Understanding the Medicare Cost Report

Purpose: This tool is intended to help hospitals understand the key areas of the Medicare cost report (MCR) that HRSA reviews when determining hospital eligibility for the 340B Program.

Background: HRSA uses a hospital's Medicare cost report to validate parent hospital (covered entity) and off-site outpatient facility (child site) 340B Program eligibility during 340B Program registration, reinstatements, recertification, and program audits. This tool outlines areas of the MCR that are used to verify hospital:

- CMS provider information
- Eligibility as a 340B covered entity
- Off-site outpatient facility eligibility for child site registration
- Entity-owned pharmacy eligibility as a shipping address

Medicare Cost Report Worksheets

Worksheet	Information Used by HRSA	Statutory Requirement or HRSA Guidance
Worksheet S, Parts I, II, & III	**Cost report filing information** (provider number, dates, signature): • Provider CMS Certification Number (CCN) (formerly known as the Medicare Provider Number) • Period From____ To____ (cost reporting period) • Part I – Cost Report Status Date, Time (cost report filing date and time) • Part II – Certification (hospital official certification statement and **encrypted** signature along with encrypted signature stamp – wet signature not acceptable)	**Section 340B, subsection (a)(4) of the Public Health Service Act**[1] describes the requirements to meet the definition of "covered entity," including CMS hospital classifications and information obtained from the most recent cost reporting period.
Worksheet S-2, Part I	**Parent hospital information** (address, control type, and CMS designation): • Lines 1 and 2 – Hospital and Hospital Health Care Complex Address • Line 21 – Type of Control • Line 35 – Indicates CMS designation as a Sole Community Hospital (SCH) • Line 105 – Indicates CMS designation as a Critical Access Hospital (CAH)	**Section 340B, subsections (a)(4)(L)(i), (M), (N), and (O) of the Public Health Service Act** describes the 340B eligibility requirement for a hospital to be: Owned or operated by a unit of State or local government, A public or private non-profit corporation which is formally granted governmental powers by a unit of State or local government, OR A private non-profit hospital which has a contract with a State or local government to provide health care services to low-income individuals who are not entitled to benefits under Medicare or Medicaid

[1] Section 340B of the Public Health Service Act, https://www.hrsa.gov/sites/default/files/hrsa/rural-health/phs-act-section-340b.pdf, accessed on 7/14/2022.

Worksheet	Information Used by HRSA	Statutory Requirement or HRSA Guidance
	• Line 116 – Indicates CMS designation as a Rural Referral Center (RRC)	Additional supporting documentation may be required to confirm the hospital meets one of the three eligibility criteria above. Examples of additional supporting documentation confirming the above requirements are outlined in **HRSA's 340B Program Hospital Registration Instructions**[2].
Worksheet E, Part A	**Hospital's disproportionate share hospital percentage** (DSH%) • Line 33 – Allowable disproportionate share percentage	**Section 340B, subsections (a)(4)(L)(ii), (M), and (O) of the Public Health Service Act** describe the minimum disproportionate share adjustment percentage (%) required for each hospital covered entity type: • DSH, CAN, and PED: DSH% > 11.75% • SCH and RRC: DSH% ≥ 8% The above requirements are confirmed in **HRSA's 340B Program Hospital Registration Instructions**. In addition, children's hospitals (PED) that file a Medicare cost report may use the data within Worksheet S-3 to calculate their DSH% (Worksheet S-3, Part I, lines 2 and 14 may be used to calculate the Disproportionate Patient Percentage [DPP]).
Worksheet A	**Expenses** for hospital cost centers: • Column 7 – Net Expenses for Allocation	**HRSA's 1994 Outpatient Hospital Facilities Guidelines**[3] state that off-site outpatient facilities must be listed as reimbursable on the hospital's most recently filed Medicare cost report and have associated outpatient expenses and charges in order to be eligible to register for the 340B Program as a child site.
Worksheet C	**Charges** for hospital cost centers: • Column 7 – Charges / Outpatient	**HRSA's 340B Program Hospital Registration Instructions** state that "if the costs and charges from more than one clinic, service or facility are rolled up to a single cost center, you will need the specific costs and charges from the working trial balance" for registration. See Appendix A for an example of a trial balance, and Appendix B for an example of how to register multiple departments that role up to a single line on the cost report as separate child sites.

