Massachusetts Hospital Cost Report[1]

HOSPITAL STATEMENT OF COSTS, REVENUES, AND STATISTICS

[1] MA Hospital Cost Report was last updated in 2016

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General Information and Submission Requirements

The Center for Health Information and Analysis (CHIA) is required by statute to collect cost reports annually from acute and non-acute hospitals.[2] CHIA uses these reports for policy development, monitoring, and informational purposes. In an effort to continually report reliable and meaningful information, CHIA has updated its annual cost report (previously known as DHCFP-403 Cost Report).

New Massachusetts Hospital Cost Report

The new Massachusetts Hospital Cost Report (Hospital Cost Report) replaces the previous DHCFP-403 Cost Report. While it collects similar information as the former cost report, it leverages data and cost finding principles already reported by hospitals to Medicare on the Centers for Medicare and Medicaid Services (CMS) 2552-10 Cost Report (2552 Cost Report), and still collects data specific to Massachusetts hospitals.

Differences from DHCFP-403 Cost Report

The Massachusetts Cost Report is a combination of sections of both the former DHCFP-403 Cost Report and the 2552 Cost Report. The primary distinction between the two reports is that the Massachusetts Cost Report seeks to collect a hospital's full costs as opposed to the Medicare-allowable costs or those costs reduce by reasonable cost limits. The Massachusetts Cost Report derives a substantial amount of information from a hospital's 2552 Cost Report. The hospital will then complete sections where information was not included on the 2552 Cost Report and/or where breakdowns of information are required. Please be advised that the Hospital Uniform Reporting Manual is no longer required; hospitals should use the Medicare Instructions for all data elements derived from that source along with instructions in this document. Appendix (B) compares schedules on this cost report to the former DHCFP-403 Cost Report.

Submission Requirements

The Massachusetts Cost Report must be an XML submission, and will replace the flat file submissions that were required for the DHCFP-403 Cost Report. Appendix (C) contains the specifications required for the XML submission. Excel versions of the report will not be accepted. Hospitals, or their respective vendors, will need to successfully test their XML files with CHIA prior to Massachusetts Cost Report submissions.

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[2] A "hospital" is defined as any institution, whether operated as a for profit or as a charity, that is advertised, announced, established or maintained for the purpose of providing diagnostic, medical, surgical, or restorative treatment for patients within or centrally based in the institution, and which is licensed as a hospital by the Department of Public Health under Section 51, Chapter 111 of the Massachusetts General Laws (M.G.L.), and any hospital licensed under Section 29, Chapter 19 of M.G.L. An institution that qualifies as a hospital although not licensed by said Department by virtue of its being owned and operated by an agency of the Commonwealth shall be deemed a "hospital" for purposes of these instructions.

There are two types of errors that can occur: warning or fatal errors. Appendix (A) contains the list of both error types. All warning errors will not result in a rejection of the submission of the cost report. All warning errors must be reviewed and corrected by the hospital prior to submission. If a warning error cannot be correct, it must be explained and the explanation must be submitted in a PDF and accompany the XML cost report submission.

A cost report submission with a fatal error will be rejected by the system. Hospitals are responsible for correcting these errors. Once the hospital corrects these errors, the corrected cost report can be submitted. The cost report will only be accepted after the errors have been corrected

Timeframes

Each hospital shall file a Massachusetts Cost Report with CHIA in accordance with the due dates specified in the regulation 957 CMR 9.04. This section states that hospitals are required to submit the cost report in accordance with the Medicare 2552 Cost Report filing schedule (for most hospitals, this is within 150 days after the end of a hospital's fiscal year).

Please contact CHIA at CHIA.data@state.ma.us if:

- The hospital is filing for a period that is less than 12 months
- There is a hospital acquisition or closure
- There are any deviations from these cost report instructions

Other Considerations

Hospital-specific instructions will be provided to hospitals with unique situations.

Submitting an XML File and PDF Warning Report (if needed)

1. Create an XML file based on the requirements noted in Appendix (C) XML Schema for Intake and PDF report with the reasons for warning errors as noted in Appendix (A) Explanation of Warning/Fatal Errors.

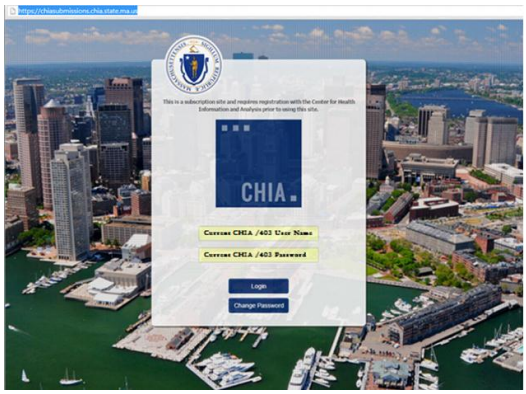
2. The file name convention should match the following for both XML and PDF:
   {HospitalID} + "_" + {FilingTypeID} + "_" + {FilingYear} + "_" + {Submission DateTime}

   a. HospitalID – Or OrgID entered – If a hospital is using a software vendor, the vendor has been provided this number and will incorporate it into its naming logic.
   b. FilingTypeID – Acute Facilities will enter "3", Non-Acute Facilities will enter "9"
   c. FilingYear – Enter the filing year
   d. Submission DateTime – Todays date and current time without dashes or slashes

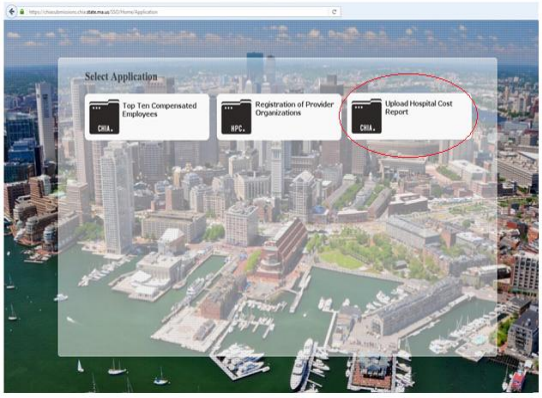
1234_CHIA_3_2015_011220161430.xml

3. The new URL for submitting Cost Report Submittal: https://chiasubmissions.chia.state.ma.us

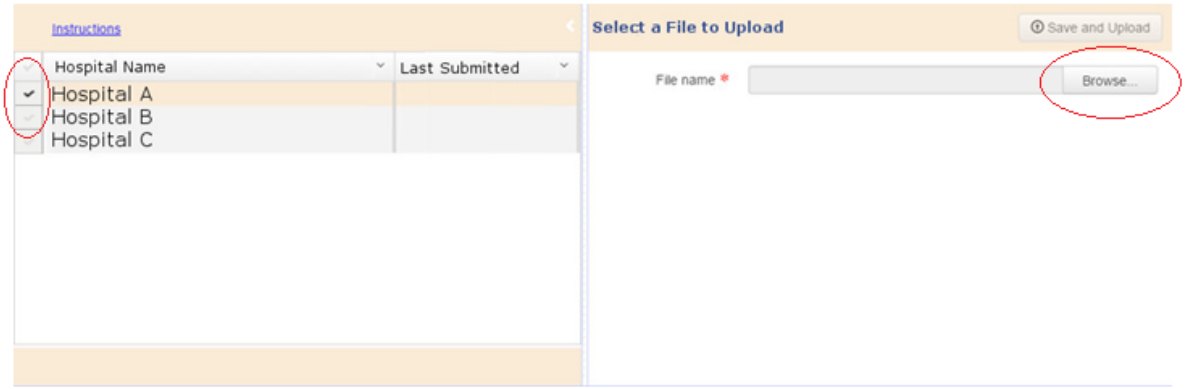
4. Login using your current CHIA / 403 username and password.



5. You will see folders for several CHIA applications. Select "Upload Hospital Cost Report"

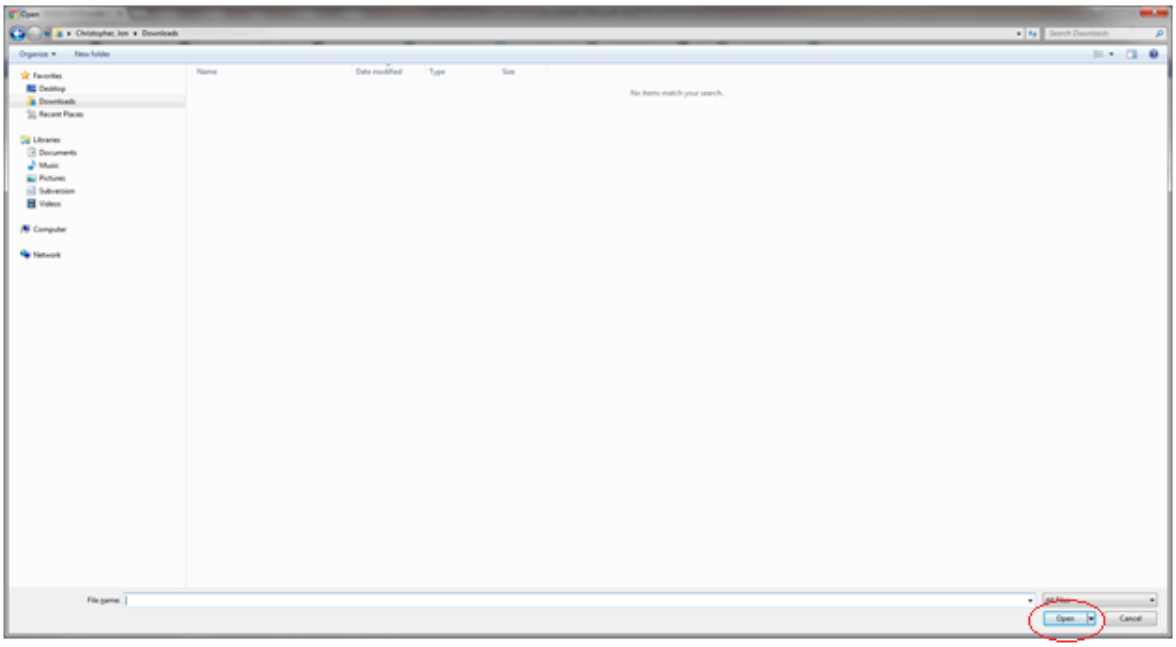


6. Locate the hospital's name in the box on the left and click on the check box. Then locate your XML or PDF file using the "Browse" button on the right. This should be done separately for XML and PDF

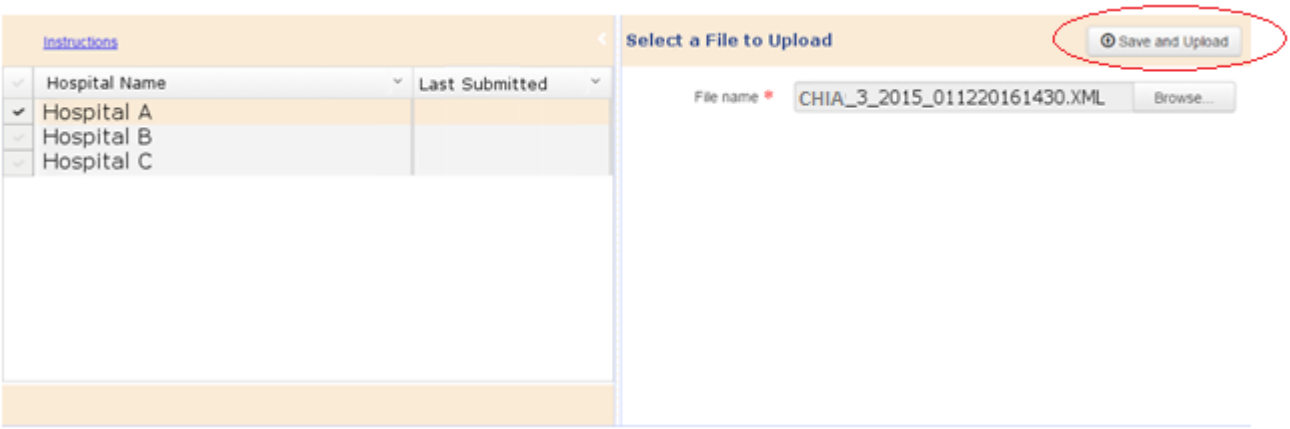


7. The use the Windows upload dialog to browse to the location of your XML and PDF file and select the file to upload.

8. Select “Open” at the bottom of the browse dialog.



9. Once the name of the file appears in the File Name field, then click on the “Save and Upload” button on the top right. Repeat the process for uploading the Warning Error Explanations in the PDF.


Instructions
Hospital Name
Last Submitted
Hospital A
Hospital B
Hospital C
Select a File to Upload
Save and Upload
File name *
CHIA_3_2015_011220161430.XML
Browse...

General Instructions

Note A

This cost report requires that any use of the following Cost Centers from the CMS–2552–10 Worksheet will be broken out into separate line items. Any reclassifications entered into the CMS–2552–10 of the following list require this segregation:

"Adults and Pediatrics" (Cost Center 30) will be segregated into separate line items: "Medical and Surgical", "Pediatric", and "Obstetric". Any further breakout for this cost center will be entered with the next sequential subscript line number, starting 30.04.

"Intensive Care Unit" (Cost Center 31) will be segregated into line items: "Adult", "Pediatric", and "Neonatal". Any further breakout for this cost center will be entered with the next sequential subscript line number, starting 31.04.

"Subprovider IPF" (Cost Center 40) will be segregated into line items: "Adult - Psych" and "Pediatric - Psych". Any further breakout for this cost center will be entered with the next sequential subscript line number, starting 40.03.

"Nursery" (Cost Center 43) to be segregated into separate line items: "Newborn" and "Special". Any further breakout for this cost center will be entered with the next sequential subscript line number, starting 43.03.

Private Referrals are patients that received ancillary services that were not registered in the hospital's Outpatient Clinic, ER, Ambulatory Surgery, or Other Clinic. These are patients that were referred to the hospital from a private physician practice for tests only. Hospitals may continue to report this information. As this cost center does not appear on the 2552, it would require subscripting Line 93 Other. Most, if not all, of the expenses attributed to this cost center would be derived from the ancillary allocation (based on gross patient service revenue) on Tabs 6, 16, 17 and 18. Please note the visits or encounters should not be recorded on Tab 5.

Note B

Entering Subscript: Standard line numbers and cost center descriptions cannot be changed and must be maintained throughout the reports. If the use of additional or different cost center description is required, adding (subscript) additional lines to the cost report. The added cost center description line will require a logical relationship to the standard line. The location of the added label must be inserted below the related standard line on the worksheet. This line is identified by the numeric subscript of the

immediately preceding line. For example, if two lines are added between lines 7 and 8, identify them as lines 7.01 and 7.02.

Any additional lines that are added for general service cost centers must have corresponding Columns built. For HCRIS Codes 00100 through 02300, any Subscript lines must be built as Columns in Tabs 13, 14, and 15. For HCRIS Codes 05000 through 07600, any Subscript lines must be built as Columns in Tabs 16, 17, and 18.

Any Line or Column numbers identified from the Cost Report will include any Subscripts, unless specified. Since most of the subscripts are entered by the hospitals, the instruction manual will assume the standard including any created. As an example, the instructions may say “Lines 190 through 194”, any sub-lines created for the specified Line 194 (194.01, 194.7) will be included.

HCRIS Codes

HCRIS, or Healthcare Cost Report Information System, are used in CMS 2552-10 to identify the Cost Centers being reported. These codes are also used in the Massachusetts Hospital Cost Report reporting, while using the matching CMS 2552-10 report for each code.

Within each worksheet, a Cost Center’s HCRIS code is identified on the left of the description. Any Subscript must include the HCRIS code for submission.

Values in the Fields

For each field within the report, the expected value will be a whole number, as a default. There are some specified entries that may require rounding two places after the decimal and will be identified in the description.

Rounding standards for Tab 14, 15, 17 and 18

From CMS.GOV 2552-10 Instructions Chapter 40, Section 4000.1

"Where a difference exists within a column as a result of computing costs using a fraction or decimal, and therefore the sum of the parts do not equal the whole, the highest amount in that column must either be increased or decreased by the difference. If it happens that there are two high numbers equaling the same amount, adjust the first high number from the top of the worksheet for which it applies."

As an example:

- Line 10, Column 10 equals 500,000 – Step-down
- Line 500, Column 10 equals 499,600 – Total

Since the difference between the Step-down and the total is 400. Within column 10, the highest amount is Line 42, Column 10 equaling 70,000. The rule will change the value in Line 42, Column 10 equaling 70,400 to make the Total value match the Step-down value.

This request will update the values in the columns when

- Tab 14 and 15 – The Step-down value is the cross-reference for the Cost Center (Line and Column are same) Column are not the same as the Total Value (Line 500) in that Column
- Tab 17 and 18 – The Total Value (Line 500) in each Column does not equal the value entered in Tab 16, Line 210 (for Tab 17 reference) or Line 213(for Tab 18 reference) matching Column

This will need to occur in every column unless identified for the following Tabs:

- Tab 14 – All Columns except Columns 0, 4a, and 24
- Tab 15 – All Columns except Columns 0 and 24
- Tab 17 – All Columns except Columns 1, 2, and 3
- Tab 18 – All Columns except Columns 1, 2, and 3

All Lines that can be referenced as the "Highest amount" in each Column except 200's, 300's, and 500's.

Tab 1 Identification and Index

Tab 1 specifies the hospital, the person completing the cost report, and the filing period. It includes an electronic signature of a qualified individual from the hospital to ensure the report's accuracy. It also includes an index of the tabs.

Line 1 is for the name of the reporting Hospital

Line 2 is for entering the fiscal year being documented as the Reporting Year

Line 3 is for the Hospital's mailing address

Line 4 is for the name of the person filing the report as the Filer Name

Line 5 is for the title of the person filing the report as the Filer Title

Line 6 is for the phone number of the person filing the report as the Filer Phone Number

Line 7 is for the Email address of the person filing the report as the Filer Email

Line 8 is for the Type of Hospital, options being "Acute" and "Non-Acute"

Line 9 is for the Medicare Provider Claim Control Number (CCN)

Line 10 will match the value from the Hospital Cost Report Submission Date. This is the date that the MA Cost Report was last saved before being filed

Line 11 will match the value from the CMS–2552–10 Start Period of the reporting period

Line 12 will match the value from the CMS–2552–10 End Period of the reporting period

Line 13 is to calculating the number of days in the reporting period. This can be determined by subtracting End Period (Line 12) from Start Period (Line 11) then adding 1

Line 14 is for the name which will represent the electronic signature of person certifying the report

Tab 2 Summary Schedule of Revenue and Expense

This schedule provides a summary of revenues and expenses for each cost center by department and by service. Expenses are identified both including and excluding capital amounts. Users of this should understand that non-distinct observation beds are separately identified in columns 9 and 10, refer to Tab 12. Organ acquisition costs have been reclassified to the inpatient cost center, refer to Tab 21. The amounts reported on this tab are incorporated from other tabs in the cost report. This tab should not be completed until the other relevant tabs are completed.

This tab reports the summary of Cost Centers. This information will match the values as directed in the instructions below.

General Service Cost Centers

Lines 1 through 23 are entered, as directed, for each of the following Columns, unless not applicable:

Column 1 – Expense Before Reclassifications: will match the values in the Tab 9 "Direct Expense" (Lines 1 through 23, Column 3)

Column 2 – Direct Expense: will match the values in the Tab 9 "Direct Expense" (Lines 1 through 23, Column 6)

Column 3 through 10: Not Applicable

Line 300 is the Total General Service Cost Centers. This is dedicated to calculating the total of Columns 1 and 2 for each respective line. Columns 3 through 10 are not applicable.

Ancillary Service Cost Centers

Lines 50 through 76 are entered, as directed, for each of the following Columns:

Column 1 – Expense Before Reclassifications: will match the values in the Tab 9 "Direct Expense" (Lines 50 through 76, Column 3)

Column 2 – Direct Expense: will match the values in the Tab 9 "Direct Expense" (Lines 50 through 76, Column 6)

Column 3 – Expense after General Costs Stepdown – Excluding Capital: will match the values in the Tab 15 "Expenses after General Service Costs Stepdown Excluding Capital" (Lines 50 through 76, Column 24)

Column 4 – Expense after General Costs Stepdown – Including Capital: will match the values in the Tab 14 "Expenses after General Service Costs Stepdown Including Capital" (Lines 50 through 76, Column 24)

Column 5 – Patient Service Expense – By Department Excluding Capital: will match the values in the Tab 18 "Allocation of Ancillary Expenses to IP & OP Routine Cost Centers EXCLUDING CAPITAL" (Line 300, Columns 4 through 30 by matching header)

Column 6 – Patient Service Expense – By Department Including Capital: will match the values in the Tab 17 "Allocation of Ancillary Expenses to IP & OP Routine Cost Centers INCLUDING CAPITAL" (Line 300, Columns 4 through 30 by matching header)

Column 7 – Gross Revenue – By Department: will match the values in the Tab 6 "Gross Patient Service Revenue" (Line 302, Columns 4 through 30) by matching the Column header in Tab 6 to the Line Item in Tab 2

Columns 8, 9 and 10: Not Applicable

Line 301 is the Total Ancillary Service Cost Centers. This is dedicated to calculating the total of Lines 50 through 76 in Columns 1 through 7.

Inpatient Routine Service Cost Centers

Lines 30.01, 30.02, and 30.03: this cost report requires that "Adults and Pediatrics" are segregated into separate line items: "Medical and Surgical", "Pediatric", and "Obstetric", (See Note A in the General Instructions).

Lines 31.01, 31.02, and 31.03: this cost report requires that the Cost Center for "Intensive Care Unit" to be segregated into separate line items: "Adult", "Pediatric", and "Neonatal", (See Note A in the General Instructions).

Lines 40.01 and 40.02: this cost report requires that the Cost Center for "Subprovider IPF" to be segregated into separate line items: "Adult - Psych" and "Pediatric - Psych" (See Note A in the General Instructions). Hospitals with discrete Psych Units should complete these lines whether or not they file these units as a subprovider for Medicare reimbursement purposes.

Lines 43.01 and 43.02: this cost report requires that the Cost Center for "Nursery" to be segregated into separate line items: "Newborn" and "Special" (See Note A in the General Instructions).

Lines 30 through 46 are entered, as directed, for each of the following Columns:

Column 1 – Expense Before Reclassifications: will match the values in the Tab 9 "Direct Expense" (Lines 30 through 46, Column 3)

Column 2 – Direct Expense: will match the values in the Tab 9 "Direct Expense" (Lines 30 through 46, Column 6)

Column 3 – Expense after General Costs Stepdown – Excluding Capital: will match the values in the Tab 15 "Expenses after General Service Costs Stepdown Excluding Capital" (Lines 30 through 46, Column 24)

Column 4 – Expense after General Costs Stepdown – Including Capital: will match the values in the Tab 14 "Expenses after General Service Costs Stepdown Including Capital" (Lines 30 through 46, Column 24)

Column 5 – Patient Service Expense – By Department Excluding Capital: will match the values in the Tab 18 "Allocation of Ancillary Expenses to IP & OP Routine Cost Centers EXCLUDING CAPITAL" (Lines 30 through 46, Column 2)

Column 6 – Patient Service Expense – By Department Including Capital: will match the values in the Tab 17 "Allocation of Ancillary Expenses to IP & OP Routine Cost Centers INCLUDING CAPITAL" (Lines 30 through 46, Column 2)

Column 7 – Gross Revenue – By Department: will match the values in the Tab 6 "Gross Patient Service Revenue" (Lines 30 through 46, Column 2)

Column 8 – Patient Service Expense – By Service Excluding Capital: will match the values found in Tab 21 "Reclassification of Organ Acquisition to Inpatient from Special Purpose Cost Centers" (Lines 30 through 46, Column 9)

Column 9 – Patient Service Expense – By Service Including Capital: will match the values found in Tab 21 "Reclassification of Organ Acquisition to Inpatient from Special Purpose Cost Centers" (Lines 30 through 46, Column 5)

Column 10 – Gross Revenue – By Service: will match the values in the Tab 6 "Gross Patient Service Revenue" (Lines 30 through 46, Column 1)

Line 302 is the Total Inpatient Routine Service Cost Centers. This is dedicated to calculating the total of Lines 30 through 46 in Columns 1 through 10

Outpatient Service Cost Centers

Lines 88 through 101 are entered, as directed, for each of the following Columns:

Column 1 – Expense Before Reclassifications: will match the values in the Tab 9 "Direct Expense" (Lines 88 through 101, Column 3)

Column 2 – Direct Expense: will match the values in the Tab 9 "Direct Expense" (Lines 88 through 101, Column 6)

Column 3 – Expense after General Costs Stepdown – Excluding Capital: will match the values in the Tab 15 "Expenses after General Service Costs Stepdown Excluding Capital" (Lines 88 through 101, Column 24)

Column 4 – Expense after General Costs Stepdown – Including Capital: will match the values in the Tab 14 "Expenses after General Service Costs Stepdown Including Capital" (Lines 88 through 101, Column 24)

Column 5 – Patient Service Expense – By Department Excluding Capital: will match the values in the Tab 18 "Allocation of Ancillary Expenses to IP & OP Routine Cost Centers EXCLUDING CAPITAL" (Lines 88 through 101, Column 2)

Column 6 – Patient Service Expense – By Department Including Capital: will match the values in the Tab 17 "Allocation of Ancillary Expenses to IP & OP Routine Cost Centers INCLUDING CAPITAL" (Lines 88 through 101, Column 2)

Column 7 – Gross Revenue – By Department: will match the values in the Tab 6 "Gross Patient Service Revenue" (Lines 88 through 101, Column 2)

Column 8 – Patient Service Expense – By Service Excluding Capital: will match the values depending on the line:

- Lines 88 through 91 will match the value found in Tab 18 "Allocation of Ancillary Expenses to IP & OP Routine Cost Centers EXCLUDING CAPITAL" (Lines 88 through 91, Column 1)
- Line 92 will match the value found in Tab 12 "Allocation of Observation Bed Costs to a Non Distinct Unit" (Line 92, Column 10)

- Lines 92.01 through 101 will match the value found in Tab 18 “Allocation of Ancillary Expenses to IP & OP Routine Cost Centers EXCLUDING CAPITAL” (Lines 92.01 through 101, Column 1)

Column 9 – Patient Service Expense – By Service Including Capital: will match the values depending on the line:

- Lines 88 through 91 will match the value found in Tab 17 “Allocation of Ancillary Expenses to IP & OP Routine Cost Centers INCLUDING CAPITAL” (Lines 88 through 91, Column 1)
- Line 92 will match the value found in Tab 12 “Allocation of Observation Bed Costs to a Non Distinct Unit” (Line 92, Column 5)
- Lines 92.01 through 101 will match the value found in Tab 17 “Allocation of Ancillary Expenses to IP & OP Routine Cost Centers INCLUDING CAPITAL” (Lines 92.01 through 101, Column 1)

Column 10 – Gross Revenue – By Service: will match the values in the Tab 6 “Gross Patient Service Revenue” (Lines 88 through 101, Column 1)

Special Purpose Cost Centers

Lines 105 through 112 are entered, as directed, for each of the following Columns:

Column 1 – Expense Before Reclassifications: will match the values in the Tab 9 "Direct Expense" (Lines 105 through 112, Column 3)

