Form CMS-2552-10
Cost Report Update

Transmittals 9 and 10

HFMA – Louisiana Chapter Summer Institute

- August 30, 2016
Contents

- Review of significant changes in Form CMS-2552-10, Transmittal #9

- Review of significant changes in Form CMS-2552-10, Transmittal #10, per most recent CMS DRAFT
Review of Significant Transmittal #9 changes

- **NOTE:** This document addresses the most significant changes in Form CMS-2552-10 Transmittal #9. It should not be considered a substitute for reviewing the instructions as issued by CMS.

- Form CMS-2552-10 Transmittal #9 is effective for cost reporting periods beginning on or after October 1, 2015. Specific effective dates will vary for some items. Some changes in Transmittal #9 are retroactive.

- CMS changes to the forms and instructions are noted in red, italicized text. Blue, italicized text is used when an entire page contains new or changed instructions, unless the page is the continuation of a previous page.
Worksheet S-2 Part I, Line 37.01

- New line to identify former MDHs that are eligible for the transitional hospital-specific payment:

  - Line 37.01--Did this hospital lose their MDH status because they are no longer in a rural area due to the implementation of the new OMB delineations in FY 2015, and they did not reclassify from urban to rural under the regulations at § 412.103 before January 1, 2016? Enter “Y” for yes or “N” for no.

- Affects completion of Worksheet E Part A, Lines 48, 49 and 100, as well as Line 15 on Exhibit 4 (Low Volume Adjustment) and Exhibit 5 (HAC Reduction Calculation)
Worksheet S-2 Part I, Line 122

- **New line to identify providers reporting state health or other taxes:**

  - **Line 122**—Does the cost report contain state health or similar taxes? Enter “Y” for yes or “N” for no in column 1. If the answer in column 1 is “Y”, enter in column 2 the Worksheet A line number where these taxes are included.

- **Per CMS, the amount entered in Column 1 should include all state health provider taxes (including Medicaid provider taxes) paid by the provider.**

- **No impact on cost report calculations or settlement**
Worksheet S-2 Part I, Line 169

- Clarification to instructions:
  
  - **Line 169**—If this is a §1886(d) provider that responded “N” for no to question 105 and “Y” for yes to question 167, enter the transition factor to be used in the calculation of your EHR incentive payment. For cost reporting periods where the transition factor is zero, enter “9.99” for software programming purposes. This line is not applicable for cost reporting periods beginning on or after October 1, 2016.

- The use of 9.99 for providers that have completed the EHR transition prevents the inappropriate issuance of Level 1 edit 10450S.
Worksheet S-10, Line 26

- Clarification to instructions for bad debt write-offs:

  - Line 26--Enter the total facility (entire hospital complex) amount of bad debts written off during this cost reporting period on balances owed by patients regardless of the date of service. 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.
Worksheet D-1 Part IV, Lines 90-93, Column 2

- Change in inpatient routine cost amount used in calculation of Observation Bed Pass Through Cost:

  - Column 2--Enter on each line the general inpatient routine cost from line 21. Enter the same amount on each line.

<table>
<thead>
<tr>
<th>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</th>
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</thead>
<tbody>
<tr>
<td>Line</td>
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<table>
<thead>
<tr>
<th>COMPUTATION OF OBSERVATION BED PASS THROUGH COST</th>
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<tr>
<td>Cost</td>
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</tr>
</tbody>
</table>

- Previously, D-1 Part I, Line 27 (General Inpatient Routine Service Cost net of Swing-Bed Cost) had been used in this calculation.

- This change will affect only those hospitals that have Swing-Bed SNF and/or Swing-Bed NF services.