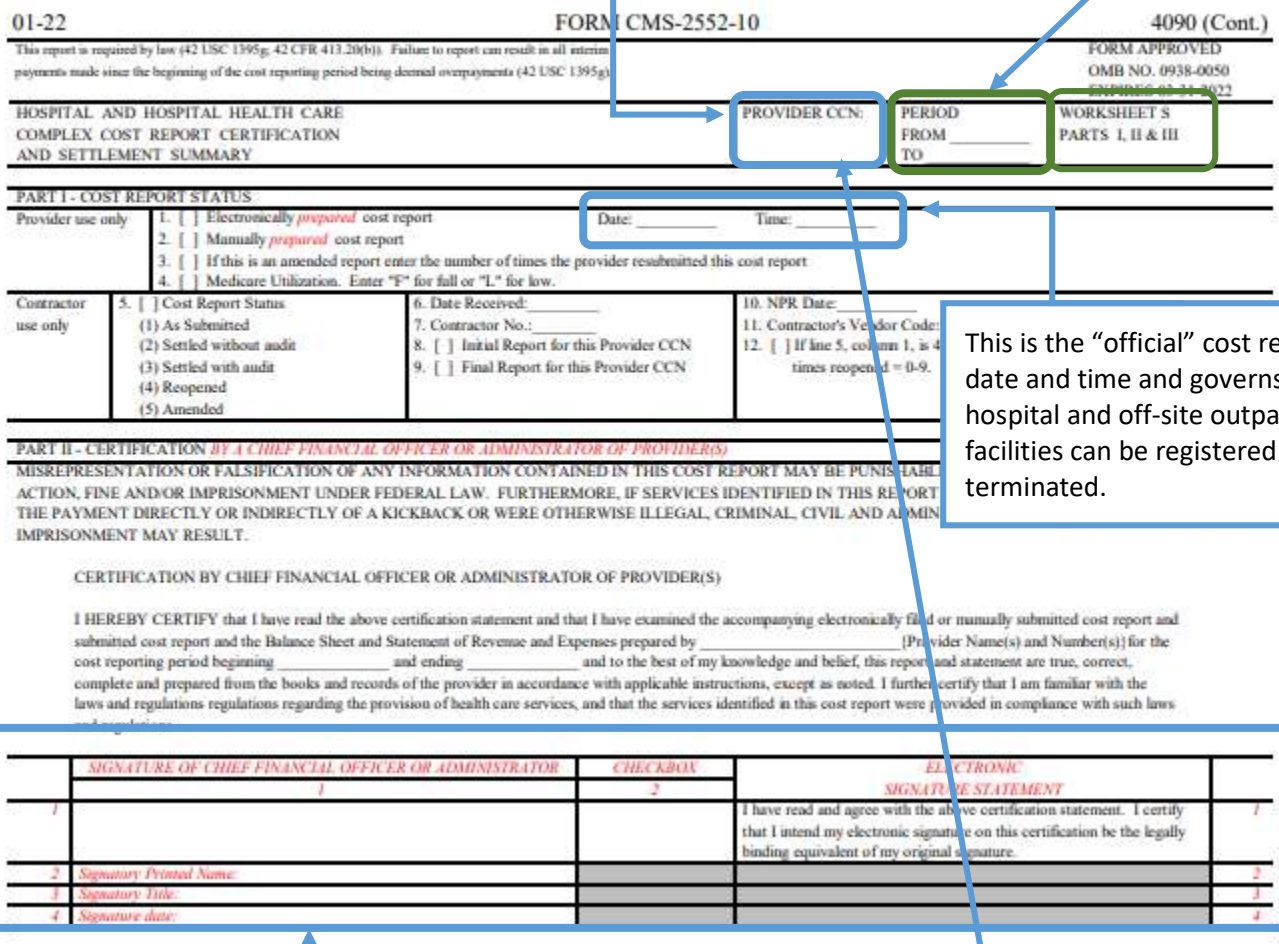
The images within Appendix A below provide additional details about what HRSA looks for when reviewing a hospital's Medicare cost report. Appendix B provides an example of how to use the hospital's Medicare cost report to identify the necessary values to input into 340B OPAIS during a child site registration.

[2] Health Resources and Services Administration (HRSA) 340B Program Hospital Registration Instructions, updated 2/11/2019, https://www.hrsa.gov/sites/default/files/hrsa/opa/hospital-registration-instruction-details.pdf, accessed on 7/14/2022.
[3] Health and Human Services (HHS) Notice Regarding Section 602 of the Veterans Health Care Action of 1992 Outpatient Hospital Facilities, Fed Reg. Vol 59, No. 180, September 19, 1994, https://www.hrsa.gov/sites/default/files/hrsa/opa/outpatient-hospital-facilities-09-1994.pdf, accessed on 7/14/2022.

Worksheet S, Parts I, II, & III

Only sites billing using this provider CCN may be registered as child sites under this parent hospital.

The cost reporting period should represent the most recently completed period and all worksheets must be for the same cost reporting period.



01-22 FORM CMS-2552-10 4090 (Cont.)

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

PROVIDER CCN: | PERIOD FROM _____ TO _____ | WORKSHEET S PARTS I, II & III

PART I - COST REPORT STATUS

Provider use only

1. [ ] Electronically *prepared* cost report
2. [ ] Manually *prepared* cost report
3. [ ] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [ ] Medicare Utilization. Enter "F" for full or "L" for low.

Date: _____ Time: _____

Contractor use only

5. [ ] Cost Report Status
(1) As Submitted
(2) Settled without audit
(3) Settled with audit
(4) Reopened
(5) Amended

6. Date Received: _____
7. Contractor No.: _____
8. [ ] Initial Report for this Provider CCN
9. [ ] Final Report for this Provider CCN

10. NPR Date: _____
11. Contractor's Vendor Code: _____
12. [ ] If line 5, column 1, is 4 times reopened = 0-9.

PART II - CERTIFICATION *BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)*

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR RELATED TO THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTIONS, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by _____ {Provider Name(s) and Number(s)} for the cost reporting period beginning _____ and ending _____ and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR 1	*CHECKBOX* 2	*ELECTRONIC SIGNATURE STATEMENT*	
1			I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	*Signatory Printed Name:*			2
3	*Signatory Title:*			3
4	*Signature date:*			4

This is the "official" cost report filing date and time and governs when a hospital and off-site outpatient facilities can be registered or will be terminated.

The Hospital Chief Financial Officer or Administrator must use an encrypted signature for Worksheet certification (wet signature not sufficient). The encrypted signature date and time must match the date/time prepared on all worksheets.