Column 2 – Direct Expense: will match the values in the Tab 9 "Direct Expense" (Lines 105 through 112, Column 6)

Column 3 – Expense after General Costs Stepdown – Excluding Capital: will match the values in the Tab 15 "Expenses after General Service Costs Stepdown Excluding Capital" (Lines 105 through 112, Column 24)

Column 4 – Expense after General Costs Stepdown – Including Capital: will match the values in the Tab 14 "Expenses after General Service Costs Stepdown Including Capital" (Lines 105 through 112, Column 24)

Column 5 – Patient Service Expense – By Department Excluding Capital: will match the values in the Tab 18 "Allocation of Ancillary Expenses to IP & OP Routine Cost Centers EXCLUDING CAPITAL" (Lines 105 through 112, Column 2)

Column 6 – Patient Service Expense – By Department Including Capital: will match the values in the Tab 17 "Allocation of Ancillary Expenses to IP & OP Routine Cost Centers INCLUDING CAPITAL" (Lines 105 through 112, Column 2)

Column 7 – Gross Revenue – By Department: will match the values in the Tab 6 "Gross Patient Service Revenue" (Lines 105 through 112, Column 2)

Column 8 – Patient Service Expense – By Service Excluding Capital: will match the values in the Tab 21 "Reclassification of Organ Acquisition to Inpatient from Special Purpose Cost Centers" (Lines 105 through 112, Column 9)

Column 9 – Patient Service Expense – By Service Including Capital: will match the values in the Tab 21 "Reclassification of Organ Acquisition to Inpatient from Special Purpose Cost Centers" (Lines 105 through 112, Column 5)

Column 10 – Gross Revenue – By Service: will match the values in the Tab 6 “Gross Patient Service Revenue” (Lines 105 through 112, Column 1)

Lines 113 through 117 are entered, as directed, for each of the following Columns:

Column 1 – Expense Before Reclassifications: will match the values in the Tab 9 “Direct Expense” (Lines 113 through 117, Column 3)

Column 2 – Direct Expense: will match the values in the Tab 9 “Direct Expense” (Lines 113 through 117, Column 6)

Column 3 – Expense after General Costs Stepdown – Excluding Capital: will match the values in the Tab 15 “Expenses after General Service Costs Stepdown Excluding Capital” (Lines 113 through 117, Column 24)

Column 4 – Expense after General Costs Stepdown – Including Capital: will match the values in the Tab 14 “Expenses after General Service Costs Stepdown Including Capital” (Lines 113 through 117, Column 24)

Column 5 – Patient Service Expense – By Department Excluding Capital: will match the values in the Tab 18 “Allocation of Ancillary Expenses to IP & OP Routine Cost Centers EXCLUDING CAPITAL” (Lines 113 through 117, Column 2)

Column 6 – Patient Service Expense – By Department Including Capital: will match the values in the Tab 17 “Allocation of Ancillary Expenses to IP & OP Routine Cost Centers INCLUDING CAPITAL” (Lines 113 through 117, Column 2)

Column 7 – Gross Revenue – By Department: will match the values in the Tab 6 “Gross Patient Service Revenue” (Lines 113 through 117, Column 2)

Column 8 – Patient Service Expense – By Service Excluding Capital: will match the values in the Tab 18 “Allocation of Ancillary Expenses to IP & OP Routine Cost Centers EXCLUDING CAPITAL” (Lines 113 through 117, Column 1)

Column 9 – Patient Service Expense – By Service Including Capital: will match the values in the Tab 17 "Allocation of Ancillary Expenses to IP & OP Routine Cost Centers INCLUDING CAPITAL" (Lines 113 through 117, Column 1)

Column 10 – Gross Revenue – By Service: will match the values in the Tab 6 "Gross Patient Service Revenue" (Lines 113 through 117, Column 1)

Line 303 is the Total Outpatient Service Cost Centers. This is dedicated to calculating the total of Lines 88 through 117 in all Columns for each respective line

Line 304 is dedicated to calculating the Subtotal of Lines 300, 301, 302, and 303 in all Columns

Non–Patient Cost Centers

Lines 190 through 194 are entered, as directed, for each of the following Columns:

Column 1 – Expense Before Reclassifications: will match the values in the Tab 9 "Direct Expense" (Lines 190 through 194, Column 3)

Column 2 – Direct Expense: will match the values in the Tab 9 "Direct Expense" (Lines 190 through 194, Column 6)

Column 3 – Expense after General Costs Stepdown – Excluding Capital: will match the values in the Tab 15 "Expenses after General Service Costs Stepdown Excluding Capital" (Lines 190 through 194, Column 24)

Column 4 – Expense after General Costs Stepdown – Including Capital: will match the values in the Tab 14 "Expenses after General Service Costs Stepdown Including Capital" (Lines 190 through 194, Column 24)

Column 5 – Patient Service Expense – By Department Excluding Capital: will match the values in the Tab 18 "Allocation of Ancillary Expenses to IP & OP Routine Cost Centers EXCLUDING CAPITAL" (Lines 190 through 194, Column 1)

Column 6 – Patient Service Expense – By Department Including Capital: will match the values in the Tab 17 "Allocation of Ancillary Expenses to IP & OP Routine Cost Centers INCLUDING CAPITAL" (Lines 190 through 194, Column 1)

Column 7 – Gross Revenue – By Department: will match the values in the Tab 6 "Gross Patient Service Revenue" (Lines 190 through 194, Column 1)

Column 8 – Patient Service Expense – By Service Excluding Capital: will match the values in the Tab 18 "Allocation of Ancillary Expenses to IP & OP Routine Cost Centers EXCLUDING CAPITAL" (Lines 190 through 194, Column 1)

Column 9 – Patient Service Expense – By Service Including Capital: will match the values in the Tab 17 "Allocation of Ancillary Expenses to IP & OP Routine Cost Centers INCLUDING CAPITAL" (Lines 190 through 194, Column 1)

Column 10 – Gross Revenue – By Service: will match the values in the Tab 6 “Gross Patient Service Revenue” (Lines 190 through 194, Column 1)

Line 305 is the Total Non–Patient Cost Centers. This is dedicated to calculating the total of Lines 190 through 194 in all Columns for each respective line

Line 500 is dedicated to calculating the Total sum of Lines 304 and 305 in all Columns

Tab 3 Patient Service Statistical Data

On this tab, hospitals are to report their weighted average licensed beds, weighted average available beds, and weighted average staffed beds. In addition, this tab allows hospitals to report inpatient days and discharges by inpatient service cost center.

Inpatient Routine Service Cost Centers

Most of the Inpatient Routine lists Service Cost Centers are the responsibility of the hospitals. The following Cost Centers are made up of eight separate Columns. Hospitals are required to enter numerical values for each entry, unless specified.

Lines 1, 2, and 3 are the responsibility of the hospital. The new state cost report requires that "Adults and Pediatrics" are segregated into separate line items: "Medical and Surgical", "Pediatric", and "Obstetric", (See Note A in the General Instructions).

Lines 4, 5, and 6 are the responsibility of the hospital. This cost report requires that the Cost Center for "Intensive Care Unit" to be segregated into separate line items: "Adult", "Pediatric", and "Neonatal", (See Note A in the General Instructions).

Lines 11 and 12 are the responsibility of the hospital. This cost report requires that the Cost Center for "Subprovider IPF" to be segregated into separate line items: "Adult - Psych" and "Pediatric - Psych" (See Note A in the General Instructions). Hospitals with discrete Psych Units should complete these lines whether or not they file these units as a subprovider for Medicare reimbursement purposes.

Lines 15 and 16 are the responsibility of the hospital. This cost report requires that the Cost Center for "Nursery" to be segregated into separate line items: "Newborn" and "Special" (See Note A in the General Instructions).

Lines 7 through 19, not including any lines listed above, are entered as directed, for each of the following Columns.

Column 1 – Weighted Average Licensed Beds: is dedicated to entering the average number of licensed beds for each service. This is determined by first calculating the sum of the calendar days each bed was available during this reporting year. Hospitals are responsible for entering a value for this field. That sum is then divided by the number of days within the reporting year.

Column 2 – Weighted Average Available Beds: is dedicated to entering the average number of available beds for each service. This is determined by first calculating the sum of the calendar days each bed was available during this reporting year. Hospitals are responsible for entering a value for this field. That sum is then divided by the number of days within the reporting year.

Column 3 – Weighted Average Staffed Beds: is dedicated to entering the average number of staffed bed days for each service. This is determined by first calculating the sum of the calendar days each bed was staffed during this reporting year. Hospitals are responsible for entering a value for this field. That sum is then divided by the number of days within the reporting year.

Column 4 – Inpatient Days: is dedicated to entering the number of inpatient days for each service. The inpatient days include all days of care for all admitted patients in each unit. The day of discharge or death will not be included. Hospitals are responsible for entering a value for this field. NOTE: Equivalent Observation Bed Days should not be included in this Column

Column 5 – Discharges: is dedicated to entering the number of discharges for each service. The value in this field must reflect any form of discharges from the hospital including deaths. Hospitals are responsible for entering a value for this field.

Column 6 – Percentage Occupancy: is dedicated to entering the percentage of occupancy for each service. This is determined by dividing “Inpatient Days” (Column 4) by the product of multiplying “Weighted Average Staffed Beds” (Column 3) and the days in the reporting period. This calculation should be rounded two decimal places.

Column 7 – Average Daily Census: is dedicated to entering the average daily census for each service. This is determined by dividing “Inpatient Days” (Column 4) by the number of days within the reporting year. This calculation should be rounded two decimal places.

Column 8 – Average Length of Stay: is dedicated to entering the average length of stay for each service. This is determined by dividing “Inpatient Days” (Column 4) by “Discharges” (Column 5). This calculation should be rounded two decimal places.

Line 500 is dedicated to calculating the Total Line consisting of the sum of Lines 1 to 19 for each Columns 1 through 5. Columns 6 through 8 are calculated as follows:

Column 6 – Percentage Occupancy: is dedicated to entering the total percentage of occupancy. This is determined by dividing the total "Inpatient Days" (Column 4) by the product of multiplying the total "Weighted Average Staffed Beds" (Column 3) and the number of days within the reporting year. This calculation should be rounded two decimal places.

Column 7 – Average Daily Census: is dedicated to entering the total average daily census. This is determined by dividing the total "Inpatient Days" (Column 4) by the number of days within the reporting year. This calculation should be rounded two decimal places.

Column 8 – Average Length of Stay: is dedicated to entering the average length of stay for each service. This is determined by dividing "Inpatient Days" (Column 4) by "Discharges" (Column 5). This calculation should be rounded two decimal places.

Tab 4 Supplementary Information

Hospitals should report on personnel, salary and benefits, supplemental revenue from Medicaid, MassHealth providers whose revenues and expenses are included in the cost report, and malpractice insurance information. Hospitals will not routinely be required to submit malpractice insurance supporting documentation with the Hospital Cost Report as they have in prior years. CHIA reserves the right to request that a hospital provide documentation to support the reported Malpractice Expense.

Personnel

This section collects the number of paid and non–paid Full Time Equivalent (FTE) employees in each classification.

Employee Classification:

Line 1 is for Management and Supervision
Line 2 is for Technicians and Specialists
Line 3 is for Registered Nurses
Line 4 is for Licensed Practical Nurses
Line 5 is for Certified Nurse Assistants
Line 6 is for Physician Assistants
Line 7 is for Nurse Practitioners
Line 8 is for Physicians
Line 9 is for Non–Physician Medical Practitioners
Line 10 is for Aides, Orderlies, Attendants
Line 11 is for Interns, Residents, and Fellows
Line 12 is for Environment, Hotel and Food Service Employees
Line 13 is for Clerical + Other Administrative Employees

Column 1 – Number of FTEs: Include the number of full time equivalents for each employee classification in this Column. Hospitals are responsible for entering numerical values as defined in CMS 2552-10 for reporting FTEs.

Line 500 is dedicated to calculating the Total of Lines 1 through 13 for “Number of FTEs” Column

Salary and Benefit Data

This section collects the salaries and wages of personnel of hospital only. Do not include personnel who are employed by temporary staffing agencies. Hospitals are responsible for entering numerical values within the Columns for the following Lines. Line 501 is dedicated to calculating the total of Lines 14 through 19 for each Column.

Employee Classification:

Line 14 is for Registered Nurses–Medical / Surgical
Line 15 is for Registered Nurses– Specialist
Line 16 is for Licensed Practical Nurses
Line 17 is for Certified Nurse Assistants
Line 18 is for Physician Assistants
Line 19 is for Nurse Practitioners

Column 1 – Salaries and Wages (Excludes Overtime and Shift Differentials): will be used to document any base wage, salary, or bonus payments. Do not include any shift differentials or overtime differentials paid to the employee. Do not include the employer's share of payroll taxes. Hospitals are responsible for entering numerical values within this Column.

Column 2 – Shift Differential Wages: will be used to document the Shift differentials wages and any amounts paid over an employee's base wage to compensate for working a second, third shift or weekend. The amounts reported must only include payments related to the shift differential. Do not include the base wages in this Column. Hospitals are responsible for entering numerical values within this Column.

Column 3 – Overtime Differential Wages: will be used to document the overtime differentials wages and any amounts paid above an employee's base wage to compensate as remuneration for overtime worked. The amounts reported must only include payments related to overtime. Do not include the base wages in this Column. Hospitals are responsible for entering numerical values within this Column.

Column 4 – Total Salaries and Wages: is dedicated to calculate the amount total sum from the salaries and wages entered in Column 1, shift differential wages entered in Column 2, and overtime wages entered in Column 3 for each Line.

Column 5 – Fringe Benefits: will be used to document the fringe benefits compensation amount for each employee classification. Hospitals are responsible for entering numerical values within this Column.

Column 6 – Total Hours: is dedicated to calculating the total number of hours worked for each employee classification as listed. Hospitals are responsible for entering numerical values within this Column.

Line 501 is dedicated to calculating the Total of Lines 14 through 19 for each Column

Medicaid Supplement Revenue

Data reported in this section identifies the supplementary revenue for the Medicaid program. Hospitals are responsible for entering the amount of revenue, name and purpose of the supplement programs within the Columns for the following Lines; Line 502 is dedicated to calculating the total of Lines 20 through 25 when needed.

Type of Revenue:

Line 20 is for Disproportionate Share Hospital Supplement
Line 21 is for Federally Mandated Disproportionate Share
Line 22 is for Safety Net Revenue
Line 23 is for Supplemental Revenue
Line 24 and 25 are for Other (Types of Revenue)

Column 1 – Name of Program: Hospitals are responsible for entering the Name of the Supplementary Program in this Column. Hospitals are responsible for entering text only in this Column, except for Line 502.

Column 2 – Revenue Amount: will be used to enter the Revenue Amount for each revenue type in this Column. Hospitals are responsible for entering numerical values within this Column.

Column 3 – Amount Included in NPSR: will be used to enter the amount of revenue reported for each type listed that is also reported as Net Patient Service Revenue. Hospitals are responsible for entering numerical values within this Column.

Column 4 – Restricted Use: will be either "Yes" or "No" to identify the available use of the revenue. Hospitals are responsible for entering text only in this Column, except for Line 502.

Column 5 – Purpose of Restricted Use: If a "Yes" was entered in Column 4, provide the reason for restricted use. Hospitals are responsible for entering text only in this Column, except for Line 502.

Line 502 is dedicated to calculating the Total of Lines 20 through 25, Columns 2 and 3 only.
Columns 1, 4, and 5 do not require totals and are not applicable.

MassHealth Providers

Hospitals are required to disclose all MassHealth providers whose expenses and revenues are reported on this Cost Report.

Lines 26 through 30 are entered, as directed, for each of the following Columns, unless not applicable:

Column 1 – Name of Provider: Provide the name of the provider, in this Column, only if provider is affiliated with a different hospital, for each line. Hospitals are responsible for entering text within this Column.

Column 2 – MassHealth (VPN) Number: is dedicated to entering the Organization's Vendor Payment Number (VPN), for MassHealth Program per Provider. Hospitals are responsible for entering numeric only values within this Column.

Column 3 – Medicare Provider Number: is dedicated to entering each listed Provider's number for Medicare. Hospitals are responsible for entering numeric only values within this Column.

Column 4 – Address (if different from Hospital): is dedicated to entering each Provider if address is different. Hospitals are responsible for entering values within this Column.

Malpractice Insurance

Provide the amount for each Malpractice Insurance.

Line 31 is for Malpractice Self Insured amounts, Self-malpractice policy, the hospital acts as its own insurance company
Line 32 is for Malpractice Stop Loss amounts, Commercial malpractice policy, purchased through commercial insurer to limit the hospital losses
Line 33 is for Malpractice Other Purchased amounts, Commercial malpractice policy, purchased through commercial Insurer
Line 34 is for Malpractice Paid Reserves (Paid within 75 days of FYE closing) amounts, Amount of self-insurance accrued liability paid within 75 days after close of cost reporting period
Line 35 is for Malpractice Unpaid Reserves (Not Paid within 75 days of FYE closing) amounts, Amount of self-insurance accrued liability not paid within 75 days after close of cost reporting period

Column 1 – Amount: will be used to enter the amount of expenses for the cost reporting year. Hospitals are responsible for entering numerical values within this Column.

Line 503 is dedicated to calculating the total of Lines 31 through 35 for "Amount" Column

Tab 5 Statistical Data and Revenue by Payer

This tab requires hospitals to enter inpatient service days and outpatient visits by cost center and by payer. Hospitals will also enter their gross patient service revenue, detail of deductions from gross patient service revenue in total, and net patient service revenue by payer on this tab.

This tab is divided up into four different sections across 13 categories, each listed by Columns. Hospitals are required to enter numerical values in each Column, for each section, unless specified. The information about the classification of payers for these columns will be consistent with the payer codes for 957 CMR 8.00. This list can be downloaded from the Chia website: chiamass.gov/payer-codes

Statistical Data for Inpatient Routine Service (Days)

Line 30.01 is for Medical and Surgical days (See Note A in the General Instructions)
Line 30.02 is for Pediatric days (See Note A in the General Instructions)
Line 30.03 is for Obstetric days (See Note A in the General Instructions)
Line 31.01 is for Intensive Care Unit days / Adult (See Note A in the General Instructions)
Line 31.02 is for Intensive Care Unit days / Pediatric (See Note A in the General Instructions)
Line 31.03 is for Intensive Care Unit days / Neonatal (See Note A in the General Instructions)
Line 32 is for Coronary Care Unit days
Line 33 is for Burn Intensive Care Unit days
Line 34 is for Surgical Intensive Care Unit days
Line 35 is for Other Special Care, and specified subscripts, days
Line 40.01 is for Sub–provider IPF days / Adult – Psych (See Note A in the General Instructions)
Line 40.02 is for Sub–provider IPF days / Pediatric – Psych (See Note A in the General Instructions)
Line 41 is for Sub–provider IRF days
Line 42 is for Sub–provider, and specified subscripts, days
Line 43.01 is for Nursery / Newborn days (See Note A in the General Instructions)
Line 43.02 is for Nursery / Special days (See Note A in the General Instructions)
Line 44 is for Skilled Nursing Facilities days
Line 45 is for Nursing Facility days
Line 46 is for Other Long Term Care days
Line 300 is dedicated to calculating the Total Patient Days. This is the total of Lines 30 through 46 for each Column 2 through 14. Column 1 will follow the instructions below
Line 47 is for Discharges

Column 1 – Total Columns 2 through 13: This Column is dedicated to calculating the total of each line, unless not applicable, for Columns 2 through 13

Column 2 – Medicare Managed: This Column is dedicated to entering the amount of days each service reported for the payers under this payer type

Column 3 – Medicare Non–Managed: This Column is dedicated to entering the amount of days each service reported for the payers under this payer type

Column 4 – Medicaid Managed: This Column is dedicated to entering the amount of days each service reported for the payers under this payer type

Column 5 – Medicaid Non–Managed: This Column is dedicated to entering the amount of days each service reported for the payers under this payer type

Column 6 – Workers Compensation: This Column is dedicated to entering the amount of days each service reported for the payers under this payer type

Column 7 – Self–Pay: This Column is dedicated to entering the amount of days each service reported as self-pay

Column 8 – Other Government: This Column is dedicated to entering the amount of days each service reported for the payers under this payer type

Column 9 – Commercial Managed Care: This Column is dedicated to entering the amount of days each service reported for the payers under this payer type

Column 10 – Commercial Non–Managed Care: This Column is dedicated to entering the amount of days each service reported for the payers under this payer type

Column 11 – Other: This Column is dedicated to entering the amount of days for the insurers/donated from Foundation or Research Grants for Patient Care

Column 12 – ConnectorCare: This Column is dedicated to entering the amount of days each service reported for ConnectorCare Plans. Qualified Health Plan Should be reported as Connector Care. A Qualified Health Plan (QHP) is a health insurance program available through the Massachusetts Health Connector. Qualified Health Plans meet minimum coverage standards and make it possible for Massachusetts residents to get quality, affordable health coverage for themselves and their families. Depending on a family's income and size, the family may receive a subsidy towards premium costs.

Column 13 – Health Safety Net: This Column is dedicated to entering the amount of days each service for services paid for by the Health Safety Net

Column 14 – Non Patient Service: This Column is dedicated to entering the amount of days for the services listed below:

Services rendered to other than hospital patients
Services to other hospitals and institutions (no third party billing)

Services to doctors and employees (not as patients)

Statistical Data for Outpatient Service (Visits)

Line 88 is for Rural Health Clinic visits
Line 89 is for Federally Qualified Health Center visits
Line 90 is for Clinic visits
Line 91 is for Emergency visits
Line 92 is for Observation Beds – Non Distinct visits
Line 92.01 is for Observation Beds – Distinct visits
Line 93 is for Other Outpatient Service (Specify with subscript) visits
Line 94 is for Home Program Dialysis visits
Line 95 is for Ambulance Services visits
Line 96 is for Durable Medical Equipment–Rented visits
Line 97 is for Durable Medical Equipment–Sold visits
Line 98 is for Other (Specify with subscript) visits
Line 99 is for Outpatient Rehabilitation Provider (Specify with subscript) visits
Line 100 is for Intern–Resident Service (not approved teaching program) visits
Line 101 is for Home Health Agency visits

Line 301 is dedicated to calculating the Total Outpatient Visits. This is the total of Lines 88 through 101 for each Column 2 through 14. Column 1 will follow the instructions below

Column 1 – Total Columns 2 through 13: This Column is dedicated to calculating the total of each line, unless not applicable, for Columns 2 through 13

Column 2 – Medicare Managed: This Column is dedicated to entering the amount of visits each service reported for the payers under this payer type

Column 3 – Medicare Non–Managed: This Column is dedicated to entering the amount of visits each service reported for the payers under this payer type

Column 4 – Medicaid Managed: This Column is dedicated to entering the amount of visits each service reported for the payers under this payer type

Column 5 – Medicaid Non–Managed: This Column is dedicated to entering the amount of visits each service reported for the payers under this payer type

Column 6 – Workers Compensation: This Column is dedicated to entering the amount of visits each service reported for the payers under this payer type

Column 7 – Self–Pay: This Column is dedicated to entering the amount of visits each service reported as self-pay

Column 8 – Other Government: This Column is dedicated to entering the amount of visits each service reported for the payers under this payer type

Column 9 – Commercial Managed Care: This Column is dedicated to entering the amount of visits each service reported for the payers under this payer type

Column 10 – Commercial Non–Managed Care: This Column is dedicated to entering the amount of visits each service reported for the payers under this payer type

Column 11 – Other: This Column is dedicated to entering the amount of visits for the insurers/donated from Foundation or Research Grants for Patient Care

Column 12 – ConnectorCare: This Column is dedicated to entering the amount of visits each service reported for ConnectorCare Plans

Column 13 – Health Safety Net: This Column is dedicated to entering the amount of visits each service rendered eligible and enrolled as Health Safety Net patients.

Column 14 – Non Patient Service: This Column is dedicated to entering the amount of visits for the services listed below:

Services rendered to other than hospital patients
Services to other hospitals and institutions (no third party billing)
Services to doctors and employees (not as patients)

Revenue Data - Gross Patient Service

Line 206 is for Inpatient GPSR
Line 207 is for Outpatient GPSR
Line 302 is dedicated to calculating the Total GPSR. This is the total of Lines 206 and 207 for each Column 2 through 14. Column 1 will follow the instructions below

Column 1 – Total Columns 2 through 13: This Column is dedicated to calculating the total of each line, unless not applicable, for Columns 2 through 13

Column 2 – Medicare Managed: This Column is dedicated to entering GPSR for each service reported for the payers under this payer type

Column 3 – Medicare Non–Managed: This Column is dedicated to entering GPSR for each service reported for the payers under this payer type

Column 4 – Medicaid Managed: This Column is dedicated to entering GPSR for each service reported for the payers under this payer type

Column 5 – Medicaid Non–Managed: This Column is dedicated to entering GPSR for each service reported for the payers under this payer type

Column 6 – Workers Compensation: This Column is dedicated to entering GPSR for each service reported for the payers under this payer type

Column 7 – Self–Pay: This Column is dedicated to entering GPSR for each service reported as self-pay

Column 8 – Other Government: This Column is dedicated to entering GPSR for each service reported for the payers under this payer type

Column 9 – Commercial Managed Care: This Column is dedicated to entering GPSR for each service reported for the payers under this payer type

Column 10 – Commercial Non–Managed Care: This Column is dedicated to entering GPSR for each service reported for the payers under this payer type

Column 11 – Other: This Column is dedicated to entering GPSR for the insurers/donated from Foundation or Research Grants for Patient Care

Column 12 – ConnectorCare: This Column is dedicated to entering GPSR for each service reported for ConnectorCare Plans

Column 13 – Health Safety Net: This Column is dedicated to entering GPSR for each service rendered eligible and enrolled as Health Safety Net patients.

Column 14 – Non Patient Service: This Column is dedicated to entering GPSR for the services listed below:

Services rendered to other than hospital patients
Services to other hospitals and institutions (no third party billing)
Services to doctors and employees (not as patients)

Revenue Data - Net Patient Service

Line 208 is for Inpatient NPSR (Includes Premium Revenue). Input not required for Columns 6 through 14

Line 209 is for Outpatient NPSR (Includes Premium Revenue). Input not required for Columns 6 through 14

Line 303 is dedicated to calculating the Total NPSR, which includes premium revenue. Column 1 will follow the instructions below. Columns 2 through 5 will calculate the total of Lines 208 and 209. Hospitals are required to enter the totals for Columns 6 through 14.