- This is a retroactive change for all Form CMS-2552-10 cost reports.
Modification to instructions for former MDHs:

- Line 48--SCHs are paid the highest of the federal payment rate, the hospital-specific rate (HSR) determined based on a FFY 1982 base period (see 42 CFR 412.73), the hospital-specific rate determined based on a FFY 1987 base period (see 42 CFR 412.75), for cost reporting periods beginning on or after October 1, 2000, the hospital-specific rate determined based on a FFY 1996 base period (see 42 CFR 412.77), or for cost reporting periods beginning on or after January 1, 2009, the hospital-specific rate determined based on a FFY 2006 base period (see 42 CFR 412.78). MDHs are paid the highest of the federal payment rate, or the federal rate plus 75 percent of the amount of the excess over the federal rate of the highest rate for the 1982, 1987, or 2002 (see 42 CFR 412.79), base period hospital specific rate. Effective January 1, 2016, former MDHs that lost their MDH status because they are no longer in a rural area due to the new OMB delineations in FY 2015 (Worksheet S-2, Part I, line 37.01 is yes) will transition from payments based, in part, on the hospital-specific rate to payments based entirely on the Federal rate. For discharges occurring on or after January 1, 2016, and before October 1, 2016, these former MDHs will receive the Federal rate plus two-thirds of 75 percent of the amount by which the Federal rate payment is exceeded by the hospital’s hospital-specific rate payment. For FY 2017, that is, for discharges occurring on or after October 1, 2016, and before October 1, 2017, these former MDHs will receive the Federal rate plus one-third of 75 percent of the amount by which the Federal rate payment is exceeded by the hospital’s hospital-specific rate. For FY 2018, that is, for discharges occurring on or after October 1, 2017, these former MDHs will be paid based solely on the Federal rate. For SCHs, MDHs and former MDHs, enter the applicable hospital-specific payments.

Providers affected by this change who are also subject to the Low Volume Adjustment and/or the HAC Reduction Adjustment should refer to the revised instructions for Line 15 on Exhibits 4 and 5, respectively.
Worksheet E Part A, Line 49

- **Modification to instructions for former MDHs:**
  
  Line 49-- For SCHs, enter the greater of line 47 or 48, plus the amount from line 29.01. For MDH discharges occurring on or after October 1, 2006, and before October 1, 2017, if line 47 is greater than line 48, enter the amount on line 47, plus the amount from line 29.01. For MDHs, if line 48 is greater than line 47, enter the amount on line 47, plus 75 percent of the amount that line 48 exceeds line 47, plus the amount from line 29.01. Hospitals not qualifying as SCH or MDH providers will enter the amount from line 47, plus the amount from line 29.01.

  For former MDHs (Worksheet S-2, Part I, line 37.01 is yes), effective for cost reporting periods that begin or overlap January 1, 2016, and end on or before September 30, 2016, if line 48 is greater than line 47, enter the amount on line 47, plus two thirds of (75 percent of the amount that line 48 exceeds line 47, times (the number of days in the cost reporting period between January 1, 2016 and September 30, 2016 divided by the total number of days in the cost reporting period)), plus the amount from line 29.01. For cost reporting periods that begin or overlap October 1, 2016, if line 48 is greater than line 47, enter the amount on line 47, plus two thirds of (75 percent of the amount that line 48 exceeds line 47, times (the number of days in the cost reporting period prior to October 1, 2016, divided by the total number of days in the cost reporting period)), plus one third of (75 percent of the amount that line 48 exceeds line 47, times (the number of days in the cost reporting period beginning on or after October 1, 2016 and before October 1, 2017, divided by the total number of days in the cost reporting period)), plus the amount from line 29.01.

- **Providers affected by this change who are also subject to the Low Volume Adjustment and/or the HAC Reduction Adjustment should refer to the revised instructions for Line 15 on Exhibits 4 and 5, respectively.** Ending date of 9/30/2016 above was added in the Transmittal #10 DRAFT.
Worksheet E Part A, Line 70.88

- New line to report Volume Decrease Adjustments for SCHs and MDHs:

  - **Line 70.88**--Enter the volume decrease adjustment for SCH or MDH hospitals in accordance with 42 CFR 412.92(e) or 412.108(d), respectively.
Worksheet E Part A, HSP Bonus Payment, HVBP & HRR Adjustments

- Modification to instructions for former MDHs:

**Hospital Specific Payment (HSP) Bonus Payment HVBP Adjustment and HRR Adjustment**--The ACA 2010 §§3001 and 3025 implemented HVBP and HRR and applied special rules for MDHs through FFY13. Effective for discharges occurring on or after October 1, 2013, MDHs that receive a HSP bonus payment on the cost report are subject to a HVBP and HRR adjustment for that bonus payment amount. The HSP bonus payment amount is 75 percent of the amount that line 48 exceeds line 47. Complete lines 100 through 104 only when line 48 exceeds line 47.