Note: Certain facility types are identified by the following numbering convention in their provider CCN:

- Childrens (PED): ##-33##
- Critical Access (CAH): ##-13##

Worksheet S-2, Part I

4090 (Cont.) FORM CMS-2552-10 01-22

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | PROVIDER CCN: | PERIOD FROM ____ TO ____ | WORKSHEET S-2 PART I

Hospital and Hospital Health Care Complex Address:

1	Street:	P.O. Box:			1
2	City:	State:	ZIP Code:	County:	2

Hospital and Hospital-Based Component Identification:

	Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	Hospital									3
4	Subprovider- IPF									4
5	Subprovider- IRF									5
6	Subprovider- (Other)									6
7	Swing Beds-SNF									7
8	Swing Beds-NF									8
9	Hospital-Based SNF									9
10	Hospital-Based NF									10
11	Hospital-Based OLTC									11
12	Hospital-Based HHA									12
13	Separately Certified ASC									13
14	Hospital-Based Hospice									14
15	Hospital-Based Health Clinic-RHC									15
16	Hospital-Based Health Clinic-FQHC									16
17	Hospital-Based (CMHC, CORF and OPT)									17
18	Renal Dialysis									18
19	Other									19
			To:							20
21	Type of control (see instructions)									21

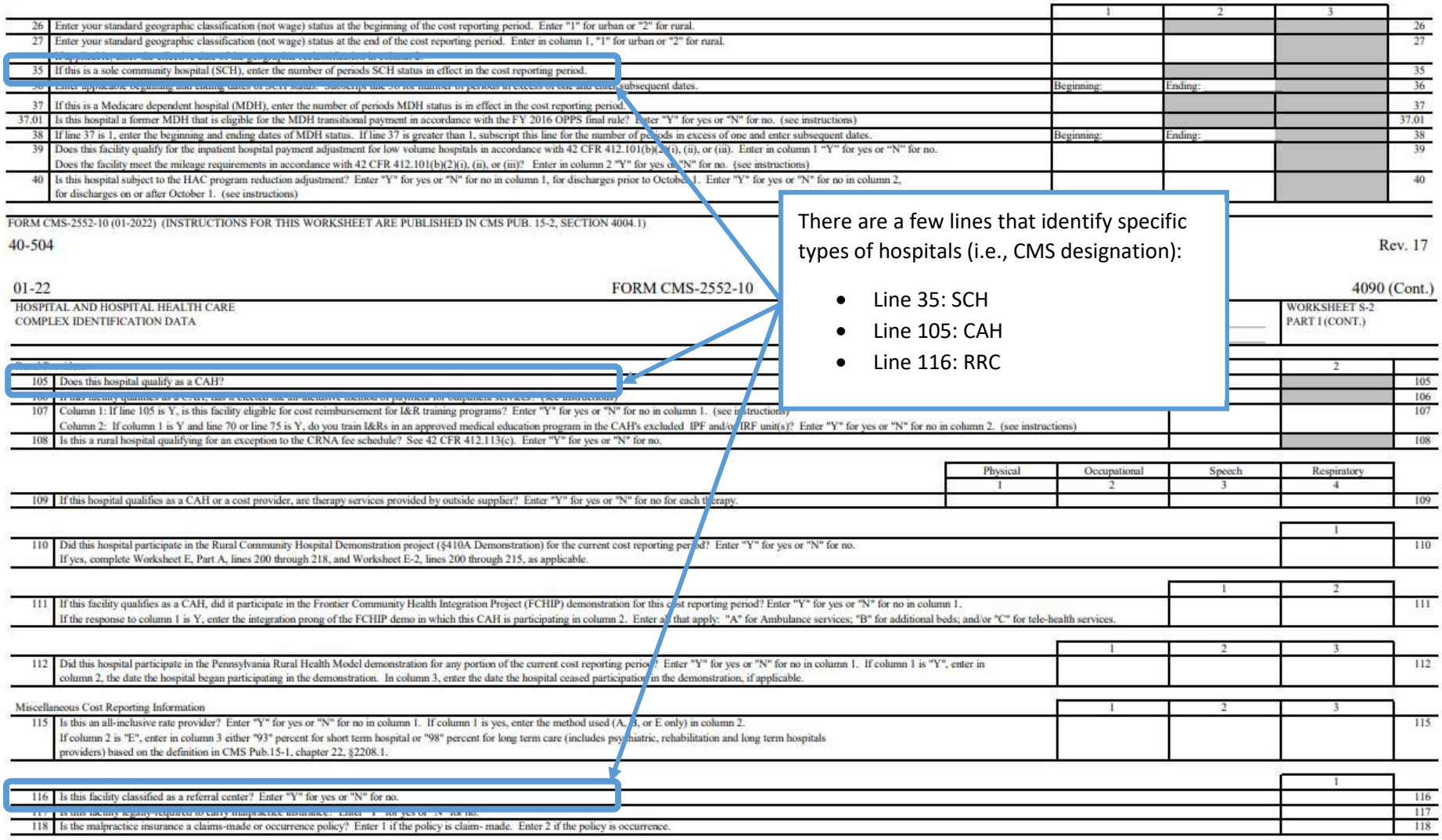
This is the address of the parent hospital. Any service with a different physical address needs to be individually registered as a child site on 340B OPAIS.

The type of control is taken from the CMS Hospital Cost Report Information System (HCRIS) and indicates the hospital's classification or designation. Control type options for line 21 are listed here. Control types 3-6 are not eligible to register for the 340B Program.

Line 21--Indicate the type of control under which the hospital operates:

1 = Voluntary Nonprofit, Church
2 = Voluntary Nonprofit, Other
3 = Proprietary, Individual
4 = Proprietary, Corporation
5 = Proprietary, Partnership
6 = Proprietary, Other
7 = Governmental, Federal
8 = Governmental, City-County
9 = Governmental, County
10 = Governmental, State
11 = Governmental, Hospital District
12 = Governmental, City
13 = Governmental, Other

Worksheet S-2, Part I (continued)



		1	2	3	
26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.				26
27	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural.				27
35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.				35
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:		36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.				37
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with the FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)				37.01
38	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:		38
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii). Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)				39
40	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)				40

FORM CMS-2552-10 (01-2022) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4004.1)

40-504 Rev. 17

01-22 FORM CMS-2552-10 4090 (Cont.)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2 PART I (CONT.)

