HCRIS Specifications for the HCFA 2552-96
Table 3 - List of Data Elements with Worksheet, Line, and Column Designations

WORKSHEET S

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD	FIELD SI	USAGE
Part O:					
Cost Report Status Code (1=as submitted) (2=settled) (3=settled with audit) (4=reopened) (5=amended)	1	1	1		X
Date the "As Submitted" Cost Report was received from the provider (MM/DD/YY)	1	2	8		X
Enter I for Initial, F for Final, N for neither	1	3	1		X
Nu mber of times report has been Reopened	1	4	2		X
Fiscal Intermediary Number	2	2	5		X
Notice of Program Reimbursement Date (MM/DD/YY)	2	4	8		X
Part II:					
Balances due Provider or (Program) in Total					
Title V	100	1	11		-9
Title XVIII, Part A	100	2	11		-9
Title XVIII, Part B	100	3	11		-9
Title XIX	100	4	11		-9
Balances due Provider or (Program) by Component:					
Title XVIII, Part A	1-3, 5, 7	2	11		-9
Title XVIII, Part B	1-3, 5, 7, 8	3	11		-9
Title XIX	1--8	4	11		-9
Balances due Provider or (Program) for ICF:					
Title XIX	6.01	4	11		-9
Balances due Provider or (Program) for RHC/FQHC:					
Title XVIII, Part B	9	3	11		-9
Title XIX	9	4	11		-9

WORKSHEET S-2

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD	FIELD SI	USAGE
Hospital and Health Care Complex Address:					
Street	1	1	36		X
P.O. Box	1	2	9		X
City	1.01	1	36		X
State	1.01	2	2		X
Zip Code (xxxxx-xxxx or xxxxx left justified)	1.01	3	10		X
County	1.01	4	36		X
For the Hospital:					
Name	2	1	36		X
Provider Number (xxxxxx)	2	2	6		X
National Provider Identifier	2	2A	10		X
Certification Date (MM/DD/YY)	2	3	8		X
Title XVIII Payment System	2	5	1		X
Title XIX Payment System	2	6	1		X

T4:
1. Worksheet S, Part II: Line 6.01, col 4 for the ICF/MR
2. Wksht S, Part II, Line 9, Columns 3 and 4

T14:
Line 1, Columns 1, 3, & 4, and Line 2, Columns 2 &4 added.

HCRIS Specifications for the HCFA 2552-96
Table 3 - List of Data Elements with Worksheet, Line, and Column Designations

WORKSHEET S-2

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD	FIELD SI	USAGE
For each Subprovider, each Hospital-Based Hospice, the Separately Certified ASC, each Hospital-Based Clinic, each Outpatient Rehabilitation Provider, and each Renal Dialysis:					
Provider Number (xxxxxx)	3, 11, 12, 14-16	2	6		X
National Provider Identifier	3, 11, 12, 14-16	2A	10		X
Certification Date (MM/DD/YY)	3, 11, 12, 14-16	3	8		X
Title XVIII Payment System	3, 11, 12, 14, 15	5	1		X
Title XIX Payment System	3, 11, 12, 14, 15	6	1		X
For the Swing-Bed SNF, the Hospital-Based SNF, and each Hospital-Based HHA:					
Provider Number (xxxxxx)	4, 6, 9	2	6		X
National Provider Identifier	4, 6, 9	2A	10		X
Certification Date (MM/DD/YY)	4, 6, 9	3	8		X
Title XVIII Payment System	4, 6, 9	5	1		X
Title XIX Payment System	4, 6, 9	6	1		X
For the Swing-Bed NF and the Hospital-Based NF:					
Provider Number (xxxxxx)	5 & 7	2	6		X
National Provider Identifier	5 & 7	2A	10		X
Certification Date (MM/DD/YY)	5 & 7	3	8		X
Title XIX Payment System	5 & 7	6	1		X
For the ICF/MR:					
Provider Number (xxxxxx)	7.01	2	6		X
National Provider Identifier	7.01	2A	10		X
Certification Date (MM/DD/YY)	7.01	3	8		X
Title V Payment System	7.01	4	1		X
Title XIX Payment System	7.01	6	1		X

T7:
Transmittal 7 closed Line 12, Columns 5 and 6. HCRIS still wants to collect Line 12, Columns 5 and 6 for older cost reports if they are contained in the ECR file.