For a former MDH (Worksheet S-2, Part I, line 37.01 is yes), for FY 2016 the HSP bonus payment amount determined for the period of January 1, 2016 through September 30, 2016 is two-thirds of 75 percent of the amount by which line 48 exceeds line 47. For FY 2017, the HSP bonus payment amount determined for the period of October 1, 2016 through September 30, 2017, is one-third of 75 percent of the amount by which line 48 is exceeds line 47.
Modification to instructions for former MDHs:

**Line 100**—If line 48 is greater than line 47, enter the pro rata share of the HSP bonus payment amount in columns 1 and 2. Enter in column 1, {((line 48 minus line 47) times 75 percent) times (the number of days in the cost reporting period prior to October 1 divided by the total days in the cost reporting period)}. Enter in column 2, {((line 48 minus line 47) times 75 percent) times (the number of days in the cost reporting period on or after October 1 divided by the total days in the cost reporting period)}. If the hospital does not have MDH status for the entire cost reporting period, prorate accordingly.

For former MDHs for FY 2016, for cost reporting periods that begin on or after January 1, 2016, enter in column 1, two thirds of {((line 48 minus line 47) times 75 percent) times (the number of days in the cost reporting period on or after January 1, 2016 through September 30, 2016, divided by the total days in the cost reporting period)}. Enter in column 2, one third of {((line 48 minus line 47) times 75 percent) times (the number of days in the cost reporting period on or after October 1, 2016 through September 30, 2017, divided by the total days in the cost reporting period)}. For cost reporting periods that overlap January 1, 2016, and end on or before September 30, 2016, enter zero in column 1, and enter in column 2, two thirds of {((line 48 minus line 47) times 75 percent) times (the number of days in the cost reporting period on or after January 1, 2016 through September 30, 2016, divided by the total days in the cost reporting period)}. For cost reporting periods that overlap January 1, 2016, and October 1, 2016, enter in column 1, two thirds of {((line 48 minus line 47) times 75 percent) times (the number of days in the cost reporting period on or after January 1, 2016 through September 30, 2016, divided by the total days in the cost reporting period)}. Enter in column 2, one third of {((line 48 minus line 47) times 75 percent) times (the number of days in the cost reporting period on or after October 1, 2016 through September 30, 2017, divided by the total days in the cost reporting period)}. 
Modification to instructions for former MDHs (continued):

For former MDHs for FY 2017, for cost reporting periods that begin October 1, 2016, enter in column 2, one third of {((line 48 minus line 47) times 75 percent) times (the number of days in the cost reporting period on or after October 1, 2016 through September 30, 2017, divided by the total days in the cost reporting period)}. For cost reporting periods that overlap October 1, 2016, enter in column 1, two thirds of {((line 48 minus line 47) times 75 percent) times (the number of days in the cost reporting period prior to October 1, 2016, divided by the total days in the cost reporting period)}. Enter in column 2, one third of {((line 48 minus line 47) times 75 percent) times (the number of days in the cost reporting period on or after October 1, 2016 through September 30, 2017, divided by the total days in the cost reporting period)}. For cost reporting periods that overlap September 30, 2017, enter in column 1, one third of {((line 48 minus line 47) times 75 percent) times (the number of days in the cost reporting period between October 1, 2016 through September 30, 2017, divided by the total days in the cost reporting period)} and zero in column 2.
Worksheet E-1 Part I, Line 1

- Modified instructions to include volume adjustment payments for SCHs and MDHs:

