05/18/10

2009
INSTRUCTIONS
INSTITUTIONAL COST REPORT (NYSICR)

Current Year Issues

- A number of the traditional exempt unit rates were no longer billable on a per diem basis effective December 1, 2009 (i.e. HIV, Epilepsy, Burn, TBI, and Bone Marrow). However, the method of distinctly reporting those costs and statistics should continue for reports ending 12/31/09, 3/31/10, and 6/30/10, thereby reporting the entire year consistently.
- Exhibit 14 – Adjustments to Expenses – two additional columns have been added to separate the All Payor and Medicaid adjustments to expenses into salary and non-salary columns. The two new columns will total to the existing column 0707 for Medicare purposes. Providers will not be able to enter into the 0707 column.
- Exhibit 16 – Statement of Costs of Services from Related Organizations – two additional columns have been established so that the cost incurred and adjustments required as a result of transactions with related organizations are separated by salary very non-salary.
- Exhibit 18 – Detail of Specific Expenses – The Administrative and General section has a new line to collect the amount of SPARCS fees paid.
- Exhibit 33 – Outpatient Statistics – A new section has been established for Federally Qualified Health Centers (FQHCs).
- Exhibit 34A has been added for additional information regarding hospital based home health agencies. Worker Recruitment and Retention revenue and expenses (WRR PHL 3614-8), Worker Recruitment, Training, and Retention revenue and expenses (RTR PHL 3614-9), and Accessibility, Quality and Efficiency revenue and expenses (AQE PHL 3614-11) will be collected.
- Exhibit 40 – Detail of Specific Capital Expenses – A new section has been established to identify any variable capital cost center set up by the facility.
- Exhibit 46 – Hospital Service Revenue – Line 002 has been changed to read Outpatient Visit Fees – Clinic Only. Line 013 has been established and reads Outpatient Visit Fees – Other than Clinic. Line 014 has been established and reads CPEP Emergency Services.
- Exhibit 51 – Ratio of Cost to Charges - A new exhibit for hospitals to provide the ICR Cost Center and Revenue Codes (used by the hospital for claims payment) mapping to DOH's 90 Cost Center Groups (CCG). This mapping will be used to calculate the hospital's Ratio of Cost to Charges (RCC) Factors and costs by payor.

General Instructions

The Institutional Cost Report (ICR) has been designed for use by Hospital and Health Care Complexes in the reporting of financial and statistical data applicable to services rendered for Title XVIII and XIX. The New York State Institutional Cost Reporting System (NYSICR/EICR2552), personal computer-based program meets reporting requirements of Title XVIII (Medicare) and Title XIX (Medicaid).

The following instructions should be utilized when completing the NYSICR.

1. Due Date

   The due date for receipt of the NYSICR and DMH Supplement to meet Medicaid and DMH requirements is by close of business on Tuesday, June 01, 2010. For information regarding the due date of the CMS 2552, contact your Settlement Manager.

2. Certification and Opinion

   Included in this year's certification statements is a Declaration Control Number (DCN), which will allow both the independent auditor and the provider to attest to the matching cost report electronic file. The DCN is a date and time stamp which notes when the final report file was completed. The DCN will print on both the auditor's and provider's certification statements.

   The certification statements are to be submitted to the DOH no later than five business days following transmission of the electronic file.

3. Handwritten Changes

   The submitted computerized cost reporting forms must not have any handwritten changes made to the figures. If there are corrections made on any of the worksheets, the cost report will be unacceptable and will be returned to the provider. The report will be considered as not received on the due date and the appropriate penalty procedures will be instituted.

4. Help Lines

   Should a facility have questions regarding the report, contact the DOH analyst assigned to your hospital.

   You may also use the Internet for reporting problems with the software.
   Send e-mail messages to: bpacr@health.state.ny.us

   Please identify yourself and include your telephone number in your e-mail message.

   The toll-free helpline established by the DOH is available should any facility experience any problems with electronic submission. That number is 1-800-638-3808.

5. Resubmission

   Facilities should note that all subsequent report transmissions will generate a new DCN, and are subject to all certification requirements.

6. Complete Reports

   Facilities must complete all applicable portions of the Institutional Cost Report. Failure to provide completed documents will result in the reports being returned to the provider. Any reports found to be unacceptable or incomplete are subject to the provisions of Part 86-1.3.

7. Edits

   A hardcopy of the final existing edits must accompany the submission of the cost report and certification pages. The preparer must attest, by initialing each edit, that all non-critical edits have been reviewed and that the data referenced by those edits do not warrant adjustment. Absence of this attestation or subsequent review of the list will necessitate the resubmission of the electronic file, as well as an accompanying hardcopy of the cost report to the DOH, within 3 business days after notification by DOH of its requirement. In addition, facilities may be subject to the implementation of Part 86-1.3.

8. Filing

(A) Department of Health

The DOH requires the transmission of the Computer-generated NYSICR, and DMH Supplement (electronic file) through the Health Provider Network. In addition, one signed hardcopy of the computer-generated Institutional Cost Report, a Department of Mental Hygiene Supplement (for those hospitals required to file one), a copy of the edits and a copy of the audited financial statements should be mailed to:

Bureau of Primary and Acute Care Reimbursement
Room 1043, Corning Tower Building
Empire State Plaza
Albany, New York 12237-0720

(B) Medicare

The CMS-2552 should be filed as directed by your fiscal intermediary.

Any questions regarding the filing of the Medicare Cost Report should be directed to the facilities respective Settlement Manager.

9. Penalties

It is important to note the following regarding the filing of financial and statistical report forms:

The document submitted for Medicare is CMS-2552, and must be identical to that submitted for Medicaid, except as required by Title reporting regulations. If not, the ICR for Medicaid will be deemed unacceptable and may result in the application of Part 86-1.3.

- In accordance with Part 86-1.3, in the event a medical facility fails to file the required reports on or before the due dates, the Commissioner of Health shall not certify proposed rate schedules of a hospital to the state Director of the Budget for the rate year immediately following for each day the financial and statistical reports were not filed.

- In addition, facilities which fail to complete any portion to the NYSICR will be subject to the penalty provisions of Part 86-1.3. Third party payors will be advised to return incomplete cost reports to providers. Reports will be considered incomplete for one or more of the following:

  a. Failure to report, in detail and/or total, revenue or deductions from revenue by payor, by program/unit, except where non-applicable.

  b. Failure to report, in detail and/or total, expenditures as required, except where non-applicable.

  c. Failure to report statistical data including patient days and discharges by payor, except where non-applicable.

10. Problem areas in reporting

- Facilities participating in the WIC Program must discretely report all cost and revenues associated with this program in cost center 418.

- The Inpatient Gross Revenue Assessment and the Health Facility Cash Assessment (formerly called the NYS Revenue Assessment) should be shown as reductions to revenue on lines 363 and 364 on

Exhibit 46 of the ICR. If the revenue is included as an expense on Exhibit 11, then it should be removed on Exhibit 14 and shown as a reconciling item of Exhibit 26. If the Assessment information differs from the Audited Financial Statements, then a reconciliation should be provided on Exhibit 28 lines 4 and 9.

- Charges on Exhibit 46 and patient days and discharges on Exhibit 32, reported on a payor specific basis, must be completed accurately and completely as required by the instructions. This data and data reported on Exhibit 47 are used in the calculation of the Disproportionate Share Cap required by the Health Care Financing Administration and failure to report data accurately may result in reductions in Disproportionate Share Pool distributions.

11. Setting up the cost report

If filing a cost report for more than one facility, you may wish to set up each cost report in a separate directory. If multiple cost reports are set up in the same directory, only the last report edited and calculated will be available for printing. (The reason is only 1 set of table files is stored at a time.)

There have been numerous problems regarding the naming of the cost report. The file name must be cr 33_ _ _ _.09 (Substitute the four digit Medicare number assigned to your facility in place of the underscores.) Do not add any extensions on the file name. The cr file automatically creates the ic file. These two files must be named properly to generate a dh file which is transmittable to the Department via the HPN.

12. Retaining cost report data

Facilities should keep copies of the cr and ic files backed up on a disk after submitting the dh file to the Department of Health. A DH file cannot be loaded to the software to create a revised report, the cr and ic files are necessary for this purpose.

13. ICR Instructions for DMH Programs

All DMH certified and/or funded programs are to be reported on the ICR. There are now a finite number (16) of ICR cost centers that can be used for Mental Hygiene programs. Two of these cost centers are to be used to collapse those programs not described by the other fourteen (14) program cost centers. The details of costs, revenues and statistics, however, for the two collapsed cost centers (All Other Mental Health Programs and All Other Alcoholism Programs) will be reported by discrete program on the DMH Supplement in the same manner as the fourteen (14) specifically titled cost centers. In the event that either of these All Other cost centers contain more than one program, each individual program will be reported separately on the DMH Supplement. If your hospital has established a "discrete" program on the documents filed to receive deficit financing grants from the DMH, the "program" must be discretely reported on the DMH Supplement. If this "program" is NOT one of the hard-coded cost centers the program will be reported in ICR Cost Center 247 for mental health or Cost Center 248 Alcoholism, however, discrete reporting of the "program" would still be required on the DMH Supplement. The DMH program cost center configuration, as found on the ICR is:

ICR Cost Ctr #	Program Code	DMH Cost Center Description
216	1920	Extended Observation Beds (CPEP) – (Cost center 216 shall only be used by hospitals with OMH certified CPEP programs to report the CPEP Extended Observation Beds.)

220	0030	Alcohol Rehabilitation
225	0010	Subprovider I – Psychiatric
246	0200	Mental Health Day Treatment
249	1310	Mental Health Continuing Day Treatment
253	2320	Intensive Psychiatric Rehabilitation Treatment (IPRT)
254	2200	Mental Health Partial Hospitalization
288	See Cost Center Description	Comprehensive Psychiatric Emergency Room (CPEP) – Only those Hospitals that have OMH certified CPEP programs shall utilize this ICR cost center. This Cost Center shall only be used to report the remaining component parts of an OMH Licensed C.P.E.P.: Crisis Intervention (DMH Program Code 3130), Crisis Outreach (DMH Program Code 1680) and Crisis Residence (DMH Program Code 0910). THESE COMPONENTS WOULD BE COMBINED ON THE ICR, BUT MUST BE REPORTED DISCRETELY ON THE DMH SUPPLEMENT.
289	2100	Mental Health Clinic
291	0110	Alcohol Clinic
301	0010	Psychiatric – Non-Exempt Unit
247*	Various	All Other MENTAL HEALTH Programs not assigned to a specific ICR Cost Center listed above, shall be reported in this Cost Center.
248**	Various	All Other ALCOHOLISM Programs not assigned to a specific cost center listed above, shall be reported in this Cost Center.
420		MH Outpatient ACT Programs – shall be used to report the following programs:
	0800	Assertive Community Treatment (ACT) Teams **-** ACT Teams provide intensive treatment and support to people with psychiatric disabilities. The focus is on the improvement of an individual's quality of life in the community and reducing the need for inpatient care, by providing intense community-based treatment services by an interdisciplinary team of mental health professionals. Building on the successful components of the Intensive Case Management (ICM) program, the ACT program has low staff-outpatient ratios, 24-hour-a-day, seven-day-per-week availability, enrollment of recipients and flexible service dollars.
	8810	ACT Team – Service Dollars **-** Individual services aimed at meeting basic needs of patients. These services may include emergency services as well as job coaching, education, leisure-time services and others.

