement Manual (CMS Pub. 15-1).
 - A material or supply furnished incident to a service (for example, a suture, customized surgical kit, or clip, other than a radiological site marker).
 - Material that may be used to replace human skin (for example, a biological or synthetic material).



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- **Worksheet A - Implantable Devices continued**
 - These requirements are the OPPS criteria used to define a device for pass-through payment purposes and do not include additional criteria that are used under the OPPS to determine if a candidate device is new and represents a substantial clinical improvement, two other requirements for qualifying for pass-through payment."
 - For purposes of applying the eligibility criteria, we interpret "surgical insertion or implantation" to include devices that are surgically inserted or implanted via a natural or surgically created orifice as well as those devices that are inserted or implanted via a surgically created incision (70 FR 68630).



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- **Worksheet A - Implantable Devices continued**
 - In proposing to modify the cost report to have one cost center for medical supplies and one cost center for devices, we proposed that hospitals would determine what should be reported in the Medical Supplies cost center and what should be reported in the Medical Devices cost center using criteria consistent with those listed above that are included under §419.66(b), with some modification. Specifically, for purposes of the cost reporting instructions, we proposed that an item would be reported in the device cost center if it meets the following criteria:
 - a. If required by the FDA, the device must have received FDA approval or clearance (except for a device that has received an FDA investigational device exemption (IDE) and has been classified as a Category B device by the FDA in accordance with §§405.203 through 405.207 and 405.211 through 405.215 of the regulations) or another appropriate FDA exemption.
 - b. The device is reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body part (as required by section 1862(a)(1)(A) of the Act).



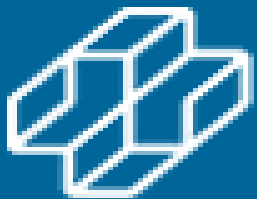
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- Worksheet A - Implantable Devices continued
 - c. The device is an integral and subordinate part of the service furnished, is used for one patient only, comes in contact with human tissue, is surgically implanted or inserted through a natural or surgically created orifice or surgical incision in the body, and remains in the patient when the patient is discharged from the hospital.
 - d. The device is not any of the following:
 - Equipment, an instrument, apparatus, implement, or item of this type for which depreciation and financing expenses are recovered as depreciable assets as defined in Chapter 1 of the Medicare Provider Reimbursement Manual (CMS Pub. 15-1).
 - A medical device that is used during a procedure or service and does not remain in the patient when the patient is released from the hospital.
 - A material or supply furnished incident to a service (for example, a surgical staple, a suture, customized surgical kit, or clip, other than a radiological site marker).
 - Material that may be used to replace human skin (for example, a biological or synthetic material).



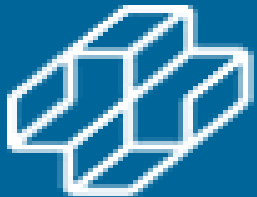
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- Worksheet A - Implantable Devices continued
 - We proposed to select the existing criteria for what type of device qualifies for payment as a transitional pass-through device under the OPPS as a basis for instructing hospitals on what to report in the cost center for Medical Supplies Charged to Patients or the cost center for Medical Devices Charged to Patients because these criteria are concrete and already familiar to the hospital community. However, the key difference between the existing criteria for devices that are eligible for pass-through payment under the OPPS in the regulations at §419.66(b) and our proposed criteria stated above to be used for cost reporting purposes is that the device that is implanted *remains in the patient when the patient is discharged from the hospital*. Essentially, **we proposed to instruct hospitals to report only implantable devices that remain in the patient at discharge in the cost center for devices**. All other devices and nonroutine supplies which are separately chargeable would be reported in the medical supplies cost center. We believe that defining a device for cost reporting purposes based on criteria that specify implantation and adding that the device must remain in the patient upon discharge would have the benefit of capturing virtually all costly implantable devices (for example, implantable cardioverter defibrillators (ICDs), pacemakers, and cochlear implants) for which charge compression is a significant concern.



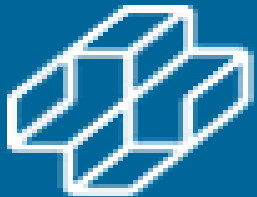
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- Worksheet A - Implantable Devices continued
 - However, we acknowledge that a definition of device based on whether an item is implantable and remains in the patient could, in some cases, include items that are relatively inexpensive (for example, urinary catheters, fiducial markers, vascular catheters, and drainage tubes), and which many would consider to be supplies. Thus, some modest amount of charge compression could still be present in the cost center for devices if the hospital does not have a uniform markup policy. In addition, requiring as a cost reporting criterion that the device is to remain in the patient at discharge could exclude certain technologies that are moderately expensive (for example, cryoablation probes, angioplasty catheters, and cardiac echocardiography catheters, which do not remain in the patient upon discharge). Therefore, some charge compression could continue for these technologies. We believe this limited presence of charge compression is acceptable, given that the proposed definition of device for cost reporting purposes would isolate virtually all of the expensive items, allowing them to be separately reported from most inexpensive supplies. separately reported from most inexpensive supplies.