  **Line 1**—Enter the total Medicare interim payments paid to you (excluding payments made under the composite rate for ESRD services), including amounts paid under PPS, pass through payments, payments from the supplemental PS&R associated with the Model 4 BPCI, and volume decrease adjustment payments received for SCHs and MDHs as reported on Worksheet E, Part A, line 70.88. The amount entered must reflect the sum of all interim payments paid on individual bills (net of adjustment bills) for services rendered in this cost reporting period. The amount entered must also include amounts withheld from your interim payments due to an offset against overpayments applicable to the prior cost reporting periods. Do not include (1) any retroactive lump sum adjustment amounts based on a subsequent revision of the interim rate, (2) tentative or net settlement amounts, or (3) interim payments payable. If you are reimbursed under the periodic interim payment method of reimbursement, enter the periodic interim payments received for this cost reporting period.
Worksheet I-1

- Modified instructions for Lines 10-16, 25 and 27 related to ESA costs:

  **Lines 10 through 16**—Include on the appropriate lines costs directly charged to the renal department after reclassifications and adjustments. Report other direct costs on line 16 that cannot be specifically identified on lines 11 through 15. **Line 15 must include all ESA costs, effective for cost reporting periods beginning on and after October 1, 2015.**

  **Line 17**—Add lines 9 through 16. The total in column 1 must agree with the total on Worksheet A, column 7 for line 74 or line 94, as appropriate.

  **Lines 18 through 26**—Enter the allocated general service costs from Worksheet B, Part I, lines 74 or 94 as listed in the chart below.

  **NOTE:** Line 25 excludes the costs of all ESA’s administered to ESRD patients in the renal department and home program identified on Worksheet B-2, lines 1, 2, 3 or 4.

  **Line 27**—Add lines 17 through 26. This total must agree with the total on Worksheet B, column 24, line 74 or line 94 if a home dialysis cost center was established, less the sum of columns 21 and 22, as appropriate.

- For cost reporting periods beginning prior to October 1, 2015, Line 27 must agree with Worksheet B Part I, Column 26, Line 74 or Line 94 as appropriate.
Worksheet I-2

Clarified instructions for Lines 14, 15, 17 and 19 related to ESA costs:

**Line 14.**—Report the direct costs of EPO net of discounts furnished in the renal department. Include all costs for patients receiving outpatient, home, or training dialysis treatments. This amount includes EPO cost furnished in the renal department or any other department if furnished to an end stage renal dialysis patient. Enter EPO amount for informational purposes only. This amount is not included in the total on line 17. *For periods beginning on or after October 1, 2015, all ESA’s should be entered on this line. (e.g. EPO, Aranesp etc.)*

**Line 15.**—Report the direct costs of Aranesp net of discounts furnished in the renal department. Include all costs for patients receiving outpatient, home, or training dialysis treatments. This amount includes Aranesp cost furnished in the renal department or any other department if furnished to an end stage renal dialysis patient. Enter Aranesp amount for informational purposes only. This amount is not included in the total on line 17. *For periods beginning on or after October 1, 2015, this line should not be completed and all amounts should be included on line 14.*

**Line 17.**—Add columns and enter totals. Since lines 14 and 15, column 9 are shaded, no costs for EPO and Aranesp *and all other ESA’s* are included in the total for line 17, column 9, and column 6, lines 14, *and 15*, should be excluded from the total.

**Line 19.**—Add lines 17 and 18. This total, *plus the amounts in column 6, lines 14 and 15*, agrees with the sum of Worksheet I-1, column 1, line 31.
Review of Significant Transmittal #10 changes

- **NOTE:** This document addresses the most significant changes in Form CMS-2552-10 Transmittal #10. It should not be considered a substitute for reviewing the instructions as issued by CMS.

- Form CMS-2552-10 Transmittal #10 currently exists in DRAFT form, so it is still subject to change. This transmittal will become effective for cost reporting periods ending on or after June 30, 2016. Specific effective dates will vary for some items. Some changes in Transmittal #10 are retroactive.