421		MH Outpatient ICM Programs – shall be used to report the following programs:
	1810	Intensive Case Management (ICM) – Activities aimed at linking the client to the service system and at coordinating the various services in order to achieve a successful outcome. The objective of case management in a mental health system is continuity of care and service. Services may include linking, monitoring and case-specific advocacy. **Linking**: The process of referring or transferring a client to all required internal and external services that include the identification and acquisition of appropriate service resources. **Monitoring**: Observation to assure the continuity of service in accordance with the client's treatment plan. **Case-Specific Advocacy**: Interceding on behalf of a client to assure access to services required in the individual service plan. Case management activities are expediting and coordinative in nature rather than the primary treatment services ordinarily provided by a therapist. Case management services are provided to enrolled clients for whom staff are assigned a continuing case management responsibility. Thus, routine referral would not be included unless the staff member making the referral retains a continuing active responsibility for the client throughout the system of service. ICM services are services which are operated under a fidelity structure defined in 18 NYCRR, Section 505 and a Memorandum of Understanding between OMH and the NYS Department of Health.
	2810	ICM Services Dollars Management - Direct costs of support provided by the county or agency for contracted management expenses.
	4810	Intensive Case Management (ICM) Non-Emergency Service Dollars - Services consistent with a patient's treatment plan, designed to be flexible and responsible to current individual needs. These services may include emergency services (when not immediate) and also may include furnishings, utilities, tuition, job related costs, job coaching, education, vocational services, leisure time services and others. This program does not include agency administration.
	5810	Intensive Case Management (ICM) Emergency Service Dollars - Individual services aimed at meeting the immediate basic needs of the patient to include transportation, medical/dental care, shelter/respite/hotel, food/meals, clothing, escort, and others. This program does not include agency administration.
422		MH Outpatient SCM Programs – shall be used to report the following programs:
	6810	Supportive Case Management - Activities aimed at linking the client to the service system and at coordinating the various

		services in order to achieve a successful outcome. The objective of case management in a mental health system is continuity of care and service. Services may include linking, monitoring and case-specific advocacy. **Linking**: The process of referring or transferring a client to all required internal and external services that include the identification and acquisition of appropriate service resources. **Monitoring**: Observation to assure the continuity of service in accordance with the client's treatment plan. **Case-Specific Advocacy**: Interceding on behalf of a client to assure access to services required in the individual service plan. Case management activities are expediting and coordinative in nature rather than the primary treatment services ordinarily provided by a therapist. Case management services are provided to enrolled clients for whom staff are assigned a continuing case management responsibility. Thus, routine referral would not be included unless the staff member making the referral retains a continuing active responsibility for the client throughout the system of service. SCM services are services which are operated under a fidelity structure defined in 18 NYCRSS, Section 505, and a Memorandum of Understanding between OMH and the NYS Department of Health.
	7810	Supportive Case Management Services (SCM) **-** Individual services aimed at meeting the basic needs of the client. These services may include emergency services as well as job coaching, education, leisure-time services and others.
423	6340	Comprehensive PROS (Personalized Recovery Oriented Services) with clinic - A comprehensive recovery oriented program for individuals with severe and persistent mental illness. The goal of the program is to integrate treatment, support and rehabilitation in a manner that facilitate the individual's recovery. Goals for individuals in the program are to: improve functioning, reduce inpatient utilization, reduce emergency services, reduce contact with the criminal justice system, increase employment, attain higher levels of education and secure preferred housing. There are four service components in the program: Community Rehabilitation and Support (CRS); Intensive Rehabilitation (IR), Vocational Support (VS) and Clinic Treatment.
424	7340	Comprehensive PROS - Includes all of the service components as the Comprehensive PROS with Clinic, except Clinical Treatment.
425	8340	Limited License PROS - A PROS program that provides only Vocational Support and Intensive Rehabilitative services.
426	9340	PROS Rehabilitation and Support - Used to report PROS services rendered by subcontract providers.

* All other Mental Health program costs not reported above are to be reported in total here. If Cost Center 247 is used for more than one program on the ICR, each individual program must be reported discretely on the DMH Supplement.

** All other Alcoholism programs not reported above are to be reported in total here.

If your hospital operates a discrete certified and/or funded program for any of the above, you must report this program in this cost center throughout the ICR and use these cost center numbers wherever applicable in the DMH Supplement. DO NOT COLLAPSE THESE PROGRAMS BACK TO LARGER HOSPITAL PROGRAMS BY RECLASS OR USE THESE COST CENTERS FOR OTHER DMH PROGRAMS OR NON-MENTAL HYGIENE PROGRAMS. DO NOT use ANY non-Mental Hygiene program cost centers for Mental Hygiene programs.

Detailed Instructions to NYSICR:

Cover Page (ICR Page 1)

Please complete the requested information on the form. The reference number, effective date and run date are for DOH internal purposes only and do not appear on the software screens and need not be completed.

Enter the month, date, and year as 8 digits, no slashes for the date prepared.

OFFICERS (ICR Page 2)

Please complete the name and address of each of the officers of the hospital.

OPINION OF INDEPENDENT CERTIFIED PUBLIC ACCOUNTANT and PROVIDER CERTIFICATION (ICR Page 3)

Included in this year's certification statements is a Declaration Control Number (DCN), which will allow both the independent auditor and the administrator to attest to the matching cost report electronic file. The DCN is a date and time stamp which notes when the final report file was completed. The DCN will print on both the auditor's and administrator's certification statements. The certification statements are to be submitted to the DOH no later then five business days following transmission of the electronic file.

Enter the appropriate CPA Firm Code as found in the following list:

Bonadio & Company	003
Deloitte & Touche	005
Ernst & Young	007
Fust Charles Chambers LLP	009
Lumsden & McCormick	013
Loeb & Troper	014
KPMG LLP	016
PricewaterhouseCoopers LLP	017
Other	010
Freed Marwick & Battaglia CPA'S PC	018
BDO Seidman LLP	019
UHY LLP	020
Rotenberg & Co LLP	021
JH Cohn LLP	022

If other (010) is selected, enter the name of the CPA firm on the line provided.

Exhibit 1 - (Worksheet S-2)-Hospital and Hospital-Health Care Complex Identification Data.

Refer to Medicare Instructions - Section 3604

Exhibit 2 - Profile of Services

Inpatient Services
Indicate the number of weighted certified beds by service category for which your hospital is licensed for on the NYS Operating Certificate in effect during the report period. If certified beds did not change during the period being reported, the weighted certified beds are equal to beds certified at the close

of the reporting period. If certified beds changed during the reporting period, weighted beds should be calculated using the number of beds times the days in service for each different bed complement, summed and divided by 365.

Authorized Ancillary Services
Indicate a Y for "Yes" and an N for "No" for each service provided during the report period for which your hospital is licensed to provide as indicated on the NYS Operating Certificate.

Outpatient Services
Indicate a "Y" for yes and an "N" for no for each service your facility was licensed to provide in accordance with your NYS Operating Certificate in effect during the report period.

Teaching Status of Hospitals
Please enter a Y for yes in the box that applies to your hospital. Teaching status of the hospital is defined in Part 86-1.52 of the Commissioner of Health's Administrative Rules and Regulations.

Exhibit 3 - (Worksheet S-3, Part I) - Hospital and Hospital-Health Care Complex - Statistical data

Refer to Medicare Instructions - Section 3605.1

Exhibit 4 - Certified Bed Capacity

The service classifications reported on Exhibit 3 (worksheet S-3) of the ICR will automatically transfer to this Exhibit as part of the software programming. The provider should enter the bed capacity as indicated on the operating certificate of NYS for the beginning and end of the reporting period.

Hospitals that are certified to provide Neonatal Care may be licensed for one, two, or all three of the following categories;

Neonatal Intensive Care
Neonatal Intermediate Care
Neonatal Continuing Care

The provider should enter the bed capacity of the appropriate service(s) it is licensed for.

The provider should enter dates of changes in certified bed capacity.

Exhibit 5 - Statement Of Inclusion Of Professional Services Provided

Exhibit deleted for cost report years after 2008

Exhibit 6- Physician Cost

This schedule is to include total compensation including fringe benefits, paid to interns and residents, supervising physicians and hospital-based physicians, that are directly charged to routine, ancillary, outpatient, or other cost centers.

The total reported on this schedule should not include any amounts for salaries and fringes reported in the opening balance of the stepdown for interns and residents, and supervising physician cost centers.

The Supervising Physician column (4826) collects the expenses for the total compensation including fringes paid to supervising physicians that are included in any ancillary or final cost center <u>at the opening balance of the stepdown</u>.

The Hospital Based Physician Column (0215) collects the expenses for the total compensation including

fringes paid to the physicians by the hospital for direct patient care that is included in any ancillary of final cost center. This compensation would be after reclasses, but before All Payor and Medicaid adjustments to expenses. The amount reported for Hospital Based Physicians should match the Professional Component column 4 from Exhibit 17 with the exception for Medicare Electing Teaching Amendment Providers.

Exhibit 7 - Downstate and Mid-Hudson Hospitals Only

Exhibit deleted for cost report years after 1997

Exhibit 8 - Services Not Covered By Blue Cross

Exhibit deleted for cost report years after 1996

Exhibit 9 - Payments To And On Behalf Of Owners, Stockholders, Officers, Directors, and Trustees
Payments To And On Behalf of Relatives of Owners, Stockholders, Officers, Directors, and Trustees

Both sections of this exhibit must be completed by all facilities. Report the name, position and all payments paid to and on behalf of all owners, stockholders, officers, directors, and trustees of the hospital for the report year in the first section. Report the name, position, and all payments paid to and on behalf of all relatives of owners, stockholders, officers, directors, and trustees of the hospital for the report year in the second section.

Directors are defined as Board of Directors, not Directors of Nursing, Finance, etc.

Officers are listed on Page 2 of the ICR: President, Secretary, Treasurer, Chief Administrative Officer, and Chief Accounting Officer.

> A fatal edit has been added to this exhibit for facilities not reporting officers' compensation. The provider must return to the Exhibit, line 091 and enter a "1" for "Yes" indicating that all officers, owners, stockholders, directors, and trustees receiving compensation that is reported on Exhibit 11 have been reported above.

Compensation is defined as the total monetary package paid for the performance of goods or services; those items that are included but not limited to the monies paid for salaries, any form of insurance (life, health, disability, etc.) paid for the employee, car allowance or value if a vehicle is provided, clothing allowance/maintenance agreement, pension, vacation, personal days, sick leave, holidays, deferred compensation/annuity plans, stock/bond or other savings investment plans, etc.

If a facility shares administrative services with another facility, the pro-ration of the compensation paid as reported on Exhibit 11 should also be reported on this Exhibit.

Exhibit 10 - Compensation Of The Five Highest Paid Administrative Officials Of The Hospital

This section must be completed by all facilities. Failure to do so will preclude hospitals from filing the report electronically. Failure to file reasonable and accurate data will result in the rejection of the report until such time as the Exhibit has been properly completed. Reporting of the compensation of the five highest paid administrative individuals refers to non-physician staff.

Compensation is defined as the total monetary package paid for the performance of goods or services; those items that are included but not limited to the monies paid for salaries, any form of insurance (life, health, disability, etc.) paid for the employee, car allowance or value if a vehicle is provided, clothing allowance/maintenance agreement, pension, vacation, personal days, sick leave, holidays, deferred compensation/annuity plans, stock/bond or other savings investment plans, etc.
If a facility shares administrative services with another facility, the pro-ration of the compensation

paid as reported on Exhibit 11 should also be reported on this Exhibit.

Exhibit 11 - (Worksheet A) - Detail of Specific Hospital Expenses

Refer to Medicare Instructions - Section 3610

Note: an additional column, "Fringe Benefits", has been added for facilities who do not report total fringe benefits in the opening balance of Employee Benefits (cost center 003) but choose to directly assign the fringe benefits to specific cost centers. Included in Fringe Benefits are such payroll related costs as FICA, SUI, vacation, holiday and sick leave, group health insurance, group life insurance, pension and retirement, workers' compensation insurance, non-payroll related benefits such as providing day care for children of employees, and other generally accepted benefits.

When completing this worksheet do not combine the inpatient areas into line 201. If the hospital operates and is licensed for separate patient units (i.e. medical/surgical, ICU, pediatrics, etc.), the costs and statistics must be reported separately to permit the allocation of costs by service level.

All certified and/or funded Mental Hygiene outpatient programs must be reported on these worksheets.

If more than one skilled nursing facility is operated by the hospital, the data should not be combined into line 268. The costs and statistics must be reported separately.

All outpatient services that receive a discrete rate must have the cost and statistics separately identified.

Alternative Level of Care
All costs and statistical data for patients receiving this level of care in a designated ALC bed or group of beds must be reported on line 219.

HIV Cost Center Codes
Those facilities which has an organized inpatient HIV care unit must use cost center code 224 to report their costs on Exhibit 11. Those facilities which have organized HIV outpatient clinics must use cost center code 263 to report their costs on Exhibit 11. These cost center codes should not be used to report any costs other than HIV expenses.

Women, Infants and Children (WIC) Program
All facilities which participate in the WIC Program must discretely report all costs and revenue associated with this program in cost center 418. Failure to discretely report this information may result in the report being determined incomplete and unacceptable.

Swing Bed Services
Do not set up a specific cost center for this service. Costs and revenue should be reported in the cost center where the swing bed occurred (i.e. Medical Surgical, Pediatrics, etc).

Exhibit 12 - (Worksheet A-6) - Reclassification

Refer to Medicare Instructions - Section 3611

Note: an additional column, "Fringe Benefits", has been added to this Exhibit to specifically identify fringe benefit reclassifications.