Column 1 – Total Columns 2 through 13: This Column is dedicated to calculating the total of each line, unless not applicable, for Columns 2 through 13

Column 2 – Medicare Managed: This Column is dedicated to entering NPSR for each service reported for the payers under this payer type

Column 3 – Medicare Non–Managed: This Column is dedicated to entering NPSR for each service reported for the payers under this payer type

Column 4 – Medicaid Managed: This Column is dedicated to entering NPSR for each service reported for the payers under this payer type

Column 5 – Medicaid Non–Managed: This Column is dedicated to entering NPSR for each service reported for the payers under this payer type

Column 6 – Workers Compensation: This Column is dedicated to entering NPSR for each service reported for the payers under this payer type

Column 7 – Self–Pay: This Column is dedicated to entering NPSR for each service reported as self-pay

Column 8 – Other Government: This Column is dedicated to entering NPSR for each service reported for the payers under this payer type

Column 9 – Commercial Managed Care: This Column is dedicated to entering NPSR for each service reported for the payers under this payer type

Column 10 – Commercial Non–Managed Care: This Column is dedicated to entering NPSR for each service reported for the payers under this payer type

Column 11 – Other: This Column is dedicated to entering NPSR for the insurers/donated from Foundation or Research Grants for Patient Care

Column 12 – ConnectorCare: This Column is dedicated to entering NPSR for each service reported for ConnectorCare Plans

Column 13 – Health Safety Net: This Column is dedicated to entering NPSR for each service rendered eligible and enrolled as Health Safety Net patients.

Column 14 – Non Patient Service: This Column is dedicated to entering NPSR for the services listed below:

Services rendered to other than hospital patients
Services to other hospitals and institutions (no third party billing)
Services to doctors and employees (not as patients)

Detail of Deductions from GPSR in Total

Line 304 is dedicated to Inpatient and Outpatient GPSR. This value will match Line 302 for each Column

Line 210 is for Less: Contractual Allowance
Line 211 is for Less: Charges for Free Care Provided
Line 212 is for Add: Payment received for Free Care
Line 213 is for Less: Provision for Bad Debt
Line 305 is dedicated to calculating Inpatient and Outpatient NPSR, which includes premium revenue. Column 1 will follow the instructions below. Columns 2 through 14 will calculate the total per the following: Line 304 less Line 210 less Line 211 plus Line 212 less Line 213.

Line 214 is for Bad Debt Write Offs

Column 1 – Total Columns 2 to 13 (excluding 14): This Column is dedicated to calculating the sum of Column 2 to 13, unless not applicable

Column 2 – Medicare Managed: This Column is dedicated to entering Contractual Allowance, Charges for Free Care Provided, Payment Received for Free Care, Provision for Bad Debt, Bad Debt Write Off, for each payers under this payer type

Column 3 – Medicare Non–Managed: This Column is dedicated to entering Contractual Allowance, Charges for Free Care Provided, Payment Received for Free Care, Provision for Bad Debt, Bad Debt Write Off, for each payers under this payer type

Column 4 – Medicaid Managed: This Column is dedicated to entering Contractual Allowance, Charges for Free Care Provided, Payment Received for Free Care, Provision for Bad Debt, Bad Debt Write Off, for each payers under this payer type

Column 5 – Medicaid Non–Managed: This Column is dedicated to entering Contractual Allowance, Charges for Free Care Provided, Payment Received for Free Care, Provision for Bad Debt, Bad Debt Write Off, for each payers under this payer type

Column 6 – Workers Compensation: This Column is dedicated to entering Contractual Allowance, Charges for Free Care Provided, Payment Received for Free Care, Provision for Bad Debt, Bad Debt Write Off, for each payers under this payer type

Column 7 – Self–Pay: This Column is dedicated to entering Contractual Allowance, Charges for Free Care Provided, Payment Received for Free Care, Provision for Bad Debt, Bad Debt Write Off, for each payers under this payer type

Column 8 – Other Government: This Column is dedicated to entering Contractual Allowance, Charges for Free Care Provided, Payment Received for Free Care, Provision for Bad Debt, Bad Debt Write Off, for each payers under this payer type

Column 9 – Commercial Managed Care: This Column is dedicated to entering Contractual Allowance, Charges for Free Care Provided, Payment Received for Free Care, Provision for Bad Debt, Bad Debt Write Off, for each payers under this payer type

Column 10 – Commercial Non–Managed Care: This Column is dedicated to entering Contractual Allowance, Charges for Free Care Provided, Payment Received for Free Care, Provision for Bad Debt, Bad Debt Write Off, for each payers under this payer type

Column 11 – Other: This Column is dedicated to entering Contractual Allowance, Charges for Free Care Provided, Payment Received for Free Care, Provision for Bad Debt, Bad Debt Write Off, for each payers under this payer type

Column 12 – ConnectorCare: This Column is dedicated to entering Contractual Allowance, Charges for Free Care Provided, Payment Received for Free Care, Provision for Bad Debt, Bad Debt Write Off, for each payers under this payer type

Column 13 – Health Safety Net: This Column is dedicated to entering Contractual Allowance, Charges for Free Care Provided, Payment Received for Free Care, Provision for Bad Debt, Bad Debt Write Off, for each payers under this payer type

Column 14 – Non Patient Service: This Column is dedicated to entering Contractual Allowance, Charges for Free Care Provided, Payment Received for Free Care, Provision for Bad Debt, Bad Debt Write Off, for each payers under this payer type

Tab 6 Gross Patient Service Revenue

Hospitals should report routine gross patient service revenues and ancillary gross patient service revenues for the inpatient routine service centers, outpatient service centers, special purpose cost centers, and Non-Patient cost centers on this tab.

The data reported on this tab aggregates Revenue Centers: Inpatient Routine Service Center, Outpatient Service Center, Special Purpose Cost Centers, and Non–Reimbursable Centers. Within these sections, sub-columns need to be reported for each Ancillary Center entered in Tab 9 "Direct Expense", Lines 50 through 76. These sub-columns will be entered to the right of the main cost center in Columns 4 through 30.

Inpatient Routine Service Center

Line 30.01 is for Medical and Surgical revenue (See Note A in the General Instructions)
Line 30.02 is for Pediatric revenue (See Note A in the General Instructions)
Line 30.03 is for Obstetric revenue (See Note A in the General Instructions)
Line 31.01 is for Intensive Care Unit days / Adult (See Note A in the General Instructions)
Line 31.02 is for Intensive Care Unit days / Pediatric (See Note A in the General Instructions)
Line 31.03 is for Intensive Care Unit days / Neonatal (See Note A in the General Instructions)
Line 32 is for Coronary Care Unit revenue
Line 33 is for Burn Intensive Care Unit revenue
Line 34 is for Surgical Intensive Care Unit revenue
Line 35 is for Other Special Care (Specify with subscript) revenue
Line 40.01 is for Sub–provider IPF days / Adult – Psych (See Note A in the General Instructions)
Line 40.02 is for Sub–provider IPF days / Pediatric – Psych (See Note A in the General Instructions)
Line 41 is for Sub–provider IRF revenue
Line 42 is for Sub–provider (Specify with subscript) revenue
Line 43.01 is for Nursery / Newborn days (See Note A in the General Instructions)
Line 43.02 is for Nursery / Special days (See Note A in the General Instructions)
Line 44 is for Skilled Nursing Facilities revenue
Line 45 is for Nursing Facility revenue
Line 46 is for Other Long Term Care revenue

Column 1 – Total GPSR: This Column is dedicated to calculating each line's total, unless not applicable, for "Routine Gross Patient Service Revenue", Column 2, and "Ancillary Gross Patient Service Revenue", Column 3.

Column 2 – Routine GPSR: This Column is dedicated to Gross Patient Service Revenue. Hospitals are responsible for entering numerical values within this Column.

Column 3 – Ancillary GPSR: This Column is dedicated to calculating each line's total, unless not applicable, for Columns 4 through 30.

Column 4 – Operating Room GPSR: This Column is dedicated to Operating Room revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 5 – Recovery Room GPSR: This Column is dedicated to Recovery Room revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 6 – Labor and Delivery Room GPSR: This Column is dedicated to Labor and Delivery revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 7 – Anesthesiology GPSR: This Column is dedicated to Anesthesiology revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 8 – Radiology Diagnostic GPSR: This Column is dedicated to Radiology Diagnostic revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 9 – Radiology Therapeutic GPSR: This Column is dedicated to Radiology Therapeutic revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 10 – Radioisotope GPSR: This Column is dedicated to Radioisotope revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 11 – Computed Tomography (CT) Scan GPSR: This Column is dedicated to Computed Tomography revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 12 – Magnetic Resonance Imaging (MRI) GPSR: This Column is dedicated to Magnetic Resonance Imaging revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 13 – Cardiac Catheterization GPSR: This Column is dedicated to Cardiac Catheterization revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 14 – Laboratory GPSR: This Column is dedicated to Laboratory revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 15 – PBP Clinical Laboratory Program Only GPSR: This Column is dedicated to PBP Clinical Laboratory Program revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 16 – Whole Blood and Packed Red Blood Cells GPSR: This Column is dedicated to Whole Blood and Packed Red Blood Cell revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 17 – Blood Storing, Processing and Transfusion GPSR: This Column is dedicated to Blood Storing, Processing and Transfusion revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 18 – Intravenous Therapy GPSR: This Column is dedicated to Intravenous Therapy revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 19 – Respiratory Therapy GPSR: This Column is dedicated to Respiratory Therapy revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 20 – Physical Therapy GPSR: This Column is dedicated to Physical Therapy revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 21 – Occupational Therapy GPSR: This Column is dedicated to Occupational Therapy revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 22 – Speech Pathology GPSR: This Column is dedicated to Speech Pathology revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 23 – Electro–Cardiology Therapy GPSR: This Column is dedicated to Electro Cardiology revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 24 – Electroencephalography GPSR: This Column is dedicated to Electroencephalography revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 25 – Medical Supplies Charged to Patients GPSR: This Column is dedicated to Medical Supplies Charged to Patients revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 26 – Implantable Devices Charged to Patients GPSR: This Column is dedicated to Implantable Devices Charged to Patients revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 27 – Drugs Special Charged to Patients GPSR: This Column is dedicated to Drugs Special Charged to Patients revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 28 – Renal Dialysis GPSR: This Column is dedicated to Renal Dialysis revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 29 – ASC (Non–Distinct Part) GPSR: This Column is dedicated to ASC (Non–Distinct Part) revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 30 – Other Ancillary (Specify with subscript) GPSR: This Column is dedicated to Other Ancillary revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Line 300 is dedicated to calculating the Total Inpatient Routine Service GPSR. This is the total of Lines 30 through 46 for each Column.

Outpatient Service Center

Line 88 is for Rural Health Clinic revenue
Line 89 is for Federally Qualified Health Center revenue
Line 90 is for Clinic revenue
Line 91 is for Emergency revenue
Line 92 is for Observation Beds Non–Distinct revenue
Line 92.01 is for Observation Beds Distinct revenue
Line 93 is for Other Outpatient Service (Specify with subscript) revenue
Line 94 is for Home Program Dialysis revenue
Line 95 is for Ambulance Services revenue
Line 96 is for Durable Medical Equipment–Rented revenue
Line 97 is for Durable Medical Equipment–Sold revenue
Line 98 is for Other (Specify with subscript) revenue
Line 99 is for Outpatient Rehabilitation Provider PR CORF (Specify with subscript) revenue
Line 100 is for Intern–Resident Service (not approved teaching program) revenue
Line 101 is for Home Health Agency revenue

Column 1 – Total GPSR: This Column is dedicated to calculating each line's total, unless not applicable, for "Routine Gross Patient Service Revenue", Column 2, and "Ancillary Gross Patient Service Revenue", Column 3.

Column 2 – Routine GPSR: This Column is dedicated to Gross Patient Service Revenue. Hospitals are responsible for entering numerical values within this Column.

Column 3 – Ancillary GPSR: This Column is dedicated to calculating each line's total, unless not applicable, for Columns 4 through 30.

Column 4 – Operating Room GPSR: This Column is dedicated to Operating Room revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 5 – Recovery Room GPSR: This Column is dedicated to Recovery Room revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 6 – Labor and Delivery Room GPSR: This Column is dedicated to Labor and Delivery revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 7 – Anesthesiology GPSR: This Column is dedicated to Anesthesiology revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 8 – Radiology Diagnostic GPSR: This Column is dedicated to Radiology Diagnostic revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 9 – Radiology Therapeutic GPSR: This Column is dedicated to Radiology Therapeutic revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 10 – Radioisotope GPSR: This Column is dedicated to Radioisotope revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 11 – Computed Tomography (CT) Scan GPSR: This Column is dedicated to Computed Tomography revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 12 – Magnetic Resonance Imaging (MRI) GPSR: This Column is dedicated to Magnetic Resonance Imaging revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 13 – Cardiac Catheterization GPSR: This Column is dedicated to Cardiac Catheterization revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 14 – Laboratory GPSR: This Column is dedicated to Laboratory revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 15 – PBP Clinical Laboratory Program Only GPSR: This Column is dedicated to PBP Clinical Laboratory Program revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 16 – Whole Blood and Packed Red Blood Cells GPSR: This Column is dedicated to Whole Blood and Packed Red Blood Cell revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 17 – Blood Storing, Processing and Transfusion GPSR: This Column is dedicated to Blood Storing, Processing and Transfusion revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 18 – Intravenous Therapy GPSR: This Column is dedicated to Intravenous Therapy revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 19 – Respiratory Therapy GPSR: This Column is dedicated to Respiratory Therapy revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 20 – Physical Therapy GPSR: This Column is dedicated to Physical Therapy revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 21 – Occupational Therapy GPSR: This Column is dedicated to Occupational Therapy revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 22 – Speech Pathology GPSR: This Column is dedicated to Speech Pathology revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 23 – Electro–Cardiology Therapy GPSR: This Column is dedicated to Electro Cardiology revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 24 – Electroencephalography GPSR: This Column is dedicated to Electroencephalography revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 25 – Medical Supplies Charged to Patients GPSR: This Column is dedicated to Medical Supplies Charged to Patients revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 26 – Implantable Devices Charged to Patients GPSR: This Column is dedicated to Implantable Devices Charged to Patients revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 27 – Drugs Special Charged to Patients GPSR: This Column is dedicated to Drugs Special Charged to Patients revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 28 – Renal Dialysis GPSR: This Column is dedicated to Renal Dialysis revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 29 – ASC (Non–Distinct Part) GPSR: This Column is dedicated to ASC (Non–Distinct Part) revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 30 – Other Ancillary (Specify with subscript) GPSR: This Column is dedicated to Other Ancillary revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Special Purpose Cost Centers

Line 105 is for Kidney Acquisition revenue
Line 106 is for Heart Acquisition revenue
Line 107 is for Liver Acquisition revenue
Line 108 is for Lung Acquisition revenue
Line 109 is for Pancreas Acquisition revenue
Line 110 is for Intestinal Acquisition revenue
Line 111 is for Islet Acquisition revenue
Line 112 is for Other Organ Acquisition (Specify with subscript) revenue
Line 113 is for Interest revenue
Line 114 is for Utilization Review SNF revenue
Line 115 is for Ambulatory Surgical (Distinct Part) revenue
Line 116 is for Hospice revenue
Line 117 is for Other Special Purpose revenue

Column 1 – Total GPSR: This Column is dedicated to calculating each line's total, unless not applicable, for "Routine Gross Patient Service Revenue", Column 2, and "Ancillary Gross Patient Service Revenue", Column 3.

Column 2 – Routine GPSR: This Column is dedicated to Gross Patient Service Revenue. Hospitals are responsible for entering numerical values within this Column.

Column 3 – Ancillary GPSR: This Column is dedicated to calculating each line's total, unless not applicable, for Columns 4 through 30.

Column 4 – Operating Room GPSR: This Column is dedicated to Operating Room revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 5 – Recovery Room GPSR: This Column is dedicated to Recovery Room revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 6 – Labor and Delivery Room GPSR: This Column is dedicated to Labor and Delivery revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 7 – Anesthesiology GPSR: This Column is dedicated to Anesthesiology revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 8 – Radiology Diagnostic GPSR: This Column is dedicated to Radiology Diagnostic revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 9 – Radiology Therapeutic GPSR: This Column is dedicated to Radiology Therapeutic revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 10 – Radioisotope GPSR: This Column is dedicated to Radioisotope revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 11 – Computed Tomography (CT) Scan GPSR: This Column is dedicated to Computed Tomography revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 12 – Magnetic Resonance Imaging (MRI) GPSR: This Column is dedicated to Magnetic Resonance Imaging revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 13 – Cardiac Catheterization GPSR: This Column is dedicated to Cardiac Catheterization revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 14 – Laboratory GPSR: This Column is dedicated to Laboratory revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 15 – PBP Clinical Laboratory Program Only GPSR: This Column is dedicated to PBP Clinical Laboratory Program revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 16 – Whole Blood and Packed Red Blood Cells GPSR: This Column is dedicated to Whole Blood and Packed Red Blood Cell revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 17 – Blood Storing, Processing and Transfusion GPSR: This Column is dedicated to Blood Storing, Processing and Transfusion revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 18 – Intravenous Therapy GPSR: This Column is dedicated to Intravenous Therapy revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 19 – Respiratory Therapy GPSR: This Column is dedicated to Respiratory Therapy revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 20 – Physical Therapy GPSR: This Column is dedicated to Physical Therapy revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 21 – Occupational Therapy GPSR: This Column is dedicated to Occupational Therapy revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 22 – Speech Pathology GPSR: This Column is dedicated to Speech Pathology revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 23 – Electro–Cardiology Therapy GPSR: This Column is dedicated to Electro Cardiology revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 24 – Electroencephalography GPSR: This Column is dedicated to Electroencephalography revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 25 – Medical Supplies Charged to Patients GPSR: This Column is dedicated to Medical Supplies Charged to Patients revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 26 – Implantable Devices Charged to Patients GPSR: This Column is dedicated to Implantable Devices Charged to Patients revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 27 – Drugs Special Charged to Patients GPSR: This Column is dedicated to Drugs Special Charged to Patients revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 28 – Renal Dialysis GPSR: This Column is dedicated to Renal Dialysis revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 29 – ASC (Non–Distinct Part) GPSR: This Column is dedicated to ASC (Non–Distinct Part) revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 30 – Other Ancillary (Specify with subscript) GPSR: This Column is dedicated to Other Ancillary revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Line 301 is dedicated to calculating the Total Outpatient Service GPSR and Special Purpose Cost Center. This is the total of Lines 88 through 117 for each Column.

Line 302 is dedicated to calculating the Total Gross Patient Service Revenue. This is the total of Lines 300 and 301 for each Column.

Non–Reimbursable Centers

Line 190 is for Gift, Flower, Coffee Shop, and Canteen Revenue
Line 191 is for Research revenue
Line 192 is for Physicians' Private Offices revenue
Line 193 is for Nonpaid Workers revenue
Line 194 is for Other Non-Patient (Specify with subscript) revenue

Column 1 – Total GPSR: This Column is dedicated to calculating each line's total, unless not applicable, for "Routine Gross Patient Service Revenue", Column 2, and "Ancillary Gross Patient Service Revenue", Column 3.

Column 2 – Routine GPSR: This Column is dedicated to Gross Patient Service Revenue. Hospitals are responsible for entering numerical values within this Column.

Column 3 – Ancillary GPSR: This Column is dedicated to calculating each line's total, unless not applicable, for Columns 4 through 30.

Column 4 – Operating Room GPSR: This Column is dedicated to Operating Room revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 5 – Recovery Room GPSR: This Column is dedicated to Recovery Room revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 6 – Labor and Delivery Room GPSR: This Column is dedicated to Labor and Delivery revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 7 – Anesthesiology GPSR: This Column is dedicated to Anesthesiology revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 8 – Radiology Diagnostic GPSR: This Column is dedicated to Radiology Diagnostic revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 9 – Radiology Therapeutic GPSR: This Column is dedicated to Radiology Therapeutic revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 10 – Radioisotope GPSR: This Column is dedicated to Radioisotope revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 11 – Computed Tomography (CT) Scan GPSR: This Column is dedicated to Computed Tomography revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 12 – Magnetic Resonance Imaging (MRI) GPSR: This Column is dedicated to Magnetic Resonance Imaging revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 13 – Cardiac Catheterization GPSR: This Column is dedicated to Cardiac Catheterization revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 14 – Laboratory GPSR: This Column is dedicated to Laboratory revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 15 – PBP Clinical Laboratory Program Only GPSR: This Column is dedicated to PBP Clinical Laboratory Program revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 16 – Whole Blood and Packed Red Blood Cells GPSR: This Column is dedicated to Whole Blood and Packed Red Blood Cell revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 17 – Blood Storing, Processing and Transfusion GPSR: This Column is dedicated to Blood Storing, Processing and Transfusion revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 18 – Intravenous Therapy GPSR: This Column is dedicated to Intravenous Therapy revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 19 – Respiratory Therapy GPSR: This Column is dedicated to Respiratory Therapy revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 20 – Physical Therapy GPSR: This Column is dedicated to Physical Therapy revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 21 – Occupational Therapy GPSR: This Column is dedicated to Occupational Therapy revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 22 – Speech Pathology GPSR: This Column is dedicated to Speech Pathology revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 23 – Electro–Cardiology Therapy GPSR: This Column is dedicated to Electro Cardiology revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 24 – Electroencephalography GPSR: This Column is dedicated to Electroencephalography revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 25 – Medical Supplies Charged to Patients GPSR: This Column is dedicated to Medical Supplies Charged to Patients revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 26 – Implantable Devices Charged to Patients GPSR: This Column is dedicated to Implantable Devices Charged to Patients revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 27 – Drugs Special Charged to Patients GPSR: This Column is dedicated to Drugs Special Charged to Patients revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 28 – Renal Dialysis GPSR: This Column is dedicated to Renal Dialysis revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 29 – ASC (Non–Distinct Part) GPSR: This Column is dedicated to ASC (Non–Distinct Part) revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Column 30 – Other Ancillary (Specify with subscript) GPSR: This Column is dedicated to Other Ancillary revenue for those appropriate lines as indicated. Hospitals are responsible for entering numerical values within this Column.

Line 500 is dedicated to calculating the Total Gross Patient Service Revenue, including the Non-Patient Centers. This is the total of Lines 302 and 190 through 194

Tab 7 Reclassifications

Hospitals should use this tab to reclassify certain costs to ensure that proper cost allocation is determined. The total of the increases in a reclassification must equal the total of the decreases in that reclassification.

Most of the data reported for Tab 7 will derive from the CMS–2552–10 Worksheet A–6 "Reclassifications."

Reclassifications of "Other Capital Related Costs" originating on CMS–2552–10 Worksheet A-7 will need to be added to this schedule and coded in Column 2 as "A7". Please note that Tab 9 "Direct Expenses" (Line 3, Column 6) must be a zero amount.

This cost report requires that any use of the following from the CMS–2552–10 Worksheet will be broken out into separate line items. Any reclassifications entered into the CMS–2552–10 of the following list require this segregation:

"Adults and Pediatrics" will be segregated into separate line items: "Medical and Surgical", "Pediatric", and "Obstetric"

"Intensive Care Unit" will be segregated into line items: "Adult", "Pediatric", and "Neonatal"

"Subprovider IPF" will be segregated into line items: "Adult - Psych" and "Pediatric - Psych"

"Nursery" to be segregated into separate line items: "Newborn" and "Special"

Insert additional lines as needed. (See Note A in the General Instructions)

Lines entered as directed for each of the following Columns, unless not applicable:

<u>Column 1 – Explanation of Reclassification(s):</u> will match the description entered in CMS–2552–10 Worksheet A–6 Column labelled "Explanation of Reclassification(s)" for each line. Hospitals are responsible for spelling out the reason for a reclassification

<u>Column 2 – Code:</u> will match the alpha character or "A7"entered in CMS–2552–10 Worksheet A–6 Column 1 for each line. Hospitals are required to enter the alpha character designated to identify the reclassification

<u>Column 3 – Increases – Cost Center:</u> will match the description entered in CMS–2552–10 Worksheet A–6 Column 2 for each line.

Column 4 – Increases – Line#: will match the value entered in CMS–2552–10 Worksheet A–6 Column 3 for each line.

Column 5 – Increases – Salary: hospitals are responsible for entering the salary increase based on the value entered in CMS–2552–10 Worksheet A–6 Column 4 for each line. The sum of the increases in Column 5 must be equal to the sum of the decreases in Column 9

Column 6 – Increases – Other: hospitals are responsible for entering any other increases based on the value entered in CMS–2552–10 Worksheet A–6 Column 5 for each line. The sum of the increases in Columns 6 must be equal to the sum of the decreases in Columns 10

Column 7 – Decreases – Cost Center: will match the description entered in CMS–2552–10 Worksheet A–6 Column 6 for each line.

Column 8 – Decreases – Line#: will match the value entered in CMS–2552–10 Worksheet A–6 Column 7 for each line.

Column 9 – Decreases – Salary: hospitals are responsible for entering the salary decrease based on the value entered in CMS–2552–10 Worksheet A–6 Column 8 for each line. The sum of the increases in Column 5 must be equal to the sum of the decreases in Column 9

Column 10 – Decreases – Other: hospitals are responsible for entering any other decreases based on the value entered in CMS–2552–10 Worksheet A–6 Column 9 for each line. The sum of the increases in Columns 6 must be equal to the sum of the decreases in Column 10

In instances where there are multiple line entries for a particular Cost Center, the net amount is required to carry forward to Tab 9, Column 4. In preparation of this, each reclassification entry for the different cost centers, identified in Tab 7 as Columns 4 and 8, in the Increase and Decrease sections (Columns 5, 6, 9, and 10) will need to be totaled together. This should be done separately from this worksheet. Calculations for these entries are the following: total sum of each individual cost center's Salary and Other found in the Increase Columns. Then subtract from that the total sum of each individual cost center's Salary and Other found in the Decrease Columns.

Line 500 is dedicated to calculating the total value entered in Columns 5, 6, 9, and 10.

Tab 8 Adjustments

Hospitals should use this tab enter adjustments and expense. Medicare entries that should be included are those that adjust expenses to reflect actual expenses incurred or allowed as well as those items which constitute recovery of expenses through sales, charges and fees. Adjustments that are not required for this tab would be those that are made pursuant to Medicare cost limitations. For example, physician and therapy service costs should not be reduced because they exceed Medicare's reasonable cost equivalent limitations. Most of the data reported for Tab 8 will match the data found in CMS–2552–10 Worksheets A–8 series.

This cost report requires that any use of the following from the CMS–2552–10 Worksheet will be broken out into separate line items. Any reclassifications entered into the CMS–2552–10 of the following list require this segregation:

"Adults and Pediatrics" will be segregated into separate line items: "Medical and Surgical", "Pediatric", and "Obstetric"

"Intensive Care Unit" will be segregated into line items: "Adult", "Pediatric", and "Neonatal"

"Subprovider IPF" will be segregated into line items: "Adult - Psych" and "Pediatric - Psych"

"Nursery" to be segregated into separate line items: "Newborn" and "Special"

Insert additional lines as needed. (See Note A in the General Instructions)

Lines 1 through 32 are entered, as directed, for each of the following Columns, unless not applicable

Lines 10 and 12 are to be entered as the individual detailed line information which will match the values in A-8-1 and A-8-2.

Lines 33 through 49 are available for any additional adjustments

The Adjustments Schedule is made up of nine Columns.