WORKSHEET S-2
(CONTINUED)

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD	FIELD SI	USAGE
Type of Control (Refer to HCFA Pub.15-I, S3604)	18	1	2		X
Type of Hospital and Subprovider (Refer to HCFA Pub.15-I,S3604)	19, 20	1	1		X
Indicate if this Hospital is either (1) Urban or (2) Rural	21	1	1		X
If your hospital is geographically classified or located in a rural area, is your bed size less than or equal to 100 beds? (Y/N)	21	2	1		X
Does this facility qualify and is currently receiving paymnets for disproportionate share in accordance with 42 CFR 412.106? (Y/N)	21.01	1	1		X
Is this facility subject to the provisions of 42 CFR 412.106(c)(2) (Pickle amendment hospitals?) (Y/N)	21.01	2	1		X
Has your facility receive geographic reclassification? (Y/N)	21.02	1	1		X
If Line 21.02, Col 1 is 'yes', report the effective date	21.02	2	8		X
Enter in column 1 your geographic location either (1) urban (2) rural.	21.03	1	1		9
If you answered urban in column 1 indicate if you received either: a wage or standard geographic reclassification to a rural location, enter in column 2 "Y" for yes and "N" for no.	21.03	2	1		X
If column 2 is yes, enter in column 3 the effective date (mm/dd/yy)	21.03	3	8		X
Does your facility contain 100 or fewer beds in accordance with 42 CFR 412.105? (Y/N)	21.03	4	1		X
Provider's actual MSA or CBSA	21.03	5	5		X
For standard geographic reclassification (not wage), what is the status at the beginning of the cost reporting period. Enter (1) for urban (2) for rural.	21.04	1	1		9
For standard geographic reclassification (not wage), what is the status at the end of the cost reporting period. Enter (1) for urban (2) for rural.	21.05	1	1		9
Does the hospital qualify for the 3 yr transition of hold harmless payments for small rural hospitals under the PPS for hosptial outpatient department services under DRA, section 5105 or the extension of this provision uner MIPPA, section 147 effective for services rendered from 1/1/09 thru 12/31/09? (Y/N)	21.06	1	1		X
Does this hospital qualify as a SCH with 100 or fewer beds under MIPPA 147? (Y/N)	21.07	1	1		X

T12: Worksheet S-2, Line 21, Col 2 added.
T12: Worksheet S-2, Lines 21.03, Columns 1 - 4 added and Lines 21.04 and 21.05, Column 1 added.
T16: Worksheet S-2, Line 21.06, Column 1 added.
T17: Worksheet S-2, Line 21.03, Column 5 added.
T19, Flash 2: Worksheet S-2, Line 21.06 description expanded to include MIPPA
T20: Worksheet S-2, Line 21.07 added.
T21: Worksheet S-2, Line 21.01, Column 2 added.

WORKSHEET S-2
(CONTINUED)

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD	FIELD SI	USAGE
Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA Section 3121? Enter in colun 2 "Y" for yes or "N" for no.	21.07	2	1		X
Which method is used to determine Medicaid days? Enter 1 if it is based on date of admission, 2 if it is based on census days, or 3 if it is based on date of discharge	21.08	1	1		9
Is this method different than the method used in the preceding cost reporting period? (Y/N)	21.08	2	2		X

T21: Line 21.08, Columns 1 and 2 added.

T22: Line 21.07, Column 2 added.