- CMS changes to the forms and instructions are noted in *red, italicized text*. *Blue, italicized text* is used when an entire page contains new or changed instructions, unless the page is the continuation of a previous page.
Worksheet S-2 Part I, Line 171, Column 2

- Line 171, Column 2 was added to capture Section 1876 Medicare days.

- **Line 171**--If this provider is a meaningful EHR technology user (line 167 is “Y”), the days associated with individuals enrolled in section 1876 Medicare cost plans must be included in the calculation of the incentive payment. Indicate if you have section 1876 days included in the days reported on Worksheet S-3, Part I, line 2, column 6, by entering “Y” for yes or “N” for no in column 1. **If column 1 is yes, enter the number of section 1876 Medicare days in column 2.**

- **No impact on settlement at this time**
Worksheet S-3 Part II, Lines 14.01 and 14.02

- New lines to enhance the wage index data collection effective for cost reporting periods beginning on or after August 1, 2016.

- Line 14 is not used for cost reporting periods beginning on/after August 1, 2016.

- Subscripted lines separate Home Office salaries from Related Organization salaries.

<table>
<thead>
<tr>
<th>14</th>
<th>Home office and/or related organization salaries and wage-related costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>14.01</td>
<td>Home office salaries</td>
</tr>
<tr>
<td>14.02</td>
<td>Related organization salaries</td>
</tr>
</tbody>
</table>
New lines to enhance the wage index data collection effective for cost reporting periods beginning on or after August 1, 2016.

For cost reporting periods beginning on or after August 1, 2016, Lines 15 and 16 will contain only the salary-related costs of Part A Physician Administrative (Line 15) and Teaching (Line 16) Services. The wage-related costs for these areas will be reported on the new Lines 25.51 and 25.52, respectively.
Worksheet S-3 Part II, Lines 25.50, 25.51, 25.52

- New lines to enhance the wage index data collection effective for cost reporting periods beginning on or after August 1, 2016.
  - **Line 25.50**--Enter the wage-related costs (as defined on lines 17 and 18) paid to personnel who are affiliated with a home office and/or related organization whose salaries are reported on line 14.01 and/or 14.02.
  - **Line 25.51**--Enter the wage-related costs (as defined on lines 17 and 18) for Part A physician services - administrative, excluding teaching physician Part A services, from the home office allocation and/or related organizations, whose salaries are reported on line 15.
  - **Line 25.52**--Enter the wage-related costs (as defined on lines 17 and 18) for Part A teaching physicians’ from the home office allocation and/or related organizations, whose salaries are reported on line 16.
Worksheet S-3 Part IV – Elimination of Exhibit 3

- Eliminated the Wage Index Pension Cost Schedule (Exhibit 3) and the corresponding instructions from the cost reporting instructions and directed providers to use the latest published Wage Index Pension Cost Schedule on the CMS website.

- Worksheet S-3 Part IV, Line 4 instructions revised:

  - Line 4--Commencing with cost reporting periods used for the FFY 2013 wage index, report pension cost for defined benefit pension plans which meet the applicable requirements for a qualified pension plan under §401(a) of the Internal Revenue Code for the wage index. The allowable pension costs to be reported for these defined benefit pension plans shall be determined in accordance with the policy adopted in the FY 2012 IPPS final rule (CMS-1518-F; 76 FR 51586 - 51590, August 18, 2011), modified in the FY 2016 IPPS final rule (CMS 1632-F; 80 FR 49505-49508, August 17, 2015) and as discussed below. Enter the pension costs from your records or from the Wage Index Pension Cost Schedule. (See CMS Pub. 15-1, chapter 21, §2142.) The Wage Index Pension Schedule is available for download from the CMS website at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Wage-Index-Files.html.
Worksheet S-3 Part IV - Lines 8.01, 8.02, 8.03

- Added lines 8.01, 8.02, and 8.03, to accommodate various categories of health insurance effective for cost reporting periods beginning on and after August 1, 2016.