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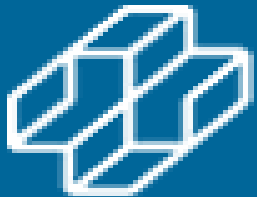
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- Worksheet A - Implantable Devices continued
 - The criteria we proposed above for instructing hospitals as to what to report in the device cost center specify that a device is not a material or supply furnished incident to a service (for example, a surgical staple, a suture, *customized surgical kit*, or clip, other than a radiological site marker) (emphasis added). We understand that hospitals may sometimes receive surgical kits from device manufacturers that consist of a high-cost primary implantable device, external supplies required for operation of the device, and other disposable surgical supplies required for successful device implantation. Often the device and the attending supplies are included on a single invoice from the manufacturer, making it difficult for the hospital to determine the cost of each item in the kit. In addition, manufacturers sometimes include with the primary device other free or "bonus" items or supplies that are not an integral and necessary part of the device (that is, not actually required for the safe surgical implantation and subsequent operation of that device). (We note that arrangements involving free or bonus items or supplies may implicate the Federal anti-kickback statute, depending on the circumstances.) One option is for the hospital to split the total combined charge on the invoice in a manner that the hospital believes best identifies the cost of the device alone.



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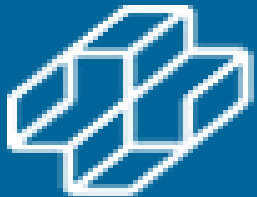
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- Worksheet A - Implantable Devices continued
 - However, because it may be difficult for hospitals to determine the respective costs of the actual device and the attending supplies (whether they are required for the safe surgical implantation and subsequent operation of that device or not), we solicited comments with respect to how supplies, disposable or otherwise, that are part of surgical kits should be reported. We are distinguishing between such supplies that are an integral and necessary part of the primary device (that is, required for the safe surgical implantation and subsequent operation of that device) from other supplies that are not directly related to the implantation of that device, but may be included by the device manufacturer with or without charge as "perks" along with the kit. If it is difficult to break out the costs and charges of these lower cost items that are an integral and necessary part of the primary device, we would consider allowing hospitals to report the costs and charges of these lower cost supplies along with the costs and charges of the more expensive primary device in the cost report cost center for implantable devices. However, to the extent that device manufacturers could be encouraged to refine their invoicing practices to break out the charges and costs for the lower cost supplies and the higher cost primary device separately, so that hospitals need not



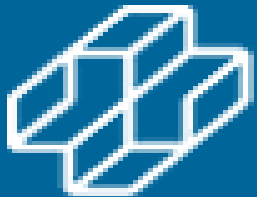
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- Worksheet A - Implantable Devices continued
 - "guesstimate" the cost of the device, this would facilitate more accurate cost reporting and, therefore, the calculation of more accurate cost-based weights. Under either scenario, even for an aggregated invoice that contains an expensive device, we believe that RTI's findings of significant differences in supply CCRs for hospitals with a greater percentage of charges in device revenue codes demonstrate that breaking the Medical Supplies Charged to Patients cost center into two cost centers and using appropriate revenue codes for devices, and crosswalking those costs to the proposed new "Implantable Devices Charged to Patients" cost center, will result in an increase in estimated device costs.



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- Worksheet A - Implantable Devices continued
- Per the IPPS Final Rules the following cost centers will be included in the new cost center (IPPS Final Rules page 48462)

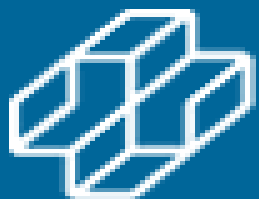
0275	Pacemaker	0276	Intraocular lens
0278	Other implants	0624	FDA Investigational device (if left in patient)

- The following codes belong in the medical supply line

0271	Nonsterile supplies	0272	Sterile supplies
0273	Take-home supplies	0623	Surgical dressings

- The following codes should be in line 66 and 67 for DME

0274	Prosthetic/orthotic	0277	Oxygen-take-home
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- Worksheet A - Implantable Devices continued
- Because there is approximately a 3-year lag between the availability of cost report data for IPPS and OPSS rate setting purposes, it may well be FY 2012 or FY 2013 before IPPS relative weights and OPSS relative weights are impacted by this change.