Column 1 - Description: will match the description on CMS–2552–10 Worksheet A-8 column labeled "Description"

Column 2 – Basis / Code: will match the description on CMS–2552–10 Worksheet A-8 Column 1

Column 3 – Amount: hospitals are responsible for entering any amounts based on the value entered in CMS–2552–10 Worksheet A–8 Column 2

Column 4 – Cost Center: will match the descriptions entered in CMS–2552–10 Worksheet A–8 Column 3

Column 5 – Cost Center Line#: will generally match the values entered in CMS–2552–10 Worksheet A–8 Column 4. Hospitals are required to edit this line to segregate Adults and Pediatrics for the cost center's line numbers affected

In instances where there are multiple line entries for a particular Cost Center, the net amount is required to carry forward to Tab 9, Column 5. In preparation of this, each adjustment entry for the different cost centers, identified in Tab 8 Column 5, will need to be totaled together. This should be done separately from this worksheet. Calculations for these entries are the following: total sum of each individual cost center's Amount.

Line 500 is designated for the total amounts from Lines 1 through 49 for Column 3 only

Tab 9 Direct Expense

This tab lists the trial balance salary and other expense amounts for general service cost centers, inpatient routine service cost centers, ancillary service cost centers, outpatient service cost centers, special purpose cost centers, and Non-Patient cost centers. Reclassifications and adjustments are then included to determine the total that is used in the stepdown allocation. Hospitals are responsible for entering numerical values in each Column.

General Service Cost Centers

Lines 1 through 23 will match the values in the CMS–2552–10 Worksheet "A" "Reclassification and Adjustments of Trial Balance Expenses"

Column 1 – Salaries: will match the values entered in the CMS–2552–10 Worksheet "A" "Reclassification and Adjustments of Trial Balance Expenses" Column 1, "Salaries", for each line item from Line 4 through 23

Column 2 – Other: will match the values entered in the CMS–2552–10 Worksheet "A" "Reclassification and Adjustments of Trial Balance Expenses" Column 2, "Other" for each Line. This Column is used to document all expenses other than salaries

Column 3 – Total: is dedicated to calculating the total of Columns 1 "Salaries" and 2 "Other" for each Line.

Column 4 – Reclassifications: is dedicated to calculating the total sum of Columns 5, 6, 9, and 10 with the matching Cost Center line items identified in Tab 7, Columns 4 and 8. The Cost Center's Increased (Salary and Other) sum is added to the Decreases (Salary and Other) sum. More information on this calculation can be found in Tab 7 section. The net total of the line item values in this Column must equal zero on line 500

Column 5 – Adjustments: is dedicated to calculating the total of the matching Cost Center line items identified in Tab 8, Column 5. More information on this calculation can be found in Tab #8 section. This Column is used to document the total adjustments made by the hospital on each Line.

Column 6 – Net Expenses For Stepdown Allocation: is dedicated to calculate the total for Columns 3, 4, and 5 for each Line

Inpatient Routine Service Cost Centers

Lines 30.01, 30.02, and 30.03 are the responsibility of the hospital for each Column. This cost report requires that "Adults and Pediatrics" are segregated into separate line items: "Medical and Surgical", "Pediatric", and "Obstetric", (See Note A in the General Instructions).

Lines 31.01, 31.02, and 31.03 are the responsibility of the hospital. This cost report requires that the Cost Center for "Intensive Care Unit" to be segregated into separate line items: "Adult", "Pediatric", and "Neonatal", (See Note A in the General Instructions).

Lines 40.01 and 40.02 are the responsibility of the hospital. This cost report requires that the Cost Center for "Subprovider IPF" to be segregated into separate line items: "Adult - Psych" and "Pediatric - Psych" (See Note A in the General Instructions). Hospitals with discrete Psych Units should complete these lines whether or not they file these units as a subprovider for Medicare reimbursement purposes.

Lines 43.01 and 43.02 are the responsibility of the hospital. This cost report requires that the Cost Center for "Nursery" to be segregated into separate line items: "Newborn" and "Special" (See Note A in the General Instructions).

Lines 30 through 46 are entered as directed for each of the following Columns, unless not applicable:

Column 1 – Salaries: will match the values entered in the CMS–2552–10 Worksheet "A" "Reclassification and Adjustments of Trial Balance Expenses" Column 1, "Salaries", for each Line 30 through 46, with the exception of (Lines 30, 31, 40, and 43, Column 1) which is the responsibility of the hospital. See above for more information.

Column 2 – Other: will match the values entered in the CMS–2552–10 Worksheet "A" "Reclassification and Adjustments of Trial Balance Expenses" Column 2, "Other" for each Line. This Column is used to document other expenses other than salaries for each Line 30 through 46, with the exception of (Lines 30, 31, 40, and 43, Column 1) which is the responsibility of the hospital. See above for more information.

Column 3 – Total: is dedicated to calculating the total of Columns 1 “Salaries” and 2 “Other” for each Line.

Column 4 – Reclassifications: is dedicated to calculating the total of the matching Cost Center line items identified in Tab 7, Columns 4 and 8. The Cost Center’s Increased (Salary and Other) sum is added to the Decreases (Salary and Other) sum. More information on this calculation can be found in Tab #7 section. The net total of the line item values in this Column must equal zero on line 500

Column 5 – Adjustments: is dedicated to calculating the total of the matching Cost Center line items identified in Tab 8, Column 5. More information on this calculation can be found in Tab #8 section. This Column is used to document the total adjustments made by the hospital on each Line.

Column 6 – Net Expenses For Stepdown Allocation: is dedicated to calculate the total for Columns 3, 4, and 5 for each Line

Ancillary Service Cost Centers

Lines 50 through 76 are entered as directed for each of the following Columns, unless not applicable:

Column 1 – Salaries: will match the values entered in the CMS–2552–10 Worksheet "A" "Reclassification and Adjustments of Trial Balance Expenses" Column 1, "Salaries", for Lines 50 through 76. Line 61 does not require data

Column 2 – Other: will match the values entered in the CMS–2552–10 Worksheet "A" "Reclassification and Adjustments of Trial Balance Expenses" Column 2, "Other" for each Lines 50 through 76. This Column is used to document other expenses other than salaries

Column 3 – Total: is dedicated to calculating the total of Columns 1 "Salaries" and 2 "Other" for each Line

Column 4 – Reclassifications: is dedicated to calculating the total of the matching Cost Center line items identified in Tab 7, Columns 4 and 8. The Cost Center's Increased (Salary and Other) sum is added to the Decreases (Salary and Other) sum. More information on this calculation can be found in Tab #7 section. The net total of the line item values in this Column must equal zero on line 500

Column 5 – Adjustments: is dedicated to calculating the total of the matching Cost Center line items identified in Tab 8, Column 5. More information on this calculation can be found in Tab #8 section. This Column is used to document the total adjustments made by the hospital on each Line.

Column 6 – Net Expenses For Stepdown Allocation: is dedicated to calculate the total for Columns 3, 4, and 5 for each Line

Outpatient Service Cost Centers

Line 92 “Observation Beds Non Distinct” does not require data entry

Lines 88 through 101 are entered as directed for each of the following Columns, unless not applicable:

Column 1 – Salaries: will match the values entered in the CMS–2552–10 Worksheet “A” “Reclassification and Adjustments of Trial Balance Expenses” Column 1, “Salaries”, for each Lines 88 through 101

Column 2 – Other: will match the values entered in the CMS–2552–10 Worksheet “A” “Reclassification and Adjustments of Trial Balance Expenses” Column 2, “Other” for each Lines 88 through 101 This Column is used to document other expenses other than salaries

Column 3 – Total: is dedicated to calculating the total of Columns 1 “Salaries” and 2 “Other” for each Line.

Column 4 – Reclassifications: is dedicated to calculating the total of the matching Cost Center line items identified in Tab 7, Columns 4 and 8. The Cost Center’s Increased (Salary and Other) sum is added to the Decreases (Salary and Other) sum. More information on this calculation can be found in Tab #7 section. The net total of the line item values in this Column must equal zero on line 500

Column 5 – Adjustments: is dedicated to calculating the total of the matching Cost Center line items identified in Tab 8, Column 5. More information on this calculation can be found in Tab #8 section. This Column is used to document the total adjustments made by the hospital on each Line.

Column 6 – Net Expenses For Stepdown Allocation: is dedicated to calculate the total for Columns 3, 4, and 5 for each Line

Special Purpose Cost Centers

Lines 105 through 117 are entered as directed for each of the following Columns, unless not applicable:

Column 1 – Salaries: will match the values entered in the CMS–2552–10 Worksheet "A" "Reclassification and Adjustments of Trial Balance Expenses" Column 1, "Salaries", for each Lines 105 through 117

Column 2 – Other: will match the values entered in the CMS–2552–10 Worksheet "A" "Reclassification and Adjustments of Trial Balance Expenses" Column 2, "Other" for each Lines 105 through 117. This Column is used to document other expenses other than salaries

Column 3 – Total: is dedicated to calculating the total of Columns 1 "Salaries" and 2 "Other" for each Line.

Column 4 – Reclassifications: is dedicated to calculating the total of the matching Cost Center line items identified in Tab 7, Columns 4 and 8. The Cost Center's Increased (Salary and Other) sum is added to the Decreases (Salary and Other) sum. More information on this calculation can be found in Tab #7 section. The net total of the line item values in this Column must equal zero on line 500

Column 5 – Adjustments: is dedicated to calculating the total of the matching Cost Center line items identified in Tab 8, Column 5. More information on this calculation can be found in Tab #8 section. This Column is used to document the total adjustments made by the hospital on each Line.

Column 6 – Net Expenses For Stepdown Allocation: is dedicated to calculate the total for Columns 3, 4, and 5 for each Line

Line 300 is designated to calculating the Subtotal of Lines 1 through 117 for each Column

Non–Reimbursable Cost Centers

Lines 190 through 194 are entered as directed for each of the following Columns, unless not applicable:

Column 1 – Salaries: will match the values entered in the CMS–2552–10 Worksheet "A" "Reclassification and Adjustments of Trial Balance Expenses" Column 1, "Salaries", for each Lines 190 through 194

Column 2 – Other: will match the values entered in the CMS–2552–10 Worksheet "A" "Reclassification and Adjustments of Trial Balance Expenses" Column 2, "Other" for each Lines 190 through 194. This Column is used to document other expenses other than salaries

Column 3 – Total: is dedicated to calculating the total of Columns 1 "Salaries" and 2 "Other" for each Line.

Column 4 – Reclassifications: is dedicated to calculating the total of the matching Cost Center line items identified in Tab 7, Columns 4 and 8. The Cost Center's Increased (Salary and Other) sum is added to the Decreases (Salary and Other) sum. More information on this calculation can be found in Tab #7 section. The net total of the line item values in this Column must equal zero on line 500

Column 5 – Adjustments: is dedicated to calculating the total of the matching Cost Center line items identified in Tab 8, Column 5. More information on this calculation can be found in Tab #8 section. This Column is used to document the total adjustments made by the hospital on each Line.

Column 6 – Net Expenses For Stepdown Allocation: is dedicated to calculate the total for Columns 3, 4, and 5 for each Line

Line 500 is designated to calculating the Total of Lines 300 and 190 through 194 for each Column

Tab 10 Reconciliation to Audited Financial Statements

Hospitals should use this tab to reconcile revenue and expenses reported to their financial statements. Hospitals shall enter a description of all variances.

The values that are required for this tab will match the values in other tabs. The following steps will describe the location of the matching values or directions to calculating the value.

Reconciliation of Net Patient Service Revenue (NPSR) to Financial Statement

(Line 1, Column 2) – NPSR, Patient Service: will match the value Tab 5 "Statistical Data and Revenue By Payer" (Line 303, Column 1)

(Line 2, Column 2) – NPSR, Non–Patient Service: will match the value of Tab 5 "Statistical Data and Revenue By Payer" (Line 303, Column 14)

(Line 3, Column 3) – Reported NPSR: is determined by finding the sum of "NPSR, Non-Patient Service" (Line 2, Column 2) and "NPSR, Patient Service" (Line 1, Column 2)

(Line 4, Column 2) – NPSR, Audited Financial Statement: Hospitals are responsible for entering numerical value from their audited financial statements

(Line 5, Column 2) – NPSR, Internal Financial Statement: Hospitals are responsible for entering numerical value from their internal financial statements (if the NPSR Audited Financial (Line 4, Column 2) statement is not available)

(Line 6, Column 2) – HSN Assessment: Hospitals are responsible for entering numerical value if HSN Assessment was reported net against NPSR in the Financial Statement

(Line 7, Column 3) – Expected Total NPSR: is determined by finding the sum of either "NPSR, Audited Financial Statement" (Line 4, Column 2) or "NPSR, Internal Financial Statement" (Line 5, Column 2) and "HSN Assessment" (Line 6, Column 2)

(Line 8, Column 3) – Difference Requiring Reconciliation: is determined by subtracting "Expected Total NPSR" (Line 7, Column 3) from "Reported NPSR" (Line 3, Column 3)

(Lines 9 through 13, Column 1) – Reconciliation Item Description: If there are any differences requiring reconciliation in (Line 8, Column 3) the Hospital is required to enter the description(s) of the reconciling item(s)

(Lines 9 through 13, Column 2) –Amount: If there are any differences requiring reconciliation in (Line 8, Column 3) the Hospital is required to enter the amount(s) of the reconciling item(s)

(Line 14, Column 2) – Amount Reconciled: This area is dedicated to calculating the sum of Lines 9 through 13 in Column 2

(Line 15, Column 2) – Amount Not Reconciled: is dedicated to calculation of subtracting "Amount Reconciled" (Line 14, Column 2) from "Difference Requiring Reconciliation" (Line 8, Column 3)

Reconciliation of Total Expense to Financial Statements

(Line 16, Column 2) –Total Expense: will match the value entered in Tab 9 "Direct Expenses" (Line 500, Column 3)

(Line 17, Column 3) – Reported Expense: will match the value (Line 16, Column 2)

(Line 18, Column 2) – Total Expense, Audited Financial Statement: Hospitals are responsible for entering the Total Expense from their audited financial statements

(Line 19, Column 2) – Total Expense, Internal Financial Statement: Hospitals are responsible for entering the Total Expense from their internal financial statements (if the Total Expense, Audited Financial (Line 18, Column 2) statement is not available)

(Line 20, Column 2) – HSN Assessment: Hospitals are responsible for entering a numerical value for the HSN Assessment, if the financials report this amount netted in NPSR

(Line 21, Column 3) – Expected Total Expense: is determined by finding the sum of "Total Expense, Audited Financial Statement" (Line 18, Column 2) or "Total Expense, Internal Financial Statement" (Line 19, Column 2) and "HSN Assessment" (Line 20, Column 2).

(Line 22, Column 3) – Difference Requires Reconciliation is calculated by subtracting "Expected Total Expense" (Line 21, Column 3) from "Reported Expense" (Line 17, Column 3)

(Lines 23 through 27, Column 1) – Reconciliation Item Description: If there is any difference requiring reconciliation in (Line 22, Column 3) the Hospital is required to enter the description(s) of the reconciling item(s)

(Lines 23 through 27, Column 2) – Amount: If there is any difference requiring reconciliation in (Line 22, Column 3) the Hospital is required to enter the amount(s) of the reconciling item(s)

(Line 28, Column 2) – Amount Reconciled: is dedicated to calculating the total amounts in Lines 23 through 27, Column 2

(Line 29, Column 2) – Amount Not Reconciled: is calculated by subtracting "Difference Requires Reconciliation" (Line 22, Column 3) from "Amount Reconciled" (Line 28, Column 2).

Tab 11 Financial Statements (Non–Acute Hospitals Only)

This tab is for Non-Acute Hospitals only. (The line numbers of this tab are consistent with the Acute Hospital Standardize Financial Fillings.) Hospitals are responsible for entering numerical values within the Lines in each section.

Balance Sheet

Assets

Current Assets

Line 6 is for Cash and Cash Equivalents. Cash Equivalents are short term, highly liquid investments (including note receivables) with a maturity of 3 months or less, excluding amounts whose use is limited by Board designation, other arrangements under trust agreements, or with third party payers.

Line 7 is for Short-Term Investments. These are the Investments in equity or fixed-income securities with a maturity of 3 to 12 months.

Line 8 is for Current Assets Whose Use is Limited. Any current portion of assets, whose use is limited, either identified as board-designated, trustee-held, or other designations.

Receivables

Line 10 is for Net Patient Accounts Receivable. Patient accounts receivable, less an allowance for uncollectable and contractual adjustments.

Line 11 is for Due from Affiliates. Transferred funds (including loans, advances, transfers, and equity contributions made) that are expected to be received from affiliated entities within the current accounting period.

Line 12 is for Third party Settlements Receivable. Includes amounts reported as current that represent final settlements due to the hospital.

Line 12.1 is for Other Current Assets. Other Current Assets includes receivables and all other current assets except those cited in Lines 10, 11, and 12.

Line 16 is for Total Current Assets. This is dedicated to calculating the total of Lines 6 through 12.1.

Non-Current Assets

Line 18 is for Assets Whose Use is Limited. This includes any non-current portion of assets, whose use is limited, identified as board-designated, trustee-held, or other designations.

Line 19 is for Contribution Receivables. This includes contributions, pledges, gifts, and bequests from donors that are not expected to be collected during the current period.

Line 19.1 is for Interest in Net Assets. FASB Statement #136 requires recipient organizations to recognize the beneficial interest in net assets of a beneficiary organization if those entities have an ongoing economic interest in one another. This beneficial interest is executed in the form of 'contribution' through transfers or promises to transfer cash and investments. Other assets include land, buildings, use of facilities or utilities, materials and supplies, intangible assets, and services.

Line 22 is for Investment in Affiliates. Amount recorded as equity investments in other entities, which are related to the hospital.

Line 25 is for Gross Property, Plant and Equipment. Gross value of land, buildings, equipment, construction in progress, and capitalized leases.

Line 26 is for Accumulated Depreciation. This includes all depreciation of PP&E and amortization of capitalized leases.

Line 27 is for Net Property, Plant and Equipment. This is dedicated to calculating the value by subtracting Line 26 from Line 25

Line 27.1 is for Other Non-current Assets. This is dedicated to entering the value of all other non-current assets.

Line 28 is for Total Non-current Assets. This is dedicated to calculating the total of Lines 18, 19, 19.1, 22, 27, 27.1.

Line 29 is for Total Assets. This is dedicated to calculating the total of Lines 16 and 28.

Liabilities and Net Assets

Current Liabilities

Line 32 is for Current Long Term Debt. This is the current portion of long-term debt, capital leases, and notes payable.

Line 34 is for Estimated Third Party Settlements. Amounts received from third parties, which may be in excess of allowable amounts and may therefore be paid back to third parties or else resolved favorably and recognized as revenue in the future. This will also include the current portion of deferred revenue.

Line 35 is for Current Liability- Due to Affiliates. Transferred funds (including loans, advances, transfers and equity contributions received) that are expected to be paid or returned to affiliated entities, within the current accounting period.

Line 36 is for Other Current Liabilities. This is for all other current liabilities.

Line 37 is for Total Current Liabilities. This is dedicated to calculating the total of Lines 32 through 36.

Non-current Liabilities

Line 39 is for Long Term Debt - Net of Current Portion. This includes any long-term debt (not including current portion), obligations under capital leases, and notes payable.

Line 42 is for Due to Affiliates. Transferred funds (including loans, advances, transfers and equity contributions received) that are expected to be paid or returned to affiliated entities. This is beyond the current accounting cycle.

Line 44 is for Other Non-current Liabilities. This is for all other non-current liabilities.

Line 45 is for Total Non-current Liabilities. This is dedicated to calculating the total of Lines 39 through 44.

Line 46 is for Total Liabilities. This is dedicated to calculating the total of Lines 37 and 45.

Net Assets

Line 48 is for Unrestricted (Net Assets). This is for the part of net assets that is neither permanently restricted nor temporarily restricted by donor imposed stipulations.

Line 49 is for Temporarily Restricted (Net Assets). The part of the net assets resulting from:

(i) Contributions and other assets whose use is limited by donor imposed stipulations that either expire with the passage of time or can be fulfilled and removed by actions pursuant to those stipulations,
(ii) Other asset enhancements and diminishments subject to the same kind of stipulations, or
(iii) Reclassification to (or from) other classes of net assets as a consequence of donor-imposed stipulations, their expiration by passage of time, or their fulfillment and removal by actions pursuant to those stipulations.

Line 50 is for Permanently Restricted (Net Assets). The part of the net assets resulting from:

(i) Contributions and other assets whose use is limited by donor imposed stipulations that neither expire with the passage of time nor can be fulfilled and removed by actions of the organization,
(ii) Other asset enhancements and diminishments subject to the same kind of stipulations,
(iii) Reclassification to (or from) other classes of net assets as a consequence of donor-imposed stipulations.

Line 51 is for Total Net Assets. This is dedicated to calculating the total of Lines 48 through 50.

Line 52 is for Total Liabilities and Net Assets. This is dedicated to calculating the total of Lines 46 and 51.

Statement of Operations

Unrestricted Revenue, Gains and Other Support

Line 55 is for Net Patient Service Revenue (including Premium Revenue). Total inpatient and outpatient revenue after deductions for free care charges and contractual adjustments. To be included in NPSR are:

(i) Prior year third party settlements,
(ii) Gross receipts for emergency bad debts,
(iii) Free care costs expected to be recovered from the uncompensated care pool,
(iv) Premium Revenue, which means, fixed amount (per individual) paid by HMOs periodically to provider as compensation for providing comprehensive services for the period.

Line 57 is for Other Operating Revenue. This includes revenue from services other than health care provided to patients, as well as sales & services to non-patients.

Line 57.1 is for Net Assets Released from Restricted Used for Operations. Net assets released from donor restrictions by incurring expenses and thus satisfying donor stipulations or by occurrence of other events or passage of a particular time period specified by the donor(s).

Line 57.2 is for Total Operating Revenue. This is dedicated to calculating the total of Lines 55, 57 and 57.1.

Line 58 is for Investment Income. All investment income which includes interest income, dividend income and realized gains (losses) from sale of investments actively traded as well as interest income and dividend income on passive investments.

Line 58.1 is for Contribution Revenue. Donation, gift or bequest of cash, or other assets from a donor that are not revocable, repayable, or reciprocal.

Line 58.2 is for Change in Interest in Net Assets. This is for the Revenue from Interest in Net Assets. For definition of this Interest in Net Assets, see description of Line 19.1.

Line 59 is for Non-operating Gains (Losses). These are gains and losses that result from a provider's peripheral or incidental transactions. These may include:

(i) Subsidies received from governmental or community agencies.
(ii) Net realized gains/losses resulting from increases and decreases in the value of 'passive' investments.
(iii) Gains/losses on sale or disposal of assets.

Line 59.1 is for Equity Method of Alternate Investments. This is to report investments accounted for by the Equity Method.

Line 64.1 is for Total Non-operating Revenue. This is dedicated to calculating the total of Lines 58, 58.1, 58.2, 59 and 59.1.

Line 65 is for Total Unrestricted Revenue Gains and Other Support. This is dedicated to calculating the total of Lines 57.2 and 64.1.

Expenses

Line 66.1 is for Salary and Benefit. This includes salaries, wages, and cost of fringe benefits such as paid vacations and contribution to pension funds. Salaries refer to any amounts of compensation. Wages refer to the pay earned by employees at a certain rate per hour, day, or week.

Line 68 is for Depreciation/ Depreciation and Amortization. Depreciation is the allocation for the cost of tangible fixed assets. Amortization refers to allocation of the cost of intangible assets (for example, periodic payments on Capital Leases).

Line 69 is for Interest. Any charges made for the use of money over a period of time.

Line 70 is for HSN Assessment. This includes Gross Assessment to the Uncompensated Care Pool.

Line 71 is not currently used and considered Not Applicable. No input required.

Line 72 is for Other Operating Expenses. All other expenses not reported in Lines 67 through 71.

Line 73 is for Total Expenses. This is dedicated to calculating the total of Lines 66.1, 68, 69, 70, 71 and 72.

Line 74 is for Excess of Revenue, Gains and Other Support Over Expenses. This is dedicated to calculating the value by subtracting Line 73 from Line 65.

CHANGE in Unrestricted Net Assets before Extraordinary Items

Line 78 is for Transfers From (To) Parent/Affiliates. Includes funds transferred from (to) parent and affiliates.

Line 78.1 is for Other Changes in Unrestricted Net Assets. This is for any changes in unrestricted net assets, except what is entered in Line 74 and 78.

Line 79 is for Total Increase/Decrease in Unrestricted Net Assets, before Extraordinary Items. This is dedicated to calculating the total of Lines 74, 78, and 78.1.

Line 80 is for Extraordinary Gains (Losses). Any gains (losses) resulting from transactions that are unusual in nature or infrequent in occurrence.

Line 81 is for Changes in Accounting Principle/Other. This is for any adjustments resulting from changes in accounting principle.

Line 82 is for Total Increase/Decrease in Unrestricted Net Assets. This is dedicated to calculating the total of Lines 79 through 81.

Tab 12 Allocation of Observation Bed Costs to a Non Distinct Unit

Hospitals will allocate non-distinct observation bed day costs included in the medical and surgical, pediatric, and obstetric inpatient cost centers to an outpatient non-distinct unit on this tab. This calculation is done both including and excluding capital. The allocation is based on patient days and bed day equivalents for the respective cost centers. With the exception of bed day equivalents, all information is derived from other tabs within the cost report. Bed day equivalents needs to be entered by the hospital. Hospitals are required to enter numerical values for each entry, unless specified.

Allocation to Non-Distinct Observation Costs (Including Capital)

(Lines 30.01, 30.02, or 30.03, Column 1) are dedicated to calculating the Total Expenses for Medical and Surgical, Pediatric, and Obstetric. These values will match the respective lines on Tab 17, "Patient Service Expense with Details of Ancillary Service Allocation Including Capital" (Lines 30.01, 30.02, or 30.03, Column 1). See Note A in the General Instructions.

(Lines 30.01, 30.02, or 30.03, Column 2) are dedicated to calculating the Patient Days for the Medical and Surgical, Pediatric, and Obstetric. These values will match the respective lines on Tab 3, "Patient Service Statistical Data" (Lines 1, 2, or 3, Column 4). See Note A in the General Instructions.

(Lines 30.01, 30.02, or 30.03, Column 3) are Not Applicable

(Lines 30.01, 30.02, or 30.03, Column 4) are dedicated to calculating the Allocation of Non-Distinct Observation Bed Day Costs totals for Medical and Surgical, Pediatric, and Obstetric. These will be determined by dividing the respective line (Lines 30.01, 30.02, or 30.03, Column 2) by the sum of values entered in line (Lines 30.01, 30.02, and 30.03, Column 2), then multiply the quotient by (Line 92, Column 5). See Note A in the General Instructions.

(Lines 30.01, 30.02, or 30.03, Column 5) are dedicated to calculating the Total Costs Net of Non-Distinct Observation Beds - Including Capital for Medical and Surgical, Pediatric, and Obstetric. These will be determined by subtracting the "Allocation of Non-Distinct Observation Bed Days Costs" by the respective line (Lines 30.01, 30.02, or 30.03, Column

4) from the “Total Expenses” same respective line (Lines 30.01, 30.02, or 30.03, Column 1).

(Line 92, Column 1) is Not Applicable

(Line 92, Column 2) is dedicated to the Non-Distinct Observation Bed Days. This value is reported as the bed day equivalents, which is the responsibility of the hospital. This is determined by dividing the number of observation bed hours by 24.

