
Medicare

Provider Reimbursement Manual

Part 2, Provider Cost Reporting Forms and Instructions, Chapter 40, Form CMS-2552-10

Department of Health and Human Services (DHHS)
Centers for Medicare and Medicaid Services (CMS)

Transmittal 11

Date: September 29, 2017

<u>HEADER SECTION NUMBERS</u>	<u>PAGES TO INSERT</u>	<u>PAGES TO DELETE</u>
4011.4 - 4012(Cont.)	40-76.1 - 40-80.2 (8pp.)	40-76.1 - 40-80 (6 pp.)
4095(Cont.) - 4095(Cont.)	40-751 - 40-751.1 (2pp.)	40-751 - 40-751.1 (2pp.)
4095(Cont.) - 4095(Cont.)	40-823 - 40-824 (2pp.)	40-823 - 40-824 (2pp.)

CLARIFIED/UPDATED MATERIAL—EFFECTIVE DATE: Cost Reporting Periods Beginning On or After October 1, 2013.

This transmittal updates Chapter 40, section 4012, Worksheet S-10 - Hospital Uncompensated and Indigent Care Data, adding the statutory authority relative to uncompensated care payments and EHR incentive payments. This transmittal clarifies the definitions and instructions for uncompensated care, non-Medicare bad debt, non-reimbursed Medicare bad debt, and charity care to include uninsured discounts, as well as modifies the calculation relative to uncompensated care costs.

Revisions include:

- Worksheet S-10:
 - Revised the instructions for line 20 for subsection (d) Puerto Rico hospitals, charity care and uninsured discounts.
 - Modified the calculation and clarified the instructions on line 21, column 2, for insured patients and non-covered charges for insured patients for days exceeding a length-of-stay limit.
 - Clarified the instructions for line 22.
 - Clarified that the amount reported on line 26 is net of recoveries.
 - Added line 27.01 to capture Medicare allowable bad debt for the entire facility.
 - Modified the instructions for line 28 to only capture the non-Medicare bad debt expense.
 - Modified the calculation for line 29.
- New Edits
 - 14005S, 14010S, 14015S, 14020S.

DISCLAIMER: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged.

CMS-Pub. 15-2-40

CHAPTER 40
HOSPITAL AND HOSPITAL
HEALTH CARE COMPLEX COST REPORT
FORM CMS-2552-10

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4012. Worksheet S-10 - Hospital Uncompensated and Indigent Care Data--Section 112(b) of the Balanced Budget Refinement Act (BBRA) requires that short-term acute care hospitals (§1886(d) of the Act) submit cost reports containing data on the cost incurred by the hospital for providing inpatient and outpatient hospital services for which the hospital is not compensated. Charity care charge data, as referenced in section 4102 of American Recovery and Reinvestment Act of 2009, may be used to calculate the EHR technology incentive payments made to §1886(d) hospitals and CAHs. *Section 1886(n)(6)(B) of the Act, as added by section 602 of Consolidated Appropriations Act, 2016 adds subsection (d) Puerto Rico hospitals as eligible hospitals under the EHR incentive program. In addition, section 1886(r)(2) of the Act, as added by section 3133 of the ACA, requires an additional payment for uncompensated care for 1886(d) DSH eligible hospitals. Charity care charge data, discounts given to uninsured patients that meet the hospital's financial assistance policy/uninsured discount policy (hereinafter referred to as "financial assistance policy" or FAP), non-Medicare bad debt, and non-reimbursed Medicare bad debt may be used in the calculation of the uncompensated care payment.* Section 1886(d) hospitals and CAHs are required to complete this worksheet.

Definitions:

Uncompensated care--Consists of charity care, non-Medicare bad debt, and non-reimbursable Medicare bad debt. Uncompensated care does not include courtesy allowances, discounts given to patients *that do not meet the hospital's charity care policy, or discounts given to uninsured patients that do not meet the hospital's FAP,* or bad debt reimbursed by Medicare.

Charity Care and Uninsured Discounts--Charity care *and uninsured discounts* result from a hospital's policy to provide all or a portion of services free of charge to patients who meet the hospital's charity care policy or FAP. *Charity care and uninsured discounts can include full or partial discounts. If a patient is not eligible for discounts under the hospital's charity care policy or FAP, then any discounts or reductions given to the standard managed care rate must not be accounted for as charity care or an uninsured discount. Discounts given to patients for prompt payment must not be included as charity care.* For Medicare purposes, charity care is not reimbursable and unpaid amounts associated with charity care are not considered as an allowable Medicare bad debt. A hospital cannot claim *as charity care* amounts of unpaid deductibles and co-insurance for which it has received reimbursement from Medicare (reimbursed Medicare bad debt). (Additional guidance provided in the instruction for line 20.)