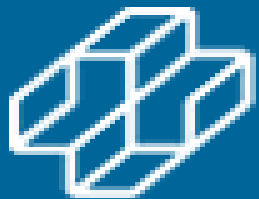


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- Worksheet D, Part V (Test Case Page 80)
 - Line 44 - For CAHs effective for services rendered on or after July 1, 2009, outpatient clinical laboratory diagnostic tests are paid at 101 percent of reasonable costs, and the beneficiary is not required to be physically present in the CAH at the time the specimen is collected. As such, enter the corresponding charges on this line. See MIPPA 2008, section 148 and CR 6395, transmittal 1729, dated May 8, 2009.
 - Line 55.30--Enter in columns 2 through 5 the charges for implantable devices charged to patients which are not paid on a fee schedule. Do not report the charges for prosthetics and orthotics. See section 3610 line 55.30



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- Worksheet E, Part A (Test Case Page 130)
 - The Average Cost per dialysis treatment will be updated annually effective 1/1/09
 - High Percentage of ESRD Beneficiary Discharges Adjustment.--Calculate the additional payment amount allowable for a high percentage of ESRD beneficiary discharges pursuant to 42 CFR 412.104. **When the average weekly cost per dialysis treatment changes within a cost reporting period, create a subscripted column 1.01 for lines 5.01 and 5.05.**
 - Line 5.05--Enter the average **weekly** cost per dialysis treatment of **\$401.43 (\$133.81 times the average number of treatments (3)). See CR 6216, Transmittal 98, dated December 12, 2008. This amount is subject to change on an annual basis. Consult the appropriate CMS change request for future rates.**
 - Line 5.06--Enter the ESRD payment adjustment (line 5.04, **column 1 times line 5.05, column 1 times line 5.01, column 1 plus, if applicable, line 5.04, column 1 times line 5.05, column 2 times line 5.01, column 2**).



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- Worksheet E, Part A (Test Case Page 130)
 - MIPPA Section 122 provided SCH's with the ability to rebase their hospital specific rate using their FFY 2006 cost report.
 - Line 7 -Additionally, for sole community hospitals only for cost reporting periods beginning on or after January 1, 2009, use the hospital specific rate based on the higher of the cost reporting periods beginning in FY 1982, 1987, 1996, or 2006. (See 42 CFR 412.78.)



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- Worksheet E, Part B (Test Case Page 132)
 - SCH TOPs instructional change
 - In accordance with MIPPA 2008, section 147, for services rendered January 1, 2009, through December 31, 2009, SCHs with 100 or fewer beds are entitled to hold harmless TOPs:
 - a. For services rendered January 1, 2009, through December 31, 2009, if Worksheet S-2, line 21.06, is “Y”, enter 85 percent of (line 1.04 minus line 1.02).



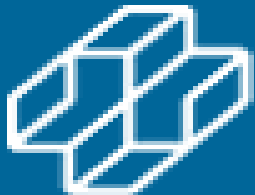
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- Worksheet E, Part B (Test Case Page 132)
 - Outpatient Outlier Reconciliation
 - **DO NOT COMPLETE THE REMAINDER OF WORKSHEET E, PART B. LINES 50 THROUGH 54 ARE FOR CONTRACTOR USE ONLY.** (Effective for hospital outpatient services furnished during cost reporting periods beginning on or after January 1, 2009.)
 - Line 50--Enter the original outlier amount from line 4 sum of all columns of this worksheet.
 - Line 51--Enter the operating outlier reconciliation amount in accordance with CMS Pub. 100-4, Chapter 4, §10.7.2.2 - §10.7.2.4.
 - Line 52--Enter the interest rate used to calculate the time value of money. (See CMS Pub. 100-4, Chapter 4, §10.7.2.2 - §10.7.2.4.)
 - Line 53-- Enter the time value of money by multiplying line 51 times line 52.
 - Line 54--Enter sum of lines 51 and 53.
 - **NOTE:** If a cost report is reopened more than one time, subscript lines 50 through 53, respectively, one time for each time the cost report is reopened.

	TO BE COMPLETED BY CONTRACTOR
50	ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)
51	OUTLIER RECONCILIATION AMOUNT (SEE INSTRUCTIONS)
52	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY
53	TIME VALUE OF MONEY (SEE INSTRUCTIONS)
54	TOTAL (SUM OF LINES 51 AND 53)