(Line 92, Column 3) is Not Applicable

(Line 92, Column 4) is dedicated to the Allocation of Non Distinct Observation Bed Day Costs. This value is determined by multiplying “Total Expense per Day” (Line 500, Column 3) total by “Non-Distinct Observation Bed Days” (Line 92, Column 2)

(Line 92, Column 5) will match the value entered in (Line 92, Column 4)

(Line 500, Column 1) is dedicated to calculating the Total of all Lines for this Column

(Line 500, Column 2) is dedicated to calculating the Total of all Lines for this Column

(Line 500, Column 3) is dedicated to the Total Expense per Day. This is calculated by dividing “Total Expenses” (Line 500, Column 1) by “Patient Days” total (Line 500, Column 2)

(Line 500, Column 4) is Not Applicable

(Line 500, Column 5) is dedicated to calculating the Total for Lines 30.01 through 92 in this Column

Allocation to Non-Distinct Observation Costs (Excluding Capital)

(Lines 30.01, 30.02, or 30.03, Column 6) are dedicated to calculating the Total Expenses for Medical and Surgical, Pediatric, and Obstetric. These values will match the respective lines on Tab 18, "Patient Service Expense with Details of Ancillary Service Allocation Excluding Capital" (Lines 30.01, 30.02, or 30.03, Column 1). See Note A in the General Instructions.

(Lines 30.01, 30.02, or 30.03, Column 7) are dedicated to calculating the total Patient Days for Medical and Surgical, Pediatric, and Obstetric. These values will match the respective lines on Tab 3, "Patient Service Statistical Data" (Lines 30.01, 30.02, or 30.03, Column 4). See Note A in the General Instructions.

(Lines 30.01, 30.02, or 30.03, Column 8) are Not Applicable

(Lines 30.01, 30.02, or 30.03, Column 9) are dedicated to calculating the Allocation of Non-Distinct Observation Bed Day Costs totals for Medical and Surgical, Pediatric, and Obstetric. These will be determined by dividing the respective line (Lines 30.01, 30.02, or 30.03, Column 7) by the sum of values entered in line (Lines 30.01, 30.02, and 30.03, Column 7), then multiply the quotient by (Line 92, Column 10). See Note A in the General Instructions.

(Lines 30.01, 30.02, or 30.03, Column 10) are dedicated to calculating Total Costs Net of NonDistinct Observation Beds - Excluding Capital for Medical and Surgical, Pediatric, and Obstetric. These will be determined by subtracting the "Allocation of Non-Distinct Observation Bed Days Costs" (Lines 30.01, 30.02, or 30.03, Column 9) from the respective line (Lines 30.01, 30.02, or 30.03, Column 6). See Note A in the General Instructions.

(Line 92, Column 6) is Not Applicable

(Line 92, Column 7) is dedicated to the Non-Distinct Observation Bed Days. This value should be reported as the bed day equivalents (number of observation bed hours divided by 24). This value should also match (Line 92, Column 2).

(Line 92, Column 8) is Not Applicable

(Line 92, Column 9) is dedicated to the Non-Distinct Observation Bed Days Costs. This value is determined by multiplying “Total Expense per Day” (Line 500, Column 3) total by “Non-Distinct Observation Bed Days” (Line 92, Column 4).

(Line 92, Column 10) will match the value in (Line 92, Column 9). This is the total costs net of Non-Distinct Observation Beds.

(Line 500, Column 6) is dedicated to calculating the Total of Lines 30.01, 30.02, and 30.03 for this Column

(Line 500, Column 7) is dedicated to calculating the Total of all Lines in this Column

(Line 500, Column 8) is dedicated to the Total Expense per Day. This is calculated by dividing “Total Expenses” (Line 500, Column 6) by “Patient Days” total (Line 500, Column 7)

(Line 500, Column 9) is Not Applicable

(Line 500, Column 10) is dedicated to calculating the Total for all Lines in this Column

Tab 13 Statistic for General Cost Stepdown

The statistics reported on this tab will be used to allocate the costs from the general service cost centers to inpatient routine service cost centers, ancillary service cost centers, outpatient service cost centers, special purpose cost centers, and Non-Patient cost centers.

The statistics reported will be used in the Stepdown Expenses Allocations in Tabs 14 and 15. To facilitate this allocation process, the following of the general format found in Tabs 13, 14, and 15 must be identical:

- Each general service cost centers' line number,
- line numbers for each routine service, ancillary service, outpatient service, special purpose, and non–reimbursable cost center
- its respective Column number across the top

The line items for the cost Centers, Lines 1 through 194, are consistent with Tab 9. Any subscripted lines on Tab 9 must also be subscripted to match with the lines on this Tab. Hospitals are required to enter numerical values in each Column, for each section, unless specified.

As described below, most of the line items will match the values entered in the CMS–2552–10 Report, Worksheet B–1 "Cost Allocation–Statistical Basis", unless specified.

General Service Cost Centers

Lines 1 through 23 are entered, as directed, for each of the following Columns, unless not applicable.

Column 1 – Capital – Buildings and Fixtures (Square Feet): will match the values in the CMS–2552–10, Worksheet B–1 (Lines 1 through 23, Column 1)

Column 2 – Capital – Movable Equipment (Dollar Value): will match the values in the CMS–2552–10, Worksheet B–1 (Lines 1 through 23, Column 2)

Column 4 – Employee Benefits Department (Gross Salaries): will match the values in the CMS–2552–10, Worksheet B–1 (Lines 1 through 23, Column 4). Data is not required for Lines 1 through 2.

Column 5A - Reconciliation: is dedicated to list the costs attributable to the difference between the total accumulated cost and reconciled costs not listed in Column 5 for allocation. Any total allocations listed in (Line 5, Column 5) or subscripted fields are to be calculated by subtracting them from the subtotaled accumulated cost reported in Tab 14 (Line 500, Column 4A). The rest of the column will be used as the following:

- Enter any amounts reported on Tab 14 Column 4A for:
  (1) Any service provided under arrangements to patients and which is not grossed up and
  (2) Negative balances
- If a cost center will not be receiving A & G costs using accumulated costs in Tab 14 Column 4A
- If not needed to report the amount receiving A & G costs then only those costs to receive overhead will receive the proper allocation. Including a statistical cost which does not relate to the allocation of administrative and general expenses that causes an improper distribution of overhead.
- Any other reported costs on Line 5, the administrative and general costs, are not needing to be reported in Tab 14 and Tab 15

Column 5 - Administrative and General (Accumulated Cost): which have not been componentized. A&G includes a wide variety of provider administrative costs such as but not limited to cost of executive staff, legal and accounting services, and facility administrative services (not already included in other general services cost centers).

(Line 5, Column 5) is calculated by totaling the sum of the values that are entered in (Lines 300, 190 through 194, Column 5).

Lines 6 through 23 in Column 5 are determined by calculating the sum of Tab 14 Column 4A and Tab 13 Column 5A for each respected line.

If this line is componentized into more than one cost center, eliminate (Line 5, Column 5). Componentized A&G lines must begin with subscripted lines/columns beginning with 5.01 and then continuing in sequential and consecutive order. For componentized A&G cost centers, the accumulated cost center line number must have a matching reconciliation column number. Include in the reconciliation column number the alpha character "A", i.e., if the accumulated cost center for A&G is line 5.01 (Other A&G), the reconciliation column designation must be 5A.01.

Columns 6 through 23: will match the values in the CMS–2552–10, Worksheet B–1, Lines 6 through 23, for the corresponding Column. Depending on the Column, some Lines will not require data.

Inpatient Routine Service Cost Centers

Lines 30.01, 30.02, and 30.03 are the responsibility of the hospital for each Column. This cost report requires that "Adults and Pediatrics" are segregated into separate line items: "Medical and Surgical", "Pediatric", and "Obstetric", (See Note A in the General Instructions).

Lines 31.01, 31.02, and 31.03 are the responsibility of the hospital. This cost report requires that the Cost Center for "Intensive Care Unit" to be segregated into separate line items: "Adult", "Pediatric", and "Neonatal", (See Note A in the General Instructions).

Lines 40.01 and 40.02 are the responsibility of the hospital. This cost report requires that the Cost Center for "Subprovider IPF" to be segregated into separate line items: "Adult - Psych" and "Pediatric - Psych" (See Note A in the General Instructions). Hospitals with discrete Psych Units should complete these lines whether or not they file these units as a subprovider for Medicare reimbursement purposes.

Lines 43.01 and 43.02 are the responsibility of the hospital. This cost report requires that the Cost Center for "Nursery" to be segregated into separate line items: "Newborn" and "Special" (See Note A in the General Instructions).

Lines 30 through 46 are entered, as directed, for each of the following Columns:

Column 1 – Capital – Buildings and Fixtures (Square Feet): will match the values in the CMS–2552–10, Worksheet B–1 (Lines 30 through 46, Column 1), with the exception of (Lines 30, 31, 40, and 43, Column 1) which is the responsibility of the hospital. See above for more information.

Column 2 – Capital – Movable Equipment (Dollar Value): will match the values in the CMS–2552–10, Worksheet B–1 (Lines 30 through 46, Column 2), with the exception of (Lines 30, 31, 40, and 43, Column 2) which is the responsibility of the hospital. See above for more information.

Column 4 – Employee Benefits Department (Gross Salaries): will match the values in the CMS–2552–10, Worksheet B–1 (Lines 30 through 46, Column 4), with the exception of (Lines 30, 31, 40, and 43, Column 4) which is the responsibility of the hospital. See above for more information.

Column 5A - Reconciliation: is dedicated to list the costs attributable to the difference between the total accumulated cost and reconciled costs not listed in Column 5 for allocation. Any total allocations listed in (Line 5, Column 5) or subscripted fields are to be calculated by subtracting them from the subtotaled accumulated cost reported in Tab 14 (Line 500, Column 4A). The rest of the column will be used as the following:

- Enter any amounts reported on Tab 14 Column 4A for:
  (1) Any service provided under arrangements to patients and which is not grossed up and
  (2) Negative balances
- If a cost center will not be receiving A & G costs using accumulated costs in Tab 14 Column 4A
- If not needed to report the amount receiving A & G costs then only those costs to receive overhead will receive the proper allocation. Including a statistical cost which does not relate to the allocation of administrative and general expenses that causes an improper distribution of overhead.
- Any other reported costs on Line 5, the administrative and general costs, are not needing to be reported in Tab 14 and Tab 15

Column 5 - Administrative and General Accumulated Cost: which have not been componentized. A&G includes a wide variety of provider administrative costs such as but not limited to cost of executive staff, legal and accounting services, and facility administrative services (not already included in other general services cost centers).

Lines 30 through 46 in Column 5 are determined by calculating the sum of Tab 14 Column 4A and Tab 13 Column 5A for each respected line.

If this line is componentized into more than one cost center, eliminate (Line 5, Column 5). Componentized A & G lines must begin with subscripted lines/columns beginning with 5.01 and then continuing in sequential and consecutive order. For componentized A&G cost centers, the accumulated cost center line number must have a matching reconciliation column number. Include in the reconciliation column number the alpha character "A", i.e., if the accumulated cost center for A&G is line 5.01 (Other A&G), the reconciliation column designation must be 5A.01.

Column 6 through 23: will match the values in the CMS–2552–10, Worksheet B–1, Lines 30 through 46, from the corresponding columns, with the exception of Lines 30, 31, 40, and 43 which is the responsibility of the hospital. See above for more information.

Ancillary Service Cost Centers

Lines 50 through 76 are entered, as directed, for each of the following Columns:

Column 1 – Capital – Buildings and Fixtures (Square Feet): will match the values in the CMS–2552–10, Worksheet B–1 (Lines 50 through 76, Column 1)

Column 2 – Capital – Movable Equipment (Dollar Value): will match the values in the CMS–2552–10, Worksheet B–1 (Lines 50 through 76, Column 2)

Column 4 – Employee Benefits Department (Gross Salaries): will match the values in the CMS–2552–10, Worksheet B–1 (Lines 50 through 76, Column 4)

Column 5A - Reconciliation: is dedicated to list the costs attributable to the difference between the total accumulated cost and reconciled costs not listed in Column 5 for allocation. Any total allocations listed in (Line 5, Column 5) or subscripted fields are to be calculated by subtracting them from the subtotaled accumulated cost reported in Tab 14 (Line 500, Column 4A). The rest of the column will be used as the following:

- Enter any amounts reported on Tab 14 Column 4A for:
  (1) Any service provided under arrangements to patients and which is not grossed up and
  (2) Negative balances
- If a cost center will not be receiving A & G costs using accumulated costs in Tab 14 Column 4A
- If not needed to report the amount receiving A & G costs then only those costs to receive overhead will receive the proper allocation. Including a statistical cost which does not relate to the allocation of administrative and general expenses that causes an improper distribution of overhead.
- Any other reported costs on Line 5, the administrative and general costs, are not needing to be reported in Tab 14 and Tab 15

Column 5 - Administrative and General Accumulated Cost: which have not been componentized. A&G includes a wide variety of provider administrative costs such as but not limited to cost of executive staff, legal and accounting services, and facility administrative services (not already included in other general services cost centers).

Lines 50 through 76 in Column 5 are determined by calculating the sum of Tab 14 Column 4A and Tab 13 Column 5A for each respected line.

If this line is componentized into more than one cost center, eliminate (Line 5, Column 5). Componentized A&G lines must begin with subscripted lines/columns beginning with 5.01 and then continuing in sequential and consecutive order. For componentized A&G cost centers, the accumulated cost center line number must have a matching reconciliation column number. Include in the reconciliation column number the alpha character "A", i.e., if the accumulated cost center for A&G is line 5.01 (Other A&G), the reconciliation column designation must be 5A.01.

Column 6 through 23: will match the values in the CMS–2552–10, Worksheet B–1, Lines 50 through 76, from the corresponding Column

Outpatient Service Cost Centers

Line 92 "Observation Beds Non Distinct" does not require data for each Column

Lines 88 through 101 are entered, as directed, for each of the following Columns:

Column 1 – Capital – Buildings and Fixtures (Square Feet): will match the values in the CMS–2552–10, Worksheet B–1 (Lines 88 through 101, Column 1)

Column 2 – Capital – Movable Equipment (Dollar Value): will match the values in the CMS–2552–10, Worksheet B–1 (Lines 88 through 101, Column 2)

Column 4 – Employee Benefits Department (Gross Salaries): will match the values in the CMS–2552–10, Worksheet B–1 (Lines 88 through 101, Column 4)

Column 5A - Reconciliation: is dedicated to list the costs attributable to the difference between the total accumulated cost and reconciled costs not listed in Column 5 for allocation. Any total allocations listed in (Line 5, Column 5) or subscripted fields are to be calculated by subtracting them from the subtotaled accumulated cost reported in Tab 14 (Line 500, Column 4A). The rest of the column will be used as the following:

- Enter any amounts reported on Tab 14 Column 4A for:
  (1) Any service provided under arrangements to patients and which is not grossed up and
  (2) Negative balances
- If a cost center will not be receiving A & G costs using accumulated costs in Tab 14 Column 4A
- If not needed to report the amount receiving A & G costs then only those costs to receive overhead will receive the proper allocation. Including a statistical cost which does not relate to the allocation of administrative and general expenses that causes an improper distribution of overhead.
- Any other reported costs on Line 5, the administrative and general costs, are not needing to be reported in Tab 14 and Tab 15

Column 5 - Administrative and General Accumulated Cost: which have not been componentized. A&G includes a wide variety of provider administrative costs such as but not limited to cost of executive staff, legal and accounting services, and facility administrative services (not already included in other general services cost centers).

Lines 88 through 101 in Column 5 are determined by calculating the sum of Tab 14 Column 4A and Tab 13 Column 5A for each respected line.

If this line is componentized into more than one cost center, eliminate (Line 5, Column 5). Componentized A&G lines must begin with subscripted lines/columns beginning with 5.01 and then continuing in sequential and consecutive order. For componentized A&G cost centers, the accumulated cost center line number must have a matching reconciliation column number. Include in the reconciliation column number the alpha character "A", i.e., if the accumulated cost center for A&G is line 5.01 (Other A&G), the reconciliation column designation must be 5A.01.

Column 6 through 23: will match the values in the CMS–2552–10, Worksheet B–1 (Lines 88 through 101, from the corresponding Column)

Special Purpose Cost Center

Lines 105 through 117 are entered, as directed, for each of the following Columns:

Column 1 – Capital – Buildings and Fixtures (Square Feet): will match the values in the CMS–2552–10, Worksheet B–1 (Lines 105 through 117, Column 1)

Column 2 – Capital – Movable Equipment (Dollar Value): will match the values in the CMS–2552–10, Worksheet B–1 (Lines 105 through 117, Column 2)

Column 4 – Employee Benefits Department (Gross Salaries): will match the values in the CMS–2552–10, Worksheet B–1 (Lines 105 through 117, Column 4)

Column 5A - Reconciliation: is dedicated to list the costs attributable to the difference between the total accumulated cost and reconciled costs not listed in Column 5 for allocation. Any total allocations listed in (Line 5, Column 5) or subscripted fields are to be calculated by subtracting them from the subtotaled accumulated cost reported in Tab 14 (Line 500, Column 4A). The rest of the column will be used as the following:

- Enter any amounts reported on Tab 14 Column 4A for:
  (1) Any service provided under arrangements to patients and which is not grossed up and
  (2) Negative balances
- If a cost center will not be receiving A & G costs using accumulated costs in Tab 14 Column 4A
- If not needed to report the amount receiving A & G costs then only those costs to receive overhead will receive the proper allocation. Including a statistical cost which does not relate to the allocation of administrative and general expenses that causes an improper distribution of overhead.
- Any other reported costs on Line 5, the administrative and general costs, are not needing to be reported in Tab 14 and Tab 15

Column 5 - Administrative and General Accumulated Cost: which have not been componentized. A&G includes a wide variety of provider administrative costs such as but not limited to cost of executive staff, legal and accounting services, and facility administrative services (not already included in other general services cost centers).

Lines 105 through 117 in Column 5 are determined by calculating the sum of Tab 14 Column 4A and Tab 13 Column 5A for each respected line.

If this line is componentized into more than one cost center, eliminate (Line 5, Column 5). Componentized A&G lines must begin with subscripted lines/columns beginning with 5.01 and then continuing in sequential and consecutive order. For componentized A&G cost centers, the accumulated cost center line number must have a matching reconciliation column number. Include in the reconciliation column number the alpha character "A", i.e., if the accumulated cost center for A&G is line 5.01 (Other A&G), the reconciliation column designation must be 5A.01.

Column 6 through 23: will match the values in the CMS–2552–10, Worksheet B–1 (Lines 105 through 117, from the corresponding Column)

Line 300 is dedicated to calculating the Subtotal of the line after the stepdown to Line 117, when applicable, for each Column

Non–Reimbursable Cost Centers

Lines 190 through 194 are entered, as directed, for each of the following Columns:

Column 1 – Capital – Buildings and Fixtures (Square Feet): will match the values in the CMS–2552–10, Worksheet B–1 (Lines 190 through 194, Column 1)

Column 2 – Capital – Movable Equipment (Dollar Value): will match the values in the CMS–2552–10, Worksheet B–1 (Lines 190 through 194, Column 2)

Column 4 – Employee Benefits Department (Gross Salaries): will match the values in the CMS–2552–10, Worksheet B–1 (Lines 190 through 194, Column 4)

Column 5A - Reconciliation: is dedicated to list the costs attributable to the difference between the total accumulated cost and reconciled costs not listed in Column 5 for allocation. Any total allocations listed in (Line 5, Column 5) or subscripted fields are to be calculated by subtracting them from the subtotaled accumulated cost reported in Tab 14 (Line 500, Column 4A). The rest of the column will be used as the following:

- Enter any amounts reported on Tab 14 Column 4A for:
  (1) Any service provided under arrangements to patients and which is not grossed up and
  (2) Negative balances
- If a cost center will not be receiving A & G costs using accumulated costs in Tab 14 Column 4A
- If not needed to report the amount receiving A & G costs then only those costs to receive overhead will receive the proper allocation. Including a statistical cost which does not relate to the allocation of administrative and general expenses that causes an improper distribution of overhead.
- Any other reported costs on Line 5, the administrative and general costs, are not needing to be reported in Tab 14 and Tab 15

Column 5 - Administrative and General Accumulated Cost: which have not been componentized. A&G includes a wide variety of provider administrative costs such as but not limited to cost of executive staff, legal and accounting services, facility administrative services (not already included in other general services cost centers).

Lines 190 through 194 in Column 5 are determined by calculating the sum of Tab 14 Column 4A and Tab 13 Column 5A for each respected line.

If this line is componentized into more than one cost center, eliminate (Line 5, Column 5). Componentized A&G lines must begin with subscripted lines/columns beginning with 5.01 and then continuing in sequential and consecutive order. For componentized A&G cost centers, the accumulated cost center line number must have a matching reconciliation column number. Include in the reconciliation column number the alpha character "A", i.e., if the accumulated cost center for A&G is line 5.01 (Other A&G), the reconciliation column designation must be 5A.01.

Column 6 through 23: will match the values in the CMS–2552–10, Worksheet B–1 (Lines 190 through 194, from the corresponding Column)

Allocation Statistical

Line 201 is not applicable for this tab.

Line 202 is the General Cost to be Allocated Including Capital. This is entered as directed for each of the following Columns:

Column 1 – Capital – Buildings and Fixtures (Square Feet): will match the value in Tab 14 "Expenses after General Service Costs Stepdown – Including Capital" (Line 1, Column 1)

Column 2 – Capital – Movable Equipment (Dollar Value): will match the value in Tab 14 "Expenses after General Service Costs Stepdown – Including Capital" (Line 2, Column 2)

Column 4 – Employee Benefits Department (Gross Salaries): will match the value in Tab 14 "Expenses after General Service Costs Stepdown – Including Capital" (Line 4, Column 4)

Column 5A - Reconciliation: Not applicable.

Column 5 – Administrative and General (Accumulated Cost): will match the value in Tab 14 "Expenses after General Service Costs Stepdown – Including Capital" (Line 5, Column 5) or if componentized, use the componentized column number.

Column 6 – Maintenance and Repairs (Square Feet): will match the value in Tab 14 "Expenses after General Service Costs Stepdown – Including Capital" (Line 6, Column 6)

Column 7 – Operation of Plant (Square Feet): will match the value in Tab 14 "Expenses after General Service Costs Stepdown – Including Capital" (Line 7, Column 7)

Column 8 – Laundry and Linen Service (Pounds of Laundry): will match the value in Tab 14 "Expenses after General Service Costs Stepdown – Including Capital" (Line 8, Column 8)

Column 9 – Housekeeping (Hours of Service): will match the value in Tab 14 "Expenses after General Service Costs Stepdown – Including Capital" (Line 9, Column 9)

Column 10 – Dietary (Meals Served): will match the value in Tab 14 "Expenses after General Service Costs Stepdown – Including Capital" (Line 10, Column 10)

Column 11 – Cafeteria (Meals Served): will match the value in Tab 14 “Expenses after General Service Costs Stepdown – Including Capital” (Line 11, Column 11)

Column 12 – Maintenance of Personnel (Number Housed): will match the value in Tab 14 “Expenses after General Service Costs Stepdown – Including Capital” (Line 12, Column 12)

Column 13 – Nursing Administration (Direct Nurses Hours): will match the value in Tab 14 “Expenses after General Service Costs Stepdown – Including Capital” (Line 13, Column 13)

Column 14 – Central Services and Supply (Costed Requisition): will match the value in Tab 14 “Expenses after General Service Costs Stepdown – Including Capital” (Line 14, Column 14)

Column 15 – Pharmacy (Costed Requisition): will match the value in Tab 14 “Expenses after General Service Costs Stepdown – Including Capital” (Line 15, Column 15)

Column 16 – Medical Records and Library (Time Spent): will match the value in Tab 14 “Expenses after General Service Costs Stepdown – Including Capital” (Line 16, Column 16)

Column 17 – Social Service (Time Spent): will match the value in Tab 14 “Expenses after General Service Costs Stepdown – Including Capital” (Line 17, Column 17)

Column 18 – Other General Service (Specify with subscript): will match the value in Tab 14 “Expenses after General Service Costs Stepdown – Including Capital” (Line 18, Column 18)

Column 19 – Non–Physician Anesthetists (Assigned Time): will match the value in Tab 14 “Expenses after General Service Costs Stepdown – Including Capital” (Line 19, Column 19)

Column 20 – Nursing School (Assigned Time): will match the value in Tab 14 “Expenses after General Service Costs Stepdown – Including Capital” (Line 20, Column 20)

Column 21 – Interns and Residents – Salaries and Fringes (Assigned Time): will match the value in Tab 14 “Expenses after General Service Costs Stepdown – Including Capital” (Line 21, Column 21)

Column 22 – Interns and Residents – Program Costs (Assigned Time): will match the value in Tab 14 “Expenses after General Service Costs Stepdown – Including Capital” (Line 22, Column 22)

Column 23 – Paramedical Education (Assigned Time): will match the value in Tab 14 "Expenses after General Service Costs Stepdown – Including Capital" (Line 23, Column 23)

Line 203 is the Unit Cost Multiplier Including Capital. This is entered as directed for each of the following Columns:

Column 1– Capital – Buildings and Fixtures (Square Feet): is determined by dividing (Line 202, Column 1) by (Line 1, Column 1)

Column 2 – Capital – Movable Equipment (Dollar Value): is determined by dividing (Line 202, Column 2) by (Line 2, Column 2)

Column 4 – Employee Benefits Department (Gross Salaries): is determined by dividing (Line 202, Column 4) by (Line 4, Column 4)

Column 5A - Reconciliation: Not applicable.

Column 5 – Administrative and General (Accumulated Cost): is determined by dividing (Line 202, Column 5) by (Line 5, Column 5)

Column 6 – Maintenance and Repairs (Square Feet): is determined by dividing (Line 202, Column 6) by (Line 6, Column 6)

Column 7 – Operation of Plant (Square Feet): is determined by dividing (Line 202, Column 7) by (Line 7, Column 7)

Column 8 – Laundry and Linen Service (Pounds of Laundry): is determined by dividing (Line 202, Column 8) by (Line 8, Column 8)

Column 9 – Housekeeping (Hours of Service): is determined by dividing (Line 202, Column 9) by (Line 9, Column 9)

Column 10 – Dietary (Meals Served): is determined by dividing (Line 202, Column 10) by (Line 10, Column 10)

Column 11 – Cafeteria (Meals Served): is determined by dividing (Line 202, Column 11) by (Line 11, Column 11)

Column 12 – Maintenance of Personnel (Number Housed): is determined by dividing (Line 202, Column 12) by (Line 12, Column 12)

Column 13 – Nursing Administration (Direct Nurses Hours): is determined by dividing (Line 202, Column 13) by (Line 13, Column 13)

Column 14 – Central Services and Supply (Costed Requisition): is determined by dividing (Line 202, Column 14) by (Line 14, Column 14)

Column 15 – Pharmacy (Costed Requisition): is determined by dividing (Line 202, Column 15) by (Line 15, Column 15)

Column 16 – Medical Records and Library (Time Spent): is determined by dividing (Line 202, Column 16) by (Line 16, Column 16)

Column 17 – Social Service (Time Spent): is determined by dividing (Line 202, Column 17) by (Line 17, Column 17)

Column 18 – Other General Service (Specify with subscript): is determined by dividing (Line 202, Column 18) by (Line 18, Column 18)

Column 19 – Non–Physician Anesthetists (Assigned Time): is determined by dividing (Line 202, Column 19) by (Line 19, Column 19)

Column 20 – Nursing School (Assigned Time): is determined by dividing (Line 202, Column 20) by (Line 20, Column 20)

Column 21 – Interns and Residents – Salaries and Fringes (Assigned Time): is determined by dividing (Line 202, Column 21) by (Line 21, Column 21)

Column 22 – Interns and Residents – Program Costs (Assigned Time): is determined by dividing (Line 202, Column 22) by (Line 22, Column 22)

Column 23 – Paramedical Education (Assigned Time): is determined by dividing (Line 202, Column 23) by (Line 23, Column 23)

Line 204 is the General Cost to be Allocated Excluding Capital. This is entered as directed for each of the following Columns:

Column 1 and 2: will not be required to have data entered

Column 4 – Employee Benefits Department (Gross Salaries): will match the value in Tab 15 "Expenses after General Service Costs Stepdown – Excluding Capital" (Line 4, Column 4)

Column 5A - Reconciliation: Not applicable.

