# Understanding the Medicare Cost Report

Apexus | 340B Prime Vendor PROGRAM

**Purpose:** This tool is intended to help hospitals understand the key areas of the Medicare Cost Report that HRSA reviews when determining 340B eligibility.

**Background:** HRSA uses a hospital's Medicare Cost Report (MCR) when validating eligibility information for hospitals, both during registration and also during audits. This tool helps identify areas of the MCR that are important for determining:

- Eligibility type and status
- CE information (address, provider number, etc)
- Eligibility of child sites and service lines

### Medicare Cost Report Worksheets

| | Information used by HRSA | Conveys Parent Site Information | Conveys Child Site Information |
|---|---|---|---|
| **Worksheet S** | Important information about cost report filing (dates, provider number, signature) | X | X |
| **Worksheet S-2** | Parent address; control type | X | X |
| **Worksheet E, Part A** | DSH % | X | X |
| **Worksheet A** | Net expenses for eligible services/clinics | X | X |
| **Worksheet C** | Outpatient charges for eligible services/clinics | X | X |



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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
EXPIRES 03-31-2019

| HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY | PROVIDER CCN: ____________ | PERIOD FROM _________ TO ___________ | WORKSHEET S PARTS I, II & III |
|---|---|---|---|

The hospital's reporting period should correspond to the filing date below. Reporting dates and filing dates should be the same on all worksheets.

PART I - COST REPORT STATUS

Provider use only
1. [ ] Electronically filed cost report Date: __________ Time: __________
2. [ ] Manually submitted 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.

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

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

This is the "official" date and time used for this filed cost report. This will impact the date and time of eligibility of clinics, as well as the termination information.

PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF A... EPOR... ACTION, FINE AND/OR IMPRISONMENT UNDER... DENT... THE PAYMENT DIRECTLY OR INDIRECTLY OF... RIMIN... IMPRISONMENT MAY RESULT.

CAH and PED hospitals are identified based on the third and forth digit of the CCN (13 and 33 respectively).

Only site billing using this provider number are eligible under this parent hospital.

CERTIFICATION BY CHIEF FINANCIAL O...

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompa... submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ___________ cost reporting period beginning ______________ and ending ______________ and to the best of my knowledg... complete and prepared from the books and records of the provider in accordance with applicable instructions, e... laws and regulations regulations regarding the provision of health care services, and that the services identified... and regulations.

[ ] I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the lega... equivalent of my original signature.

Needs to be signed and dated (electronic time stamp).

(Signed) ________________________________
*Chief Financial* Officer or Administrator of Provider(s...

________________________________
Title

________________________________
Date

PART III - SETTLEMENT SUMMARY

| | | TITLE V | TITLE XVIII | | HIT | TITLE XIX | |
|---|---|---|---|---|---|---|---|
| | | | PART A | PART B | | | |
| | | 1 | 2 | 3 | 4 | 5 | |
| 1 | HOSPITAL | | | | | | 1 |
| 2 | SUBPROVIDER - IPF | | | | | | 2 |
| 3 | SUBPROVIDER - IRF | | | | | | 3 |
| 4 | SUBPROVIDER (OTHER) | | | | | | 4 |
| 5 | SWING BED - SNF | | | | | | 5 |
| 6 | SWING BED - NF | | | | | | 6 |
| 7 | SNF | | | | | | 7 |
| 8 | NF, ICF/IID | | | | | | 8 |
| 9 | HOME HEALTH AGENCY | | | | | | 9 |
| 10 | HOSPITAL-BASED - RHC | | | | | | 10 |
| 11 | HOSPITAL-BASED - FQHC | | | | | | 11 |
| 12 | OUTPATIENT REHABILITATION PROVIDER (Specify) | | | | | | 12 |
| 200 | TOTAL | | | | | | 200 |

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete this information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

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:

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

Hospital and Hospital-Based Component Identification:

| Line | Component | Component Name | CCN Number | CBSA Number | Provider Type | Line |
|---|---|---|---|---|---|---|
| | 0 | 1 | 2 | 3 | 4 | |
| 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 |
| 20 | Cost Reporting Period (mm/dd/yyyy) | From: | To: | | | 20 |
| 21 | Type of control (see instructions) | | | | | 21 |

This address will be the address of the parent entity.
Any service with a different physical address will have to be individually registered as a child site on OPAIS.