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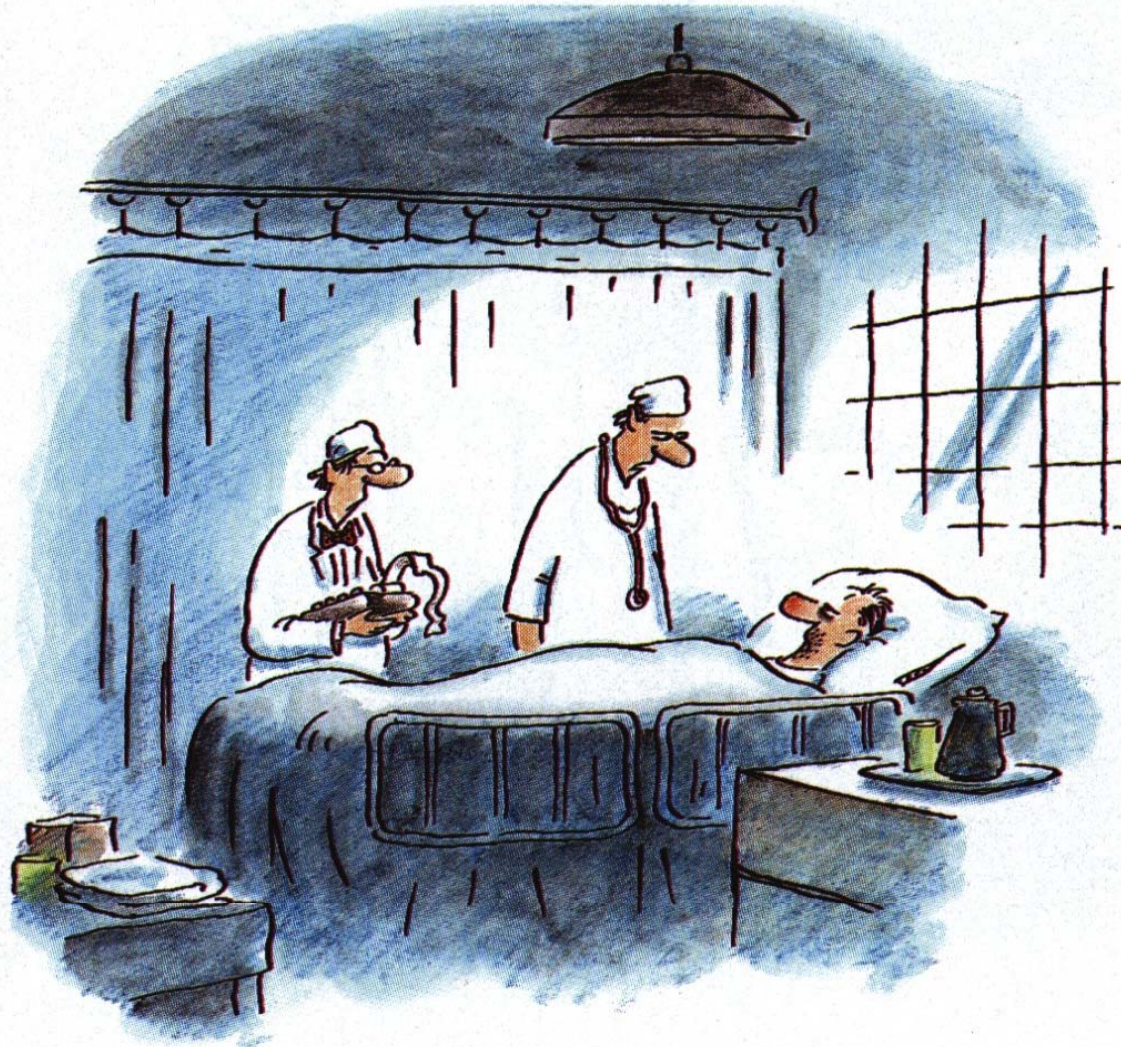
- Worksheet L, Part I (Test Case Page 199)
 - IME Hospital's will get 100% capital - While this is actually part of Transmittal 21, the cost report is calculating (or at least should be) with this revision in place.
 - The Capital IME phase out of 50% for discharges on or after 10/1/2008 to 9/30/2009, was eliminated in H.R. 1, the American Recovery and Reinvestment Act (ARRA or "stimulus bill"). Transmittal 20 included the 100% phase out of capital IME, for discharges on or after 10-1-2009, however, this was rescinded by Congress, and CMS has issued subsequent instructions to remove this "T.20 change". Capital IME continues to be allowable for discharges on or after 10-1-2009.



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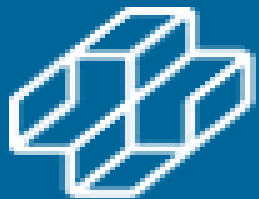
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"An accountant will be present in the operating room to ensure that costs are kept to a minimum."

Cost Report Transmittal Update 2552-96 Transmittal 21

- THESE ARE DRAFT!!!!!!!!!!!!!!!!!!!!!!
- CMS is currently consumed with the various healthcare reform proposals.
- Are effective for cost reporting periods ending on or after October 1, 2009



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Cost Report Transmittal Update 2552-96 Transmittal 21

- Significant Revisions:
 - Worksheet S-2 - Line 21.01 is amended to ascertain if for providers that qualify disproportionate share (DSH) payments are they also subject to the “Pickle” amendment.

21.01	Does your facility qualify and is currently receiving payment for disproportionate share hospital adjustment in accordance with 42 CFR 412.106? <i>Enter in column 1 "Y" for yes or "N" for no.</i> <i>Is this facility subject to the provisions of 42 CFR 412.106(c)(2) (Pickle amendment hospitals)?</i> <i>Enter in column 2 "Y" for yes or "N" for no.</i>			
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- Significant Revisions:
 - Lines 21.08 and 21.09 are added to reflect the identification of the method of accumulating the day count for Title XIX in order to refine the calculation for disproportionate share (DSH) payments in accordance with the Federal Register, volume 74, number 141, date August 27, 2009, page 43905, effective for discharges on or after October 1, 2009.
 - *Line 21.08--Indicate in column one the method used to capture Medicaid (title XIX) days during the cost reporting period by entering a "1" if days are based on the date of admission, "2" if days are base on census days (also referred to as the day count), or "3" if the days are based on the date of discharge. Is the method of identifying the days in the current cost reporting period different from the method used in the prior cost reporting period? Enter in column two "Y" for yes or "N" for no.*
 - *Line 21.09--Indicate in column one the count of labor/delivery days for Title XIX and in column two the total count of labor/delivery days for the entire facility.*