Column 5 – Administrative and General (Accumulated Cost): will match the value in Tab 15 "Expenses after General Service Costs Stepdown – Excluding Capital" (Line 5, Column 5)

Column 6 – Maintenance and Repairs (Square Feet): will match the value in Tab 15 "Expenses after General Service Costs Stepdown – Excluding Capital" (Line 6, Column 6)

Column 7 – Operation of Plant (Square Feet): will match the value in Tab 15 "Expenses after General Service Costs Stepdown – Excluding Capital" (Line 7, Column 7)

Column 8 – Laundry and Linen Service (Pounds of Laundry): will match the value in Tab 15 "Expenses after General Service Costs Stepdown – Excluding Capital" (Line 8, Column 8)

Column 9 – Housekeeping (Hours of Service): will match the value in Tab 15 "Expenses after General Service Costs Stepdown – Excluding Capital" (Line 9, Column 9)

Column 10 – Dietary (Meals Served): will match the value in Tab 15 "Expenses after General Service Costs Stepdown – Excluding Capital" (Line 10, Column 10)

Column 11 – Cafeteria (Meals Served): will match the value in Tab 15 "Expenses after General Service Costs Stepdown – Excluding Capital" (Line 11, Column 11)

Column 12 – Maintenance of Personnel (Number Housed): will match the value in Tab 15 “Expenses after General Service Costs Stepdown – Excluding Capital” (Line 12, Column 12)

Column 13 – Nursing Administration (Direct Nurses Hours): will match the value in Tab 15 “Expenses after General Service Costs Stepdown – Excluding Capital” (Line 13, Column 13)

Column 14 – Central Services and Supply (Costed Requisition): will match the value in Tab 15 “Expenses after General Service Costs Stepdown – Excluding Capital” (Line 14, Column 14)

Column 15 – Pharmacy (Costed Requisition): will match the value in Tab 15 “Expenses after General Service Costs Stepdown – Excluding Capital” (Line 15, Column 15)

Column 16 – Medical Records and Library (Time Spent): will match the value in Tab 15 “Expenses after General Service Costs Stepdown – Excluding Capital” (Line 16, Column 16)

Column 17 – Social Service (Time Spent): will match the value in Tab 15 “Expenses after General Service Costs Stepdown – Excluding Capital” (Line 17, Column 17)

Column 18 – Other General Service (Specify with subscript): will match the value in Tab 15 “Expenses after General Service Costs Stepdown – Excluding Capital” (Line 18, Column 18)

Column 19 – Non–Physician Anesthetists (Assigned Time): will match the value in Tab 15 “Expenses after General Service Costs Stepdown – Excluding Capital” (Line 19, Column 19)

Column 20 – Nursing School (Assigned Time): will match the value in Tab 15 “Expenses after General Service Costs Stepdown – Excluding Capital” (Line 20, Column 20)

Column 21 – Interns and Residents – Salaries and Fringes (Assigned Time): will match the value in Tab 15 “Expenses after General Service Costs Stepdown – Excluding Capital” (Line 21, Column 21)

Column 22 – Interns and Residents – Program Costs (Assigned Time): will match the value in Tab 15 “Expenses after General Service Costs Stepdown – Excluding Capital” (Line 22, Column 22)

Column 23 – Paramedical Education (Assigned Time): will match the value in Tab 15 “Expenses after General Service Costs Stepdown – Excluding Capital” (Line 23, Column 23)

Line 205 is the Unit Cost Multiplier Excluding Capital. This is entered as directed for each of the following Columns:

Column 1 and 2: will not be required to have data entered

Column 4 – Employee Benefits Department (Gross Salaries): is determined by dividing (Line 204, Column 4) by (Line 4, Column 4)

Column 5A - Reconciliation: Not applicable.

Column 5 – Administrative and General (Accumulated Cost): is determined by dividing (Line 204, Column 5) by (Line 5, Column 5)

Column 6 – Maintenance and Repairs (Square Feet): is determined by dividing (Line 204, Column 6) by (Line 6, Column 6)

Column 7 – Operation of Plant (Square Feet): is determined by dividing (Line 204, Column 7) by (Line 7, Column 7)

Column 8 – Laundry and Linen Service (Pounds of Laundry): is determined by dividing (Line 204, Column 8) by (Line 8, Column 8)

Column 9 – Housekeeping (Hours of Service): is determined by dividing (Line 204, Column 9) by (Line 9, Column 9)

Column 10 – Dietary (Meals Served): is determined by dividing (Line 204, Column 10) by (Line 10, Column 10)

Column 11 – Cafeteria (Meals Served): is determined by dividing (Line 204, Column 11) by (Line 11, Column 11)

Column 12 – Maintenance of Personnel (Number Housed): is determined by dividing (Line 204, Column 12) by (Line 12, Column 12)

Column 13 – Nursing Administration (Direct Nursing Hours): is determined by dividing (Line 204, Column 13) by (Line 13, Column 13)

Column 14 – Central Services and Supply (Costed Requisitions): is determined by dividing (Line 204, Column 14) by (Line 14, Column 14)

Column 15 – Pharmacy (Costed Requisitions): is determined by dividing (Line 204, Column 15) by (Line 15, Column 15)

Column 16 – Medical Records and Library (Time Spent): is determined by dividing (Line 204, Column 16) by (Line 16, Column 16)

Column 17 – Social Service (Time Spent): is determined by dividing (Line 204, Column 17) by (Line 17, Column 17)

Column 18 – Other General Service (Specify with subscript): is determined by dividing (Line 204, Column 18) by (Line 18, Column 18)

Column 19 – Non–Physician Anesthetists (Assigned Time): is determined by dividing (Line 204, Column 19) by (Line 19, Column 19)

Column 20 – Nursing School (Assigned Time): is determined by dividing (Line 204, Column 20) by (Line 20, Column 20)

Column 21 – Interns and Residents – Salaries and Fringes (Assigned Time): is determined by dividing (Line 204, Column 21) by (Line 21, Column 21)

Column 22 – Interns and Residents – Program Costs (Assigned Time): is determined by dividing (Line 204, Column 22) by (Line 22, Column 22)

Column 23 – Paramedical Education (Assigned Time): is determined by dividing (Line 204, Column 23) by (Line 23, Column 23)

Tab 14 Expenses after General Service Costs Stepdown Including Capital

On this tab, General Service department costs including capital are stepped down to inpatient, ancillary, outpatient, and Non-Patient cost centers by multiplying the general cost to be allocated by the unit cost multiplier (including capital) calculated on Tab 13.

On this tab, the costs from the non–revenue producing (General Service) departments are stepped down to the general service, inpatient, ancillary, outpatient, and non–reimbursable cost centers.

For this report to work with the statistics found in Tab 13, the following of the general format must be identical:

- Each general service cost center's line number,
- line numbers for each routine service, ancillary, outpatient service, special purpose, and non–reimbursable cost center
- its respective Column number across the top

The line items for the cost Centers, Lines 1 through 194, are consistent with Tab 9. Any subscripted lines on Tab 9 must also be subscripted to match with the lines on this Tab. Hospitals are required to enter numerical values in each Column, for each section, unless specified.

General Service Cost Centers

For each column, the first applicable line corresponds to the column's matching line number. Enter the sum of all of the prior columns on that line number. For each line below multiply the corresponding column's unit cost multiplier on Tab 13, Line 203 to applicable statistic on each line.

Lines 1 -117 and lines 190-194 are entered as directed for each of the following Columns:

Column 0 –All Net Expenses for Stepdown Allocation Including Capital: will match the value in Tab 9 "Direct Expenses" (Respective Line, Column 6)

(Line 1, Column 1) – Capital Related Costs – Buildings and Fixtures: is the sum of (Line 1, Column 0). This is the amount to be allocated.

Allocation for Column 1 Capital Related Costs – Buildings and Fixtures: is determined by multiplying the square feet of each respective line on Tab 13 "Statistic for General Cost Stepdown" Column 1 by Tab 13, "Unit Cost Multiplier Including Capital" (Line 203, Column 1).

(Line 2, Column 2) – Capital Related Costs – Movable Equipment: is the sum of (Line 2, Columns 0 and 1). This is the amount to be allocated.

Allocation for Column 2 Capital Related Costs – Movable Equipment is determined by multiplying the dollar amount of each respective line on Tab 13 "Statistic for General Cost Stepdown" Column 2 by Tab 13, "Unit Cost Multiplier Including Capital" (Line 203, Column 2).

(Line 4, Column 4) – Employee Benefits Department: is the sum of (Line 4, Columns 0 through 2). This is the amount to be allocated.

Allocation for Column 4 Employee Benefits Department is determined by multiplying the gross salaries of each respective line on Tab 13 "Statistic for General Cost Stepdown" Column 4 by Tab 13, "Unit Cost Multiplier Including Capital" (Line 203, Column 4)

Column 4A – is dedicated to calculating the Subtotal sum of Columns 0 through 4 for each Line

(Line 5, Column 5) Administrative and General: will match the value in (Line 5, Columns 0 through 4). This is the amount to be allocated.

> Allocation for Column 5 Administrative and General is determined by multiplying the Accumulated Costs of each respective line on Tab 13 "Statistic for General Cost Stepdown" Column 5 by Tab 13, "Unit Cost Multiplier Including Capital" (Line 203, Column 5)

If Line 5 is componentized in Tab 13, then use the respective line(s) and column(s) for each componentized Administrative and General Cost Center.

(Line 6, Column 6) Maintenance and Repairs: is the sum of (Line 6, Columns 4A and 5). If Line/Column 5 is subscripted, the sum for this value will not include any instance of additional subtotal columns with labels, for example, Column 5A.01. This is the amount to be allocated.

> Allocation for Column 6 Maintenance and Repairs is determined by multiplying the Square Feet of each respective line on Tab 13 "Statistic for General Cost Stepdown" Column 6 by Tab 13, "Unit Cost Multiplier Including Capital" (Line 203, Column 6)

(Line 7, Column 7) Operation of Plant: is the sum of (Line 7, Columns 4A through 6). If Line/Column 5 is subscripted, the sum for this value will not include any instance of additional subtotal columns with labels, for example, Column 5A.01. This is the amount to be allocated.

> Allocation for Column 7 Operation of Plant is determined by multiplying the Square Feet of each respective line on Tab 13 "Statistic for General Cost Stepdown" Column 7 by Tab 13, "Unit Cost Multiplier Including Capital" (Line 203, Column 7)

(Line 8, Column 8) Laundry and Linen Service: is the sum of (Line 8, Columns 4A through 7). If Line/Column 5 is subscripted, the sum for this value will not include any instance of additional subtotal columns with labels, for example, Column 5A.01. This is the amount to be allocated.

> Allocation for Column 8 Laundry and Linen Service is determined by multiplying the Pounds of Laundry of each respective line on Tab 13 "Statistic for General Cost Stepdown" Column 8 by Tab 13, "Unit Cost Multiplier Including Capital" (Line 203, Column 8)

(Line 9, Column 9) Housekeeping: is the sum of (Line 9, Columns 4A through 8). If Line/Column 5 is subscripted, the sum for this value will not include any instance of additional subtotal columns with labels, for example, Column 5A.01. This is the amount to be allocated.

Allocation for Column 9 Housekeeping is determined by multiplying the Hours of Service of each respective line on Tab 13 "Statistic for General Cost Stepdown" Column 9 by Tab 13, "Unit Cost Multiplier Including Capital" (Line 203, Column 9)

(Line 10, Column 10) Dietary: is the sum of (Line 10, Columns 4A through 9). If Line/Column 5 is subscripted, the sum for this value will not include any instance of additional subtotal columns with labels, for example, Column 5A.01. This is the amount to be allocated.

Allocation for Column 10 Dietary is determined by multiplying the Meals Served of each respective line on Tab 13 "Statistic for General Cost Stepdown" Column 10 by Tab 13, "Unit Cost Multiplier Including Capital" (Line 203, Column 10)

(Line 11, Column 11) Cafeteria: is the sum of (Line 11, Columns 4A through 10). If Line/Column 5 is subscripted, the sum for this value will not include any instance of additional subtotal columns with labels, for example, Column 5A.01. This is the amount to be allocated.

Allocation for Column 11 Cafeteria is determined by multiplying the Meal Served of each respective line on Tab 13 "Statistic for General Cost Stepdown" Column 11 by Tab 13, "Unit Cost Multiplier Including Capital" (Line 203, Column 11)

(Line 12, Column 12) Maintenance of Personnel: is the sum of (Line 12, Columns 4A through 11). If Line/Column 5 is subscripted, the sum for this value will not include any instance of additional subtotal columns with labels, for example, Column 5A.01. This is the amount to be allocated.

Allocation for Column 12 Maintenance of Personnel is determined by multiplying the Number Housed of each respective line on Tab 13 "Statistic for General Cost Stepdown" Column 12 by Tab 13, "Unit Cost Multiplier Including Capital" (Line 203, Column 12)

(Line 13, Column 13) Nursing Administration: is the sum of (Line 13, Columns 4A through 12). If Line/Column 5 is subscripted, the sum for this value will not include any instance of additional subtotal columns with labels, for example, Column 5A.01. This is the amount to be allocated.

Allocation for Column 13 Nursing Administration is determined by multiplying the Direct Nurses Hours of each respective line on Tab 13 "Statistic for General Cost Stepdown" Column 13 by Tab 13, "Unit Cost Multiplier Including Capital" (Line 203, Column 13)

(Line 14, Column 14) Central Services and Supply: is the sum of (Line 14, Columns 4A through 13). If Line/Column 5 is subscripted, the sum for this value will not include any instance of additional subtotal columns with labels, for example, Column 5A.01. This is the amount to be allocated.

Allocation for Column 14 Central Services and Supply is determined by multiplying the Costed Requisition of each respective line on Tab 13 "Statistic for General Cost Stepdown" Column 14 by Tab 13, "Unit Cost Multiplier Including Capital" (Line 203, Column 14)

(Line 15, Column 15) Pharmacy: is the sum of (Line 15, Columns 4A through 14). If Line/Column 5 is subscripted, the sum for this value will not include any instance of additional subtotal columns with labels, for example, Column 5A.01. This is the amount to be allocated.

Allocation for Column 15 Pharmacy is determined by multiplying the Costed Requisition of each respective line on Tab 13 "Statistic for General Cost Stepdown" Column 15 by Tab 13, "Unit Cost Multiplier Including Capital" (Line 203, Column 15)

(Line 16, Column 16) Medical Records & Medical Records Library: is the sum of (Line 16, Columns 4A through 15). If Line/Column 5 is subscripted, the sum for this value will not include any instance of additional subtotal columns with labels, for example, Column 5A.01. This is the amount to be allocated.

Allocation for Column 16 Medical Records & Medical Records Library is determined by multiplying the Time Spent of each respective line on Tab 13 "Statistic for General Cost Stepdown" Column 16 by Tab 13, "Unit Cost Multiplier Including Capital" (Line 203, Column 16)

(Line 17, Column 17) Social Service: is the sum of (Line 17, Columns 4A through 16). If Line/Column 5 is subscripted, the sum for this value will not include any instance of additional subtotal columns with labels, for example, Column 5A.01. This is the amount to be allocated.

Allocation for Column 17 Social Service is determined by multiplying the Time Spent of each respective line on Tab 13 "Statistic for General Cost Stepdown" Column 17 by Tab 13, "Unit Cost Multiplier Including Capital" (Line 203, Column 17)

(Line 18, Column 18) Other General Service (specify): is the sum of (Line 18, Columns 4A through 17). If Line/Column 5 is subscripted, the sum for this value will not include any instance of additional subtotal columns with labels, for example, Column 5A.01. This is the amount to be allocated.

Allocation for Column 18 Other General Service (specify) is determined by multiplying the (specify) of each respective line on Tab 13 "Statistic for General Cost Stepdown" Column 18 by Tab 13, "Unit Cost Multiplier Including Capital" (Line 203, Column 18)

(Line 19, Column 19) Nonphysician Anesthetists: is the sum of (Line 19, Columns 4A through 18). If Line/Column 5 is subscripted, the sum for this value will not include any instance of additional subtotal columns with labels, for example, Column 5A.01. This is the amount to be allocated.

Allocation for Column 19 Nonphysician Anesthetists is determined by multiplying the Assigned Time of each respective line on Tab 13 "Statistic for General Cost Stepdown" Column 19 by Tab 13, "Unit Cost Multiplier Including Capital" (Line 203, Column 19)

(Line 20, Column 20) Nursing School: is the sum of (Line 20, Columns 4A through 19). If Line/Column 5 is subscripted, the sum for this value will not include any instance of additional subtotal columns with labels, for example, Column 5A.01. This is the amount to be allocated.

Allocation for Column 20 Nursing School is determined by multiplying the Assigned Time of each respective line on Tab 13 "Statistic for General Cost Stepdown" Column 20 by Tab 13, "Unit Cost Multiplier Including Capital" (Line 203, Column 20) to be allocated.

(Line 21, Column 21) Interns & Residents-Salary & Fringes: is the sum of (Line 21, Columns 4A through 20). If Line/Column 5 is subscripted, the sum for this value will not include any instance of additional subtotal columns with labels, for example, Column 5A.01. This is the amount to be allocated.

Allocation for Column 21 Interns & Residents Service-Salary & Fringes is determined by multiplying the Assigned Time of each respective line on Tab 13 "Statistic for General Cost Stepdown" Column 21 by Tab 13, "Unit Cost Multiplier Including Capital" (Line 203, Column 21)

(Line 22, Column 22) Interns & Residents-Other Program Costs: is the sum of (Line 22, Columns 4A through 21). If Line/Column 5 is subscripted, the sum for this value will not include any instance of additional subtotal columns with labels, for example, Column 5A.01. This is the amount to be allocated.

Allocation for Column 22 Interns & Residents-Other Program Costs is determined by multiplying the Assigned Time of each respective line on Tab 13 "Statistic for General Cost Stepdown" Column 22 by Tab 13, "Unit Cost Multiplier Including Capital" (Line 203, Column 22)

(Line 23, Column 23) Paramedical Education Program (specify): is the sum of (Line 23, Columns 4A through 22). If Line/Column 5 is subscripted, the sum for this value will not include any instance of additional subtotal columns with labels, for example, Column 5A.01. This is the amount to be allocated.

Allocation for Column 23 Paramedical Education Program (specify) is determined by multiplying the Assigned Time of each respective line on Tab 13 "Statistic for General Cost Stepdown" Column 23 by Tab 13, "Unit Cost Multiplier Including Capital" (Line 203, Column 23)

Column 24 - Total Expense Including Capital After General Costs Stepdown: is dedicated to calculating the total of Columns 0 through 23 for each respective line. Subscripted Columns 5A, are not to be included in this calculation. Lines 1 through 23 are not applicable.

Outpatient Service Cost Centers

Line 92 is Not Applicable

Special Purpose Cost Centers

Line 300 is dedicated to calculating the Subtotal of Lines 2 through 117, when applicable, for each Column. This Subtotal will not include the initial value for each column's stepdown, the Net Expenses for Stepdown Allocation. The initial value will appear at the top line of each column.

Allocation Statistical

Line 201 is the Negative Cost Centers. This is reserved for reporting a general service cost center's credit balance. After receiving costs from the applicable cost centers, if a general service cost center has a credit balance at the point it is to be allocated, do not allocate the credit balance rather enter the credit balance for this line. This value, which will appear positive, is carried over when the cost center's allocation amount is negative.

Line 500 is dedicated to calculating the Total sum of Lines 300, 190 through 194, and 201 for each Column

Tab 15 Expenses After General Service Costs Stepdown Excluding Capital

On this tab, General Service department costs excluding capital are stepped down to inpatient, ancillary, outpatient, and Non-Patient cost centers by multiplying the general cost to be allocated by the unit cost multiplier (excluding capital) calculated on Tab 13.

On this tab, the costs from the non–revenue producing (General Service) departments are stepped down to the general service, inpatient, ancillary, outpatient, special purpose, and non–reimbursable cost centers.

For this report to work with the statistics found in Tab 13, the following of the general format must be identical:

- Each general service cost centers' line number,
- line numbers for each routine service, ancillary, outpatient service, special purpose, and non–reimbursable cost center
- its respective Column number across the top

The line items for the cost Centers, Lines 1 through 194, are consistent with Tab 9. Any subscripted lines on Tab 9 must also be subscripted to match with the lines on this Tab. Hospitals are required to enter numerical values in each Column, for each section, unless specified.

General Service Cost Centers

Lines 4 -117 and lines 190-194 are entered as directed for each of the following Columns:

Column 0 –All Program Net Expenses for Stepdown Allocation Excluding Capital: will match the value in Tab 9 "Direct Expenses" (Respective Line, Column 6)

(Line 1, Column 1) – Capital Related Costs – Buildings and Fixtures: is not applicable as capital costs are not being allocated on this tab.

There is no allocation for this column.

(Line 2, Column 2) – Capital Related Costs – Movable Equipment: is not applicable as capital costs are not being allocated on this tab.

There is no allocation for this column.

(Line 4, Column 4) – Employee Benefits Department: is the sum of (Line 4, Column 0). This is the amount to be allocated.

Allocation for Column 4 Employee Benefits Department: is determined by multiplying the gross salaries of each respective line on Tab 13 "Statistic for General Cost Stepdown" Column 4 by Tab 13, "Unit Cost Multiplier Excluding Capital" (Line 205, Column 4)

(Line 5, Column 5) Administrative and General: is the sum of (Line 5, Columns 0 through 4). This is the amount to be allocated.

Allocation for Column 5 Administrative and General: is determined by multiplying the Accumulated Costs of each respective line on Tab 13 "Statistic for General Cost Stepdown" Column 5 by Tab 13, "Unit Cost Multiplier Excluding Capital" (Line 205, Column 5)

If Line 5 is componentized in Tab 13, then use the respective line(s) and column(s) for each componentized Administrative and General Cost Center.

(Line 6, Column 6) Maintenance and Repairs: is the sum of (Line 6, Columns 0 through 5). This is the amount to be allocated.

Allocation for Column 6 Maintenance and Repairs is determined by multiplying the Square Feet of each respective line on Tab 13 "Statistic for General Cost Stepdown" Column 6 by Tab 13, "Unit Cost Multiplier Excluding Capital" (Line 205, Column 6)

(Line 7, Column 7) Operation of Plant: is the sum of (Line 7, Columns 0 through 6). This is the amount to be allocated.

Allocation for Column 7 Operation of Plant is determined by multiplying the Square Feet of each respective line on Tab 13 "Statistic for General Cost Stepdown" Column 7 by Tab 13, "Unit Cost Multiplier Excluding Capital" (Line 205, Column 7)

(Line 8, Column 8) Laundry and Linen Service: is the sum of (Line 8, Columns 0 through 7). This is the amount to be allocated.

Allocation for Column 8 Laundry and Linen Service is determined by multiplying the Pounds of Laundry of each respective line on Tab 13 "Statistic for General Cost Stepdown" Column 8 by Tab 13, "Unit Cost Multiplier Excluding Capital" (Line 205, Column 8)

(Line 9, Column 9) Housekeeping: is the sum of (Line 9, Columns 0 through 8). This is the amount to be allocated.

Allocation for Column 9 Housekeeping is determined by multiplying the Hours of Service of each respective line on Tab 13 "Statistic for General Cost Stepdown" Column 9 by Tab 13, "Unit Cost Multiplier Excluding Capital" (Line 205, Column 9)

(Line 10, Column 10) Dietary: is the sum of (Line 10, Columns 0 through 9). This is the amount to be allocated.

Allocation for Column 10 Dietary is determined by multiplying the Meals Served of each respective line on Tab 13 "Statistic for General Cost Stepdown" Column 10 by Tab 13, "Unit Cost Multiplier Excluding Capital" (Line 205, Column 10)

(Line 11, Column 11) Cafeteria: is the sum of (Line 11, Columns 0 through 10). This is the amount to be allocated.

Allocation for Column 11 Cafeteria is determined by multiplying the Meal Served of each respective line on Tab 13 "Statistic for General Cost Stepdown" Column 11 by Tab 13, "Unit Cost Multiplier Excluding Capital" (Line 205, Column 11)

(Line 12, Column 12) Maintenance of Personnel: is the sum of (Line 12, Columns 0 through 11). This is the amount to be allocated.

Allocation for Column 12 Maintenance of Personnel is determined by multiplying the Number Housed of each respective line on Tab 13 "Statistic for General Cost Stepdown" Column 12 by Tab 13, "Unit Cost Multiplier Excluding Capital" (Line 205, Column 12)

(Line 13, Column 13) Nursing Administration: is the sum of (Line 13, Columns 0 through 12). This is the amount to be allocated.

Allocation for Column 13 Nursing Administration is determined by multiplying the Direct Nurses Hours of each respective line on Tab 13 "Statistic for General Cost Stepdown" Column 13 by Tab 13, "Unit Cost Multiplier Excluding Capital" (Line 205, Column 13)

(Line 14, Column 14) Central Services and Supply: is the sum of (Line 14, Columns 0 through 13). This is the amount to be allocated.

Allocation for Column 14 Central Services and Supply is determined by multiplying the Costed Requisition of each respective line on Tab 13 "Statistic for General Cost Stepdown" Column 14 by Tab 13, "Unit Cost Multiplier Excluding Capital" (Line 205, Column 14)

(Line 15, Column 15) Pharmacy: is the sum of (Line 15, Columns 0 through 14). This is the amount to be allocated.

Allocation for Column 15 Pharmacy is determined by multiplying the Costed Requisition of each respective line on Tab 13 "Statistic for General Cost Stepdown" Column 15 by Tab 13, "Unit Cost Multiplier Excluding Capital" (Line 205, Column 15)

(Line 16, Column 16) Medical Records & Library: is the sum of (Line 16, Columns 0 through 15). This is the amount to be allocated.

Allocation for Column 16 Medical Records & Library is determined by multiplying the Time Spent of each respective line on Tab 13 "Statistic for General Cost Stepdown" Column 16 by Tab 13, "Unit Cost Multiplier Excluding Capital" (Line 205, Column 16)

(Line 17, Column 17) Social Service: is the sum of (Line 17, Columns 0 through 16). This is the amount to be allocated.