Exhibit 13 - (Worksheet A-7, Parts I, II and III) - Analysis of Charges in Capital Asset Balances. (Worksheet A-7, Part IV) – Reconciliation of Amounts from Wkst A, Column 2, Lines 1-4

Refer to Medicare Instructions - Section 3612

Exhibit 14 - (Worksheet A-8) - Adjustments to Expense

Refer to Medicare Instructions - Section 3613.

The provider will indicate what payor the adjustment pertains to by entering the cost center code number in the appropriate column or columns. If the All Payors column is utilized, do not make an entry in the remaining payor columns.

Exhibit 14 – Adjustments to Expenses – two additional columns have been added to separate the All Payor and Medicaid adjustments to expenses into salary and non-salary columns. The two new columns will total to the existing column 0707 for Medicare purposes. Providers will not be able to enter into the 0707 column. Revenue or expense that is readily identifiable should be reported in the appropriate column. Capital (i.e. recovery of interest or depreciation) should be reported in the non-salary column. If the revenue or expense is not clearly identifiable, then the salary/non-salary proportion of that cost center's reclassified trial balance should be applied.

Exhibit 15 - (Worksheet A-8, Exhibit 1 and Worksheet B-2) - Post Stepdown Adjustments

Note: Only final cost centers can be utilized on this Exhibit, since this Exhibit is intended to be utilized after the stepdown process is completed.
This first section is a summary of the adjustments to expense from the detailed schedules. No entry is required, since the detail will automatically transfer.

The three following segments should be completed as the post-stepdown adjustment applies to one or more payors. If it applies to all payors, enter only on that segment. If you enter post-stepdown adjustments for multiple payors, do not use the same lines for both payors. For example, if the adjustments for Medicare are on lines 003 and 004, then use lines 005 and 006 for Medicaid.

Refer to Medicare Instructions - Section 3619.

The first two Medicare post-stepdown adjustment lines are now reserved for two automatic post stepdown adjustments that may be required for providers of outpatient renal dialysis services. The amounts entered on these lines are transferred from Worksheet S-5, Lines 13 and 13.01 to remove Epoietin costs from Renal Dialysis and Home Program Dialysis cost centers (Lines 57 and 64).

Exhibit 16 - (Worksheet A-8-1) Statement of Costs of Services from Related Organizations

Refer to Medicare Instructions - Section 3614

Two additional columns have been added to separate the Net Adjustments Column (column 0707) required as a result of transactions with related organizations into salary and non-salary columns. The two new columns will total to the existing column 0707 for Medicare purposes. Costs that are readily identifiable should be reported in the appropriate column. Capital should be reported in the non-salary column. If the costs are not clearly identifiable, then the salary/non-salary proportion of that cost center's reclassified trial balance should be applied.

Exhibit 17 - (Worksheet A-8-2) - Provider Based Physicians Adjustment

Refer to Medicare Instructions Section 3615.

Exhibit 18 - Detail of Specific Expenses

Administrative and General:
Report the details of administrative and general expenses that are included in cost centers 22 through 26 and 095 of Exhibit 11 column 3, and also report the details of any additional administrative and

general expenses that are reported elsewhere on Exhibit 11.
Note: this section has been expanded to include a column for directly assigned fringe benefits.

Operation and Maintenance of Plant:
Report the details of operation and maintenance of plant expenses that are included in cost centers 004 and 041 of Exhibit 11 column 3, and also report the details of any additional operation and maintenance of plant expenses that are included elsewhere in Exhibit 11. Note: this section has been expanded to include a column for directly assigned fringe benefits.

All fuel oil should be reported on line 054.

Hospitals that operate parking facilities or have contracted for parking or have arrangements with related corporations for parking must give specific identification of these costs between employee parking and parking for community convenience. These costs should be identified on lines 068 and 069 under Operation and Maintenance of Plant. The reporting of these costs should be concurrent with the reporting of parking lot receipts identified as other income on line 017 of Exhibit 26A, of the ICR.

Employee Health and Welfare:
Report the details of employee health and welfare expenses that are included in cost center 003 of Exhibit 11 column 3, and any other dedicated employee health and welfare expense cost centers established by the provider on Exhibit 11 plus the total of fringe benefits, column 2.01 on Exhibit 11.

Exhibit 19 - (Worksheet B-1) Routine Allocation Statistics

Refer to Medicare Instructions - Section 3617

Exhibit 20 - (Worksheet B-3) Ancillary Allocation Statistics

Section designed to be self-explanatory

Exhibit 21 - Balance Sheet for Computation of Return on Equity Capital of Proprietary Providers

Exhibit deleted for cost report years after 1996

Exhibit 22 - Computation of Return on Equity Capital of Proprietary Providers

Exhibit deleted for cost report years after 1996

Exhibit 23 - (Worksheet G) - Balance Sheet

Refer to Medicare Instructions - Section 3640

Definitions:

CURRENT ASSETS

Cash On Hand and in Banks
These cash accounts represent the amount of cash on deposit in banks that is immediately available for use in financing unrestricted fund activities, amounts of cash that are on hand for minor disbursements, and amounts of cash that are held in savings accounts and certificates of deposit.

Temporary Investments
Current securities, evidenced by certificates of ownership or indebtedness, should be recorded in these accounts.

Notes Receivable & Accounts Receivable
These accounts should reflect the amounts due from hospital patients and their third-party sponsors.

Other Receivables
The balances in these accounts reflect pledges, grants and legacies due the hospital as well as miscellaneous receivables due from staff, employees, affiliates, etc. An allowance for the estimated amount of uncollectible pledges should also be recorded.

ALLOWANCES FOR UNCOLLECTIBLE

Notes & Accounts Receivable
These are valuation (or contra-asset) accounts. Credit balances represent the estimated amount of uncollectible receivables from patients and third-party payers.

Inventory
These balances reflect the cost of unused hospital supplies. Any generally accepted cost method (e.g., FIFO, LIFO, etc.) may be used as long as it is consistent with that of the preceding accounting period. The extent of inventory control and detailed record keeping will depend upon the size and organizational complexity of the hospital.

Prepaid Expenses
These prepaid asset and other asset accounts represent costs incurred that are properly chargeable to a future accounting period.

FIXED ASSETS

Land
The balance of this account reflects the cost of land used in hospital operations. Included here is the cost of off-site sewer and water lines, public utility charges for servicing the land, governmental assessments for street paving and sewers, the cost of permanent roadways and of grading of a non-depreciable nature, the cost of curbs and of sidewalks whose replacement is not the responsibility of the hospital, as well as other land expenditures of a non-depreciable nature. Unlike buildings and equipment, land does not deteriorate with use or with the passage of time; therefore, no depreciation is accumulated.

Land Improvements
All land expenditures of a depreciable nature that are used in hospital operations are charged to this account. This would include the cost of on-site sewer and water lines; paving of roadways, parking lots, curbs and sidewalks (if replacement is the responsibility of the hospital), as well as the cost of shrubbery, fences and walls.

Building & Fixed Equipment
The cost of all buildings and subsequent additions used in hospital operations shall be charged to this account. Included are all architectural, consulting and legal fees related to the acquisition or construction of buildings. Interest paid for construction financing is a cost of the building and is included in this account. Fixed equipment should fulfill the following requirements: affixed to the building, not subject to transfer or removal; a life of two or more years, but less than that of the building to which it is affixed; used in hospital operations. Fixed equipment includes such items as boilers, generators, elevators, engines, pumps and refrigeration machinery, including the plumbing, wiring, etc., necessary for equipment operations.

Leasehold Improvements
All expenditures for the improvement of a leasehold used in hospital operations shall be charges to this account.

Movable Equipment
Equipment to be charged to this account has the following general characteristics: ability to be moved, as distinguished from fixed equipment; used in hospital operations; and a useful life of greater than 1 year.

Non-depreciable Equipment
The balance in this account is used to record intangible assets. If such intangible assets are being amortized, the asset value is to be shown net of amortization. This account may also include depreciable assets not used in hospital operations.
Accumulated Depreciation or Amortization on: Land Improvements, Building & Fixed Equipment Leasehold Improvements & Moveable Equipment
The balances in these accounts reflect the amortization or depreciation accumulated on the fixed assets used in the hospital operations.

ASSETS LIMITED AS TO USE

Sinking Fund Assets
The balance in the account is for funds paid in conjunction with a FHA mortgage and held by the mortgagor for retirement mortgage principal.

Debt Service Reserve Fund
The balance in this account is funds paid in conjunction with revenue bonds and held by the mortgagor for retirement of mortgage principal.

Undistributed Bond Proceeds
The balance in this account represents the unexpended bond proceeds held by public finance agencies.

Self Insurance Fund Trusteed Assets
The balance in this account represents the amount of funds being held or invested for self insurance.

Assets Held As Collateral for Construction Program Financing
The balance in this account represents the amount investments and other assets use as collateral in obtaining the construction financing.

Depreciation Fund Assets
The balance in this account represents the amount of funds or investments being held to replacement of fixed assets.

Deferred Employee Compensation Plan Assets
The balance in this account represents the funds or investments held to pay employees at a future data for deferred compensation.

Operating Escrow
The balance in this account represents funds held in conjunction with 28A and 28B bonding for approved operating costs or approved project renovations.

Investments
Securities with a maturity greater than one year evidenced by Certificates of ownership or indebtedness, should be recorded in these accounts.

Deposit on Leases
The balance in this account represents the total deposits on all leases.

Due from Owners/Officers
The balance in this account represents the total of all cash or notes due from all owners/officers.

CURRENT LIABILITIES

Accounts Payable
The balances in these accounts reflect the amounts due to trade and other creditors for supplies and services purchased.

Salaries, Wages & Fees Payable
The balances in these accounts reflect the actual or estimated liabilities of the Hospital for salaries, wages and fees payable.

Payroll Taxes Payable
The balances in these account reflect the actual or estimated liabilities of the Hospital related to payroll.

Notes & Loans Payable (Short Term)
These balances reflect liabilities of the hospital to vendors, banks and others, evidenced by promissory notes due and payable within one year.

Current Portion of Long Term Debt
These balances reflect amount payable within one year on liabilities of the Hospital to vendors, banks and others, evidenced by promissory notes due, or the current portion of the hospital's mortgage and payables.

Deferred Income
Deferred income is defined as income received or accrued which is applicable to services to be rendered within the next accounting period and/or the current year's effect of deferred income items classified as non-current liabilities. Deferred income applicable to accounting periods extending beyond the next accounting period should be included in Other Non-Current Liabilities.

Accelerated Payments
Include in these accounts liabilities to third-party payors for current financing and other types of advances payable within one year. Do not include liabilities to third-party payors arising from reimbursement settlements. Such liabilities must be included in Due to Third-Party Payors.

Due to Other Funds
These accounts reflect the amounts due to other funds by the Operating Fund. Under no circumstances should these accounts be construed as payables in the sense that an obligation external to the hospital exists.

Research Grants
These accounts reflect the unexpected funds from research grants.

Due to Third Party Payors
These accounts reflect reimbursement settlements due to third party payors which will be paid within one year.

LONG-TERM LIABILITIES

Mortgage Payable, Notes Payable and Unsecured Loans
These accounts reflect those liabilities that have maturity dates extending more than one year beyond the current year-end. These balances are net of the amount recorded under current portion of Long Term debt.

Loans From Owners- Prior to 7/1/66, On or after 7/1/66
The balance in these accounts represents the amount of loans or notes to owners.

Due to Third Party Payors
The balance in this account represents the total of all liabilities owed to third party payors which will not be paid within one year.

Self Insured Liability and Deferred Employee Compensation
The balance in these accounts represent the liability for expenses accrued or the assets being held to pay for these expenditures.

CAPITAL ACCOUNTS

General Fund Balance
Unrestricted Fund balances represent the difference between the total of Unrestricted Fund Assets and Unrestricted Fund Liabilities, i.e., the net assets of the Unrestricted Fund. Separate sub-accounts may be maintained for the above when applicable. The Transfers from Restricted Funds for Capital Outlay account should be credited for the cost of capital items purchased by the Unrestricted Fund with funds from the Plant Replacement and Expansion Fund. The fair market value of donated property, plant and equipment (at the date of donation) should be credited to the Donated Property, Plant and Equipment account. At the end of the year these accounts should be closed out to the Fund Balance account.

Depreciation Funds represents amounts restricted by third-party payors for replacement of specified assets.

Specific Purpose Fund Balance
The credit balances of these accounts represent the net amount of this restricted fund's assets available for its designated purpose. These accounts must be credited for all income earned on restricted fund assets, as well as gains on the disposal of such assets. If, however, such items are to be treated as Unrestricted Fund income (considering legal requirements and donor intent), the Restricted Fund Balance account should be charged, and the Due to Operating Fund account credited, for such income.