Non-Medicare bad debt--*Charges for* health services for which a hospital determines the non-Medicare patient has *a financial responsibility* to pay, but the non-Medicare patient *does not pay.* *These amounts are subject to the cost-to-charge ratio (CCR).* (Additional guidance provided in the instructions for lines 28 and 29.)

Medicare bad debt--*When furnishing services to a Medicare beneficiary, a provider incurs costs in furnishing such covered services. A Medicare beneficiary may be responsible for paying a share of those costs as part of their applicable deductible and/or coinsurance amounts. When a Medicare beneficiary, or other responsible party, fails to pay the deductible and/or coinsurance amounts, the provider has incurred costs of furnishing services that are unrecovered. If the unpaid deductible and coinsurance amounts meet the criteria of 42 CFR 413.89, then these amounts may be allowable as Medicare bad debt (see CMS Pub. 15-1, chapter 3). Amounts reimbursed as a Medicare bad debt cannot be claimed as charity care.*

Non-reimbursable Medicare bad debt--The amount of allowable Medicare coinsurance and deductibles considered to be uncollectible but are **not** reimbursed by Medicare under the requirements of 42 CFR 413.89(h) and CMS Pub. 15-1, chapter 3. (Additional guidance provided in the instructions for lines 27 and 27.01.)

Net revenue--Actual payments received or expected to be received from a payer (including co-insurance payments from the patient) for services delivered during this cost reporting period. Net revenue will typically be charges (gross revenue) less contractual allowance. (Applies to lines 2, 9, and 13.)

Public Programs--Federal, State, and/or local government programs paying, in full or in part, for health care (e.g., Medicare, Medicaid, CHIP and/or other Federal, State, or locally operated programs).

Instructions:

Cost-to-charge ratio:

Line 1--Enter the **CCR** resulting from Worksheet C, Part I, line 202, column 3, divided by Worksheet C, Part I, line 202, column 8.

For all inclusive rate no-charge-structure providers, enter your ratio as calculated in accordance with CMS Pub. 15-1, chapter 22, §2208.

Medicaid:

NOTE: The amount on line 18 must not include the amounts on lines 2 and 5. That is, the amounts on lines 2 and 5 are mutually exclusive from the amount on line 18.

Line 2--Enter the inpatient and outpatient payments received or expected for title XIX covered services delivered during this cost reporting period. Include payments for an expansion Children's Health Insurance Program (CHIP) program, which covers recipients who would have been eligible for coverage under title XIX. Include payments for all covered services except physician or other professional services, and include payments received from Medicaid managed care programs. If not separately identifiable, disproportionate share (DSH) and supplemental payments are included in this line. For these payments, report the amount received or expected for the cost reporting period, net of associated provider taxes or assessments.

Line 3--Enter "Y" for yes if you received or expect to receive any DSH or supplemental payments from Medicaid relating to this cost reporting period. Otherwise enter "N" for no.

Line 4--If you answered yes to question 3, enter "Y" for yes if all of the DSH or supplemental payments you received from Medicaid are included in line 2. Otherwise enter "N" for no and complete line 5.

Line 5--If you answered no to question 4, enter the DSH or supplemental payments the hospital received or expects to receive from Medicaid relating to this cost reporting period that were not included in line 2, net of associated provider taxes or assessments.

Line 6--Enter all charges (gross revenue) for title XIX covered services delivered during this cost reporting period. These charges relate to the services for which payments were reported on line 2.

Line 7--Calculate the Medicaid cost by multiplying line 1 times line 6.

Line 8--Enter the difference between net revenue and costs for Medicaid by subtracting the sum of lines 2 and 5 from line 7. If line 7 is less than the sum of lines 2 and 5, then enter zero.

Children's Health Insurance Program:

Line 9--Enter all payments received or expected for services delivered during this cost reporting period that were covered by a stand-alone CHIP program. Stand-alone CHIP programs cover recipients who are not eligible for coverage under title XIX. Include payments for all covered services except physician or other professional services, and include any payments received from CHIP managed care programs.

Line 10--Enter all charges (gross revenue) for services delivered during this cost reporting period that were covered by a stand-alone CHIP program. These charges relate to the services for which payments were reported on line 9.

Line 11--Calculate the stand-alone CHIP cost by multiplying line 1 times line 10.

Line 12--Enter the difference between net revenue and costs for stand-alone CHIP by subtracting line 9 from line 11. If line 11 is less than line 9, then enter zero.