- **Lines 8, 8.01, 8.02, and 8.03**--Effective for cost reporting periods beginning prior to August 1, 2016, complete line 8 if the hospital has purchased or self-funded insurance. Effective for cost reporting periods beginning on or after August 1, 2016, complete line 8.01 if the hospital has self-funded insurance without a TPA. Complete line 8.02 if the hospital has self-funded insurance with a TPA. Complete line 8.03 if the hospital purchases health insurance. (See the instructions under Worksheet S-3, Part II, regarding health insurance as a wage-related cost for the wage index).
Worksheet S-10

- Changed the reference to State Children’s Health Insurance Program (SCHIP) to Children’s Health Insurance Program (CHIP) in the instructions and on the worksheet.

- Clarified instructions for Line 20 for the total initial payment obligation of patients approved for charity care:

  **Line 20**—For cost reporting periods beginning prior to October 1, 2016, enter the total initial payment obligation, measured at full charges, of patients who are given a full or partial discount based on the hospital’s charity care criteria for care delivered during this cost reporting period for the entire facility. For cost reporting periods beginning on or after October 1, 2016, enter the total initial payment obligation, measured at full charges, of patients who are given a full or partial discount based on the hospital’s charity care criteria for care written off during this cost reporting period, regardless of when the services were provided.
Clarified instructions for Line 20 for the total initial payment obligation of patients approved for charity care (continued):

- Include charity care for all services except physician and other professional services. Do not include charges for *patients given courtesy discounts or charges for* uninsured patients given discounts without meeting the hospital's charity care criteria. 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. *Enter in column 1, the total charges for uninsured patients, including patients with coverage from an entity that does not have a contractual relationship with the provider. Enter in column 2, the deductible and coinsurance payments required by the payer for insured patients covered by a public program or private insurer with which the provider has a contractual relationship. Do not include in column 2 amounts of deductible and coinsurance claimed as a Medicare bad debt.*
Worksheet S-9, Parts III and IV

### PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015

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<th>Hospital Service</th>
<th>Unduplicated Days</th>
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<td>Hospice Routine Home Care</td>
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<tr>
<td>Hospice Inpatient Respite Care</td>
<td>12</td>
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<tr>
<td>Hospice General Inpatient Care</td>
<td>13</td>
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<tr>
<td>Total Hospice Days</td>
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</tbody>
</table>

### PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015

<table>
<thead>
<tr>
<th>Hospital Service</th>
<th>Unduplicated Days</th>
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<td>Title XVIII</td>
</tr>
<tr>
<td>Hospice Inpatient Respite Care</td>
<td>15</td>
</tr>
<tr>
<td>Hospice General Inpatient Care</td>
<td>16</td>
</tr>
</tbody>
</table>

- Effective for cost reporting periods beginning on or after October 1, 2015, hospital-based hospices will no longer complete Parts I and II, but will complete the new Parts III and IV.

- Skilled Nursing Facility days are no longer shown as a subset of Title XVIII and Title XIX unduplicated days.

- Part IV collects unduplicated days at contracted facilities. Part IV days are a subset of the days reported in Part III.
Worksheet K-series replaced by Worksheet O-series

- Modified instructions to reflect that the Worksheet K series no longer applies to hospital-based hospices effective for cost reporting periods beginning on or after October 1, 2015.

- Effective for cost reporting periods beginning on or after October 1, 2015, hospital-based hospices complete the new Worksheet O series in accordance with the statutory requirements of Section 3132 of the ACA.
Worksheet M-series

- Modified instructions to convey that the Worksheet M series no longer applies to hospital-based FQHCs, effective for cost reporting periods beginning on or after October 1, 2014. However, hospital-based rural health clinics still complete the “M” worksheet series.

- Revised forms and instructions to comply with the regulations at 42 CFR 413.78(a), to ensure that no separate graduate medical education (GME) payment is calculated for the hospital-based RHC or FQHC.
Worksheet S-11, Worksheet N Series

- Worksheet S-11 captures statistics related to hospital-based FQHCs paid under the FQHC prospective payment system that meet the requirements set forth in 42 CFR 413.65(n). Worksheet S-11 supersedes Worksheet S-8 for FQHCs only and it is effective for cost reporting periods beginning on or after October 1, 2014.