Donor Created-Endowment Fund Balance-Restricted, Unrestricted and Governing Body Created -Endowment Fund Balance
The credit balances of these accounts represent the net amount of this restricted fund's assets available for its designated purpose. These accounts must be credited for all income earned on restricted fund assets, as well as gains on the disposal of such assets. If, however, such items are to be treated as Operating Fund income (considering legal requirements and donor intent), the Restricted Fund Balance account should be charged, and the Due to Operating Fund account credited, for such income.

Plant Fund Balance- Invested in Plant and Reserve for Plant Fund Improvement
The credit balances of these accounts represents the net amount of this restricted fund's assets available for its designated purpose. These accounts must be credited for all income earned on restricted funds assets, as well as gains and losses on the disposal of such assets. If, however, such items are to be treated as Unrestricted Fund income (considering legal requirements and donor intent), the Restricted Fund Balance account should be charged, and the Due to Unrestricted Fund account credited, for such income.

Exhibit 24 - (Worksheet G-1) Changes in Fund Balance

Refer to Medicare Instructions - Section 3640

Exhibit 25 - Statement of Cash Flows

This Exhibit should be completed in accordance with the provider's Audited Financial Statements.

Exhibit 26 - (Worksheet G-2) Statement of Revenues and Operating Expenses

Refer to Medicare Instructions - Section 3640.

Exhibit 26A - (Worksheet G-3) Statement of Revenues and Expenses

Refer to Medicare Instructions - Section 3640.

For an amount to appear on lines 24.07, 24.08, and/or 23, Exhibit 27 must be completed.

Any Health Facility Cash Assessment paid on non-patient related services or non-operating income should be reported on line 507 as a positive.

All unrealized investment income or loss must be reported on lines 510 and 511. This income is not required to be offset.

Any realized special purpose organization investment income that is donor restricted is required to be reported on lines 020 or 503. This income is not required to be offset. Lines 121 and 502 must be used to report the realized special purpose organization investment income that is unrestricted. For Medicaid purposes, this unrestricted income should be offset first to reduce operating interest expense and then used to reduce capital interest expense.

The provider reimbursement manual, CMS Pub.15-1, Section 1011.7 defines special purpose organizations as follows:

> "A provider may establish a separate, special purpose organization to conduct certain of the provider's patient-care-related or nonpatient-care-related activities (e.g., a development foundation assumes the provider's fund raising activity). Often, the provider does not own the special purpose organization, and has no common governing body membership. However, such a special purpose organization is considered to be related to a provider if:
>
> a. The provider controls the special purpose organization through contracts or other legal documents that give the provider the authority to direct the special purpose organization's activities, management, and policies; or
>
> b. The provider is, for all practical purposes, the sole beneficiary of a special purpose organization's activities. The provider should be considered the special purpose organization's sole beneficiary if one or more of the three following circumstances exist:
>
> 1. A special purpose organization has solicited funds in the name of and with the expressed or implied approval of the provider, and substantially all the funds solicited by the organization were intended by the contributor or were otherwise required to be transferred to the provider or used at its discretion or direction;
>
> 2. The provider has transferred some of its resources to a special purpose organization, substantially all of whose resources are held for the benefit of the provider; or

3. The provider has assigned certain of its functions (such as operation of a dormitory) to a special purpose organization that is operating primarily for the benefit of the provider."

Please note: the principal of a gift can be restricted while the income may be unrestricted. For Medicaid purposes, any unrestricted realized income from gifts or grants should be offset.

Exhibit 27 - Appropriations from Special Funds

Note: OMH Deficit Funding Grants should only be reported in the Government Grants Section; they should not be reported in the Appropriations from Special Funds Offsets/Non-Offsets Sections.

Facilities must report governmental grants by inpatient and outpatient funding on this Exhibit.

Note: an additional column has been added to indicate what cost center the grant corresponds to. If more than one cost center is applicable, enter the cost center to which the majority of the grant pertains to. The entire amount of the grant must be reported.

Public Hospitals should report their health care worker recruitment and retention revenues as a government grant on one of the "other" lines in the inpatient column.

The revenue hospitals receive from CHCCDP (Community Health Care Conversion Demonstration Program) should be reported as a government grant on this exhibit.

Exhibit 28 - Reconciliation to the Audited Financial Statements

This Exhibit was designed to reconcile the provider's accounting books and records to the Audited Financial Statements prepared by the Certified Public Accountant.

Exhibit 29 - Notes to Financial Statements

This Exhibit should reflect the notes included in the Audited Financial Statements. See the dedicated help screen for more information.

An alternative to completing this exhibit is available by attaching a pdf file of the Notes to the Financial Statements to the DH file. Create a PDF file of the facility's Exhibit 29 information from a document created in Word or other word processing software prior to creating the DOH extract file. You will be prompted for the PDF file's name and location during the DOH extract file's creation.

Exhibit 30 - Inpatient and Swing Bed Statistics

Inpatient Statistics
Statistical data reported on Exhibit 3, (worksheet S-2) of the ICR will automatically transfer to this exhibit as part of the software programming. ALC days should be input on this schedule by service.

Hospitals that are certified to provide Neonatal Care may be licensed for one, two, or all three of the following categories:

Neonatal Intensive Care
Neonatal Intermediate Care
Neonatal Continuing Care

The provider should enter the days and discharges of the appropriate service(s) it is licensed for.

In the column titled "Medicare Days for Patients who are Medicaid Eligible", report the patients who

have Medicare as their primary payor who would otherwise be eligible for Medicaid or who have Medicaid as their secondary payor.

In the column titled " Less ALC Days" on the EICR software, the only services that should show ALC days are the services that are included in the acute section on Exhibit 32. Do not report exempt unit ALC days in this column.

It should be noted that swing bed utilization is not considered an inpatient statistic, therefore it should be reported under Swing Bed Utilization only.

SWING BED UTILIZATION - Qualified hospitals participating in the swing bed program established under Part 406 are required to complete the swing bed utilization schedule. Under the swing bed program, hospitals may utilize available designated beds to provide nursing home program services.

The number of patients, discharges and patient days should be reported by facilities who have been approved in the Department of Health's Swing Bed Utilization Program.

Exhibit 31 – Statistical Data, Special Service Statistics

Exhibit deleted for cost report years after 2008

Exhibit 31A - Transfer Statistics

This Exhibit is designed to report patient transfer statistics to be utilized in the transfer of costs to final cost centers.

The statistics for the Emergency Room, Psych ER, and General Clinic columns must be visits. These columns will only allow input to inpatient cost centers.
The statistics for the Non-Approved Interns and Residents Program column must be hours. This column will allow input for inpatient and outpatient cost centers.

Exhibit 32 - Patient Days And Discharges By Source Of Payment -Definitions Specific Payor Codes

Statistical information is to be reported in its entirety for EACH different rate code provided by the facility. Detailed payors' data maintained by the facility should be reported in the most appropriate category and not combined or reported in the "Other" category.

Alternate level of care (ALC) days should not be included in the "Patient Days" column, but should be listed separately in the "ALC Patient Days" column; For each service- ALC days should be reported whether or not the patients were housed in a separate unit.

Patient days and discharges are defined as follows:

PATIENT DISCHARGES - an inpatient shall be defined as discharged when:
(1) the patient is released from the facility to a non-acute care setting; or
(2) the patient expires in the facility; or
(3) the patient is transferred to a facility or unit that is exempt from the case-based system except when the patient is a newborn transferred to an exempt hospital for neonatal services. Such infants shall be classified as transfer patients; or
(4) it is a neonate being released from a hospital providing neonatal specialty services back to the community hospital of birth for weight gain.

PATIENT DAYS - the number of days during which a patient remains in acute care or exempt unit status. This is computed according to the following guidelines: (1) each day begins at midnight and continues for twenty-four hours; (2) the day of admission is counted as a full day; (3) the day of

death, transfer, or discharge is not counted. If discharge, transfer or death occurs on the same day as admission, the length of stay is considered to be one patient day.

ALC DAYS - the number of days that services were provided by a hospital to a patient for whom it has been determined that inpatient hospital services are not medically necessary, but that post-hospital extended care services are medically necessary, consistent with utilization review standards, and are being provided by the hospital and are not otherwise available.

TRANSFERS - an inpatient who is not discharged, as defined herein, or moved between divisions of a merged or consolidated facility, or who is not assigned to a DRG specifically identified as a DRG for transferred patients only, and who meets one of the following conditions:

(1) is transferred from an acute care facility reimbursed under the DRG case-based payment system to another acute care facility reimbursed under this system;
(2) is transferred to an out-of -state acute care facility; or
(3) is a neonate who is being transferred to an exempt hospital for neonatal services.

Transfers shall include, but not be limited to transfers between more than two acute care facilities, and transfers from those hospitals excluded from the DRG case-based system because of participation in an approved Medicaid cost control program or demonstration, to a hospital reimbursed pursuant to the DRG case-based payment system.

ADMISSION - patients admitted upon referral and under the care of a licensed and currently registered practitioner who is granted admitting privileges by the governing body.

Rate codes are defined as follows:

ACUTE - for the purpose of this section of the ICR, the category "Acute", in addition to medical/surgical, shall include areas such as ICU, CCU, pediatrics, maternity, routine nursery (newborn), neonatal, approved premature nursery, as well as any services for which the hospital did not receive exempt unit status and any similar corresponding separate rates. Alcohol and Drug Detox programs certified by OASAS should be reported separately.

PSYCHIATRIC - any patient days/discharges/ALC patient days for those service areas incurred in providing daily bedside care to Psychiatric inpatients on the basis of physicians' orders and approved nursing care plans.

Comprehensive Psychiatric Emergency Program (CPEP), Extended Observation Beds
Beds operated by the Comprehensive Psychiatric Emergency Program which are located in or adjacent to the emergency room of a CPEP and are available 24 hours per day, seven days per week to provide extended assessment and evaluation as well as a safe and humane environment for up to 72 hours for those presenting to the CPEP. This program is one of four program components which, when provided together, form the Office of Mental Health licensed Comprehensive Psychiatric Emergency Program (CPEP). The other program components of the CPEP are: Crisis Intervention (CPEP, Code 3130), Crisis Outreach (CPEP, Code 1680), and Crisis Residence (CPEP, Code 1910). Please note: Extended Observation Beds utilizes ICR Cost Center 216.

HIV - any patient days/discharges/ALC patient days incurred in providing daily bedside care to Human Immunodeficiency Virus (HIV) positive patients for those services which are organized and provided on a concentrated or continuous basis to meet special health care needs. Each service shall be provided with a concentration of professional staff and supportive services that are appropriate to the scope of services provided.

ALCOHOL REHAB - any patient days/discharges/ALC patient days incurred in providing daily bedside

care to Alcohol Rehabilitation patients. The hospital must also employ specially trained personnel to staff this unit. and at least one psychiatrist on the medical staff.

DRUG REHAB - any patient days/discharges/ALC days incurred in providing daily bedside care to Drug Rehabilitation patients. The hospital must also employ specially trained personnel to staff this unit with at least one psychiatrist on the medical staff.

EPILEPSY - any patient days/discharges/ALC days incurred in providing daily bedside care to Epilepsy patients for those services which are organized and provided on a concentrated or continuous basis to meet special health care needs. Each service shall be provided with a concentration of professional staff and supportive services that are appropriate to the scope of services provided.

OTHER SPECIFY - any patient days/discharges/ALC days incurred in providing daily bedside care for the patients specified. This cost center should be specified in Title 10 NYCRR.
PHYSICAL MEDICAL REHAB - any patient days/discharges/ALC days incurred in providing daily bedside care for the Medical Rehabilitation patients for rehabilitation services consistent with the needs of the patients. Individualized, goal-oriented, comprehensive and coordinated services will be designed to minimize the effects of physical, mental, social and vocational disadvantages and to effect a realization of the patient's potential for useful and productive activity while ensuring the health and safety of the patient.

TBI/COMA - any patient days/discharges/ALC days incurred in providing daily bedside care to TBI/COMA patients. Inpatient rehabilitation programs for traumatic brain injured patients are intensive rehabilitation programs designed to prevent and/or minimize chronic disabilities while restoring the individual to the optimal level of physical, cognitive, and behavioral functioning.

A coma recovery program is closely linked though may be separate from the inpatient rehabilitation unit. It is designed to assess and manage Rancho level 1-3 patients who are not yet able to participate in an inpatient rehabilitation program.