Other state or local indigent care program:

Line 13--Enter all payments received or expected for services delivered during this cost reporting period for patients covered by a state or local government indigent care program (other than Medicaid or CHIP), where such payments and associated charges are identified with specific patients and documented through the provider's patient accounting system. Include payments for all covered services except physician or other professional services, and include payments from managed care programs.

Line 14--Enter all charges (gross revenue) for services delivered during this cost reporting period for patients covered by a state or local government program, where such charges and associated payments are documented through the provider's patient accounting system. These charges should relate to the services for which payments were reported on line 13.

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

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

Grants, donations and total unreimbursed cost for Medicaid, CHIP, and state/local indigent care:

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

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

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

Uncompensated care:

For each line 20 through 23, enter in column 3, the sum of columns 1 and 2.

Line 20--

For cost reporting periods beginning prior to October 1, 2016, and for subsection (d) Puerto Rico hospitals under 1886(n)(6)(B) beginning on or after October 1, 2016:

Enter the total initial payment obligation, measured at full charges, *for patients, including uninsured patients*, who are given a full or partial discount based on the hospital's charity care policy or FAP for *healthcare services* delivered during this cost reporting period for the entire facility. Include charity care/FAP charges for all services except physician and other professional services. Do not include charges for patients given courtesy allowances.

Enter in column 1, the full charges for uninsured patients and patients with coverage from an entity that does not have a contractual relationship with the provider. *In addition, enter in column 1, charges for non-covered services provided to patients eligible for Medicaid or other indigent care programs if such inclusion is specified in the hospital's charity care policy or FAP and the patient meets the hospital's policy criteria.* Enter in column 2, the deductible and coinsurance payments required by the payer for insured patients covered by a public program or private insurer with which the provider has a contractual relationship that were written off to charity care. *In addition, enter in column 2, non-covered charges for days exceeding a length-of-stay limit for patients covered by Medicaid or other indigent care programs if such inclusion is specified in the hospital's charity care policy or FAP and the patient meets the hospital's policy criteria.* Do not include in column 2 amounts of deductible and coinsurance claimed as Medicare bad debt. *For columns 1 and 2, do not reduce charges by any payments made for the patient liability; instead report these amounts on line 22.*

For cost reporting periods beginning on or after October 1, 2016:

Enter the actual charge amounts for the entire facility (except physician and other professional services), *of uninsured patients who were given a full or partial discounts* that were: (1) determined in accordance with the hospital's charity care policy *or FAP*, and (2) *written off* during this cost reporting period, regardless of when the services were provided. Do not include charges for patients given courtesy discounts or charges for uninsured patients with or without full or partial discounts who do not meet the hospital's charity care criteria *or FAP*. Charges for non-covered services provided to patients eligible for Medicaid or other indigent care programs (including charges for days exceeding a length-of-stay limit) can be included, if such inclusion is specified in the hospital's charity care policy *or FAP* and the patient meets the hospital's *policy* criteria.

Enter in column 1, the total charges, or the portion of the total charges, written off to charity care, for uninsured patients, and patients with coverage from an entity that does not have a contractual relationship with the provider *who meet the hospital's charity care policy or FAP.* *In addition, enter in column 1, charges for non-covered services provided to patients eligible for Medicaid or other indigent care programs, if such inclusion is specified in the hospital's charity care policy or FAP and the patient meets the hospital's policy criteria.* The *total charges or the portion of total charges* is the amount the patient is not responsible for paying (e.g., 100% of charges if the patient qualified for 100% discount or 70% of charges if the patient qualified for a 70% partial discount).

Enter in column 2, the deductible and coinsurance payments required by the payer for insured patients covered by a public program or private insurer with which the provider has a contractual relationship that were written off to charity care. *In addition, enter in column 2, the non-covered charges for days exceeding a length-of-stay limit for patients covered by Medicaid or other indigent care programs if such inclusion is specified in the hospital's charity care policy or FAP and the patient meets the hospital's policy criteria.* Do not include in column 2 amounts of deductible and coinsurance claimed as Medicare bad debt.

Note: When reporting charity care or uninsured discounts for cost reporting periods beginning on or after October 1, 2016, amounts a hospital received for charity care charges reported on line 20 of a prior cost reporting period and not reported on line 22 of a prior cost reporting period, must be offset on line 22 of the current cost report. Lines 20 and 22 must be completed independently. Do not record on line 20 net charity care charges; line 20 must include all charges and line 22 must include all receipts.

Column 3: Enter the sums of columns 1 and 2.

