Medicare

Department of Health and Human Services (DHHS)

Provider Reimbursement Manual

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

Centers for Medicare and Medicaid Services (CMS)

Transmittal 1 **Date: December 2010**

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NEW/REVISED MATERIAL--*EFFECTIVE DATE:* Cost Reporting Periods Beginning on or After May 1, 2010.

This transmittal introduces Chapter 40, Hospital and Hospital Health Care Complex Cost Report, Form CMS-2552-10, which contains instructions for the completion of the new cost report forms to be filed by hospitals and hospital health care complexes.

The following is a summary of the major revisions to the cost reporting forms:

Form CMS 2552-96 Wkst.	Form CMS 2552-10 Wkst.	Summary of Changes
S	S, Parts I, II &III	Added Part I for cost report status, Part II is now the certification and Part III is now the settlement summary.
S-2	S-2, Part I	Expanded the questions that will generate other worksheets on the cost report.
	S-2, Part II	Included the Hospital Cost Report Questionnaire CMS Form 339 into CMS-2552-10.
S-3, Part I	S-3, Part I	Re-designated the subscripted lines and columns into whole number lines and columns.
S-3, Part II & III	S-3, Part II & III	Re-designated the subscripted lines and columns into whole number lines and columns.
	S-3, Part IV	New worksheet to capture wage related cost that was formerly on the hospital cost report questionnaire CMS Form 339.
S-3, Part V		New worksheet to capture contract labor and benefit cost.

NOTE: No overhead expenses are allocated to this cost center since it relates to services for program beneficiaries only. The cost reporting treatment is similar to that of services furnished under arrangement to program beneficiaries only. (See CMS Pub. 15-1, §2314.) These costs are apportioned among the various programs on the basis of program charges for provider clinical laboratory tests for all programs for which you reimburse the pathologist.

Line 62--Include the direct expenses incurred in obtaining blood directly from donors as well as obtaining whole blood and packed red blood cells from suppliers. Do not include in this cost center the processing fee charged by suppliers. The processing charge is included in the blood storing, processing, and transfusion cost center. Identify this line with the appropriate cost center code (Table 5 - electronic reporting specifications) for the cost of administering blood clotting factors to hemophiliacs. (See §4452 of BBA 1997, OBRA 1989 & 1993.)

Line 63--Include the direct expenses incurred for processing, storing, and transfusing whole blood, packed red blood cells, and blood derivatives. Also include the processing fee charged by suppliers.

Line 71--The cost of medical supplies charged to patients is for low cost medical supplies generally not traceable to individual patients. Do not include high cost implantable devices on this line. The cost of this cost center generally is not the direct cost of the cost center, but rather allocated to this cost center on Worksheet B from cost center 14 (central service and supply) based on the recommended statistic of costed requisitions. Where providers directly assign costs to this cost center, such amounts must be reported in this cost center on Worksheet A. (see Pub. 15-1, §2307)

Line 72--Include the expense of implantable devices charged to patients. The types of items includable on this line are high cost implantable devices that remain in the patient upon discharge and are chargeable and traceable to individual patients. Do not include low cost medical supplies on this line. When determining what costs are reported in this cost center, providers should use costs associated with implantable devices bearing revenue codes identified in the FR, Vol. 73, No. 161, page 48462, dated August 19, 2008. This amount is generally not input on Worksheet A, but rather allocated to this cost center on Worksheet B from cost center 14 (central service and supply) based on the recommended statistic of costed requisitions. Where providers directly assign costs to this cost center, such amounts must be reported in this cost center on Worksheet A. (see Pub. 15-1, §2307) Identify this line with the appropriate cost center code according to Table 5 in §4095 of the electronic reporting specifications.

NOTE: Hospitals maintain the option to directly assign costs to a specific cost center (Pub. 15-1, §2307) or, if such costs are overhead costs, they can be placed in the appropriate overhead cost center and allocated to the applicable cost centers. This applies generally to all cost centers, but is re-emphasized for medical supplies charged to patients (line 71) and implantable devices charged to patients (line 72).

Line 74--If you furnish renal dialysis treatments, account for such costs by establishing this separate ancillary service cost center. In accumulating costs applicable to the cost center, include no other ancillary services even though they are routinely administered during the course of the dialysis treatment. However, if you physically perform a few minor routine laboratory services associated with dialysis in the renal dialysis department, such costs remain in the renal dialysis cost center. Outpatient maintenance dialysis services are reimbursed under the composite rate reimbursement system. For purposes of determining overhead attributable to the drugs Epoetin and Aranesp, include the cost of the drug in this cost center. The drug costs will be removed on worksheet B-2 after stepdown.

NOTE: ESRD physician supervisory are not included as your costs under the composite rate reimbursement system. Supervisory services are included in the physician's monthly capitation rate.

Line 75--Enter the cost of ASCs that are not separately certified as a distinct part but which have a separate surgical suite. Do not include the costs of the ancillary services provided to ASC patients. Include only the surgical suite costs (i.e., those used in lieu of operating or recovery rooms).

Lines 77 - 87--Reserved for future use.

Lines 88 - 93--Use these lines for outpatient service cost centers.

NOTE: For lines 88 and 89, any ancillary service billed as clinic, RHC, and FQHC services must be reclassified to the appropriate ancillary cost center, e.g., radiology-diagnostic, PBP clinical lab services - program only. A similar adjustment must be made to program charges.