21.08	<i>Which method is used to determine Medicaid days? Enter in column 1, 1 if it is based on date of admission 2 if it is based on census days, or 3 if it is based on date of discharge. Is this method different than the method used in the last cost reporting period? Enter in column 2, "Y" for yes and "N" for no.</i>			
21.09	<i>Enter in col. 1 labor and delivery days for Title XIX. Enter in col. 2 labor and delivery days in total for this facility.</i>			



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- Significant Revisions:
 - Worksheet S-3, Part I - Line 26, columns 5 and 6 are revised to reflect the exclusion of observation patient days from the computation of the disproportionate patient percentage (DPP) and from the computation of bed days available for the purpose of computing indirect medical education (IME) in accordance with the Federal Register, volume 74, number 141, date August 27, 2009, page 43905, effective for discharges on or after October 1, 2009.
 - Worksheet A - As a provider invoked option, nonstandard cost centers for Cardiac Rehabilitation, Hyperbaric Oxygen Therapy, and Lithotripsy are established for use on worksheet A as identified in Table 5 of the electronic reporting specifications.
 - Line 55.01 the “Implantable Devices Charged to Patients” cost center as established in T20 is re-designated to line 55.30.



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- Significant Revisions:
 - Worksheet E, Part A - Revised the calculation of lines 3 and 4.01 to reflect the exclusion of subsequently admitted observation days from the computation of the disproportionate patient percentage (DPP) and the reduction of total observation days from the computation of bed days available for the purpose of computing indirect medical education (IME) in accordance with the Federal Register, volume 74, number 141, date August 27, 2009, page 43905, effective for discharges on or after October 1, 2009.



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Cost Report Transmittal Update 2552-96 Transmittal 21

- Significant Revisions:

- Line 4.01--*For cost reporting periods beginning prior to October 1, 2004 and beginning on or after October 1, 2009*, enter the percentage resulting from the calculation of Medicaid patient days (Worksheet S-3, Part I, column 5, line 12 plus line 2, *(plus Worksheet S-2, line 21.09, column 1 for cost reporting periods beginning on or after October 1, 2009)*), minus the sum of lines 3 and 4) to total days reported on Worksheet S-3, column 6, line 12 *(plus Worksheet S-2, line 21.09, column 2 for cost reporting periods beginning on or after October 1, 2009)* minus the sum of lines 3 and 4. Increase total days by any employee discount days reported on worksheet S-3, Part I, column 6, line 28.
- For cost reporting periods beginning on or after October 1, 2004, *and beginning on or before September 30, 2009*, enter the percentage resulting from the calculation of the total Medicaid patient days (Worksheet S-3, Part I, column 5, line 12 plus line 2, plus column 5.01, line 26, minus the sum of lines 3 and 4) to total days reported on Worksheet S-3, column 6, line 12, plus column 6.01, line 26, minus the sum of lines 3 and 4. Increase total days by any employee discount days reported on worksheet S-3, Part I, column 6, line 28.

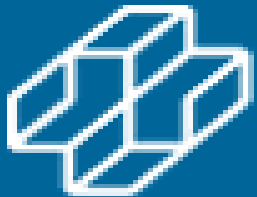


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Cost Report Transmittal Update 2552-96 Transmittal 21

- Significant Revisions:
 - As published in the FFY 2010 Final Inpatient PPS regulations on 8/27/09
 - DSH Days Revisions – Effective for cost report periods beginning on or after 10/1/09
 - Exclude ALL Observation Days from the DSH calculation and IME available bed count determination
 - CMS, after “further examination of existing policy” has decided to Include Labor and Delivery Room Days
 - Labor and Delivery Room Days will be included in the DSH calculation as inpatient days as long as the patient eventually is admitted

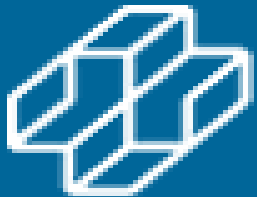


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Cost Report Transmittal Update

2552-96 Transmittal 21

- Significant Revisions:
- “for cost reporting periods beginning on or after October 1, 2009, we proposed to change our existing policy regarding patient days to include, in the DPP calculation, patient days associated with maternity patients who were admitted as inpatients and were receiving ancillary labor and delivery services at the time the inpatient routine census is taken, regardless of whether the patient occupied a routine bed prior to occupying a bed in a distinct ancillary labor and delivery room and regardless of whether the patient occupied a routine bed prior to occupying an ancillary labor and delivery bed and regardless of whether the patient occupies a “maternity suite” in which labor, delivery, recovery, and postpartum care all take place in the same room. We believed that this proposed policy would be consistent with our existing policy under section 2205 of the PRM-I regarding counting patient days associated with other ancillary areas (such as surgery and post anesthesia).
- We note that we did not propose to change our policy on patient days for labor and delivery patients who are *not* admitted to the hospital as inpatients.”