Line 21--Enter in column 1, the cost of patients approved for charity care and uninsured discounts by multiplying line 20, column 1, times the CCR on line 1. Enter in column 2, the deductibles and coinsurance not subject to the CCR on line 1 (line 20 minus line 25) plus the non-covered charges for insured patients for days exceeding a length-of-stay limit that are subject to the CCR on line 1 (line 25 multiplied by line 1).

Line 22--For cost reporting periods beginning prior to October 1, 2016, and for subsection (d) Puerto Rico hospitals under 1886(n)(6)(B) beginning on or after October 1, 2016, enter payments received or expected to be received from patients who have been approved for charity care or uninsured discounts for healthcare services delivered during this cost reporting period. Include such payments for all services except physician or other professional services. Payments from payers should not be included on this line. Use column 1 for uninsured patients and patients with coverage from an entity that does not have a contractual relationship with the provider, and use column 2 for patients covered by a public program or private insurer with which the provider has a contractual relationship.

For cost reporting periods beginning on or after October 1, 2016, charity care charges or uninsured discounts reported on line 20 include amounts written off with no expectation of payment. Enter all payments received during this cost reporting period, regardless of when the services were provided, from patients for amounts previously written off on line 20 as charity care or uninsured discounts. Enter such payments for the entire facility, except physician or other professional services. Use column 1 for payments received from uninsured patients and patients with coverage from an entity that does not have a contractual relationship with the provider, and use column 2 for payments received from patients covered by a public program or a private insurer with which the provider has a contractual relationship. Do not include grants or other mechanisms of funding for charity care on line 22. Payments entered on this line must not exceed charity care or uninsured discount amounts written off in the cost reporting period. Do not include payments received that represent a patient's liability, or amounts that were not previously written off on line 20 as charity care or uninsured discounts.

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

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

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

Line 26--Enter the total facility (entire hospital complex) amount of bad debts (*Medicare bad debts and non-Medicare bad debts*), *net of recoveries*, written off during this cost reporting period on balances owed by patients regardless of the date of service. Include such bad debts for all services except physician and other professional services. Amounts from line 20 above must not be included here. The amount reported must also include the amounts reported on Worksheets: E, Part A, line 64; E, Part B, line 34; E-2, line 17, columns 1 and 2; E-3, Part I, line 11; E-3, Part II, line 23; E-3, Part III, line 24; E-3, Part IV, line 14; E-3, Part V, line 25; E-3, Part VI, line 8; E-3, Part VII, line 34; I-5, line 5 (line 5.05, column 2 for cost reporting periods that overlap or begin on or after January 1, 2011); J-3, line 21; M-3, line 23; and N-4, line 9. For privately insured patients, do not include bad debts that were the obligation of the insurer rather than the patient.

Line 27--Enter the total facility (entire hospital complex) Medicare reimbursable (also referred to as adjusted) bad debts, *pursuant to 42 CFR 413.89(h)*, as the sum of Worksheets: E, Part A, line 65; E, Part B, line 35; E-2, line 17, columns 1 and 2 (line 17.01, columns 1 and 2 for cost reporting periods that begin on or after October 1, 2012); E-3, Part I, line 12; E-3, Part II, line 24; E-3, Part III, line 25; E-3, Part IV, line 15; E-3, Part V, line 26; E-3, Part VI, line 10; I-5, line 11; J-3, line 21 (line 22 for cost reporting periods that begin on or after October 1, 2012); M-3, line 23 (line 23.01 for cost reporting periods that begin on or after October 1, 2012); and N-4, line 10.

Line 27.01--Enter the total facility (entire hospital complex) Medicare allowable bad debts as the sum of Worksheets: E, Part A, line 64; E, Part B, line 34; E-2, line 17, columns 1 and 2; E-3, Part I, line 11; E-3, Part II, lines 23; E-3, Part III, line 24; E-3, Part IV, line 14; E-3, Part V, line 25; E-3, Part VI, line 8; I-5, line 5.05, column 2; J-3, line 21; M-3, line 23; and N-4, line 9. *The amount entered on this line must also be included in the amount on line 26.*

Line 28--Calculate the *non-Medicare bad debt* expense by subtracting line 27.01 from line 26.

Line 29--Calculate the cost of non-Medicare and non-reimbursable Medicare bad debt expense. *The cost of non-Medicare bad debt expense is calculated by multiplying line 28 by the CCR on line 1. The cost of non-reimbursable Medicare bad debt expense is calculated by subtracting line 27 from line 27.01 (this amount is not multiplied by the CCR on line 1). Enter the sum of the non-Medicare bad debt expense and the non-reimbursable Medicare bad debt expense.*

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

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

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