		2	
105	Does this hospital qualify as a CAH?		105
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)		106
107	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)		107
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR 412.113(c). Enter "Y" for yes or "N" for no.		108

		Physical 1	Occupational 2	Speech 3	Respiratory 4	
109	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					109

		1	
110	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.		110

		1	2	
111	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.			111

		1	2	3	
112	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.				112

Miscellaneous Cost Reporting Information		1	2	3	
115	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.				115

		1	
116	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		116
117	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim- made. Enter 2 if the policy is occurrence.		118

There are a few lines that identify specific types of hospitals (i.e., CMS designation):

- Line 35: SCH
- Line 105: CAH
- Line 116: RRC

Worksheet E, Part A

4090 (Cont.) FORM CMS-2552-10 01-22

CALCULATION OF REIMBURSEMENT SETTLEMENT	PROVIDER CCN: / COMPONENT CCN:	PERIOD: FROM / TO	WORKSHEET E, PART A

Check applicable box: [ ] Hospital [ ] PARHM Demonstration

PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS

1	DRG amounts other than outlier payments		1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		1.04
2	Outlier payments for discharges (see instructions)		2
2.01	Outlier reconciliation amount		2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)		2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		2.04
3	Managed care simulated payments		3
4	Bed days available divided by number of days in the cost reporting period (see instructions)		4
	Indirect Medical Education Adjustment Calculation for Hospitals		
5	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996 (see instructions)		5
6	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		6
7	MMA §422 reduction amount to the IME cap as specified under 42 CFR 412.105(f)(1)(iv)(B)(1)		7
7.01	ACA §5503 reduction amount to the IME cap as specified under 42 CFR 412.105(f)(1)(iv)(B)(2). If the cost report straddles July 1, 2011, see instructions.		7.01
8	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		8
8.01	The amount of increase if the hospital was awarded FTE cap slots under §5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under §5506 of ACA. (see instructions)		8.02
9	Sum of lines 5 plus 6, minus lines 7 and 7.01, plus/minus line 8, plus lines 8.01 and 8.02 (see instructions)		9
10	FTE count for allopathic and osteopathic programs in the current year from your records		10
11	FTE count for residents in dental and podiatric programs		11
12	Current year allowable FTE (see instructions)		12
13	Total allowable FTE count for the prior year		13
14	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997; otherwise enter zero.		14
15	Sum of lines 12 through 14 divided by 3		15
16	Adjustment for residents in initial years of the program		16
17	Adjustment for residents displaced by program or hospital closure		17
18	Adjusted rolling average FTE count		18
19	Current year resident to bed ratio (line 18 divided by line 4)		19
20	Prior year resident to bed ratio (see instructions)		20
21	Enter the lesser of lines 19 or 20 (see instructions)		21
22	IME payment adjustment (see instructions)		22
22.01	IME payment adjustment - Managed Care (see instructions)		22.01
	Indirect Medical Education Adjustment for the Add-on for §422 of the MMA		
23	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		23
24	IME FTE resident count over cap (see instructions)		24
25	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		25
26	Resident to bed ratio (divide line 25 by line 4)		26
27	IME payments adjustment factor (see instructions)		27
28	IME add-on adjustment amount (see instructions)		28
28.01	IME add-on adjustment amount - Managed Care (see instructions)		28.01
29	Total IME payment (sum of lines 22 and 28)		29
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		29.01
	Disproportionate Share Adjustment		
30	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		30
31	Percentage of Medicaid patient days to total patient days (see instructions)		31
33	Allowable disproportionate share percentage (see instructions)		33

Line 33 indicates the hospital's disproportionate share adjustment percentage (DSH%). All hospitals (except for CAH) need to meet a minimum DSH% threshold to be eligible for the 340B Program.

Understanding the Medicare Cost Report

Worksheet A

11-17 FORM CMS-2552-10 4090 (Cont.)

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES | PROVIDER CCN: | PERIOD: FROM TO | WORKSHEET A

		COST CENTER DESCRIPTIONS (omit cents)	SALARIES 1	OTHER 2	TOTAL (col. 1 + col. 2) 3	RECLASSIFI-CATIONS 4	RECLASSIFIED TRIAL BALANCE (col. 3 ± col. 4) 5	ADJUSTMENTS 6	NET EXPENSES FOR ALLOCATION (col. 5 ± col. 6) 7	
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room								50
51	05100	Recovery Room								51
52	05200	Labor Room and Delivery Room								52
53	05300	Anesthesiology								53
54	05400	Radiology-Diagnostic								54
55	05500	Radiology-Therapeutic								55
56	05600	Radioisotope								56
57	05700	Computed Tomography (CT) Scan								57
58	05800	Magnetic Resonance Imaging (MRI)								58
59	05900	Cardiac Catheterization								59
60	06000	Laboratory								60
61	06100	PBP Clinical Laboratory Services-Program Only								61
62	06200	Whole Blood & Packed Red Blood Cells								62
63	06300	Blood Storing, Processing, & Trans.								63
64	06400	Intravenous Therapy								64
65	06500	Respiratory Therapy								65
66	06600	Physical Therapy								66
67	06700	Occupational Therapy								67
68	06800	Speech Pathology								68
69	06900	Electrocardiology								69
70	07000	Electroencephalography								70
71	07100	Medical Supplies Charged to Patients								71
72	07200	Implantable Devices Charged to Patients								72
73	07300	Drugs Charged to Patients								73
74	07400	Renal Dialysis								74
75	07500	ASC (Non-Distinct Part)								75
76		Other Ancillary (specify)								76
77	07700	Allogeneic Stem Cell Acquisition								77
		OUTPATIENT SERVICE COST CENTERS								
88	08800	Rural Health Clinic (RHC)								88
89	08900	Federally Qualified Health Center (FQHC)								89
90	09000	Clinic								90
91	09100	Emergency								91
92	09200	Observation Beds								92
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop, & Canteen								190
191	19100	Research								191
192	19200	Physicians' Private Offices								192
193	19300	Nonpaid Workers								193
194		Other Nonreimbursable (specify)								194
200		TOTAL (sum of lines 118 through 199)				- 0 -				200

50-118

190+

Lines 190 and above represent nonreimbursable cost centers.