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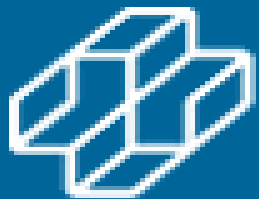
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Cost Report Transmittal Update

2552-96 Transmittal 21

- Significant Revisions:
- Also effective for cost report periods beginning on or after 10/1/09
 - “effective for cost reporting periods beginning on or after October 1, 2009, a hospital may report Medicaid-eligible days in the numerator of the Medicaid fraction of the DPP of a cost reporting period based on date of admission, date of discharge, or dates of service.
 - However, we indicated that under the proposed revised policy, a hospital would be required to notify CMS (through the fiscal intermediary or MAC) in writing if the hospital chooses to change its methodology of counting days in the numerator of the Medicaid fraction of the DPP. We proposed to require that the written notification be submitted at least 30 days prior to the beginning of the cost reporting period to which the requested change would apply. The written notification must specify the changed methodology the hospital wishes to use and the cost reporting period to which the requested change would apply. We proposed that a hospital would only be able to make such a change effective on the first day of the beginning of a cost reporting period and the change would have to be effective for the entire cost reporting period; that is, a hospital would not be permitted to change its methodology in the middle of a cost reporting period.

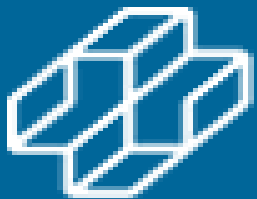


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Cost Report Transmittal Update 2552-96 Transmittal 21

- Significant Revisions:
 - This change would also be effective for all subsequent cost reporting periods unless the hospital submits a subsequent notification to change its methodology for a future cost reporting period. We noted that we would expect that a hospital would rarely decide to change the methodology it uses to count days in the numerator of the Medicaid fraction of the DPP and that such a change would be prompted out of necessity (for example, the State Medicaid agency changes the methodology it uses to provide patient Medicaid eligibility information to hospitals). In addition, we proposed that if a hospital changes its methodology for counting days in the numerator of the Medicaid fraction, CMS, or the fiscal intermediary or MAC, would have the authority to adjust the inpatient days reported by the hospital in a cost reporting period to prevent “double counting” of days in the numerator of the Medicaid fraction of the DPP of the Medicare DSH calculation reported in another cost reporting period



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Cost Report Transmittal Update 2552-96 Transmittal 21

- Significant Revisions:
 - Worksheet E, Part A - Revised lines 55 and 56 to reflect the outlier reconciliation time value of money as input amounts.
 - Worksheet E, Part B - Revised line 53 to reflect the outlier reconciliation time value of money as an input amount.

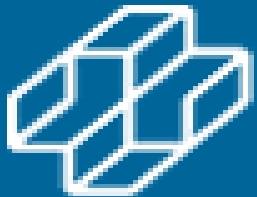


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Cost Report Transmittal Update 2552-96 Transmittal 21

- Significant Revisions:
 - Worksheet E-3, Part I - Revised the instructions for inpatient rehabilitation facilities (IRF) to reflect the update for the low income patient (LIP) adjustment factor and the medical education adjustment factor both effective for discharges on or after October 1, 2009 in accordance with the Federal Register, volume 74, number 141, dated August 7, 2009, page 39774.
 - Worksheet L, Part I - Revised this section to reinstate the full capital IME teaching adjustment factor (previously addressed in T20) applied to for fiscal year 2009 and subsequent in accordance with the Federal Register, volume 74, number 165, dated August 27, 2009 43929. This gives providers the full capital IME teaching amount for discharges occurring on or after October 1, 2008.
 - Worksheet M-3 - Line 14 is revised to reflect the implementation of Medicare improvement for Patients and Providers Act (MIPPA) 2008, section 102 implementing the phase out of the outpatient mental health treatment limitation over a 5 year period, from 2010 - 2014.



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- Significant Revisions:
 - Worksheet M-4 - Columns 2.01 and 2.02 are added to capture relevant data and calculate the costs of H1N1 influenza vaccines; and the simultaneous administration of H1N1 influenza and seasonal influenza vaccines and administration in accordance with CR 6633, publication 100-20, transmittal 547, dated August 28, 2009.

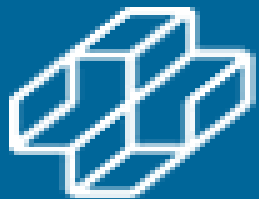


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Cost Report Transmittal Update 2552-10

- Published in the Federal Register on July 2, 2009
- Effective for Cost Report periods beginning on or after February 1, 2010
- Several New Forms



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Cost Report Transmittal Update 2552-10

- Per CMS, here is why they are revising the 2552 forms
 - Clarify existing instructions and definitions.
 - Standardize reporting of legislative and policy changes incorporated in the prior version of the hospital cost report (FORM CMS-2552-96) through transmittal updates.
 - Standardize subscripted lines and renumber forms.
 - Reorganize data on Worksheet S-2, which drives the cost report, for a better flow.
 - Remove obsolete worksheets.
 - Delete obsolete cost centers.