- Effective for cost reporting periods beginning on or after October 1, 2014, hospital-based FQHCs complete the new Worksheet N series and are reimbursed under the FQHC prospective payment system.

- Hospital-based rural health clinics (RHCs) continue to complete Worksheet S-8 and the Worksheet M series.
New line to record acquisition costs related to allogeneic stem cell transplants effective for services rendered on or after January 1, 2017.

- **Line 112.50**—Record any acquisition costs related to allogeneic stem cell transplants as defined in CMS Pub. 100-04, chapter 3, §90.3.3. Acquisition charges for allogeneic stem cell transplants apply only to allogeneic transplants, for which stem cells are obtained from a donor (other than the recipient himself or herself). Acquisition charges do not apply to autologous transplants (transplanted stem cells are obtained from the recipient himself or herself), because autologous transplants involve services provided to the beneficiary only (and not to a donor), for which the hospital may bill and receive payment. Unlike the acquisition costs of solid organs for transplant (e.g., hearts and kidneys), which are paid on a reasonable cost basis, acquisition costs for allogeneic stem cells are included in prospective payment. This cost center flows through cost finding and accumulates any appropriate overhead costs.
Worksheet E, Part A, Line 35.03

- Modified instructions for partial-year MDH/SCH:

  - For SCH/MDH status changes, subscript line 35.04 for portions of the cost reporting period under MDH status, and line 35.05 for portions of the cost reporting period under SCH status. For SCH or MDH status changes, subscript column 1 for any portion of the cost reporting period under IPPS status. Enter on columns 1 (and subscripts) and 2, lines 35.04 and 35.05, the pro rata share of the hospital’s uncompensated care payment amounts reported on columns 1 and 2, line 35.03.

  - For example, a hospital with a 2015 calendar year cost reporting period loses its MDH status on October 15, 2015. Enter on line 35.04, column 1, for the period of January 1, 2015 through September 30, 2015, the uncompensated care payment amount from line 35.03, column 1. Enter on line 35.04, column 1.01, the pro rata share of the uncompensated care payment amount from line 35.03, column 1 (IPPS status for the period of October 15, 2015 through December 31, 2015), ((78 days/365 days) times line 35.03, column 2). Enter on line 35.04, column 2, the pro rata share of the uncompensated care payment amount from line 35.03, column 2 (MDH status for the period of October 1, 2015 through October 14, 2015), ((14 days/365 days) times line 35.03, column 2).

- Allows proper comparison of PPS amount to HSP amount for the period that the hospital was an MDH, for Worksheet E Part A, Line 49
### Worksheet E, Part A, Lines 54 and 54.01

<table>
<thead>
<tr>
<th>Line</th>
<th>Description</th>
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<tbody>
<tr>
<td>54</td>
<td>Special add-on payments for new technologies</td>
</tr>
<tr>
<td>54.01</td>
<td>Islet isolation add-on payment</td>
</tr>
</tbody>
</table>

- **Line 54** -- Enter the special add-on payment for new technologies (see 42 CFR 412.87 and 412.88). *Include in the add-on payment for new technologies payments associated with Model 4 BPCI.*

- **Line 54.01** -- Enter the special add-on payment for islet isolation cell transplantation (see CR 9570).
Worksheet E-3, Part IV, Lines 1.01 - 1.04

- Added lines 1.01 through 1.04 to accommodate the new payment categories for Long-Term Care Hospitals in accordance with the 2016 Inpatient Prospective Payment final rule effective for discharges in cost reporting periods beginning on or after October 1, 2015.

- Complete lines 1.01 through 1.04 for discharges occurring in cost reporting periods beginning on or after October 1, 2015. See 42 CFR 412.522. These amounts may be obtained from the PS&R and/or your records.

- **Line 1.01**--Enter the full standard LTCH PPS payment.

- **Line 1.02**--Enter the short stay outlier standard payment amount.

- **Line 1.03**--Enter the cost based site neutral payment amount.

- **Line 1.04**--Enter the LTCH PPS comparable site neutral payment amount, which may include high cost outlier payments.