WORKSHEET S-2
(CONTINUED)

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD	FIELD SI	USAGE
Is this Hospital classified as a Referral Center? (Y/N)	22	1	1		X
Does this Facility operate a Transplant Center? (Y/N)	23	1	1		X
Certification Dates in MM/DD/YY format:					
Medicare Certified Kidney Transplant Center	23.01	2	8		X
Medicare Certified Heart Transplant Center	23.02	2	8		X
Medicare Certified Liver Transplant Center	23.03	2	8		X
Medicare Certified Lung Transplant Center	23.04	2	8		X
If Medicare Pancreas Transplants are performed, enter the more recent date of July 1, 1999 or the certification dates for the kidney transplants (MM/DD/YY)	23.05	2	8		X
Medicare Certified Intestinal Transplant Center	23.06	2	8		X
Medicare Certified Islet Transplant Center	23.07	2	8		X
(MM/DD/YY) for all these termination dates					
Medicare Certified Kidney Transplant Center Termination Dt	23.01	3	8		X
Medicare Certified Heart Transplant Center Term Date	23.02	3	8		X
Medicare Certified Liver Transplant Center Term Date	23.03	3	8		X
Medicare Certified Lung Transplant Center Term Date	23.04	3	8		X
Medicare Certified Pancreas Transplant Center Term Dt	23.05	3	8		X
Medicare Certified Intestinal Transplant Center Term Date	23.06	3	8		X
Medicare Certified islet Transplant Center Term Date	23.07	3	8		X
If an Organ Procurement Organization (OPO), what is the OPO Number?	24	2	6		X
OPO Term Date (MM/DD/YY)	24	3	8		X
If this is a Medicare transplant center, Enter the CCN	24.01	2	6		X
Enter the certification date or recertification date (after 12/26/07)	24.01	3	8		X

T17: Line 23.07, Column 2 added.

T18: Worksheet S-2, Lines 23.01 - 24, Column 3 added.
T19: Worksheet S-2, Line 24.01, Columns 2 and 3 added.

HCRIS Specifications for the HCFA 2552-96
Table 3 - List of Data Elements with Worksheet, Line, and Column Designations
WORKSHEET S-2
(CONTINUED)

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD	FIELD SI	USAGE
Is this a teaching hospital or affiliated with a teaching hospital? (Y/N)	25	1	1		X
Is this teaching program in accordance with HCFA Pub 15-I, Chap 4? (Y/N)	25.01	1	1		X
If line 25.01 is yes, was Medicare participation and approved teaching program status in effect during the first month of the cost reporting period? If "Y", complete Wkst. E-3, Part IV. If "N", complete Wkst. D-2, Part II.	25.02	1	1		X
As a teaching hospital, did you elect cost reimbursement for physicians' services as defined in CMS Pub. 15-I, section 2148? If "Y", complete Worksheet D-9.	25.03	1	1		X
Are you claiming costs on line 70 of Worksheet A? If "Y", complete Worksheet D-2.	25.04	1	1		X
Has your facility's direct GME FTE cap been reduced under 42 CFR Secs. 413.79 (c)(3) or 413.105(f)(l)(iv)(B)? Enter "Y" for yes and "N" for no.	25.05	1	1		X
Has your facility's direct IME FTE cap been reduced under 42 CFR Secs. 413.79 (c)(3) or 413.105(f)(l)(iv)(B)? Enter "Y" for yes and "N" for no.	25.05	2	1		X
Has your facility received additional GME FTE resident cap slots under 42 CFR Secs 413.79 (c)(4) or 412.105(f)(l)(iv)(C)? Enter "Y" for yes and "N" for no.	25.06	1	1		X
Has your facility received additional IME FTE resident cap slots under 42 CFR Secs 413.79 (c)(4) or 412.105(f)(l)(iv)(C)? Enter "Y" for yes and "N" for no.	25.06	2	1		X
Has your facility's trained residents in non profit setting during the cost reporting period? Enter "Y" for yes or "N" for no in column 1	25.07	1	1		X
If line 25.07 is yes, enter in column 1 the weighted number of non-primary care FTE residents attributable to rotations occuring in all non-provider settings.	25.08	1	9		9(6).99
If line 25.07 is yes, enter in column 1 the unweighted number of primary care FTE residents attributable to rotations occuring in all non-provider settings:					
Program name	25.09-25.50	1	12		X
Program code	25.09-25.50	2	9		X
Number of unweighted FTE by specialty for each primary care specialty program in which residents are trained	25.09-25.50	3	9		9(6).99

T15:
Worksheet S-2, lines 25.05 and 25.06, colums 1 and 2 added.