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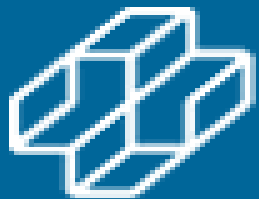
- Good News
 - 339 will finally be part of the cost report as part of the new form W/S S-2, Part II.
 - 40 total questions
 - 339 Exhibits will still need to be filled out
 - No clarification as to whether they will be done via the cost report or done manually as they are now
- Bad News
 - W/S A-7 and W/S G series still need to be done



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Cost Report Transmittal Update 2552-10

- Significant Revisions
 - W/S S-2, Part I – Is now organized in a more orderly fashion (for instance, all teaching hospital questions are grouped together in questions 35-42)



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Cost Report Transmittal Update 2552-10

- Significant Revisions
 - DSH Data now will go to S-2, Lines 20-22
 - As the draft instructions read, the data does not flow to
 - S-3, Part I
 - E, Part A (in addition, the DSH calculation will still need to be done off the cost report)

20	Does your facility qualify and is currently receiving disproportionate share hospital payment in accordance with 42 CFR 412.106, or low income payment in accordance with 42 CFR 412.624 (e)(2)? Enter "Y" for yes and "N" for no.						
21	If line 20 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.	In State Medicaid paid days 1	In State Medicaid eligible days 2	Out-of State Medicaid paid days 3	Out-of State Medicaid eligible days 4	Medicaid HMO days 5	Other Medicaid days 6
22	If line 20 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 1	In State Medicaid eligible days 2	Out-of State Medicaid paid days 3	Out-of State Medicaid eligible days 4	Medicaid HMO days 5	Other Medicaid days 6



Cost Report Transmittal Update 2552-10

- Significant Revisions
 - Wage Index
 - 339 Exhibit 6 (listing of wage related costs) is now W/S S-3, Part IV
 - NEW SCHEDULE
 - W/S S-3, Part V – Wage Index Contract Labor and Benefit Cost



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Cost Report Transmittal Update 2552-10

DRAFT		FORM CMS-2552-10		4090 (Cont.)	
HOSPITAL CONTRACT LABOR AND BENEFIT COST			PROVIDER NO.:	PERIOD: FROM _____ TO _____	WORKSHEET S-3, PART V
PART V - Contract Labor and Benefit Cost					
Hospital and Hospital-Based Component Identification:					
	Component	Component Name	Provider Number	Contract Labor	Benefit Cost
	0	1	2	3	4
1	Hospital				1
2	Subprovider- IPF				2
3	Subprovider- IRF				3
4	Subprovider- (Other)				4
5	Swing Beds-SNF				5
6	Swing Beds-NF				6
7	Hospital-Based SNF				7
8	Hospital-Based NF				8
9	Hospital-Based OLTC				9
10	Hospital-Based HHA				10
11	Separately Certified ASC				11
12	Hospital-Based Hospice				12
13	Hospital-Based Health Clinic (RHC/FQHC)				13
14	Hospital-Based-CMHC				14
15	Renal Dialysis				15



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Cost Report Transmittal Update 2552-10

- Significant Revisions
 - W/S S-10 is completely revised



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Cost Report Transmittal Update 2552-10

DRAFT		FORM CMS-2552-10		4090 (Cont.)	
HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		PROVIDER NO.:	PERIOD: FROM _____ TO _____	WORKSHEET S-10	
Uncompensated and indigent care cost computation				1	
1	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)				1
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", then enter DSH or supplemental payments from Medicaid				5
6	Medicaid charges				6
7	Medicaid cost (line 1 times line 6)				7
8	Difference between 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 revenue and costs for stand-alone SCHIP (line 9 minus line 11)				12
Other state or local 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 revenue and costs for state or local indigent care program (line 13 minus line 15)				16
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



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	Uninsured patients	Insured patients	Total (col. 1+ col. 2)	
	1	2	3	
19	Total initial obligation of patients approved for charity care (at full charges) for the entire facility			19
20	Initial obligation of patients for charity care (at full charges) for §1886(d) hospitals or CAHs			20
21	Cost of initial obligation of patients approved for charity care (line 1 times line 19)			21
22	Partial payment by patients approved for charity care			22
23	Cost of charity care (line 21 minus line 22)			23
			1	
24	Does the amount in line 19 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," charges for patient days beyond an indigent care program's length of stay limit			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 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



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- Significant Revisions
 - Cost Center Line Numbers have been revised.
 - For Instance - ER was line 61 and is now 91