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Net Federal PPS payment (see instructions)</td>
<td>1</td>
</tr>
<tr>
<td>1.01</td>
<td>Full standard payment amount</td>
<td>1.01</td>
</tr>
<tr>
<td>1.02</td>
<td>Short stay outlier standard payment amount</td>
<td>1.02</td>
</tr>
<tr>
<td>1.03</td>
<td>Site neutral payment amount - Cost</td>
<td>1.03</td>
</tr>
<tr>
<td>1.04</td>
<td>Site neutral payment amount - IPPS comparable</td>
<td>1.04</td>
</tr>
</tbody>
</table>
Worksheet E-4, Lines 10.01, 15.01, 16.01

- Added lines 10.01, 15.01, and 16.01, to accommodate unweighted FTE counts:

  - **Line 10.01**--Enter in column 2, the unweighted dental and podiatric resident FTE count for the current year. This amount used for informational purposes only and does not impact the calculations on this worksheet.

  - **Line 15.01**--Enter the unweighted number of FTE residents in the initial years of a program in column 1 for primary care and OB/GYN, and in column 2 for nonprimary care FTEs. Use line 15 instructions to determine the unweighted FTE resident counts for this line. This amount used for informational purposes only and does not impact the calculations on this worksheet.

  - **Line 16.01**--Enter the temporary unweighted FTE residents that were displaced by program or a hospital closure in column 1 for primary care, and in column 2 for nonprimary care FTEs, which you would not be able to count without a temporary cap adjustment. (42 CFR 413.79(h).) This amount used for informational purposes only and does not impact the calculations on this worksheet.

- These amounts are used to reconcile with amounts in the Intern and Resident Information System (IRIS) and do not impact the settlement summary.
Worksheet I-1

- Modified instructions for Lines 10-16 (duplicates Transmittal #9 change.)
- Modified instructions for Line 27 (Subtotal) to reflect the applicable reconciliation to Worksheet B Part I, based on cost reporting period beginning date.

Lines 10 through 16--Include on the appropriate lines costs directly charged to the renal department after reclassifications and adjustments. Report other direct costs on line 16 that cannot be specifically identified on lines 11 through 15. **Line 15 must include all ESA costs, effective for cost reporting periods beginning on and after October 1, 2015.**

Line 27--**For cost reporting periods beginning prior to October 1, 2015, add lines 17 through 26. This total must agree with the total on Worksheet B, Part I, column 26, line 74 or line 94, if a home dialysis cost center was established. Effective for cost reporting periods beginning on or after October 1, 2015, add lines 17 through 26. This total must agree with the total on Worksheet B, Part I, column 24, line 74, or line 94 if a home dialysis cost center was established, less the sum of columns 21 and 22, as appropriate.**
Worksheets I-2 and I-3

- Clarified instructions for Lines 14 and 15 to include all ESA costs on Line 14 for cost reporting periods beginning on or after October 1, 2015.

**Line 14.**--Report the direct costs of EPO net of discounts furnished in the renal department. Include all costs for patients receiving outpatient, home, or training dialysis treatments. This amount includes EPO cost furnished in the renal department or any other department if furnished to an end stage renal dialysis patient. Enter EPO amount for informational purposes only. This amount is not included in the total on line 17. For cost reporting periods beginning on or after October 1, 2015, this line will be identified as “All ESAs” and providers must enter the direct costs of all ESAs net of discounts furnished in the renal department on this line.

**Line 15.**--Report the direct costs of Aranesp net of discounts furnished in the renal department. Include all costs for patients receiving outpatient, home, or training dialysis treatments. This amount includes Aranesp cost furnished in the renal department or any other department if furnished to an end stage renal dialysis patient. Enter Aranesp amount for informational purposes only. This amount is not included in the total on line 17. For cost reporting periods beginning on or after October 1, 2015, do not complete this line and enter all ESA amounts on line 14.
Contact

Joseph W. Sellars, Director
KPMG LLP
501 Riverside Avenue
Suite 500
Jacksonville, FL 32202
904-350-1234
jwsellars@kpmg.com