This is used for initial parent entity eligibility, and shows the type of control of the hospital. See instructions for types of entities: https://www.costreportdata.com/worksheet_formats.html

Inpatient PPS Information

| Line | | 1 | 2 | 3 | Line |
|---|---|---|---|---|---|
| 22 | Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR 412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR 412.106 (c )(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no. | | | | 22 |
| 22.01 | Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) | | | | 22.01 |
| 22.02 | Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. | | | | 22.02 |
| 22.03 | Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. | | | | 22.03 |
| 23 | Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no. | | | | 23 |

| Line | | In-State Medicaid paid days | In-State Medicaid eligible unpaid days | Out-of State Medicaid paid days | Out-of State Medicaid eligible unpaid days | Medicaid HMO days | Other Medicaid days | Line |
|---|---|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 | 6 | |
| 24 | If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. | | | | | | | 24 |
| 25 | If this provider is an IRF, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid day[...] Medicaid paid days in column 3, out-of state Medicaid eligible unpaid days in column 4 Medicaid HMO paid an[...] | | | | | | | 25 |

| Line | | 1 | 2 | 3 | Line |
|---|---|---|---|---|---|
| 26 | Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Ent[...] | | | | 26 |
| 27 | Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in c[...] If applicable, enter the effective date of the geographic reclassification in column 2. | | | | 27 |
| 35 | If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting [...] | | | | 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) or (ii)? 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) or (ii)? 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 |

There are a few lines that can help identify the type of hospital:
-Line 35: SCH
-Line 116: RRC

| CALCULATION OF REIMBURSEMENT SETTLEMENT | PROVIDER CCN: ________________ COMPONENT CCN: ________________ | PERIOD: FROM __________ TO _____________ | WORKSHEET E, PART A |
|---|---|---|---|

| Line | PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS | Prior to October 1 | On or after October 1 | Line |
|---|---|---|---|---|
| 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 |
| 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 which 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 |
| 32 | Sum of lines 30 and 31 | | | 32 |
| 33 | Allowable disproportionate share percentage (see instructions) | | | 33 |
| 34 | Disproportionate share adjustment (see instructions) | | | 34 |
| | Uncompensated Care Adjustment | Prior to October 1 | On or after October 1 | |
| 35 | Total uncompensated care amount (see instructions) | | | 35 |
| 35.01 | Factor 3 (see instructions) | | | 35.01 |
| 35.02 | Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions) | | | 35.02 |
| 35.03 | Pro rata share of the hospital uncompensated care payment amount (see instructions) | | | 35.03 |
| 35.04 | Pro rata share of the hospital uncompensated care payment amount (MDH) (see instructions) | | | 35.04 |
| 35.05 | Pro rata share of the hospital uncompensated care payment amount (SCH) (see instructions) | | | 35.05 |
| 36 | Total uncompensated care (sum of columns 1 and 2 on line 35.03) | | | 36 |
| | Additional Payment for High Percentage of ESRD Beneficiary Discharges (lines 40 through 46) | | | |
| 40 | Total Medicare discharges, excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (se | | | 40 |
| 41 | Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685 (see instructi | | | 41 |
| 41.01 | Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684, an | | | 41.01 |
| 42 | Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment) | | | 42 |
| 43 | Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685 (see inst | | | 43 |
| 44 | Ratio of average length of stay to one week (line 43 divided by line 41.01 divided by 7 days) | | | 44 |
| 45 | Average weekly cost for dialysis treatments (see instructions) | | | 45 |
| 46 | Total additional payment (line 45 times line 44 times line 41.01) | | | 46 |
| 47 | Subtotal (see instructions) | | | 47 |
| 48 | Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only (see i | | | 48 |
| 49 | Total payment for inpatient operating costs (see instructions) | | | 49 |
| 50 | Payment for inpatient program capital (from Wkst. L, Pt. I, or Pt. II, as applicable) | | | 50 |
| 51 | Exception payment for inpatient program capital (Wkst. L, Pt. III) (see instructions) | | | 51 |
| 52 | Direct graduate medical education payment (from Wkst. E-4, line 49) (see instructions). | | | 52 |
| 53 | Nursing and allied health managed care payment | | | 53 |
| 54 | Special add-on payments for new technologies | | | 54 |
| 54.01 | Islet isolation add-on payment | | | 54.01 |
| 55 | Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69) | | | 55 |

Line #33 shows the DSH Adjustment %; this is needed for the entity to be 340B eligible (exception is CAH).

Some hospital types do not file WS E, Part A, but may still need to calculate this to show eligibility. WS S-3 may be used for the data needed for this calculation.