Understanding the Medicare Cost Report

11-17 FORM CMS-2552-10 4090 (Cont.)

COMPUTATION OF RATIO OF COSTS TO CHARGES | PROVIDER CCN: | PERIOD: FROM _____ TO _____ | WORKSHEET C PART I

COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs: Total Costs	Costs: RCE Dis-allowance	Costs: Total Costs	Charges: Inpatient	Charges: Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
	1	2	3	4	5	6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS											
30	Adults and Pediatrics (General Routine Care)											30
31	Intensive Care Unit											31
32	Coronary Care Unit											32
33	Burn Intensive Care Unit											33
34	Surgical Intensive Care Unit											34
35	Other Special Care (specify)											35
40	Subprovider IPF											40
41	Subprovider IRF											41
42	Subprovider (Specify)											42
43	Nursery											43
44	Skilled Nursing Facility											44
45	Nursing Facility											45
46	Other Long Term Care											46
	ANCILLARY SERVICE COST CENTERS											
50	Operating Room											50
51	Recovery Room											51
52	Labor Room and Delivery Room											52
53	Anesthesiology											53
54	Radiology-Diagnostic											54
55	Radiology-Therapeutic											55
56	Radioisotope											56
57	Computed Tomography (CT) Scan											57
58	Magnetic Resonance Imaging (MRI)											58
59	Cardiac Catheterization											59
60	Laboratory											60
61	PBP Clinical Laboratory Services-Prgm. Only											61
62	Whole Blood & Packed Red Blood Cells											62
63	Blood Storing, Processing, & Trans.											63
64	Intravenous Therapy											64
65	Respiratory Therapy											65
66	Physical Therapy											66
67	Occupational Therapy											67
68	Speech Pathology											68

Reimbursable clinics (lines 50-118) must also show outpatient charges in order to register for the 340B Program as a child site of the hospital.

Appendix A: Example Trial Balance

FY2021 Trial Balance
7/1/2020-6/30/2021

			Worksheet A				Worksheet C		
Dept ID	Dept Name	Cost Report Line	Salaries/Wages	Other Expenses	Total Expenses		Inpatient Revenue	Outpatient Revenue	Total Revenue
OR0121	Operating Room	50.00	$ 50,000.00	$ 35,000.00	$ 85,000.00		$ 127,500.00	$ 148,750.00	$ 276,250.00
OR0122	Pre Op	50.00	$ 25,000.00	$ 18,000.00	$ 43,000.00		$ 64,500.00	$ 75,250.00	$ 139,750.00
OR0123	PACU	50.00	$ 28,000.00	$ 20,000.00	$ 48,000.00		$ 72,000.00	$ 84,000.00	$ 156,000.00
			Subtotal	**$ 103,000.00**	**$ 73,000.00**	**$ 176,000.00**		**$ 264,000.00**	**$ 308,000.00**	**$ 572,000.00**
RD0221	Diagnostic Radiology	54.00	$ 40,000.00	$ 15,000.00	$ 55,[illegible]00		$ 68,750.00	$ 82,500.00	$ 151,250.00
RD0222	Xray	54.00	$ 40,000.00	$ 15,[illegible]00	$ 5,[illegible]00		$ 68,750.00	$ 82,500.00	$ 151,250.00
			Subtotal	**$ 80,000.[illegible]**	**$ [illegible]0,00[illegible]**		**$ 137,500.00**	**$ 165,000.00**	**$ 302,500.00**
HC0321	Internal Medicine Clinic - Hospital	90.00	$ [illegible]000.0[illegible]	$ [illegible]00	$ 575,000.00		$ -	$ 1,150,000.00	$ 1,150,000.00
HC0322	Family Practice Clinic - Hospital	90.0[illegible]	$ 45[illegible]0.00	$ [illegible],50[illegible]00	$ 517,500.00		$ -	$ 1,035,000.00	$ 1,035,000.00
HC0323	Pediatrics Clinic - Hospital	90.00	$ [illegible]00	$ 56,250.00	$ 431,250.00		$ -	$ 862,500.00	$ 862,500.00
HC0324	Pain Clinic - Hospital	90.00	$ 675,000.00	$ 101,250.00	$ 776,250.00		$ -	$ 1,552,500.00	$ 1,552,500.00
HC0325	Dermatology Clinic - Hospital	90.00	$ 750,000.00	$ 112,500.00	$ 862,500.00		$	$ 1,725,000.00	$ 1,725,000.00
HC0326	Cardiology Clinic - Hospital	90.00	$ 875,000.00	$ 131,250.00	$ 1,006,250.00		$ -	$ 2,012,500.00	$ 2,012,500.00
HC0327	Neurology Clinic - Hospital	90.00	$ 888,000.00	$ 133,200.00	$ 1,021,200.00		$ -	$ 2,042,400.00	$ 2,042,400.00
HC0328	Gastroenterology Clinic - Hospital	90.00	$ 809,000.00	$ 121,350.00	$ 930,350.00		$ -	$ 1,860,700.00	$ 1,860,700.00
			Subtotal	**$ 5,322,000.00**	**$ 798,300.00**	**$ 6,120,300.00**	**Subtotal**	**$ -**	**$ 12,240,600.00**	**$ 12,240,600.00**
OC0421	Opthalmology Clinic - Offsite	90.01	$ 872,000.00	$ 130,800.00	$ 1,002,800.00		$ -	$ 2,206,160.00	$ 2,206,160.00
OC0422	Rheumatology Clinic - Offsite	90.01	$ 815,000.00	$ 122,250.00	$ 937,250.00		$ -	$ 2,061,950.00	$ 2,061,950.00
OC0423	OB/GYN Clinic - Offsite	90.01	$ 789,000.00	$ 118,350.00	$ 907,350.00		$ -	$ 1,996,170.00	$ 1,996,170.00
OC0424	Neurology Clinic - Offsite	90.01	$ 857,000.00	$ 128,550.00	$ 985,550.00		$ -	$ 2,168,210.00	$ 2,168,210.00
OC0425	Dermatology Clinic - Offsite	90.01	$ 775,000.00	$ 116,250.00	$ 891,250.00		$ -	$ 1,960,750.00	$ 1,960,750.00
			$ 799,000.00	$ 119,850.00	$ 918,850.00		$ -	$ 2,021,470.00	$ 2,021,470.00
			[illegible]	**$ 4,907,000.00**	**$ 736,050.00**	**$ 5,643,050.00**	**Subtotal**	**$ -**	**$ 12,414,710.00**	**$ 12,414,710.00**
				$ 10,412,000.00	**$ 1,637,350.00**	**$ 12,049,350.00**	**Total**	**$ 401,500.00**	**$ 25,128,310.00**	**$ 25,529,810.00**