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GENERAL SERVICE COST CENTERS		
1	00100	Capital Related Costs-Buildings and Fixtures
2	00200	Capital Related Costs-Movable Equipment
3	00300	Other Capital Related Costs
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
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)

INPATIENT ROUTINE SERVICE COST CENTERS		
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)
43	04300	Nursery
44	04400	Skilled Nursing Facility
45	04500	Nursing Facility
46	04600	Other Long Term Care



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ANCILLARY SERVICE COST CENTERS		
50	05000	Operating Room
51	05100	Recovery Room
52	05200	Delivery Room and Labor Room
53	05300	Anesthesiology
54	05400	Radiology-Diagnostic
55	05500	Radiology-Therapeutic
56	05600	Radioisotope
57	05700	Laboratory
58	05800	PBP Clinical Laboratory Services-Program Only
59	05900	Whole Blood & Packed Red Blood Cells
60	06000	Blood Storing, Processing, & Trans.
61	06100	Intravenous Therapy
62	06200	Respiratory Therapy
63	06300	Physical Therapy
64	06400	Occupational Therapy
65	06500	Speech Pathology
66	06600	Electro cardiology
67	06700	Electroencephalography
68	06800	Medical Supplies Charged to Patients
69	06900	Implantable Devices Charged to Patients
70	07000	Drugs Charged to Patients
71	07100	Renal Dialysis
72	07200	ASC (Non-Distinct Part)
73		Other Ancillary (specify)
OUTPATIENT SERVICE COST CENTERS		
90	09000	Clinic
91	09100	Emergency
92	09200	Observation Beds
93		Other Outpatient Service (specify)

OTHER REIMBURSABLE COST CENTERS		
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	09900	Outpatient Rehabilitation Provider (specify)
100	10000	Intern-Resident Service (not appvd. tching. prgm.)
101	10100	Home Health Agency
SPECIAL PURPOSE COST CENTERS		
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
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)
118		SUBTOTALS (sum of lines 1-117)
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)



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- Significant Revisions
 - W/S D-4 – Inpatient Charges is now W/S D-3
 - W/S D-6 - Organ Acquisition is now W/S D-4
 - W/S D-9 – Teaching Physicians is now W/S D-5



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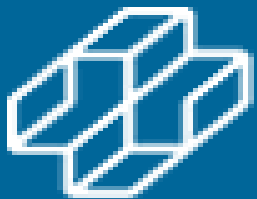
- Significant Revisions
 - W/S E, Part A is cleaned up and renumbered (for instance, the DSH information is now on lines 27-31).
 - W/S E, Part B is cleaned up and renumbered



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- Significant Revisions
 - NEW SCHEDULES
 - W/S E-3, Part I - To be used only by TEFRA reimbursed providers
 - W/S E-3, Part II – To be used by IP Psych providers
 - W/S E-3, Part III – To be used by IP Rehab providers
 - W/S E-3, Part IV – To be used by LTC providers
 - W/S E-3, Part V – To be used by cost reimbursed providers only (they used to use W/S E-3, Part II)
 - W/S E-3, Part VI – To be used for Medicare SNF reimbursement (they used to use W/S E-3, Part III)
 - W/S E-3, Part VII – To be used for Title V and Title XIX SNF Reimbursement
 - W/S E-4 – To be used to calculate Direct GME and ESRD Direct GME (they used to use E-3, Part IV)

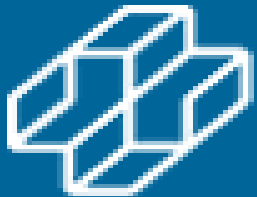


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Cost Report Transmittal Update 2552-10

- Here is CMS's estimates for the time and money it takes to prepare the 2552 cost report.
 - The total burden for the new FORM CMS-2552-10 is estimated to be 4,151,064 hours and \$62,265,960 which are increases of 60,590 hours and \$13,180,272. The changes to the burden are a result of:
 - On a per respondent basis, revisions to the MCR (prior to inclusion of the FORM CMS-339) to streamline data collection, clarify instructions and definitions, and eliminate obsolete worksheets resulted in a burden reduction of 5 hours.
 - On a per respondent basis, incorporating the FORM CMS-339 in the revised MCR increased the burden by 16 hours.
 - The estimated number of respondents decreased by 7 (from 6,175 as of 9/27/2007 to 6,168 as of 03/11/2009).
 - The standard rate per hour has been indexed for cost of living adjustment (COLA) from \$12 to \$15. The \$12/hour was the 1996 rate, which was the last time the hospital cost report was updated.



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Cost Report Transmittal Update 2552-10

- A full copy of the proposed 2552-10 forms and instructions can be found at the following website.
- <http://www.cms.hhs.gov/PaperworkReductionActof1995/PRAL/ItemDetail.asp?ItemID=CMS1224069>

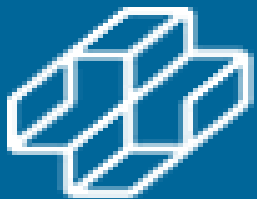


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- Any Questions?



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