ALCOHOL AND DRUG DETOX – any patient days/discharges/ALC days incurred in providing daily bedside care for those inpatients in Alcohol or drug Detox programs certified by OASAS.

CRITICAL ACCESS HOSPITAL - any patient days/discharges/ALC days incurred in providing daily bedside care for those inpatients in a facility that qualifies as a Critical Access Hospital (CAH).

Payor source are defined as follows:

MEDICARE - utilization for patients for which billing for services has been directly submitted to the Medicare third party fiscal intermediary; these persons are over 65 years of age or disabled and receiving Social Security benefits for over two years or those people with End Stage Renal Disease (ESRD) and are eligible to receive federal health insurance for the aged and disabled through Title XVIII of the Social Security Act.

MEDICAID - utilization for patients for which billing for services has been directly submitted to the Medicaid third party fiscal intermediary; these people are medically indigent and are eligible to receive health care benefits through Provisions of the State Social Services Law. This program is government funded and State administered to provide medical benefits for certain low income persons.

NON-PROFIT MEDICAL INDEMNITY INSURANCE - utilization for patients for which billing for services has been directly submitted to a non-profit medical indemnity insurance carrier licensed pursuant to Article 43 of the State Insurance Law for payment of services provided to beneficiaries insured through a medical indemnity insurance policy with such carriers. Article 43 carriers licensed by the State Insurance Department include indemnity insurance policies offered by Blue Cross Plans, Blue Shield, GHI and other miscellaneous indemnity non-profit insurance carriers.

COMMERCIAL INDEMNITY INSURANCE - utilization for patients for which billing for services has been directly submitted to for-profit medical indemnity medical insurance carrier licensed under Article 42 of the State Insurance Law for payment of services provided to beneficiaries insured through a medical indemnity insurance policy with such carrier.

HMO/MEDICARE - utilization for Medicare patients whose services are covered under a premium policy with a federally authorized Health Maintenance Organization which has been billed directly for services rendered.

HMO/PHSP MEDICAID - utilization for Medicaid patients whose services are covered under a premium policy with a Health Maintenance Organization or NYS licensed Prepaid Health Service Plan (PHSP) which has been billed directly for services rendered. This would include patients covered by the Family Health Plus program.

HMO/PHSP OTHER - utilization for Non-Medicare/Non-Medicaid patients whose services are covered under a premium policy with a Health Maintenance Organization or NYS licensed Prepaid Health Service Plan which has been directly billed for services rendered. This would include patients covered by the Children's Health Plus program.

SELF INSURED - any utilization for patients whose services are covered by a self-insured fund which is either self-administered or administered by a third-party agent for the purpose of processing claims on such funds behalf.

WORKER'S COMPENSATION - utilization for patients for which billing has been submitted to the Worker's Compensation because the patient's admission or service is the result of occupational related illness or injury.

NO FAULT - utilization for patients for which billing for services has been submitted to an insurance carrier for services rendered to patients for illness or injury arising from the use, maintenance or operation of a motor vehicle.

UNINSURED/SELF-PAY - utilization for patients having no third-party or other insurance coverage and are thus solely responsible for payment of the charges, whether in full or in part, for the services rendered. In cases where the patient is insured but the service provided is completely uncovered by the insurer, the case is to be considered a self-pay case. Conversely, if the service provided is partially covered by a third-party insurance carrier the case should not be designated as self-pay and should be reported in accordance with the definitions established for other patient categories described herein.

GOVERNMENT - utilization for patients in which services rendered will be paid by programs administered by Federal, State, or Local governments other than Medicaid and Medicare. Examples of such programs include Physically Handicapped Children's Program, CHAMPUS/VA, payments made by correction facilities for services rendered to inmates, etc.

FREE (Charity, Hill Burton) - utilization provided to a patient free of charge or at a reduced charge as a result of a patient's indigent income status or the hospital's charity care policy. This will include free care provided to cases in compliance with obligations entered into under the Hill-Burton Program as well as other forms of care provided consistent with this definition.

COURTESY - utilization for patients whose services are provided at reduced rates or free of charge through a courtesy arrangement established with a specific class of patients, e.g. employees, clergy, etc.

UNCOMPENSATED CARE COLLECTIONS – in accordance with Section 2807-k5-a(c), uncompensated care need distributions on and after January 1, 2010 shall be reduced by the sum of all payment amounts

collected for all uninsured patients. For each inpatient service provided, report the amount of cash received during the reporting year associated with that service's Uninsured/Self Pay and Free (Charity, Hill Burton) discharges. As you are reporting the collections on a cash basis, include all cash collected during 2009 (for calendar year filers), whether it pertains to a prior year or 2009.

Exhibit 33 - Statistical Data, Patient Visits, Patient Characteristics, Ambulatory Visits for Source of Payment

The provider should refer to Exhibit 32 instructions regarding definitions for Payor Source.

The provider should complete those outpatient services statistics which are applicable to the hospital. Space has been provided for up to 4 "Other" Services not hardcoded. The provider should type the specific name in the space provided. Space has also been provided to identify what cost center number corresponds to the "Other" visits.

Both columns, "Number of Visits" and "Excluding Inpatient Admissions" must be completed even if the number of visits are the same for both columns.

Do not include Home Health Agency visits on this Exhibit. Those statistics should be entered on Exhibit 34.

The statistic for Ambulatory Surgery is procedures, not visits.

UNCOMPENSATED CARE COLLECTIONS – in accordance with Section 2807-k5-a(c), uncompensated care need distributions on and after January 1, 2010 shall be reduced by the sum of all payment amounts collected for all uninsured patients. For each outpatient service provided, report the amount of cash received during the reporting year associated with that service's Uninsured/Self Pay and Free (Charity, Hill Burton) visits excluding inpatient admissions. As you are reporting the collections on a cash basis, include all cash collected during 2009 (for calendar year filers), whether it pertains to a prior year or 2009.

Exhibit 34 - Hospital Based Home Health Agencies (Home Care Program)

This exhibit must be completed by all hospitals desiring reimbursement for home health care services. Home health care services are defined as services performed in the patient's place of residence by nurses, therapists, or home health aides. They may also include home based medical, social services provided in the patient's place of residence. This exhibit must include a Home Health Agency Operating Certificate Number. Do not report your Home Health Agency visits on Exhibit 33.

Detail visits by payor for approved Home Health Services provided by the hospital during the reporting period. These services would include, Nursing, Physical Therapy, Speech Therapy, and Occupational Therapy. All corresponding charges are to be reported distinctly on Exhibit 46.

Detail hours by payor for Home Health Aides services by the hospital during the reporting period. All corresponding charges are to be reported on Exhibit 46.

Report on line 108 the total criminal history record checks performed in accordance with provisions of Part 400.23 of Title 10 of the Codes, Rules and Regulations of the State of New York (NYCRR).
Report on line 109 the total expenses, fees, and related administrative costs associated with the criminal history record checks reported on the previous line.
Report on line 110 the sum of payments collected from all uninsured/self pay and free patients. Do not include co-pays and deductibles that insured patients pay. As you are reporting the collections on a cash basis, include all cash collected during 2009, whether it pertains to a prior year or 2009.

Exhibit 34A – Revenue and Expense Details for Home Health Agency Add-Ons

This exhibit must be completed by all hospitals receiving reimbursement for home health care services; specifically the rate add-ons associated with PHL 3614(8) through (11). Any provider that completed Exhibit 34 should also complete this exhibit which details the revenue and expenses associated with the following Home Health Agency (HHA) rate add-ons:

1) Worker Recruitment and Retention (WRR) - (PHL 3614-8).
2) Worker Recruitment, Training and Retention (RTR) - (PHL 3614-9 & 10).
3) Accessibility, Quality and Efficiency (AQE) - (PHL 3614-11).
   Note: this add-on is only applicable to certified HHA's NOT located in a city with a population of over one million persons.

The Public Health Law details what each of these add-ons to the HHA therapy and aides rates should be used for and providers were required to attest that the funds would be used solely for those purposes.

Line 111 – Worker Recruitment and Retention Revenue – report all revenue accrued from the rate add-on calculated in accordance with the Public Health Law Article 3614, Section 8.
Line 112 – Worker Recruitment, Training and Retention Revenue – report all revenue accrued from the rate add-on calculated in accordance with the Public Health Law Article 3614, Sections 9 and 10.
Lines 113 through 123 – identify the HHA expenses associated with the funds received for Worker Recruitment and Retention and Worker Recruitment, Training and Retention. Allowable costs for HHA services shall not include expenses funded by the WRR and RTR add-ons, therefore it is important that these expenses are reported properly. For any amounts reported on lines 119 through 123 of this exhibit, a description of the expenses must be provided.
Line 131 – Accessibility, Quality and Efficiency Revenue – report all revenue accrued from the rate add-on calculated in accordance with the Public Health Law Article 3614, Section 11.
Lines 132 through 143 - identify the HHA expenses associated with funds received for Accessibility, Quality and Efficiency. Allowable costs for HHA services shall not include expenses funded by the AQE add-on, therefore it is important that these expenses are reported properly. For any amounts reported on lines 139 through 143 of this exhibit, a description of the expenses must be provided.
Lines 151 through 155 – please provide the breakdown of the total WRR, RTR and AQE expenses by service. These amounts will be used to adjust allowable costs for Therapy and Aides on your facility's Home Health Agency rate exhibit. Please note that the total add-on expenses (Line 160) should equal Line 130 + Line 150.

Exhibit 35 - Hospital Personnel Wage Survey

The data required for this exhibit are for the report period.

NOTE: Columns 1 and 2 are to one decimal place.
Column 1 To compute full time equivalents, divide the total paid hours (including vacation, sick leave and overtime) for all employees in each title by the number of hours in the standard workweek, then divide by the number of weeks in the payroll period. If different classification of employees within each title (i.e., part-time, union, non-union) have different standard workweek hours, compute the full-time equivalent employees for each classification separately and combine the result. If employees are paid for unused sick leave, exclude the hours so paid from the calculations.
Column 2 Enter standard number of hours in the workweek for that title.

NOTE: Columns 3 to 8 are whole numbers only.

Column 3 Enter total hours paid exclusive of on-call hours (straight time plus overtime as recorded on your payroll records).

Column 4 Enter the total overtime hours included in Column 3.

Column 6 Enter the total payroll dollars paid exclusive of retroactive pay. Include pay for on-call hours.

Column 7 Enter total overtime dollars (straight time plus premium pay) included in Column 6.

Please review all entries to ensure that no mathematical or typing errors exist and that the average hourly wage (Column 9) is appropriate for the job title.

The following is a brief description of selected job titles:

Medicine and Health Services Managers (Nursing Service Directors, Emergency Medical Service Coordinators, Medical Records Administrators, etc.)
Plans, organizes, directs, controls or coordinates medicine and health services. Includes department heads.

All Other Managers and Administrators
Top and middle level managers, administrators and executives. Primary duties are policy making, planning, staffing, directing or controlling the hospital. Excludes first-line supervisors and managers with first-line duties.

Accountants, Auditors and Other Financial Specialists
Plan and administer accounting services, advice on tax and accountancy problems, conduct audits, and plan and administer other financial activities, such as budget analysis, credit review and reimbursement.

All Other Management Support Occupations
Includes purchasing agents, personnel, training and labor relations specialists, management analysts and other professional, paraprofessional and technical titles that assist management in policy making planning, staffing, directing or controlling the hospital.

Social Workers Includes but not limited to the following titles:
-Social Workers, Medical and Psychiatric (Drug or Alcohol Addiction Counselors; Medical Caseworkers; etc.)

-Counsels and aids individuals and families with problems that may arise during or following the recovery from physical or mental illness by providing supportive services designed to help people understand, accept, and follow medical recommendations. Include Chemical Dependency Counselors.

-Social Workers (Caseworkers; Community Organization Workers; etc.)
Counsels and aids individuals and families requiring social service assistance. Includes Community Organization Social Workers who plan, organize and work with community groups to solve problems.

Post Graduate Trainees
Interns, residents and fellows providing patient care services as part of a medical training program approved by the ACGME, AOA, or an equivalent accrediting program approved by the New York State Education Department.
Respiratory Therapists (Inhalation Therapists, etc.)
Sets up and operates various types of equipment, such as iron lungs, oxygen tents, resuscitators, and incubators, to administer oxygen and other gases to patients.

Occupational Therapists (Industrial Therapists, etc.)
Plan, organize, and participate in medically oriented occupational program to rehabilitate patients who are physically or mentally ill.