EXAMPLE

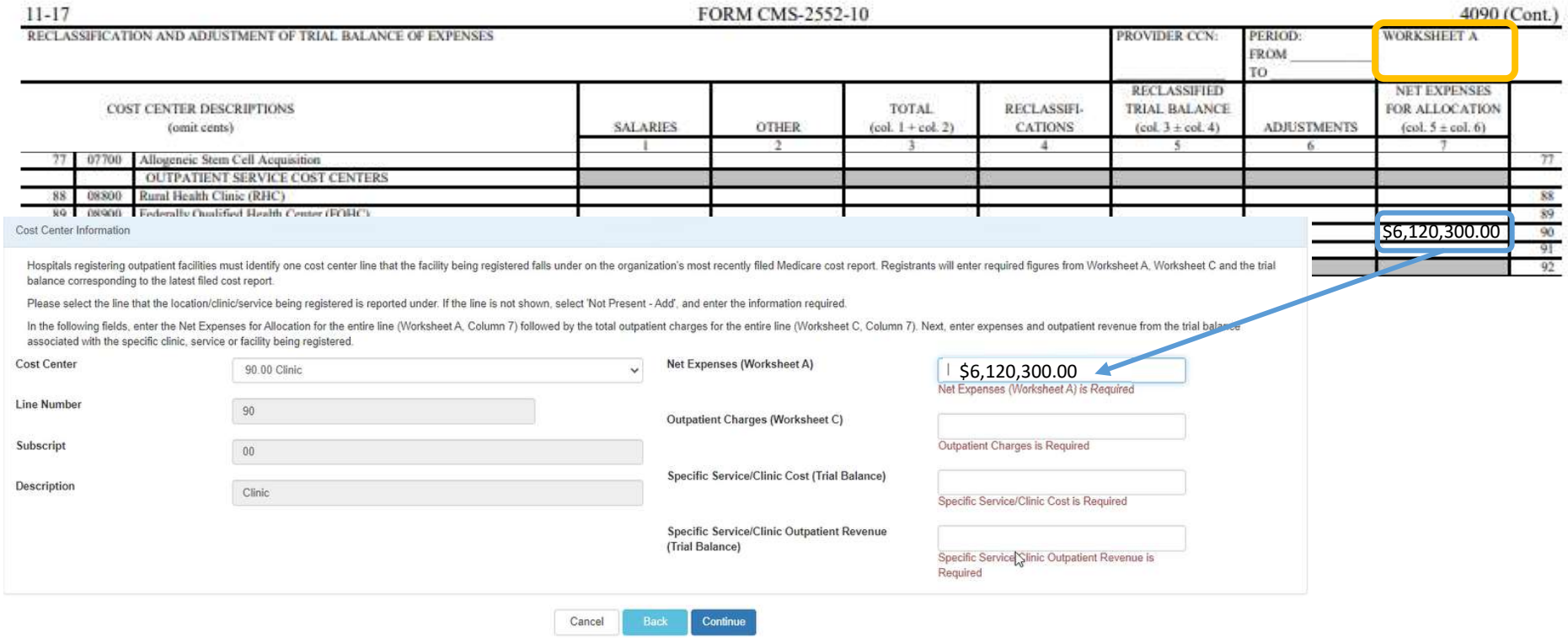
The Trial Balance itemizes individual departments that operate under a single line on the MCR. It is common to have many departments under line 90.00, as it represents the clinics integral to the hospital. In order to register for the 340B Program, each department must have **expenses** and **outpatient revenue**.

Appendix B: Registration Example – Multiple Departments Rolling up to a Single Line on the MCR

A covered entity recently opened a Cardiology, Neurology, and Gastroenterology clinic within the four walls of the hospital. These clinics newly appear on the most recently filed MCR under line 90.00 (departments HC0326, HC0327, and HC0328 in the example trial balance above). The covered entity would like to register these clinics on 340B OPAIS during the next quarterly 340B registration period.

Example: Cardiology Clinic – Hospital registration

Step 1: Identify the **Net Expenses for Allocation** for line 90.00 from Worksheet A, Column 7, and input into the "Net Expenses (Worksheet A)" field within the "Cost Center Information" box on 340B OPAIS during registration.



Step 2: Identify the **Outpatient Charges** for line 90.00 from Worksheet C, Column 7, and input into the "Outpatient Charges (Worksheet C)" field within the "Cost Center Information" box on 340B OPAIS during registration.