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

PROVIDER CCN: ____________ PERIOD: FROM ___________ TO ___________ WORKSHEET A

| | | COST CENTER DESCRIPTIONS (omit cents) | SALARIES | OTHER | TOTAL (col. 1 + col. 2) | RECLASSIFI-CATIONS | RECLASSIFIED TRIAL BALANCE (col. 3 ± col. 4) | ADJUSTMENTS | NET EXPENSES FOR ALLOCATION (col. 5 ± col. 6) | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | 1 | 2 | 3 | 4 | 5 | 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 |
| 93 | | Other Outpatient Service (specify) | | | | | | | | 93 |
| 93.99 | 09399 | Partial Hospitalization Program | | | | | | | | 93.99 |

Typically, lines 50 - 118 are potentially reimbursable.

Clinics/services must be reimbursable on the most recently-filed cost report to be considered 340B eligible.
Any with a separate physical address must also be separately registered on OPAIS.

HRSA will also verify that the line has a net expense in order to be eligible.

FORM CMS-2552-10 (11-2017) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4013)

| 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 | | | Charges | | | Cost or Other Ratio | TEFRA Inpatient Ratio | PPS Inpatient Ratio | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Total Costs | RCE Dis-allowance | Total Costs | Inpatient | Outpatient | Total (column 6 + column 7) | | | | |
| | | 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 must show outpatient charges in column 7

**OPA University Hospital**
**FY2011 Trial Balance 7/1/2010-6/30/12**

EXAMPLE

| Dept ID | Clinic name | CR Line | Salary Expenses | Non-Salary Expenses | Total Expenses | Inpatient Rev | Outpatient Rev | Total Pat Revenue |
|---|---|---|---|---|---|---|---|---|
| H0122 | Hand Clinic | 50 | $ 50.00 | $ 865.00 | $ 915.00 | $ 452.00 | $ 879.00 | $ 1,331.00 |
| H0123 | Physical Therapy Clinic | 50 | $ 76.00 | $ 367.00 | $ 443.00 | $ 586.00 | $ 846.00 | $ 1,432.00 |
| H0124 | Occupational Therapy Clinic | 50 | $ 23.00 | $ 298.00 | $ 1,358.00 | $ 553.00 | $ 254.00 | $ 2,763.00 |
| H0125 | Outpatient Pediatric Therapy | 50 | $ 138.00 | $ 442.00 | $ 580.00 | $ 125.00 | $ 564.00 | $ 689.00 |
| | | total | $ 287.00 | $ 1,972.00 | $ 2,259.00 | $ 1,716.00 | $ 2,543.00 | $ 5,727.00 |
| H1123 | Neurology Clinic | 90 | $ 586.00 | $ 984.00 | $ 1,570.00 | $ 852.00 | $ 789.00 | $ 1,641.00 |
| H3021 | Eye Institute | 90 | $ 423.00 | $ 256.00 | $ 679.00 | $ 456.00 | $ 654.00 | $ 1,110.00 |
| H2561 | Dermatology Clinic | 90 | $ 46.00 | $ 872.00 | $ 2,249.00 | $ 213.00 | $ 321.00 | $ 2,751.00 |
| H5543 | Radiology Clinic | 90 | $ 986.00 | $ 423.00 | $ 1,409.00 | $ 852.00 | $ 258.00 | $ 1,110.00 |
| H2614 | Cardiology Clinic | 90 | $ 365.00 | $ 5,896.00 | $ 6,261.00 | $ 963.00 | $ 369.00 | $ 1,332.00 |
| | | total | $ 2,406.00 | $ 8,431.00 | $ 10,837.00 | $ 3,336.00 | $ 2,391.00 | $ 5,727.00 |
| H1234 | Pain Clinic | 90 | $ 231.00 | $ 714.00 | 945 | | | |
| H2345 | OBGYN Associates | 90 | $ 462.00 | $ 753.00 | 1215 | | | |
| H34567 | OPA ENT Clinic | 90 | $ 11.00 | $ 357.00 | 2160 | | | |
| H5678 | Surgery Clinic | 90.1 | $ 1,852.00 | $ 1,824.00 | 3676 | | | |

Trail Balance Sheet allows CEs to show individual clinics/services operating under a single line. It is very common to have many different clinics under line 90. In order to be eligible, each should also show expenses and outpatient revenues. Please consult the cost report instructions when adding a line to the cost center to ensure it is subscripted correctly.