Physical Therapists (Physiotherapists; Pediatric Physical Therapists; Pulmonary Physical Therapists;

etc.)
Apply techniques and treatments that help relieve pain, increase the patient's strength, and decrease or prevent deformity and crippling.

Speech Pathologists and Audiologists (Speech Therapists; Speech Clinicians; etc.)
Examine and provide remedial services for persons with speech and hearing disorders and perform research related to speech and language problems.

All Other Therapists
Includes but not limited to corrective and recreational titles, etc.

Certified Registered Nurse Anesthetist
Administers or assists in administration of anesthesia under physician supervision and has successfully passed the certification examination and is certified by the Council on Certification of Nurse Anesthetists.

Nurse Practitioner
Provides primary health care in collaboration with a licensed physician. Person must be a registered nurse, who has graduated from an NP program recognized by the New York State Education Department.

Registered Nurses, Non-Supervisory, Including Head Nurse
This category refers only to registered nurses, including head nurse, involved in hands-on care. They must be licensed by the New York State Education Department (excludes CRNA and Nurse Practitioners).

Nurse Supervisor
Supervises and coordinates activities of nursing personnel engaged in specific nursing services, such as obstetrics, pediatrics or surgery, or for two or more patient care units.

Supervises Head Nurses in carrying out their responsibilities in the management of nursing care. Evaluates performance of Head Nurse and nursing care as a whole and suggests modifications. Inspects unit areas to verify that patient needs are met.

Licensed Practical Nurse
Performs a wide variety of patient care activities and accommodative services for assigned hospital patients, as directed by the Head Nurse and/or team leader.

Physician's Assistants (Ophthalmic Medical Assistants; Orthopedic Physician's Assistants; Surgeon's Assistants; Gynecological Assistants; Pediatric Physician's Assistants; etc.; excludes Nurses)
Provide patient services under direct supervision and responsibility of doctor of medicine or osteopathy. Elicit detailed patient histories and do complete physical examinations. Reach tentative diagnosis and order appropriate laboratory tests. Require substantial educational preparation, usually at colleges or junior colleges.

Pharmacists (Druggists; Registered Pharmacists, etc.)
Compound and dispense medications following prescriptions issued by physicians, dentists or other authorized medical practitioners.

Laboratory Technologist/Technician
Is responsible, under technical supervision, for the accurate completion of any of a wide variety of standard laboratory procedures. Illustrative examples include: performs complete routine chemical, physical and microscopic urinalyses; performs common tests in hematology and blood chemistry; does blood and spinal fluid serology, does gastric analyses and standard bacteriological examinations; prepares standard media, cultures, reagents, stains and solutions; sterilizes equipment; may take specimens; keeps records of work performed and results.

Radiologic Technologists/Technicians
Take X-rays, CAT scans, or administer non-radioactive materials into patient's blood stream for diagnostic and therapeutic purposes. Demonstrate portions of the human body on X-ray film or fluoroscopic screen. Maintain and safely use equipment and supplies necessary to demonstrate portions of the human body on X-ray film or fluoroscopic screen for diagnostic purposes.

Psychologists (Clinical Psychologists; Social Psychologists; etc.)
Collect, interpret and apply scientific data relating to human behavior and mental processes. Activities are in either applied fields of psychology or in basic science fields and research. Includes occupations in personnel research and in administration of testing and counseling programs; excludes psychiatrists.

Dietitians and Nutritionists (Public Health Nutritionists; etc.)
Organize, plan and conduct food service or nutritional program to assist in promotion of health and control of disease. May administer activities of food service department. May plan, organize, and conduct programs in nutritional research.

Medical Secretaries/Secretaries
Performs secretarial duties utilizing specific knowledge of medical terminology and hospital, clinic, or laboratory procedures. Duties include taking dictation, and compiling and recording medical charts, reports, and correspondence using a typewriter. Duties may also include preparing and sending bills to patients or recording appointments. Includes but not limited to the following titles:

-Secretaries
Relieve officials of clerical work and minor administrative and business detail by scheduling appointments, giving information to callers, taking dictation, composing and typing routine correspondence and other records. May perform various other assigned clerical duties.

-Stenographers (Stenotype Operators, etc.)
Takes dictation in shorthand of correspondence, reports, and other material and operates typewriter or word processor to transcribe dictated material. Also perform variety of clerical duties, except when working in a stenographic pool. In addition to stenographic duties, may transcribe material from sound records.

-Receptionists and Information Clerks (Appointment Clerks, etc.)
Answers inquiries and obtains information for general public (customers, visitors and other interested parties) concerning activities conducted at an establishment, location of offices or persons within firm, departments within store, or services within hotel.

-Typists (Clerk-Typists; Medical Transcriptionists; etc.)
Types letters, reports, stencils, forms, addresses, or other straight copy material from rough draft, corrected copy, or voice recording. May perform other clerical duties as assigned.

Clerks - All Titles
Includes but not limited to the following titles:

-Adjustment Clerks (Customer Complaint Clerks, etc.)
-Billing (Medical Insurance) Clerks
-Bookkeeping, Accounting and Auditing Clerks
-File Clerks
-General Office Clerks
-Hospital Admitting Clerks
-Order Clerks
-Personnel Clerks
-Purchasing Clerks

-Record Clerks

All Protective Occupations
Stand guard at entrance gate or walk about premises of hospital to prevent theft, violence, or infractions of rules; guard property against fire, theft, vandalism, and illegal entry; direct patrons or employees and answer questions relative to services of establishment; control traffic to and from buildings and grounds.

Nursing Aides, Orderlies, and Attendants
Work under the direction of nursing or medical staff to provide auxiliary services in care of patients. Perform duties such as answering patient's call bell, serving and collecting food trays, and feeding patients. Orderlies are primarily concerned with the care of male patients, setting up treatment, and relieving nurses of heavier work.

Physical and Corrective Therapy Assistants and Aides
Prepare patient and/or administer physical therapy treatment such as massages, heat, light and sound treatment, and traction. Instruct, motivate, and assist patients with learning and improving functional activities. Normally work under the direction of a Physical or Corrective Therapist.

Patient Food Service Worker - (Excluding Cooks)
Excludes dining room and cafeteria workers. Include only those non-supervisory personnel who are involved in preparing and providing food to patients. Include only those food service workers who normally work on patient meal preparation.

Housekeeping Aides, Attendants and Porters
Cleans and services hospital building areas, moves furniture, equipment and supplies in and around hospital departments and performs a variety of housekeeping duties, to maintain the hospital in an orderly and sanitary condition.

After receiving instructions as to area and specific work assignment, assembles necessary cleaning supplies and equipment for transporting to the designated area and performs assigned duties.

Maintenance Workers
Excludes stationary engineers who should be reported under category "All Other".

Includes workers who repair, maintain and adjust motor vehicles, equipment, machines and tools including such work as machinery repair, auto repair and communications equipment repair. Workers may also install, as well as repair, equipment and machinery. Repair work may be performed on or off premises. Includes but not limited to the following titles:
-Air Conditioning and Refrigeration Mechanics
-Electro-medical and Bio-medical Equipment Repairers
-General Heating
-Machinery Maintenance Mechanics (Power Plant Mechanics, etc.)
-Maintenance Repairers

Questions
Questions regarding this exhibit should be directed to: Mr. Philip Mossman, Bureau of HCRA Operations and Financial Analysis at (518) 474-1673.

Exhibit 36 - Hospital Personnel and Contracted FTE's

The number of employees reported on this exhibit must be consistent with the salaries as reported on Exhibit 11, column 5 of the ICR. To compute full-time equivalents (FTEs), divide the total annual paid hours (including vacation, sick leave and overtime) for all employees in each cost center by the number of hours in the standard workweek, then divide the rest by 52. If different classifications of employees

within each cost center (i.e. part-time, union, non-union) have different standard workweek hours, compute the full-time equivalent employees for each classification separately and combine the result. If employees are paid for unused sick leave, exclude the hours so paid from the calculations. If a sampling technique is utilized, the number of full-time equivalent employees must be computed for a minimum of one day period per quarter.

Report the average number of full time equivalent employees to one decimal place only. For example, 40 FTEs should be expressed as 40.0.

Report the standard number of hours in the working week to one decimal please only. For example, report 40 hours as 40.0.

Contracted FTE's
If there are any service contracts, such as laundry and linen, housekeeping, security, or agency nurses, provide the full-time equivalent (FTE) employees supplied by the contract, by cost center. If only contracted hours are available, divide the hours by the standard number of hours in the work week to convert to an FTE component.

Exhibit 37 -Trend Factor Weights Survey

Exhibit deleted for cost report years after 1999.

Exhibit 38 – Trend Factor Labor Subweights Survey

Exhibit deleted for cost report years after 1999.

Exhibit 39 - Union Affiliation Representation

This Exhibit has been designed to be self-explanatory. Question 1 must be completed with a Y or N as appropriate. Other union affiliations not listed must be identified by name and union affiliation on the other (specify) lines.

Exhibit 40 - Details of Specific Capital Expenses

This Exhibit has been established to report the detail of capital reported on Exhibit 11, Column 5, of the ICR. Columns have been established for Buildings and Fixtures, Movable Equipment, and Direct Charged Capital. For purposes of this Exhibit, Old and New Capital should be consolidated in each category.

The total of this Exhibit must account for 100% of the capital in all cost centers through reclasses reported on Exhibit 11, Column 5.

Identify any variable cost centers that were established specifically for capital purposes.

Exhibit 41 - Medicaid Funded Depreciation Schedule (For Voluntary Facilities Only)

Funding of allowable depreciation by voluntary hospitals is required in the provisions of Section 86-1.23(b) of the Commissioner of Health's Administrative Rules and Regulations. In instances where funding is required, such fund may be used only for capital expenditures with approval as required for the amortization of capital indebtedness. Funding for plant and fixed equipment shall mean the transfer of monies to the funded accounts shall occur by the end of the fiscal period in which the depreciation is recorded. Board – designated funds and the accrual of liabilities to the funded depreciation accounts (due to/from accounts) shall not be recognized as funding of depreciation. Deposits to the funded depreciation accounts must remain in such accounts to be considered as valid funding transactions unless expended for the purpose for which it was funded. Note that the exhibit

requires identification of investment income attributable to funded depreciation in accordance with Part 86-1.23(b).

Exhibit 42 - Statement of Medicaid Waiver of the Depreciation Funding Requirements

If your facility is requesting a waiver, state the reason why a waiver should be granted.

Exhibit 43 - Rent and Equity

This Exhibit is required for all facilities.

This exhibit identifies cost centers where rental expense is reported for arms length/non arms length arrangements.

Exhibit 44 - Direct Charged Capital

This Exhibit should identify capital-related costs that are directly assigned to a cost center other than 001, 002, 042 and 043, after re-class; that is, at the point of the beginning of the step-down. The total of these directly assigned capital related costs should be entered in column 1 and then distributed between buildings and fixtures and movable equipment.

The reported cost information will be utilized in the promulgation of Medicaid rates. Failure to provide the details of direct charged capital for movable equipment and buildings and fixtures may result in rate reductions.

Exhibit 45 - Lease Schedule

Exhibit Deleted for cost report years after 1997

Exhibit 46 - Hospital Service Revenue

The data required by this exhibit is the supporting details of certain information contained on Exhibit 26 and 26A of the ICR. The net and total revenue data found on these forms must agree.

The "summary" columns will automatically total amounts for Inpatient and Total All Services.

The NYS ICR software programming requires revenue reporting of all Exhibit 11 activated cost centers. The column structure has been developed to conform with those cost centers established in the ICR.

Those facilities which have operated a non-distinct ambulatory surgery service must report the associated revenues in this section.

This Exhibit has been expanded to require the reporting of gross charges by Payor. In addition, the allowances and Bad Debt detail have been modified. This data is needed to better identify payor revenues and must be reported by hospitals. Failure to report may result in the report being determined incomplete and unacceptable.

Note that routine and ancillary service charges are required to be reported separately for ALC patients, whether or not the facility had a discrete ALC unit or received a separate ALC rate.

Purpose
This schedule is meant to provide a breakdown of revenue into the components of revenue by routine and ancillary service, and allowance by payer. It will also be used to determine the outpatient bad debt need for the Bad Debt & Charity Care Pools.

Definitions
Gross Charges - full established rates for services rendered undiminished by related deductions except corrections.

ROUTINE SERVICES

Daily Care - Inpatient
This line item is used to report the routine gross charges for inpatient daily hospital services. Typically this charge includes room, dietary, nursing services, minor medical and surgical supplies, medical and psychiatric social services, and use of equipment and facilities for which a separate charge is not made. Referred to as the room and board charge.