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COMPUTATION OF RATIO OF COSTS TO CHARGES | PROVIDER CCN: | PERIOD: FROM _____ TO _____ | WORKSHEET C PART I

	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Dis-allowance	Costs Total Costs	Charges Inpatient	Charges Outpatient	Charges Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		1	2	3	4	5	6	7	8	9	10	11	
69	Electrocardiology												69
70	Electroencephalography												70
71	Medical Supplies Charged to Patients												71
72	Implantable Devices Charged to Patients												72
73	Drugs Charged to Patients												73
74	Renal Dialysis												74
75	ASC (Non-Distinct Part)												75
76	Other Ancillary (specify)												76
77	Allogeneic Stem Cell Acquisition												77
	OUTPATIENT SERVICE COST CENTERS												
88	Rural Health Clinic (RHC)												88
89	Federally Qualified Health Center (FQHC)												89
90	Clinic							$12,240,600.00					90
91	Emergency												91
92	Observation Beds (see instructions)												92
													93
													93.99

Cost Center Information

Hospitals registering outpatient facilities must identify one cost center line that the facility being registered falls under on the organization's most recently filed Medicare cost report. Registrants will enter required figures from Worksheet A, Worksheet C and the trial balance corresponding to the latest filed cost report.

Please select the line that the location/clinic/service being registered is reported under. If the line is not shown, select 'Not Present - Add', and enter the information required.

In the following fields, enter the Net Expenses for Allocation for the entire line (Worksheet A, Column 7) followed by the total outpatient charges for the entire line (Worksheet C, Column 7). Next, enter expenses and outpatient revenue from the trial balance associated with the specific clinic, service or facility being registered.

Cost Center: 90.00 Clinic

Line Number: 90

Subscript: 00

Description: Clinic

Net Expenses (Worksheet A): $6,120,300.00
Net Expenses (Worksheet A) is Required

Outpatient Charges (Worksheet C): $12,240,600.00
Outpatient Charges is Required

Specific Service/Clinic Cost (Trial Balance):
Specific Service/Clinic Cost is Required

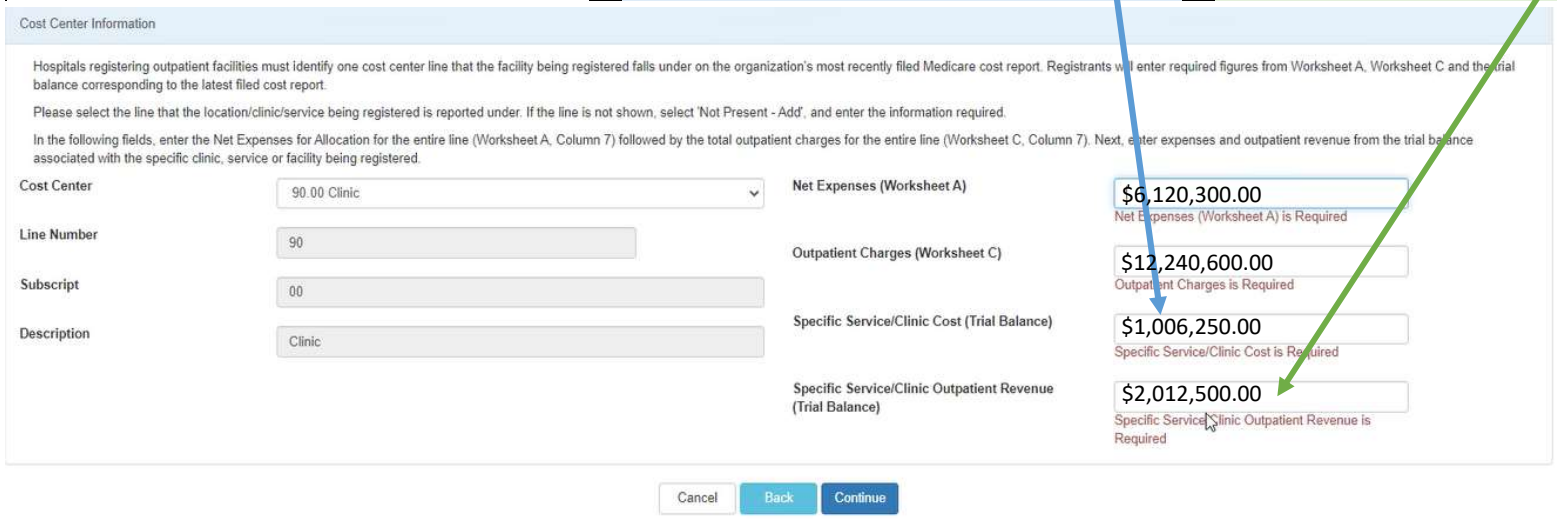
Specific Service/Clinic Outpatient Revenue (Trial Balance):
Specific Service/Clinic Outpatient Revenue is Required

Cancel | Back | Continue

Step 3a: Identify the **Total Expenses** for the specific department from the Expense trial balance and input into the "Specific "Service/Clinic Cost (Trial Balance)" field within the "Cost Center Information" box on 340B OPAIS during registration.

Step 3b: Identify the **Outpatient Revenue** for the specific department from the Revenue trial balance and input into the "Specific Service/Clinic Outpatient Revenue (Trial Balance)" field within the "Cost Center Information" box on 340B OPAIS during registration.