Allocation for Column 17 Social Service is determined by multiplying the Time Spent of each respective line on Tab 13 "Statistic for General Cost Stepdown" Column 17 by Tab 13, "Unit Cost Multiplier Excluding Capital" (Line 205, Column 17)

(Line 18, Column 18) Other General Service (specify): is the sum of (Line 18, Columns 0 through 17). This is the amount to be allocated.

Allocation for Column 18 Other General Service (specify) is determined by multiplying those specified service of each respective line on Tab 13 "Statistic for General Cost Stepdown" Column 18 by Tab 13, "Unit Cost Multiplier Excluding Capital" (Line 205, Column 18)

(Line 19, Column 19) Nonphysician Anesthetists: is the sum of (Line 19, Columns 0 through 18). This is the amount to be allocated.

Allocation for Column 19 Nonphysician Anesthetists is determined by multiplying the Assigned Time of each respective line on Tab 13 "Statistic for General Cost Stepdown" Column 19 by Tab 13, "Unit Cost Multiplier Excluding Capital" (Line 205, Column 19)

(Line 20, Column 20) Nursing School: is the sum of (Line 20, Columns 0 through 19). This is the amount to be allocated.

Allocation for Column 20 Nursing School is determined by multiplying the Assigned Time of each respective line on Tab 13 "Statistic for General Cost Stepdown" Column 20 by Tab 13, "Unit Cost Multiplier Excluding Capital" (Line 205, Column 20) to be allocated.

(Line 21, Column 21) Interns & Residents-Salary & Fringes: is the sum of (Line 21, Columns 0 through 20). This is the amount to be allocated.

Allocation for Column 21 Interns & Residents-Salary & Fringes is determined by multiplying the Assigned Time of each respective line on Tab 13 "Statistic for General Cost Stepdown" Column 21 by Tab 13, "Unit Cost Multiplier Excluding Capital" (Line 205, Column 21)

(Line 22, Column 22) Interns & Residents-Other Program Costs: is the sum of (Line 22, Columns 0 through 21). This is the amount to be allocated.

Allocation for Column 22 Interns & Residents-Other Program Costs is determined by multiplying the Assigned Time of each respective line on Tab 13 "Statistic for General Cost Stepdown" Column 22 by Tab 13, "Unit Cost Multiplier Excluding Capital" (Line 205, Column 22)

(Line 23, Column 23) Paramedical Education Program (specify): is the sum of (Line 23, Columns 0 through 22). This is the amount to be allocated.

Allocation for Column 23 Paramedical Education Program (specify) is determined by multiplying the Assigned Time of each respective line on Tab 13 "Statistic for General Cost Stepdown" Column 23 by Tab 13, "Unit Cost Multiplier Excluding Capital" (Line 205, Column 23)

Column 24 - Total Expense Excluding Capital After General Costs Stepdown: is dedicated to calculating the total of Columns 0 through 23 for each respective line. Lines 1 through 23 are not applicable.

Line 300 is dedicated to calculating the Subtotal of Lines 4 through 117, when applicable, for each Column. This Subtotal will not include the initial value for each column's stepdown, the Net Expenses for Stepdown Allocation. The initial value will appear at the top line of each column.

Allocation Statistical

Line 201 is the Negative Cost Centers. This is reserved for reporting a general service cost center's credit balance. After receiving costs from the applicable cost centers, if a general service cost center has a credit balance at the point it is to be allocated, do not allocate the credit balance rather enter the credit balance for this line.

Line 500 is dedicated to calculating the Total sum of Lines 300, 190 through 194, and 201 for each Column

Tab 16 Ancillary Service Statistic (Gross Patient Service Revenue) for Costs Allocation

The statistics required on this tab are Gross Patient Service Revenue (GPSR) and will be used to allocate ancillary costs to inpatient routine service cost centers, outpatient service cost centers, special purpose cost centers, and Non-Patient cost centers. Hospitals should note that Non-Distinct Observations should not receive allocations of ancillary expenses on this tab. Ancillaries are allocated to Non-Distinct Observation units on Tab 12.

The statistics reported will be used in the Stepdown Expenses Allocations in Tabs 17 and 18. To facilitate this allocation process, the following of the general format found in Tabs 16, 17, and 18 must be identical:

- Each general service cost center's line number,
- line numbers for each routine service, ancillary outpatient service, other reimbursable special purpose, and non–reimbursable cost center
- its respective Column number across the top

The line items for the Cost Centers' descriptions are consistent with Tab 6. Any subscripted lines on Tab 6 must also be subscripted to match with the lines on this Tab. Hospitals are required to enter numerical values in each Column, for each section, unless specified.

Inpatient Routine Service Cost Centers

Lines 30 through 46 are entered, as directed, for each of the following Columns:

Columns 4 through 30: will match the values entered from Tab 6 "Gross Patient Service Revenue" (Line 30 through 46, Columns 4 through 30)

Outpatient Service Cost Centers

Line 92 “Observation Beds Non Distinct” does not require data

Lines 88 through 101 are entered, as directed, for each of the following Columns:

Columns 4 through 30: will match the values entered from Tab 6 “Gross Patient Service Revenue” (Lines 88 through 101, Columns 4 through 30)

Special Purpose Cost Centers

Lines 105 through 117 are entered, as directed, for each of the following Columns:

Columns 4 through 30: will match the values entered from Tab 6 “Gross Patient Service Revenue” (Lines 105 through 117, Columns 4 through 30)

Line 300 is dedicated to calculating the Subtotal for Lines 30 through 117 in each Column

Non–Reimbursable Cost Centers

Lines 190 through 194 are entered, as directed, for each of the following Columns:

Columns 4 through 30: will match the values entered from Tab 6 “Gross Patient Service Revenue” (Lines 190 through 194, Columns 4 through 30)

Allocation Statistical

Line 500 is dedicated to calculating the Total Line for Lines 300 and Lines 190 through 194 in all Columns

Line 210 is the Ancillary Cost to be Allocated Including Capital. The Column header names will match the values found in Tab 14 on the same cost center line, Column 24. As an example, Column 4 “Operating Room GPSR” will match the value in Tab 14 “Expenses after General Service Costs Stepdown Including Capital” (Line 50, Column 24)

Line 211 is the Unit Cost Multiplier Including Capital. This is determined by dividing Line 210 by Line 500 for each Column

Line 213 is the Ancillary Cost to be Allocated Excluding Capital. The Column header name will match the value found in Tab 15 on the same cost center line, Column 24. As an example, Column 4 “Operating Room GPSR” will match the value in Tab 15 “Expenses after General Service Costs Stepdown Excluding Capital” (Line 50, Column 24)

Line 214 is the Unit Cost Multiplier Excluding Capital. This is determined by dividing Line 213 by Line 500 for each Column

Tab 17 Allocation of Ancillary Expenses to IP & OP Routine Cost Centers INCLUDING CAPITAL

This tab shows the ancillary costs including capital allocation to inpatient, outpatient, and other cost centers. These are calculated by multiplying the ancillary cost to be allocated by the unit cost multiplier including capital calculated on Tab 16. This tab shows costs before the allocation of non-distinct observation costs and organ acquisition costs. Hospitals should note that Non-Distinct Observations should not receive allocations of ancillary expenses on this tab. Ancillaries are allocated to Non-Distinct Observation units on Tab 12.

This tab shows the distribution of total expenses including capital after stepdown by inpatient, outpatient, and non–patient services.

The statistics reported will be used in the Expense Allocation in Tab 16. To facilitate this allocation process, the following of the general format found in Tabs 16 and 17 must be identical:

- line numbers for each routine service, ancillary outpatient service, other reimbursable special purpose, and non–reimbursable cost center
- its respective Column number across the top

Inpatient Routine Service Cost Centers

Lines 30 through 46 are entered, as directed, for each of the following Columns:

Column 1 – Total Expense: is dedicated to calculating the total for each line in Columns 2 and 3

Column 2 – After General Cost Expense Including Capital: will match the value from the same cost center in Tab 14 “Expenses after General Service Costs Stepdown Including Capital” (Lines 30 through 46, Column 24)

Column 3 – Ancillary Expense Allocation: is dedicated to calculating the Total for (Lines 30 through 46, Columns 4 through 30)

Columns 4 through 30: will be determined by multiplying the matching coordinates in Tab 16, (Lines 30 through 46, Columns 4 through 30) by the appropriate GPSR "Unit Cost Multiplier Including Capital", Tab 16 (Line 211, appropriate Column)

Outpatient Service Cost Centers

Line 92 “Observation Beds Non Distinct” does not require data

Lines 88 through 101 are entered, as directed, for each of the following Columns:

Column 1 – Total Expense: is dedicated to calculating the total for each line in Columns 2 and 3

Column 2 – After General Cost Stepdown Expense Including Capital: will match the value from the same cost center in Tab 14 “Expenses after General Service Costs Stepdown Including Capital” (Lines 88 through 101, Column 24)

Column 3 – Ancillary Expense Allocation: is dedicated to calculating the Total for (Lines 88 through 101, Columns 4 through 30)

Columns 4 through 30: will be determined by multiplying the matching coordinates in Tab 16, (Lines 88 through 101, Columns 4 through 30) by the appropriate GPSR “Unit Cost Multiplier Including Capital”, Tab 16 (Line 211, appropriate Column)

Special Purpose Cost Centers

Lines 105 through 117 are entered, as directed, for each of the following Columns:

Column 1 – Total Expense: is dedicated to calculating the total for each line in Columns 2 and 3

Column 2 – After General Cost Stepdown Expense Including Capital: will match the value from the same cost center in Tab 14 "Expenses after General Service Costs Stepdown Including Capital" (Lines 105 through 117, Column 24)

Column 3 – Ancillary Expense Allocation: is dedicated to calculating the Total for (Lines 105 through 117, Columns 4 through 30)

Columns 4 through 30: will be determined by multiplying the matching coordinates in Tab 16, (Lines 105 through 117, Columns 4 through 30) by the appropriate GPSR "Unit Cost Multiplier Including Capital", Tab 16 (Line 211, appropriate Column)

Line 300 is dedicated to calculating the Subtotal for Lines 30 through 117 for each Column

Non–Reimbursable Cost Centers

Lines 190 through 194 are entered, as directed, for each of the following Columns:

Column 1 – Total Expense: is dedicated to calculating the total for each line in Columns 2 and 3

Column 2 – After General Cost Stepdown Expense Including Capital: will match the value from the same cost center in Tab 14 "Expenses after General Service Costs Stepdown Including Capital" (Line 190 through 194, Column 24)

Column 3 – Ancillary Expense Stepdown: is dedicated to calculating the total for (Line 190 through 194, Columns 4 through 30)

Columns 4 through 30: will be determined by multiplying the matching coordinates in Tab 16 (Lines 190 through 194, Columns 4 through 30) by the appropriate GPSR "Unit Cost Multiplier Including Capital", Tab 16 (Line 211, appropriate Column)

Line 500 is dedicated to calculating the Total for Lines 300 and 190 through 194 for each Column

Tab 18 Allocation of Ancillary Expenses to IP & OP Routine Cost Centers EXCLUDING CAPITAL

This tab shows the ancillary costs excluding capital allocation to inpatient, outpatient, and other cost centers. These are calculated by multiplying the ancillary cost to be allocated by the unit cost multiplier including capital calculated on Tab 16. This tab shows costs before the allocation of non-distinct observation costs and organ acquisition costs. Hospitals should note that Non-Distinct Observations should not receive allocations of ancillary expenses on this tab. Ancillaries are allocated to Non-Distinct Observation units on Tab 12.

This tab shows the distribution of total expenses excluding capital after stepdown by inpatient, outpatient, and non–patient services.

The statistics reported will be used in the Expense Allocation in Tab 16. To facilitate this allocation process, the following of the general format found in Tabs 16 and 18 must be identical:

- line numbers for each routine service, ancillary outpatient service, other reimbursable special purpose, and non–reimbursable cost center
- its respective Column number across the top

Inpatient Routine Service Cost Centers

Lines 30 through 46 are entered, as directed, for each of the following Columns:

Column 1 – Total Expenses: is dedicated to calculating the total for each line in Columns 2 and 3

Column 2 – After General Cost Stepdown Expense Excluding Capital: will match the value from the same cost center in Tab 15 “Expenses after General Service Costs Stepdown Excluding Capital” (Lines 30 through 46, Column 24)

Column 3 – Ancillary Expense Stepdown: is dedicated to calculating the Total for (Line 30 through 46, Columns 4 through 30)

Columns 4 through 30: will be determined by multiplying the matching coordinates in Tab 16 (Lines 30 through 46, Columns 4 through 30) by the appropriate GPSR "Unit Cost Multiplier Excluding Capital", Tab 16 (Line 214, appropriate Column)

Outpatient Service Cost Centers

Line 92 “Observation Beds Non Distinct” does not require data

Lines 88 through 101 are entered, as directed, for each of the following Columns:

Column 1 – Total Expenses: is dedicated to calculating the total for each line in Columns 2 and 3

Column 2 – After General Cost Stepdown Expense Excluding Capital: will match the value from the same cost center in Tab 15 “Expenses after General Service Costs Stepdown Excluding Capital” (Lines 88 through 101, Column 24)

Column 3 – Ancillary Expense Stepdown: is dedicated to calculating the Total for (Lines 88 through 101, Columns 4 through 30)

Columns 4 through 30: will be determined by multiplying the matching coordinates in Tab 16 (Lines 88 through 101, Columns 4 through 30) by the appropriate GPSR “Unit Cost Multiplier Excluding Capital”, Tab 16 (Line 214, appropriate Column)

Special Purpose Cost Centers

Lines 105 through 117 are entered, as directed, for each of the following Columns:

Column 1 – Total Expenses: is dedicated to calculating the total for each line in Columns 2 and 3

Column 2 – After General Cost Stepdown Expense Excluding Capital: will match the value from the same cost center in Tab 15 "Expenses after General Service Costs Stepdown Excluding Capital" (Lines 105 through 117, Column 24)

Column 3 – Ancillary Expense Stepdown: is dedicated to calculating the Total for (Lines 105 through 117, Columns 4 through 30)

Columns 4 through 30: will be determined by multiplying the matching coordinates in Tab 16 (Lines 105 through 117, Columns 4 through 30) by the appropriate GPSR "Unit Cost Multiplier Excluding Capital", Tab 16 (Line 214, appropriate Column)

Line 300 is dedicated to calculating the Subtotal for Lines 30 through 117 for each Column

Non–Reimbursable Cost Centers

Lines 190 through 194 are entered, as directed, for each of the following Columns:

Column 1 – Total Stepdown Expense: is dedicated to calculating the total for each line in Columns 2 and 3

Column 2 – After General Cost Stepdown Expense Excluding Capital: will match the value from the same cost center in Tab 15 "Expenses after General Service Costs Stepdown Excluding Capital" (Lines 190 through 194, Column 24)

Column 3 – Ancillary Expense Stepdown: is dedicated to calculating the Total (Lines 190 through 194, Columns 4 through 30)

Columns 4 through 30: will be determined by multiplying the matching coordinates in Tab 16 (Lines 190 through 194, Columns 4 through 30) by the appropriate GPSR "Unit Cost Multiplier Excluding Capital", Tab 16 (Line 214, appropriate Column)

Line 500 is dedicated to calculating the Total for Lines 300 and 190 through 194 in each Column

Tab 19 340B Pharmacy Schedule

This tab is required for hospitals that participate in the 340B Pharmacy Program. Hospitals that do not participate in this program should not report information on this tab.

The purpose of this schedule is to collect information on physician staffing, non-staffing expenses, revenue, statistics, and co-payments for analysis related to 340B Pharmacy Program.

(Line 1, Column 1) is dedicated to entering the name of the Pharmacy claiming participation of the 340B Program. Entry in this line will be alpha–numeric.

Pharmacy Staffing Information

Hospitals must complete the Pharmacy staffing information as it identifies the direct staffing within the Pharmacy department.

Lines 2 through 9 are entered, as directed, for each of the following Columns:

Column 1 – Other (Specify): is dedicated to listing any other items requiring documentation for the appropriate line

Column 2 – Expenses: is dedicated to list any expenses for the appropriate line

Column 3 – Pharmacy FTEs: is dedicated to documenting the amount of FTEs for the appropriate line

Line 10 is dedicated to calculating the Subtotal, Lines 2 through 9 for each Column

Lines 11 and 12 are entered, as directed, for each of the following Columns:

Column 1 – Other (Specify): is dedicated to listing any other items requiring documentation for the appropriate line

Column 2 – Expenses: is dedicated to list any expenses for the appropriate line

Column 3 – Pharmacy FTEs: is dedicated to documenting the amount of FTEs for the appropriate line

Line 13 is dedicated to calculating the Subtotal, Lines 11 and 12 for each Column

Line 14 is dedicated to calculating the Total Pharmacy Staffing Expenses, Lines 10 and 13 for each Column

Non–Staffing Expenses

Hospitals must complete the "Non–Staffing Expenses" section; as it allocates non–staffing expenses among the categories listed in the lines below.

Lines 15 through 26 are entered, as directed, for each of the following Columns:

Column 1 – Other (Specify): is dedicated to listing any other items requiring documentation for the appropriate line

Column 2 – Expenses: is dedicated to listing any expenses for the appropriate line

Line 27 is dedicated to calculating the Subtotal Non–Staffing Expenses, Lines 15 through 26 for each Column

Line 28 is dedicated to entering the Administration Allocation for each Column. There will be an estimated ¼ Administrative Allocation to be reported within the annual cost report for the Pharmacy cost center:

Column 1 – Other (Specify): is dedicated to listing any other items requiring documentation for the appropriate line

Column 2 – Expenses: is dedicated to list any expenses for the appropriate line

Line 29 is dedicated to calculating the Total Non–Staffing Expenses, Lines 27 and 28 for each Column

Line 30 is dedicated to calculating the Total Staffing and Non–Staffing Expenses, Lines 14 and 29 for each Column

Total Revenue

Hospitals must complete the "Total Revenue" section; as it reports the Gross Pharmacy Revenue among the categories described in the lines below.

Line 31 is for Medicare

Line 32 is for MassHealth Fee–For–Service / PCC Plan. PCC Plan members and other MassHealth FFS members are paid directly by MassHealth.

Line 33 is for MassHealth MCO: MassHealth members enrolled in Neighborhood Health Plan, Boston Medical Center HealthNet Plan, Network Health or Fallon Community Health Plan.

Line 34 is for ConnectorCare plans

Line 35 is for Commercial / Private Third Parties: Neighborhood Health Plan (NHP Commercial Members Only), Blue Cross / Blue Shield, Tufts Health Plan, RX America, Unicare (Including CMSP and Health Start programs), etc.

Line 36 is for Health Safety Net (HSN): Prescriptions that are dispensed to a HSN–eligible recipient and billed to the HSN according to 114.6 CMR 14.00 Health Safety Net Payments and Funding.

Line 37 is for Patient Assistance Programs HSN eligible Recipients: Prescriptions that are dispensed to a HSN–eligible recipient from donated drugs as part of the Patient Assistance Program (bulk replacements, patient assistance programs, etc.)

Line 38 is for Patient Assistance Programs: Prescriptions that are dispensed to a NON–HSN eligible recipient from donated drugs as part of a Patient Assistance Program

Line 39 is for DPH Programs I: Programs supported by DPH initiatives via funding (Family Planning, Refugee, HDAP, etc.)

Line 40 is for DPH Programs II: Supported by DPH initiatives for drugs that are provided to TB Clinics, etc.

Line 41 is for State Capitated Programs: Programs administered by capitated payment methods (PACE, SCO, etc.)

Line 42 is for Patient Payments: Payments from patients who pay for any prescriptions without any other insurance or HSN payment.

Line 43 is for Other Patient Revenue: Payments in the form of copays, co–insurance or partial payments for patients that use some other source as the primary payment (MassHealth, ComMedicare, Commercial, HSN, etc.)

Line 44 is dedicated to calculating the Subtotal, Lines 31 through 43 for each Column

Line 45 is for Donated Goods and Services: Should equal total of Donated Salaries and Donated Services listed above

Line 46 is for Bad Debt Expense

Line 47 is for Other Income, Specify with subscript. This also includes grants

Line 48 is for Farmworker's Grant, Cash Prescriptions for Employees

Line 49 is dedicated to calculating the Subtotal, Lines 45 through 48 for each Column

Line 50 is dedicated to calculating the Total Revenue, Lines 44 and 49 for each Column

Line 51 is dedicated to calculating the Profit (Loss) from the 340B Pharmacy Program. This is determined by subtracting Line 30 from Line 50 for each Column

For the above items listed, the data is entered, as directed, in the following Columns:

Column 1 – Other (Specify): is dedicated to listing any other items requiring documentation for the appropriate line

Column 2 – Revenue: is dedicated to list any revenue for the appropriate line

Statistics

The Hospital must enter the Pharmacy Statistics for each reimbursement plan listed. More information about the reimbursement plan can be found in the "Total Revenue" section.

Lines 52 through 64 are entered, as directed, for each of the following Columns:

Column 1 – Number of Prescriptions, Brand: is dedicated to documenting the number of brand prescriptions filled

Column 2 – Number of Prescriptions, Generic: is dedicated to documenting the number of generic prescriptions filled

Column 3 – Number of Prescriptions, Total: is dedicated to calculating the total of Columns 1 and 2 for each Line

Column 4 – Ingredient Cost of Prescriptions, Brand: is dedicated to documenting the cost of brand prescriptions filled

Column 5 – Ingredient Cost of Prescriptions, Generic: is dedicated to documenting the cost of generic prescriptions filled

Column 6 – Ingredient Cost of Prescriptions, Total: is dedicated to calculating the total of Columns 4 and 5 for each Line

Column 7 – Revenue from Prescriptions, Brand: is dedicated to documenting the revenue for brand prescriptions filled

Column 8 – Revenue from Prescriptions, Generic: is dedicated to documenting the revenue for generic prescriptions filled

Column 9 – Revenue from Prescriptions, Total: is dedicated to calculating the total of Columns 7 and 8 for each Line

Line 65 is dedicated to calculating the Total, Lines 52 through 64 for each Column

Co–Payments

The Hospital must enter the Pharmacy Co–Payments for each reimbursement plan listed. More information about the reimbursement plan can be found in the "Total Revenue" section.

Lines 66 through 69 are entered, as directed, for each of the following Columns:

Column 1 – Number of Prescriptions, Brand: is dedicated to documenting the number of brand prescriptions filled

Column 2 – Number of Prescriptions, Generic: is dedicated to documenting the number of generic prescriptions filled

Column 3 – Number of Prescriptions, Total: is dedicated to calculating the total of Columns 1 and 2 for each Line

Column 4 – Ingredient Cost of Prescriptions, Brand: is dedicated to documenting the cost of brand prescriptions filled

Column 5 – Ingredient Cost of Prescriptions, Generic: is dedicated to documenting the cost of generic prescriptions filled

Column 6 – Ingredient Cost of Prescriptions, Total: is dedicated to calculating the total of Columns 4 and 5 for each Line

Column 7 – Revenue from Prescriptions, Brand: is dedicated to documenting the revenue for brand prescriptions filled

Column 8 – Revenue from Prescriptions, Generic: is dedicated to documenting the revenue for generic prescriptions filled

Column 9 – Revenue from Prescriptions, Total: is dedicated to calculating the total of Columns 7 and 8 for each Line

Line 70 is dedicated to calculating the Total, Lines 66 through 69 for each Column

Tab 20 Physician Compensation

Hospitals are required to report information on the salaries of all of the hospital's physicians, both contracted and salaried. The information on this tab may differ from the 2552 Cost Report, which only requires information about physicians subject to reasonable compensation equivalent (RCE) limits.

This tab disaggregates All Physicians Compensation into (3) parts: Professional Component, Provider Component, and Other Physicians Compensation.

General Service Cost Centers

Lines 1, 2, and 3 does not require data for each Column

Lines 4 -23 are entered as directed for each of the following Columns:

Column 1 – Total Compensation: is dedicated to calculating the total for each line in Columns 2, 3, and 4

Column 2 - Professional Component: hospitals are responsible for entering all physicians' compensation for services to individual patients

Column 3 - Provider Component: hospitals are responsible for entering all providers' compensation for services that benefit patients in general

Column 4 – Other Physician Compensation: This column should include amounts paid for fringe benefits, deferred compensation, costs of physician membership in professional societies, continuing education, malpractice, and any other items of value (excluding office space or billing and collection services).

Inpatient Routine Service Cost Centers

The information on this schedule will be a total compensation for all physicians.

"Adults and Pediatrics" will be segregated into separate line items: "Medical and Surgical", "Pediatric", and "Obstetric"
"Intensive Care Unit" will be segregated into line items: "Adult", "Pediatric", and "Neonatal"
"Subprovider IPF" will be segregated into line items: "Adult - Psych" and "Pediatric - Psych"
"Nursery" to be segregated into separate line items: "Newborn" and "Special"
Insert additional lines as needed. (See Note A in the General Instructions)

Lines 30 through 46 are entered, as directed, for each of the following Columns:

Column 1 – Total Compensation: is dedicated to calculating the total for each line in Columns 2, 3, and 4

Column 2 - Professional Component: hospitals are responsible for entering all physicians' compensation.

Column 3 - Provider Component: hospitals are responsible for entering all providers' compensation.

Column 4 – Other Physician Compensation: This column should include amounts paid for fringe benefits, deferred compensation, costs of physician membership in professional societies, continuing education, malpractice, and any other items of value (excluding office space or billing and collection services).

Ancillary Service Cost Centers

Line 61 does not require data for each Column

Lines 50 through 76 are entered, as directed, for each of the following Columns:

Column 1 – Total Compensation: is dedicated to calculating the total for each line in Columns 2, 3, and 4

Column 2 - Professional Component: hospitals are responsible for entering all physicians' compensation.

Column 3 - Provider Component: hospitals are responsible for entering all providers' compensation.

Column 4 – Other Physician Compensation: This column should include amounts paid for fringe benefits, deferred compensation, costs of physician membership in professional societies, continuing education, malpractice, and any other items of value (excluding office space or billing and collection services).

Outpatient Service Cost Centers

Line 92 “Observation Beds Non Distinct” does not require data for each Column

Lines 88 through 101 are entered, as directed, for each of the following Columns:

Column 1 – Total Compensation: is dedicated to calculating the total for each line in Columns 2, 3, and 4

Column 2 - Professional Component: hospitals are responsible for entering all physicians’ compensation.

Column 3 - Provider Component: hospitals are responsible for entering all providers’ compensation.

Column 4 – Other Physician Compensation: This column should include amounts paid for fringe benefits, deferred compensation, costs of physician membership in professional societies, continuing education, malpractice, and any other items of value (excluding office space or billing and collection services).

Special Purpose Cost Centers

Lines 105 through 117 are entered, as directed, for each of the following Columns:

Column 1 – Total Compensation: is dedicated to calculating the total for each line in Columns 2, 3, and 4

Column 2 - Professional Component: hospitals are responsible for entering all physicians' compensation.

Column 3 - Provider Component: hospitals are responsible for entering all providers' compensation.

Column 4 – Other Physician Compensation: This column should include amounts paid for fringe benefits, deferred compensation, costs of physician membership in professional societies, continuing education, malpractice, and any other items of value (excluding office space or billing and collection services).