Note: Public hospitals should report the dollars received for inpatient UPL (Upper Payment Limit) IGT (Intergovernmental Transfer) revenue here.

Outpatient Visit Fees – Clinic Only
This line item is used to report the routine gross charges earned from services provided in the hospital's clinic services.

Note: Public hospitals should report the dollars received for outpatient UPL (Upper Payment Limit) IGT (Intergovernmental Transfer) revenue related to clinic services here.

Outpatient Visit Fees – Other than Clinic
This group of accounts is used to report the routine gross charges earned from services provided to patients that were not admitted to a bed. Clinic, Emergency Service, CPEP Emergency Services, Ambulance, and Home Health Agency Fees should not be reported on this line as they are reported separately.

Note: Public hospitals should report the dollars received for outpatient UPL (Upper Payment Limit) IGT (Intergovernmental Transfer) revenue related to other than clinic here.

Emergency Service Fees
This item is used to report the routine gross charges earned from emergency treatment to the ill and injured who require immediate medical or surgical care on an unscheduled basis.

CPEP Emergency Service Fees
This item is used to report the routine gross charges earned from OMH certified Comprehensive Psychiatric Emergency Room programs.

Ambulance Fee
This item is used to report gross charges for the transportation of the sick and injured via ambulance.

Home Health Agency-All Purchased Services
This item is used to report all the gross charges earned from providing care to patients in their residence on the basis of physician's orders and an approved plan of care established and periodically reviewed by the physician. It is for patients who require convalescent and/or major restorative services at a level less intensive than institutional requirements.

GROSS CHARGES BY PAYOR
These lines should be used to report all gross charges, routine and ancillary, by payor.

ALLOWANCES AND OTHER SPECIFIC DEDUCTIONS (ADDITIONS)

ALLOWANCES

Definition:
Allowance - the difference between gross charges from services rendered and amounts received (or to be received) from patients or third party payers. Allowances should be distinguished from uncollectible accounts resulting from credit losses.

Medicare Allowances
Report allowances for patients for which billing for services has been directly submitted to the Medicare third party fiscal intermediary for those persons over 65 years of age, or the disabled receiving Social Security benefits for over two years, or those with ESRD and are eligible to receive federal health insurance for the aged and disabled through Title XVIII of the Social Security Act.

Medicaid Allowances
Report allowances for patients for which billing for services has been directly submitted to the Medicaid third party fiscal intermediary for those who are medically indigent and are eligible to receive health care benefits through Provisions of the State Social Services Law. Dollars received by Non – Public hospitals for recruitment and retention of health care workers should be treated as all other Medicaid revenues. For Public hospitals, monies received related to health care recruitment and retention should be reported on Exhibit 27. Public hospitals receiving monies related to Upper Payment Limit, should report 100 % of these monies as Medicaid revenues.

Non-Profit Indemnity Insurance
Report allowances for patients' services which have been billed directly to a not for profit medical indemnity insurance carriers licensed pursuant to Article 43 of the State Insurance Law for payment of services provided to beneficiaries insured through a medical indemnity insurance policy with such carriers.

Commercial Indemnity Insurance
Report allowances for patients' services which have been billed directly to proprietary medical indemnity insurance carriers licensed pursuant to Article 42 of the State Insurance Law for payment of services provided to beneficiaries insured through a medical indemnity insurance policy with such carriers.

HMO/Medicare
Report allowances for Medicare patients' services which have been billed directly to a federally authorized Health Maintenance Organization for patients covered under such premium policies.

HMO/PHSP Medicaid
Report allowances for Medicaid patients' services which have been billed directly to a Health Maintenance Organization or NYS licensed Prepaid Health Service Plan for patients covered under such premium policies.

HMO/PHSP Other
Report allowances for Non-Medicare/Non-Medicaid patients' services which have been billed directly to a Health Maintenance Organization or NYS licensed Prepaid Health Services Plan for patients covered under such premium policies.

Self Insured
Report allowances for patients' services which are covered by a self insured fund which is either self administered or administered by a third party agent for the purpose of processing claims on behalf of such funds.

Worker's Compensation
Report allowances for patients' services which have been billed to Worker's Compensation because the services rendered are the result of occupational related illness or injury.

No Fault

Report allowances for patients' services which have been billed to an insurance carrier for services rendered to patients for illness or injury arising from the use or maintenance of a motor vehicle.

Uninsured/Self Pay
Report allowances for patients having no third party or other insurance coverage and is thus solely responsible for payment of the charges, whether in full or in part (not related to the charity care policy of the hospital), for the services rendered. In cases where the patient is insured but the service provided is completely uncovered by the insurer, the case is to be considered a self pay case. Conversely, if the service provided is partially covered by a third-party insurance carrier, the case should not be designated as self-pay and should be reported in accordance with the definitions established for other patient categories described herein.

Governmental
Report allowances for patients' services that will be paid by programs administered by Federal, State, or Local governments other than Medicaid or Medicare. Examples of such programs include Physically Handicapped Children's Program, CHAMPUS/VA, payments made by correction facilities for services rendered to inmates, etc.

Free (Charity, Hill Burton)
Report allowances for self pay/uninsured patients' services provided free of charge or at a reduced charge as a result of the hospital's charity care policy. This should include obligations entered into under the Hill Burton Program as well as charity care.

Courtesy
Report allowances for patients' services provided at reduced rates or free of charge through a courtesy arrangement established with a specific class of patients, e.g. employees, clergy, etc.

Third Party Rate Adjustments Prior Period Lump Sum
Report any Medicare or Medicaid adjustments to current year's revenue resulting from adjustments to prior period rates that were not accrued for in the prior period(s).

Employee Discounts
Effective 1/1/98 all employee discounts should be shown as courtesy allowances.

OTHER DEDUCTIONS (ADDITIONS) TO CHARGES

DISPROPORTIONATE SHARE AND PROFESSIONAL EDUCATION PAYMENTS - entries in this section should be negative since they represent increases to revenues.

Indigent Care Pool Distribution
This line item should be used to report all receipts, expected receipts, and prior year recasts from the Indigent Care Pool.

This line would also include any funds received from General Hospital Indigent Care Pool (Section 2807-k of the Public Health Law) or the High Need Indigent Care Adjustment Pool (Rural and High Need Indigent Care Adjustment payments as referenced in Section 2807-w of the Public Health Law.)

Intergovernmental Transfer Revenue
This line item should be used by public hospitals to report uncompensated care payments (disproportionate share payments) associated with intergovernmental transfers.
Note: Intergovernmental payments associated with upper payment limit (UPL) payments should not be reported on this line; they are to be reported as Inpatient/Outpatient Medicaid Gross Charges.

Public Indigent Care Adjustment

This line item should be used by public hospitals to report payments made in accordance with Section 2807-c14-f of the Public Health Law as contained in the HealthCare Reform Act of 1996.

OMH/OASAS Disproportionate Share
This adjustment represents accrued disproportionate share (DSH) payments for hospitals, in accordance with Chapter 119 of the Laws of 1997. These payments replace Office of Mental Health and/or Office of Alcoholism and Substance Abuse Services (OASAS) approved net deficit financing in certain Article 28 voluntary hospitals effective April 1, 1997. These payments must be reported within the appropriate mental health or alcoholism and substance abuse program.

Professional Education Pool Distribution
This line item should be used to report all receipts and expected receipts from the Professional Education pool.

HEALTH CARE SURCHARGES/ASSESSMENTS - entries in this section should be positive.

Indigent Care Pool Contribution
This line item should be used to report all payments and expected payments to the Indigent Care Pool. This contribution should be reported in both inpatient and outpatient columns.

Inpatient Gross Revenue Assessment
This line item should be used to report the 1% assessment on net-inpatient revenue. The inpatient gross revenue assessment is also referred to as the "Statewide Bad Debt and Charity Care Pool Assessment."

Health Facility Cash Assessment
Each month, hospitals licensed under Article 28 of the Public Health Law are assessed a percentage on cash receipts from patient services and general operations. This assessment is on both inpatient and outpatient services and as such should be reported in the appropriate columns. Any assessment paid on non-patient related services or non-operating income should be reported on Exhibit 26A, line 507 as a positive.

Professional Education Pool Contribution
This line item should be used to report all payments and expected payments to the Professional Education Pool. This contribution should be reported in inpatient columns only.

BAD DEBT
These deductions represent the estimated amount of current revenue that will not be realized as a result of credit losses on accounts or notes receivable that were created or acquired in providing services to patients.

Exhibit 47 - Disproportionate Share Payment Limit (DSH) Report

The purpose of this report is to establish the maximum payment limit for DSH payments in accordance with federal statute. DSH payments include indigent care pool distributions, public indigent care adjustment payments, OMH/OASAS disproportionate share payments and intergovernmental transfer DSH payments. The law states that DSH payments cannot exceed the costs of providing inpatient and outpatient services to Medicaid and uninsured patients, net of revenues received.

For each of the listed categories, enter the net patient services revenue, total expenses and the calculated net gain/(loss).

All reported amounts should be in accordance with generally accepted accounting principles and be consistent with the reporting of revenues and expenses on the Statement of Revenues and Expenses (Exhibit 26A, lines 005 and 006) of the ICR and the audited financial statements.

Within the context of this report, uninsured shall mean patients without insurance or other third party coverage for the unit of service billed including units of service, which, although provided to patients who are insured, are not covered. Uninsured shall not encompass instances of underinsurance such as where services are provided to patients who, although they are insured, are not fully covered for that unit of service.

Medicaid revenues and expenses reported shall apply to only inpatient (including exempt units) and outpatient hospital services. Please report all skilled nursing facility revenue and expenses (including Medicaid and uninsured) on the "other" lines of this report.

Medicaid and uninsured outpatient revenues and expenses shall include referred ambulatory services.

Medicaid revenues and expenses include both Medicaid fee-for-service and Medicaid Managed Care (i.e. HMO-Medicaid) revenues and expenses.

Note: Medicaid revenues must include 100% of any payments made to public hospitals related to Upper Payment Limits.

Medicaid and uninsured inpatient and outpatient revenues should not include indigent care pool payments, public indigent care adjustment payments, OMH/OASAS disproportionate share payments and intergovernmental transfer DSH payments. Further, do not include payments from the professional education pool as Medicaid revenue. All of these DSH revenues shall be included in "other" revenues.

For exempt hospitals and exempt units of hospitals whose inpatient billings are on a per diem basis, there may be instances where some units of services (days) are insured and others are not, e.g., lengths of stay during which benefits are fully exhausted. Those units of service (days) occurring after the exhaustion of benefits will be deemed uninsured for the purposed of this report. This treatment does not apply to non-exempt, per discharge billings.

Net patient services revenue: reported on an accrual basis, net of any discounts or allowances, consistent with aggregate revenue reporting on the ICR and Audited Financial Statements, i.e., if retroactive rate adjustments are recorded as current year income in the aggregate on the ICR and Audited Financial Statements, such adjustments must be reflected in revenue on the DSH limit report. Please note that there is a separate line on Exhibit 47 to report Medicaid inpatient revenues which are being reported in the current year, but apply to periods prior to the implementation of the DSH payment limits (April 1, 1994 for public hospitals and April 1, 1995 for non-public hospitals).

Expenses: include all costs incurred in the provision of services to Medicaid and uninsured patients. Costs are to be allocated using one of the following methods:

(1) RCC - Ratio of costs to charges;
(2) Payor gross charges to total gross charges by service; or
(3) Days (flat rate providers only).

Note: Any transaction between a public hospital and its sponsoring government entity should be reported as an other Revenue/Expense item, and therefore would not be included on Exhibit 47.

Net gain/(loss): for each of the categories listed, net gain/(loss) equals net patient services revenue less total expenses.

Note: There should be records and worksheets to support the assertions in this statement in the custody of the facility. These records include, but are not limited to ledger abstracts, income summaries and expense records.

Any questions relating to this exhibit should be directed to Roland Guilz of the Bureau of HCRA Operations and Financial Analysis at (518) 474-1673.

Exhibit 48 - Bad Debt and Charity Care (BD&CC) Report, Report of Charges, Collections, Write-offs & Uncollectibles for SELF-PAY CASES ONLY

Exhibit Deleted for cost report years after 1997

Exhibit 49 – (Worksheet S-10) – Hospital Uncompensated Care Data

Refer to Medicare Instructions – Section 3609.4

Exhibit 50 – Patient Financial Aid Report

Effective for dates of service after 1/1/2007 for all inpatient and outpatient services.

Line 1: This line represents total hospital costs incurred rendering services to uninsured patients. It is a transfer from Exhibit 47, column 4802, lines 002 plus 031. There are no overrides available.