FY2021 Trial Balance 7/1/2020-6/30/2021			Worksheet A			Worksheet C		
Dept ID	Dept Name	Cost Report Line	Salaries/Wages	Other Expenses	Total Expenses	Inpatient Revenue	Outpatient Revenue	Total Revenue
HC0321	Internal Medicine Clinic - Hospital	90.00	$ 500,000.00	$ 75,000.00	$ 575,000.00	$ -	$ 1,150,000.00	$ 1,150,000.00
HC0322	Family Practice Clinic - Hospital	90.00	$ 450,000.00	$ 67,500.00	$ 517,500.00	$ -	$ 1,035,000.00	$ 1,035,000.00
HC0323	Pediatrics Clinic - Hospital	90.00	$ 375,000.00	$ 56,250.00	$ 431,250.00	$ -	$ 862,500.00	$ 862,500.00
HC0324	Pain Clinic - Hospital	90.00	$ 675,000.00	$ 101,250.00	$ 776,250.00	$ -	$ 1,552,500.00	$ 1,552,500.00
HC0325	Dermatology Clinic - Hospital	90.00	$ 750,000.00	$ 112,500.00	$ 862,500.00	$ -	$ 1,725,000.00	$ 1,725,000.00
HC0326	Cardiology Clinic - Hospital	90.00	$ 875,000.00	$ 131,250.00	$ 1,006,250.00	$ -	$ 2,012,500.00	$ 2,012,500.00
HC0327	Neurology Clinic - Hospital	90.00	$ 888,000.00	$ 133,200.00	$ 1,021,200.00	$ -	$ 2,042,400.00	$ 2,042,400.00
HC0328	Gastroenterology Clinic - Hospital	90.00	$ 809,000.00	$ 121,350.00	$ 930,350.00	$ -	$ 1,860,700.00	$ 1,860,700.00
			Subtotal $ 5,322,000.00	$ 798,300.00	$ 6,120,300.00	Subtotal $ -	$ 12,240,600.00	$ 12,240,600.00



Repeat steps 1-3 to register the Neurology and Gastroenterology clinics, using same information from Worksheet A, Column 7, line 90.00; Worksheet C, Column 7, line 90.00; and the **department-specific** Total Expenses and Outpatient Revenue from the trial balances. Each department that is registered should have unique values entered into the "Specific "Service/Clinic Cost (Trial Balance)" and "Specific Service/Clinic Outpatient Revenue (Trial Balance)" fields in 340B OPAIS during registration.

Example: Neurology Clinic – Hospital

FY2021 Trial Balance 7/1/2020-6/30/2021			Worksheet A			Worksheet C		
Dept ID	Dept Name	Cost Report Line	Salaries/Wages	Other Expenses	Total Expenses	Inpatient Revenue	Outpatient Revenue	Total Revenue
HC0321	Internal Medicine Clinic - Hospital	90.00	$ 500,000.00	$ 75,000.00	$ 575,000.00	$ -	$ 1,150,000.00	$ 1,150,000.00
HC0322	Family Practice Clinic - Hospital	90.00	$ 450,000.00	$ 67,500.00	$ 517,500.00	$ -	$ 1,035,000.00	$ 1,035,000.00
HC0323	Pediatrics Clinic - Hospital	90.00	$ 375,000.00	$ 56,250.00	$ 431,250.00	$ -	$ 862,500.00	$ 862,500.00
HC0324	Pain Clinic - Hospital	90.00	$ 675,000.00	$ 101,250.00	$ 776,250.00	$ -	$ 1,552,500.00	$ 1,552,500.00
HC0325	Dermatology Clinic - Hospital	90.00	$ 750,000.00	$ 112,500.00	$ 862,500.00	$ -	$ 1,725,000.00	$ 1,725,000.00
HC0326	Cardiology Clinic - Hospital	90.00	$ 875,000.00	$ 131,250.00	$ 1,006,250.00	$ -	$ 2,012,500.00	$ 2,012,500.00
HC0327	Neurology Clinic - Hospital	90.00	$ 888,000.00	$ 133,200.00	$ 1,021,200.00	$ -	$ 2,042,400.00	$ 2,042,400.00
HC0328	Gastroenterology Clinic - Hospital	90.00	$ 809,000.00	$ 121,350.00	$ 930,350.00	$ -	$ 1,860,700.00	$ 1,860,700.00
			Subtotal	**$ 5,322,000.00**	**$ 798,300.00**	**$ 6,120,300.00**	**Subtotal**	**$ - $ 12,240,600.00 $ 12,240,600.00**

Example: Gastroenterology Clinic – Hospital

FY2021 Trial Balance 7/1/2020-6/30/2021			Worksheet A			Worksheet C		
Dept ID	Dept Name	Cost Report Line	Salaries/Wages	Other Expenses	Total Expenses	Inpatient Revenue	Outpatient Revenue	Total Revenue
HC0321	Internal Medicine Clinic - Hospital	90.00	$ 500,000.00	$ 75,000.00	$ 575,000.00	$ -	$ 1,150,000.00	$ 1,150,000.00
HC0322	Family Practice Clinic - Hospital	90.00	$ 450,000.00	$ 67,500.00	$ 517,500.00	$ -	$ 1,035,000.00	$ 1,035,000.00
HC0323	Pediatrics Clinic - Hospital	90.00	$ 375,000.00	$ 56,250.00	$ 431,250.00	$ -	$ 862,500.00	$ 862,500.00
HC0324	Pain Clinic - Hospital	90.00	$ 675,000.00	$ 101,250.00	$ 776,250.00	$ -	$ 1,552,500.00	$ 1,552,500.00
HC0325	Dermatology Clinic - Hospital	90.00	$ 750,000.00	$ 112,500.00	$ 862,500.00	$ -	$ 1,725,000.00	$ 1,725,000.00
HC0326	Cardiology Clinic - Hospital	90.00	$ 875,000.00	$ 131,250.00	$ 1,006,250.00	$ -	$ 2,012,500.00	$ 2,012,500.00
HC0327	Neurology Clinic - Hospital	90.00	$ 888,000.00	$ 133,200.00	$ 1,021,200.00	$ -	$ 2,042,400.00	$ 2,042,400.00
HC0328	Gastroenterology Clinic - Hospital	90.00	$ 809,000.00	$ 121,350.00	$ 930,350.00	$ -	$ 1,860,700.00	$ 1,860,700.00
			Subtotal	**$ 5,322,000.00**	**$ 798,300.00**	**$ 6,120,300.00**	**Subtotal**	**$ - $ 12,240,600.00 $ 12,240,600.00**