Line 300 is designated to calculate the total for the all previous Lines reported for Columns 1 through 4.

Non–Reimbursable Cost Centers

Lines 190 through 194 are entered, as directed, for each of the following Columns:

Column 1 – Total Compensation: is dedicated to calculating the total for each line in Columns 2, 3, and 4

Column 2 - Professional Component: hospitals are responsible for entering all physicians' compensation.

Column 3 - Provider Component: hospitals are responsible for entering all providers' compensation.

Column 4 – Other Physician Compensation: This column should include amounts paid for fringe benefits, deferred compensation, costs of physician membership in professional societies, continuing education, malpractice, and any other items of value (excluding office space or billing and collection services).

Line 500 is dedicated to calculating the Total sum of Lines 300 and 190 through 194 for each Column

Tab 21 Reclassification of Organ Acquisition to Inpatient from Special Purpose Cost Centers

This tab is the mechanism for hospitals to appropriately reclassify organ acquisition costs to the Inpatient Routine Service Cost center. Hospitals should reclassify organ acquisition costs in the Special Purpose Cost Centers to Inpatient Routine Cost Centers for allocations both including and excluding capital using the number of organs as the basis of allocation.

In this Tab, hospitals are to reclassify organ acquisition reported in the Special Purpose Cost Center Lines to the Inpatient Cost Centers as appropriate.

Lines 30.01, 30.02, and 30.03 are the responsibility of the hospital. This cost report requires that the Cost Center for "Adults and Pediatrics" to be segregated into separate line items: "Medical and Surgical", "Pediatric", and "Obstetric", (See Note A in the General Instructions).

Lines 31.01, 31.02, and 31.03 are the responsibility of the hospital. This cost report requires that the Cost Center for "Intensive Care Unit" to be segregated into separate line items: "Adult", "Pediatric", and "Neonatal", (See Note A in the General Instructions).

Lines 40.01 and 40.02 are the responsibility of the hospital. This cost report requires that the Cost Center for "Subprovider IPF" to be segregated into separate line items: "Adult - Psych" and "Pediatric - Psych" (See Note A in the General Instructions). Hospitals with discrete Psych Units should complete these lines whether or not they file these units as a subprovider for Medicare reimbursement purposes.

Lines 43.01 and 43.02 are the responsibility of the hospital. This cost report requires that the Cost Center for "Nursery" to be segregated into separate line items: "Newborn" and "Special" (See Note A in the General Instructions).

Allocation Including Capital

Lines 30.01, 30.02, and 30.03 are entered, as directed, for each of the following Columns:

Column 1 – Number of Organs: Not Applicable

Column 2 – Total Costs before Allocation of Organ Acquisition Costs Including Capital: will match the value entered in Tab #12 (Line 30.01, 30.02, or 30.03, Column 5), appropriate line

Column 3 - Increase: Hospitals are responsible for entering the Increase for each Cost Center

Column 4 – Decrease: Hospitals are responsible for entering the Decrease for each Cost Center

Column 5 – Total Costs Net of NonDistinct Observation Beds Including Organ Acquisition: is dedicated to calculating the total value of Columns 2, 3, and 4 for each Line

Lines 31 through 46 are entered, as directed, for each of the following Columns:

Column 1 – Number of Organs: Not Applicable

Column 2 – Total Costs: will match the value entered in Tab #17 (Line 31 through 46, Column 1), appropriate line

Column 3 - Increase: Hospitals are responsible for entering the Increase for each Cost Center

Column 4 – Decrease: Hospitals are responsible for entering the Decrease for each Cost Center

Column 5 – Total Costs Including Organ Acquisition: is dedicated to calculating the total value of Columns 2, 3, and 4 for each Line

Lines 105 through 112 are entered, as directed, for each of the following Columns:

Column 1 – Number of Organs: Hospitals are responsible for entering the total number of organs for each Cost Center

Column 2 – Total Costs: will match the value entered in Tab #17 (Line 105 through 112, Column 1), appropriate line

Column 3 - Increase: Hospitals are responsible for entering the Increase for each Cost Center

Column 4 – Decrease: Hospitals are responsible for entering the Decrease for each Cost Center

Column 5 – Total Costs Including Organ Acquisition: is dedicated to calculating the total value of Columns 2, 3, and 4 for each Line

Line 500 is dedicated to calculating the Total sum of Lines 30 through 46 and 105 through 112 for each Column

Allocation Excluding Capital

Lines 30.01, 30.02, and 30.03 are entered, as directed, for each of the following Columns:

Column 6 – Total Costs before Allocation of Organ Acquisition Costs Excluding Capital: will match the value entered in Tab #12 (30.01, 30.02, or 30.03, Column 10), appropriate line

Column 7 - Increase: Hospitals are responsible for entering the Increase for each Cost Center

Column 8 – Decrease: Hospitals are responsible for entering the Decrease for each Cost Center

Column 9 – Total Costs Net of NonDistinct Observation Beds Including Organ Acquisition: is dedicated to calculating the total value of Columns 6, 7, and 8 for each Line

Lines 31 through 46 are entered, as directed, for each of the following Columns:

Column 6 – Total Costs: will match the value entered in Tab #18 (Line 31 through 46, Column 1), appropriate line

Column 7 - Increase: Hospitals are responsible for entering the Increase for each Cost Center

Column 8 – Decrease: Hospitals are responsible for entering the Decrease for each Cost Center

Column 9 – Total Costs Including Organ Acquisition: is dedicated to calculating the total value of Columns 6, 7, and 8 for each Line

Lines 105 through 112 are entered, as directed, for each of the following Columns:

Column 6 – Total Costs: will match the value entered in Tab #18 (Line 105 through 112, Column 1), appropriate line

Column 7 - Increase: Hospitals are responsible for entering the Increase for each Cost Center

Column 8 – Decrease: Hospitals are responsible for entering the Decrease for each Cost Center

Column 9 – Total Costs Including Organ Acquisition: is dedicated to calculating the total value of Columns 6, 7, and 8 for each Line

Line 500 is dedicated to calculating the Total sum of Lines 30 through 46 and 105 through 112 for each Column

Appendix (A) Explanation of Warning/Fatal Errors

This Section describes the criterion that will produce Warning and/or Fatal errors. It is the responsibility of the hospital to recognize these errors. Warning errors are required to be explained by the hospital and reasons for the errors must be submitted in PDF format as described on page 4. Any cost report submission with a fatal error will be rejected by the system.

The list below defines each Warning Edit. Each Column identifies the following:

Column 1 – Description of Error: defines the description of the error.

Column 2 – Tab/Line/Column Reference: Identifies where the Warning Edit is located in the workbook.

Column 3 – Type: Identifies if the error is either a 'Warning' or 'Fatal' errors.

Each warning is described below:

	Description of Error	Tab/Line/Column Reference	Type
1	To ensure hospital identifies the description when required to "specify" cost centers	"Specify" Cost Center with data in Column must fill in a text description	Warning
2	To ensure hospital identifies the description for "subscripted " cost centers	"Subscripted" Cost Center with suffixes .01 -.99 with data in that line or column must fill in a text description of the "Subscripted"	Warning
3	To ensure the following expenses equal the same total that were transferred from different tabs: Direct Expense, Expense After General Service Stepdown Including Capital, Patient Service Expense by Department Including Capital, Patient Service by Service Including Capital	Tab 2, Line 500, Column 2, 4, 6, 9 must have the same value	Warning

	Description of Error	Tab/Line/Column Reference	Type
4	To ensure the following expenses equal the same total that were transferred from different tabs: Expense after General Costs Stepdown Excluding Capital, Patient Service Expense by Department Excluding Capital, and Patient Service Expense by Service Excluding Capital	Tab 2, Line 500, Column 3, 5, 8 must have the same value	Warning
5	To ensure the following gross revenues equal the same total on different tabs: Gross Revenue by Department and Gross Revenue by Service	Tab 2, Line 304, Column 7 and 10 must have the same value and Tab 5, Column 1, Line 302	Warning
6	To ensure all statistic data are presented for licensed beds, available beds, staffed beds, and inpatient days and discharges. All five columns must have data if any column has data reported	If any column on Tab 3, Lines 1 to 19, Columns 1 to 5 has an amount then there must be data in all Columns 1-5	Warning
7	To ensure inpatient days reported in Tab 3 match the inpatient days in Tab 5	Tab 3, Line 500, Column 4 should equal to Tab 5, Line 300, Column 1	Warning
8	To ensure discharges reported in Tab 3 match the discharges in Tab 5	Tab 3, Line 500, Column 5 should equal to Tab 5, Line 47, Column 1	Warning
9	Net Patient Service Revenue (NPSR) must be less than Gross Service Revenue (GPSR)	Tab 5, Line 303, Column 1 should be less than Tab 5, Line 302, Column 1	Warning
10	A negative entry is not allowed for reporting of statistical data such as days and visits.	Tab 5, Line 30 to 46, 47, and 88-101, Column 1 must have positive values	Warning
11	To ensure Filer name is entered	Tab 1, Line 4, Column 1 has not been entered	Warning
12	To ensure Filer title is entered	Tab 1, Line 5, Column 1 has not been entered	Warning
13	To ensure filing certification is entered	Tab 1, Line 14, Column 1 has not been entered	Warning
14	To ensure Distinct Unit Observation Beds data is consistently reported for visits, revenue and expense	Tab 5, Line 92.01, Column 1 Tab 6, Line 92.01, Columns 2 and 3 Tab 9, Line 92.01, Column 6 Tab 13, Line 92.01 Columns 1-23	Warning
15	To ensure data entered for salary and benefits	Tab 4, Salary and Benefit, Line 14 to 19, Column 1 to 6, must have value greater than zero	Warning
16	To ensure GPSR on Tab 5 to GPSR on Tab 6	Tab 5, Line 302, Column 1 should equal to Tab 6, Line 302, Column 1	Warning

	Description of Error	Tab/Line/Column Reference	Type
17	To ensure Ancillary Cost Centers report revenue, expense, and statistics for each applicable line	If Tab 6, Line 500, Column 4 to 30 has a value then the corresponding lines in Tab 9, Lines 50-76, Column 6, must have value and Tab 13, Lines 50-76, Columns 1-23 must have a value	Warning
18	To ensure inpatient cost centers report revenue, expense, and statistics for each applicable line	If Tab 6, Lines 30-46, Column 2 has a value then the corresponding lines in Tab 9, Lines 30-46, Column 6, must have value and Tab 13, Lines 30-46, Columns 1-23 must have a value	Warning
19	To ensure Outpatient and Special Purpose Cost Centers report revenue, expense, and statistics for each applicable line	If Tab 6, Lines 88-117, Column 2 has a value then the corresponding lines in Tab 9, Lines 88-117, Column 6, must have value and Tab 13, Lines 88-117, Columns 1-23 must have a value	Warning
20	To ensure Non-Patient cost centers report revenue, expense, and statistics for each applicable line	If Tab 6, Lines 190-194, Column 2 has a value then the corresponding lines in Tab 9, Lines 190-194, Column 6, must have value and Tab 13, Lines 190-194, Columns 1-23 must have a value	Warning
21	A reminder to hospital to separate Adult and Pediatric inpatient services on the 2552-10 CMS report into inpatient services of a) Medical and Surgical, b) Pediatric and c) Obstetric To ensure Non-Patient cost centers report revenue, expense and statistics for each applicable line	If Tab 3, Line 1, Column 3 has a value and no value in Tab 3, Line 2, Column 3 and / or no value in Tab 3, Line 3, Column 3 then a flag to confirm that the hospital has no service appropriate to reporting on Line 2 and Line 3. If Tab 3, Line 4, Column 3 has a value and no value in Tab 3, Line 5, Column 3 and / or no value in Tab 3, Line 6, Column 3 then a flag to confirm that the hospital has no service appropriate to reporting on Lines 5 and Line 6. If Tab 3, Line 11, Column 3 has a value and no value in Tab 3, Line 12, Column 3 then a flag to confirm that the hospital has no service appropriate to reporting on Line 12. If Tab 3, Line 15, Column 3 has a value and no value in Tab 3, Line 16, Column 3 then a flag to confirm that the hospital has no service appropriate to reporting on Line 16.	Warning
22	To ensure Acute hospitals reports malpractice insurance premium	Tab 1, Line 8, Column 1 text is "Acute" then Tab 4, Lines 31-35, Column 1 must contain a value	Warning

	Description of Error	Tab/Line/Column Reference	Type
23	To ensure the reporting of hospital Outpatient Gross Patient Service Revenue (GPSR)	Tab 5, Line 207, Column 1 must contain a positive value	Warning
24	To ensure the reporting of Net Patient Service Revenue (NPSR) and Premium Revenue for inpatient service	Tab 5, Line 208, Columns 1 to 5 must contain a positive value	Warning
25	To ensure the reporting of Total Net Patient Service Revenue (NPSR) for payers in Column 6 to 14	Tab 5, Line 303, Column 6 to 14 must contain a positive value	Warning
26	To ensure statistics are reported for general service costs	General Service Cost Centers on Tab 9, Lines 1-23, Column 6, there must be corresponding statistics on Tab 13, Column 1 through 23	Warning

Each Fatal error is described below:

	Description of Error	Tab/Line/Column Reference	Type
1	To ensure Tab 7 Reclassifications, increases and decreases net to zero	Tab 7, Line 500, Column 5 must agree with Tab 7, Line 500, Column 9 and Tab 7, Line 500, Column 6 must agree with Tab 7, Line 500, Column 10	Fatal
2	To ensure Non Distinct Unit Observation Bed Visits on Tab 5 is not the same as Non Distinct Observation Bed Days (hours / 365) on Tab 12	Tab 5, Line 92, Column 1 is not the same as Tab 12, Line 4, Column 2	Fatal
4	To ensure Non-Acute hospital reports financial statements	Tab 1, Line 8, Column 1 text is "NonAcute" then Tab 11, Lines 52, 65, 74 and 82, Column 1 must contain values	Fatal
5	To ensure the reporting of Inpatient Gross Patient Service Revenue (GPSR)	Tab 5, Line 206, Column 1 must contain a positive value	Fatal
6	To ensure the matching of GPSR to Expense including capital	If Tab 6, Lines 30 to 46, Column 1 contain a value, then Tab 17, Line 30 to 46, Column 1 must also contain a value	Fatal
7	To ensure the matching of GPSR to Expense excluding capital	If Tab 6, Lines 30 to 46, Column 1 contain a value, then Tab 18, Line 30 to 46, Column 1 must also contain a value	Fatal
8	To ensure the sum of reclassification entries result to a zero	Tab 9, Line 500 Column 4, must contain a zero value	Fatal
9	To ensure cost center line reference is posted for the reclassification increase entry	Tab 7, if there is a value in Column 5 or 6, there must be a line reference in Column 4	Fatal
10	To ensure cost center line reference is posted for the reclassification decrease entry	Tab 7, if there is a value in Column 9 or 10, there must be a line reference in Column 8	Fatal
11	To ensure reclassification entries are related to cost center originated from the Direct Expense Tab.	Tab 7, value in Column 4 and 8 must have corresponding cost center in Tab 9	Fatal
12	To ensure Tab 21 Reclassifications, increases and decreases net to zero	Tab 21, Line 500, Column 3 must agree with Tab 21, Line 500, Column 4 and Tab 21, Line 500, Column 7 must agree with Tab 21, Line 500, Column 8	Fatal

Appendix (B) Comparison of the new Hospital Cost Report to the Former 403 Cost Report

Hospital Cost Report	403 Cost Report	Explanation of Revisions
Cost Centers	Cost Centers	The new cost report utilizes the same cost centers as the CMS-2552-10. In addition, hospitals are required to segregate Adult & Pediatrics (into three cost centers of Medical & Surgical, Pediatrics, and Obstetrics) and Intensive Care (into three centers of Adult, Pediatric and Neonatal). The Subprovider IPF Cost Center must be segregated into two centers of Adult-Psych and Pediatric-Psych and the Nursery Cost Center into two centers of Newborn and Special Care.
Tab 1 Identification and Index	Schedule I: General Information Schedule XXVI: Certification Statement	This Tab contains information that was previously reported on two schedules in the 403. It contains the hospital's information, the preparer's contact information, the certification statement as well as the index.
Tab 2 Summary Schedule of Revenue and Expense	Schedule II: Summary Schedule	This Tab is similar to the 403 Schedule II except that four columns have been eliminated (Non-physician FTE, Physician FTE, Number of Units and Units of Measures). The Tab has the same column and cost center presentation as the 403.
Tab 3 Patient Service Statistical Data	Schedule III: Patient Statistics	Several columns of the 403 statistical data elements are no longer required: weighted average available beds, transfer in/transfer out, and admissions.
Tab 4 Supplementary Information	Schedule IV: Supplementary Information Schedule VB: Medicaid Net Revenue	This Tab eliminates all parts in the 403 Schedule IV, except for FTE, Salary/Benefits, and MassHealth Providers. There is a new section for reporting malpractice expense and FTEs for Physician Assistants and Nurse Practitioners. This Tab also includes the Medicaid Supplement Revenue previously on 403 Schedule VB.
Tab 5 Statistical Data and Revenue by Payer	Schedule VA: Payer Information	Similar layout to the 403.
Tab 6 Gross Patient Service Revenue	Schedule VI: Gross Patient Service Revenue	Similar layout to the 403.
Tab 7	Schedule XI: Preliminary	Similar layout to the 2552 W/S A-6.

Hospital Cost Report	403 Cost Report	Explanation of Revisions
Reclassifications	Adjusting Entries Schedule XIIA & B: Summary of Preliminary Adjusting Entries	
Tab 8 Adjustments	No Equivalent on 403	Similar layout to the 2552 W/S A-8. Hospitals should edit only costs that reduce costs solely to the Medicare's reasonable costs limits.
Tab 9 Direct Expense	Schedule IX: Direct Expenses	Similar layout to the 2552 W/S A.
Tab 10 Reconciliation to Audited Financial Statements	Schedule VIA: Reconciliation of Patient Service Revenue Schedule IXA: Reconciliation of Expenses	This Tab consolidates reconciliation of revenue and expenses to the audited financials.
Tab 11 Financials Statement (Non-Acute Hospital Only)	Schedule XXIIIA-E: Financial Statements (Non-Acute Hospital Only)	This format mirrors CHIA's filing required for acute hospitals.
Tab 12 Allocation of Observation Beds Cost to a Non Distinct Unit	Schedule IIIB: Supplementary Information- Observation Days Schedule XVIIA / XVIIIA, Excluding and Including Capital	This Tab is redesigned to consolidate the calculation of observation bed days and cost allocation to a non-distinct observation unit. Previously, the observation bed day calculation was on 403 Schedule IIIB and the cost allocation was on 403 Schedule XVIIA and XVIIIA.
Tab 13 Statistic for General Cost Stepdown	Schedule XIII: Stepdown Statistics	Similar layout to the 2552 W/S B-1.
Tab 14 Expenses after General Service Costs Stepdown INCLUDING Capital	Schedule XV: Stepdown Expenses Including Capital	Similar to the 403 which provided stepdown of General Service Cost Centers including capital costs.
Tab 15 Expenses after General Service Costs Stepdown EXCLUDING Capital	Schedule XIV: Stepdown Expenses Excluding Capital	Similar to the 403 which provided stepdown of General Service Cost Centers excluding capital costs.
Tab 16 Ancillary Service Statistic (GPSR) for Costs Allocation	Schedule XVI: Patient Service Statistics	Same layout as the 403, but gross patient service revenue is the statistical basis to distribute ancillary service costs as opposed to service units.
Tab 17 Allocation of Ancillary Expenses to IP & OP	Schedule XVIII: Patient Service Expense - Including Capital	Same layout as the 403.

Hospital Cost Report	403 Cost Report	Explanation of Revisions
Routine Cost Centers INCLUDING Capital		
Tab 18 Allocation of Ancillary Expenses to IP & OP Routine Cost Centers EXCLUDING Capital	Schedule XVII: Patient Service Expense - Excluding Capital	Same layout as the 403.
Tab 19 340B Pharmacy Schedule	Schedule XXVIII: 340B Annual Pharmacy Reporting	No change.
Tab 20 Physician Compensation	Schedule XXV: Physician Compensation	The Physician Compensation Tab was redesigned to include the compensation classifications from the 2552. All physician compensation must be reported on this schedule.
Tab 21 Reclassification of Organ Acquisition to Inpatient from Special Purpose Cost Centers	No Equivalent on 403	This new Tab allows organ acquisition costs to be reclassified from the Special Purpose Cost center to Inpatient Cost Centers, consistent with the 2552 report.
No Equivalent on new report	Schedule IIIA, Reconciliation of Patient Days Schedule VII, Other Income and Recovery of Expense Schedule VIIA, Amortization of Gains and Losses Schedule VIIB, Supplementary Other Income and Recovery of Expenses Schedule VIIC, Reconciliation of Other Income Schedule VIII, Specific Free Care Income Schedule X, Summary of Non-Patient Expenses	Not required in the new report

Appendix (C) XML Schema for Intake

Report Identification

Each XML Submission must start with the version control number and the encoding ID followed by the report name. The initial XML versioning will be 1, until newer versions are needed. When this happens, notifications will be presented by Administrative Bulletin.

```
Report Header
        <?xml version="1.0" encoding="utf-8"?>
        <MHCR>…….</MHCR>
```

Hospital Identification and reporting year

Each XML submission must include the below information about the filing. Each submitted XML file may only contain information for one hospital.

- Organization ID
- Hospital Name
- Filing Year

```
Hospital ID and Reporting year
        <Organization>
                <Orgid>5423</Orgid>
                <Name>Hospital Name</Name>
        </Organization>
        <FilingYear>2016</FilingYear>
```

Cost Report Data

Tab Data

Each tab will be delimitated by `<Tab>……</Tab>`.
Tab name and tab number are required for the start of each tab.

```
Tab Name and Year
<Name>Statistic for General Cost Stepdown</Name>
                <TabID ID="13"></TabID>
```

Row/Column data

The XML schema is row centric with each row delimited by
`<SeqNumber ID ="#">……</SeqNumber>`.

SeqNumber surrounds major or parent rows, all sub-rows remain between their parent seqNumberID. SeqNumber starts at 1 regardless of row number and restarts on each tab.

The standard tag structure for value is SeqNumber, RowID, ColumnID then Value.

```
Standard Value Structure

        <SeqNumber ID ="1">
         <RowID ID ="4"></RowID>
          <ColumnID ID ="4"></ColumnID>
          <Value>532456</Value>
        </SeqNumber>
```

Note: For any null or zero values, column and row data does not need to be sent unless column or row value has any of the below listed modifiers.

Row/Column Modifiers

There are many case in the report that require information beyond the standard structure, in this case modifier tags are required.

Tag	Use
<RowName></RowName>	Alters or adds name to row or sub row.
<HCRIS></HCRIS>	Add HCRIS to given row
<ColumnName></ColumnName>	Alters or adds column name
<SubColumnName Name =""></SubColumnName>	Only used on Tab 13 to add allocation method text
<SubColumn></SubColumn>	Indicates the following tags are part of a sub column connected to parent.
<SubRow></SubRow>	Indicates the following tags are part of a sub row connected to parent.

```
Row with Altered Name
               <SeqNumber ID ="2">
                      <RowID ID ="98"></RowID>
                      <HCRIS>05950</HCRIS>
                      <RowName>Infusion &amp; Respiratory Services </RowName>
                      <ColumnID ID ="1"></ColumnID>
                      <Value>545234</Value>
                      <ColumnID ID ="2"></ColumnID>
                      <Value>58764</Value>
               </SeqNumber>
```

Row and Sub Row with Altered Names


```
<SeqNumber ID ="3">
 <RowID ID ="98">
       <HCRIS>05950</HCRIS>
       <RowName>Infusion &amp; Respiratory Services</RowName>
       <ColumnID ID ="1"></ColumnID>
       <Value>154856</Value>
       <ColumnID ID ="2"></ColumnID>
       <Value>125456</Value>
        <SubRow>
              <SubRowID>98.01</SubRowID>
              <HCRIS>05951</HCRIS>
              <RowName>Employee Assistance Program</RowName>
              <ColumnID ID ="1"></ColumnID>
              <Value>145566</Value>
              <ColumnID ID ="2"></ColumnID>
              <Value>157968</Value>
       </SubRow>
   </RowID>
</SeqNumber>
```


Row with sub column


```
<SeqNumber ID ="4">
 <RowID ID = "4"></RowID>
   <ColumnID ID ="23">
   <SubColumn>
   <SubColumnID>23.01</SubColumnID>
   <ColumnName>Clinical Pastoral Education</ColumnName>
   <Value>-1348127</Value>
</SubColumn>
<SubColumn>
  <SubColumnID>23.02</SubColumnID>
  <ColumnName>Pharmacy Education Program</ColumnName>
  <Value>-1348127</Value>
</ColumnID>
</SubColumn>
```

Sub Rows with Sub Columns


```xml
<SeqNumber ID = "4">
   <RowID ID ="23">
         <subrow>
              <subrowID>23.01</subrowID>
              <HCRIS>02301</HCRIS>
              <RowName>Clinical Pastoral Education</RowName>
              <ColumnID ID ="23">
                <SubColumn>
                  <SubColumnID>23.01</SubColumnID>
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                  <Value>12453</Value>
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  </RowID>
</SeqNumber>
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XML for Massachusetts Cost Report

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    <CHIAOrgID></CHIAOrgID>
    <CHIAOrgName></CHIAOrgName>
       <FilingYear></FilingYear>
  </Organization>
  <Tab TabID="">
    <!-- With Row and Column-->
    <Sequence SeqID="">
      <Row RowID="">
        <HCRIS></HCRIS>
        <RowName>(Optional)</RowName>
        <Column ColumnID="">
          <ColumnName>(Optional)</ColumnName>
          <ColumnValue></ColumnValue>
      </Row>
       </Sequence>
    <!-- With Row, Column, and SubColumn -->
    <Sequence SeqID="">
    <Row RowID="">
      <HCRIS></HCRIS>
      <RowName>(Optional)</RowName>
      <Column ColumnID="">
        <ColumnName>(Optional)</ColumnName>
        <ColumnValue></ColumnValue>
        <SubColumn SubColumnID="">
          <SubColumnName>SubColumn (Mandatory)</SubColumnName>
          <SubColumnValue></SubColumnValue>
        </SubColumn>
      </Column>
    </Row>
       </Sequence>
    <!-- With Row, SubRow, and Column-->
    <Sequence SeqID="">
      <Row RowID="">
      <HCRIS></HCRIS>
      <RowName>(Optional)</RowName>
        <SubRow SubRowID="">
        <SubRowName>SubRow (Mandatory)</SubRowName>
        <Column ColumnID="">
          <ColumnName>(Optional)</ColumnName>
          <ColumnValue></ColumnValue>
        </Column>
      </SubRow>
    </Row>
       </Sequence>
    <!-- With Row, SubRow, Column, and SubColumn-->
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    <Row RowID="">
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      <RowName>(Optional)</RowName>
      <SubRow SubRowID="">
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            <SubColumnName>SubColumn (Manditory)</SubColumnName>
```

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        </Column>
      </SubRow>
    </Row>
       </Sequence>
     </Tab>
</MHCR>
```