Line 2a: This line represents the hospital costs incurred and **line 2b** represents the hospital costs that are uncollected amounts in providing services to uninsured patients found to be eligible for patient financial aid pursuant to the hospitals financial aid policy. Facilities will need to convert charges to cost using the RCC approach.

Example: (2a) If the charges to the hospital are $20,000, the RCC is 50%, then the costs are $10,000.

Example: (2a) Capture the costs of those patients who had service dates between 1/1/09 and 12/31/09. Do include any 2008 discharged patients who were deemed eligible for financial assistance subsequent to the filing of and therefore not included on the 2008 ICR.

Example: (2b) This line represents the uncollected amount. In the example above, if the cost was $10,000 and the facility's sliding scale reduces it to $5,000, and the patient pays $3,000, report the $7,000 ($10,000 less $3,000 paid).

Lines 3a and 3b: On these lines, report hospital costs incurred (3a) and uncollected amounts for deductibles and coinsurance (3b) in rendering services to patients with insurance or other third party payer coverage found to be eligible for financial aid assistance pursuant to the hospitals financial aid policy. Costs for these lines shall mean the patient liability of hospital charges. Facilities do not need convert the charges to cost. If an amount is written off and is not a patient responsibility, it will not be considered in either line. **If your hospital does not provide financial aid to insured patients, leave lines 3a and 3b blank and move to number four.**

Example 1: (3a) This line is for those patients who have insurance for the service performed, report the patients' liability. If the charges are $20,000, the insurance pays something, the patient's deductible is $2,000 and according to the charity care policy of the hospital the patient is responsible for 50%, then report $2,000.

Charges	**$20,000**
Patient Liability	**$ 2,000**
Charity	**$ 1,000**
Patient Pays	**$ 500**

Example 1: (3b) This line is for the portion not paid by the patient. If the patient in the 3a example was responsible for $2,000 and paid $500, report the $1,500.

Example 2: (3a) If the charges are $20,000 and the patient's insurance is 80/20, the charity care policy

reduction is 50%, report the patient's liability which is 20% of the $20,000 or $4,000.

Charges	**$20,000**
Patients Liability	**$ 4,000**
Charity	**$ 2,000**
Patient Pays	**$ 1,500**

Example 2: (3b) If the patient above is responsible for $4,000 and pays $1,500, then report $2,500 on line 3b.

Line 4: This section represents the number of patients (New York State residents) organized by U.S. zip codes (5 digits only, no text or 4 digit extensions) who submitted applications for financial assistance and the results of those applications as of the close of this reporting period. The Applied column (class code 4932) represents the number of patients who applied for financial assistance for this reporting period and will be the sum of the subsequent 4 columns. The Approved column (class code 4933) represents the number of patients approved for this reporting period. The Denied column (class code 4934) represents the number of patients denied for financial assistance during this period of time. The Pending column (class code 4935) represents the number of applications for financial assistance that are still pending at the end of the reporting period. The Incomplete column (class code 4936) represents the number of applications that are incomplete at the end of the reporting period due to the patient not providing required data. . The last line under the zip code section, line 356, reads "Not NYS". Both out of country and out of state patients would be reported in aggregate on this line.

Three columns have been added for reporting year 2008. Enter the number of appeals submitted, approved, and denied during the reporting year by zip code.

Example: (4) If a patient does not submit an application, but qualifies as a result of the facility's presumptive eligibility criteria, then record the patient as approved.

Example: (4) If there are several dates of service for the same patient during the reporting period, you count the patient once. For the patient who submitted multiple applications and has had an approval and a denial, count the patient in the approved column because that patient has received financial aid during the reporting period.

Example: (4) Include the applications for those patients whose discharge date was during 2008. If someone was a patient in 2008, and applied, but the determination is not made by the end of the reporting period, you would include the application in the pending column. Count someone whose discharge date was during 2007, but did not apply until 2008 and was not included in the 2007 ICR.

Example: (4) In cases where a patient does not have a residence (homeless), enter the hospital's zip code to properly record the data.

Line 5 : This line represents the reimbursement received from the Indigent Care Pool. Report all cash received during the reporting period from the Indigent Care and High Need Pool, both Sections 2807-k and Section 2807-w of the Public Health Law. This includes all components (regular, high need, rural and GME components).

Line 6: This line represents the amount of money that has been expended on charity care from charitable bequests made or trusts established for the purpose of providing financial assistance to eligible patients in accordance with the terms and conditions of such bequests/trusts set up for this purpose to patients who qualify in accordance with the terms and conditions of the bequest or trust.

Line 7: Answer Y for yes if your hospital is located in a social service district that allows hospitals to assist patients with Medicaid eligibility applications and complete (a) through (e). If the answer is no, place an N in the box and move to line 8. If line 7 is Y, enter on line (a) the number of applications (based on discharge date of service) for Medicaid eligibility where hospitals assisted patients in

applying for Medicaid during the reporting period. The amount on line (a) should equal the sum of lines (b) through (e). Enter on line (b) the number of these applications approved during the reporting period. Enter on line (c) the number of these applications denied during the reporting period. Enter on line (d) the number of these applications pending at the end of the reporting period. Enter on line (e) the number of these applications incomplete due to patients not providing required information during the reporting period.

Example: (7) By Social Service District, it is interpreted to be your local county Social Services.

Example: (7) If someone from Social Services comes to the hospital to assist patients in filing for Medicaid benefits, but no hospital personnel assist, they should not be reported here.

Line 8: This line represents the financial losses resulting from services provided under Medicaid. It is a transfer from Exhibit 47, column 4803, lines 001 plus 030. There are no overrides available.

Line 9: This line represents the number of liens placed on the primary residence of patients for the reporting period. Most likely the liens will apply to prior periods, i.e., by the time the hospital has gone through the entire process, it will most likely occur in a different reporting period then when the patient was hospitalized.

Example: (9) In looking at the law, the law speaks solely of liens on the primary residences, so unless a judgment specifically refers to the patient's primary residence, it would not be counted. Regarding a hospital being unable to obtain information regarding a lien - the hospital is expected to exercise "due diligence" in obtaining this information if the matter is in the control of a collection agency. It is our expectation that the collection agency would be required to notify the hospital if the collection agency is placing a lien on the patient's primary residence on behalf of the hospital regarding a patient's outstanding account. If the hospital has sold an account to a collection agency and as a result, will not receive any additional payment, then the hospital is considered removed from any further actions of the collection agency and would not be expected to report any liens the agency is placing on the patient.

Exhibit 51 – Ratio of Cost to Charges

This exhibit allows a hospital to provide its ICR Cost Center and Revenue Codes (used by hospitals for claims payment) mapping to the Department of Health's 89 Cost Center Groups (CCG). This mapping will be used to calculate the hospital's Ratio of Cost to Charges (RCC) Factors and costs by payer.

In total, there are 82 CCGs that will be used to map ICR Cost Centers and Revenue Codes with the numbers ranging from 3 to 89. These CCGs are displayed at the end of the instructions for Exhibit 51. The table displays 3 items for each CCG: the CCG Number, the type of CCG [AC (Accommodation) or AN (Ancillary)] and the CCG Name/Description. Some of the CCGs that are currently not used are not displayed in the table.

Since there is not a 1 to 1 mapping between ICR Cost Centers and Revenue Codes, the CCGs are the medium to map these two codes.

PART I: Ratio of Cost to Charges - ICR Cost Center to Cost Center Group Mapping:

Line 001: Flat Rate hospitals are defined as hospitals which have not published a charge schedule for all ancillary patient services as provided in Section 2803(1)(j).

Part I provides the mapping of the hospital's ICR cost centers to the CCGs. The initial mapping provided on the exhibit is based on the Department's standard mapping. A hospital can edit the standard mapping in order to refine it for their facility.

If a variable ICR cost center is used and the standard CCG mapping displayed is highlighted in Red, the hospital is required to assign this ICR cost center to a CCG Number. Failure to make this assignment will result in the user being locked out of Parts II & III.

The CCG mapping provided on Part I will be used for the summation of the ICR costs and charges by ICR Cost Center into these CCGs. These summed ICR costs and charges will be used to calculate the RCC factors for these CCGs that are used to calculate costs by Payer.

If a CCG is not used on Part I, an RCC factor will not be calculated for that CCG. Also, It will not be available for use on Parts II & III.

PART II: Ratio of Cost to Charges - Inpatient Charge Mapping (Revenue Codes):

Part II allows for the mapping of Revenue Codes used by the hospital on their INPATIENT claims to CCGs. The Revenue Codes are listed and the hospital will be required to choose the corresponding CCG Number. CCGs can be used multiple times.

The Revenue codes obtained from the National Uniform Bill Committee (NUBC) are on the DOH web site in the SPARCS INPUT Data Dictionary Appendix H (UB Accommodation Codes) and Appendix I (UB Revenue Codes) at: http://www.health.state.ny.us/statistics/sparcs/sysdoc/appendix.htm. They can also be referenced under the Help Contents page of the Software under Special Topics.

PART III: Ratio of Cost to Charges - Outpatient Charge Mapping (Revenue Codes):

Part III allows for the mapping of Revenue Codes used by the hospital on their OUTPATIENT claims to CCGs. The Revenue Codes are listed and the hospital will be required to choose the corresponding CCG Number. CCGs can be used multiple times.

COST CENTER GROUPS					
Cost Center Group	**AN or AC**	**Department Description**	**Cost Center Group**	**AN or AC**	**Department Description**
3	AC	AIDS	45	AN	Occupational Therapy
4	AN	Ambulance Services	46	AN	Oncology
5	AN	Ambulatory Surgical Care	47	AN	Operating Room Services
6	AN	Anesthesiology	48	AN	Organ Acquisition
7	AN	Audiology	49	AN	Osteopathic Services
8	AN	Blood	50	AN	Other Diagnostic Services
9	AN	Blood Storing & Processing	51	AN	Other Donor Bank
10	AC	Burn Intensive Care	52	AC	Other Intensive Care
11	AN	C.A.T. Scan	53	AC	Other Room & Board
12	AN	Cardiology	55	AN	Other Therapeutic Services
13	AN	Cast Room	56	AN	Outpatient Services/Clinic
14	AC	Coronary Intensive Care	57	AN	Outpatient Special Residence
15	AN	Delivery Room And Labor Room	58	AN	Patient Convenience Items
16	AC	Detoxification	59	AC	Pediatric Acute
17	AN	Diagnostic Radiology/Other Imaging Services	60	AC	Pediatric Intensive Care
18	AN	Durable Medical Equipment (Other than Renal)	61	AN	Pharmacy/Drugs Requiring Specific Identification
19	AN	EEG (Electroencephalography)	62	AN	Physical Therapy
20	AN	EKG/ECG (Electrocardiogram)	63	AC	Premature Nursery
21	AN	Emergency Room Services	64	AN	Preventive Care Services
22	AC	Epilepsy	65	AN	Professional Fees
23	AN	Free-Standing Clinic	66	AC	Psychiatric Acute

24	AN	Gastro-Intestinal Service	67	AN	Psychiatric/Psychological Treatments/Services
25	AN	Home IV Therapy Services	68	AN	Pulmonary Function
26	AN	Home Health	69	AN	Recovery Room
27	AC	Hospice	70	AC	Rehabilitation - Medical Acute
28	AN	Hospice Service	71	AC	Rehabilitation - Alcohol & Drug
29	AN	Incremental Nursing Charge Rate	72	AN	Respiratory Therapy
30	AN	Inpatient/Outpatient/Home Dialysis	73	AC	Room & Board/Other Service
31	AN	Intravenous Therapy	74	AC	Self Care
32	AN	Invalid / Non-Reimbursable	76	AC	Skilled Nursing Facility
33	AN	Laboratory/Pathological Laboratory	77	AN	Special Charges
34	AC	Leave of Absence	78	AN	Speech-Language Pathology
35	AN	Lithotripsy	79	AC	Sterile Environment
36	AN	Magnetic Resonance Technology	80	AN	Telemedicine Services
37	AC	Maternity	81	AN	Therapeutic Radiology
39	AC	Medical/Surgical Acute	82	AN	Treatment or Observation Room
40	AC	Medical/Surgical Intensive Care	83	AC	CPEP
41	AN	Medical/Surgical Supplies and Devices	84	AC	SNF - Vent
42	AC	Neonatal Intensive Care	87	AN	Medical Implants Charged to Patients
43	AC	Newborn Nursery	88	AN	Reserved for Internal Payer/National/State Use
44	AN	Nuclear Medicine	89	AN	Referred Ambulatory