T23:
Worksheet S-2, Lines 25.07 thru 25.50

WORKSHEET S-2
(CONTINUED)

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD	FIELD SI	USAGE
If this is a Sole Community Hospital (SCH), enter the # of periods.	26	1	1		9
If this is a SCH, enter the applicable SCH dates:					
Beginning	26.01	1	8		X
Ending	26.01	2	8		X
Beginning	26.02	1	8		X
Ending	26.02	2	8		X
If this a sole community hospital (SCH) for any part of the cost reporting period, enter the number of periods within this cost reporting period that SCH status was in effect and SCH was either physically located or classified in a rural area.	26.03	1	1		9
Beginning date SCH status applies in this period (mm/dd/yy)	26.04	1	8		X
Ending date SCH status applies in this period (mm/dd/yy)	26.04	2	8		X
Beginning date SCH status applies in this period (mm/dd/yy)	26.04	3	8		X
Ending date SCH status applies in this period (mm/dd/yy)	26.04	4	8		X
Does this Hospital have an agreement under either section 1883 or section 1913 for "swing beds"? (Y/N)	27	1	1		X
If 27 is yes, enter the agreement date (MM/DD/YY)	27	2	8		X

T12:
Worksheet S-2, Line 26.03, Column 1 and Line 26.04, Columns 1 - 4 added.

06/06/2004: Added Line 26.02 to specs. Before there was just a note saying to subscript Line 26.01 if more than 1 period of SCH status is identified.

T15:
Worksheet S-2, line 26.02, columns 1 and 2 usage changed from 8 to 10.

HCRIS Specifications for the HCFA 2552-96
Table 3 - List of Data Elements with Worksheet, Line, and Column Designations
WORKSHEET S-2
(CONTINUED)

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD	FIELD SI	USAGE
If this facility contains a hospital based SNF, are all patients under managed care or there were no Medicare utilization enter 'Y', if 'N' complete lines 28.01 and 28.02 Applicable for reporting periods beginning on or after 7/1/98	28	1	1		X
If hospital based SNF, enter appropriate transition period	28.01	1	3		9
Wage index adjustment factor for applicable period	28.01	2	11		9(7).9(4)
Wage index adjustment factor for applicable period	28.01	3	11		9(7).9(4)
Hospital Based SNF Facility Specific Rate	28.02	1	11		9(9).9(2)
Is SNF urban (1) or rural (2)?	28.02	2	1		X
SNF MSA Code or 2 character SSA state code if a Rural based facility	28.02	3	4		X
Hospital Based SNF CBSA code or State Code	28.02	4	5		X
A notice published in the Federal Register Vol. 68 No. 149 which provided for an increase in the RUG payments for services beginning 10/01/2003. This increase is expected to be used for direct patient care and related expenses.					
Enter the percentage of total expenses for each of the following categories to total SNF revenue from inpatient care service					
Staffing	28.03	1	4		9.99
Recruitment	28.04	1	4		9.99
Retention of employees	28.05	1	4		9.99
Training	28.06	1	4		9.99
Is the increased spending associated with direct patient care and related spending reflects each of the categories? (Y/N)					
Staffing	28.03	2	1		X
Recruitment	28.04	2	1		X
Retention of employees	28.05	2	1		X
Training	28.06	2	1		X
Other (Specify)	28-07-28.20	0	36		X
Enter the percentage of total expenses for other expenses to total SNF revenue from inpatient care service	28-07-28.20	1	4		9.99
Is the increased spending associated with direct patient care and related spending reflects Other?(Y/N)	28-07-28.20	2	1		X

T11:
Lines 28.03 through 28.20 added.
T15:
Lines 28.02, column 4 added.

WORKSHEET S-2
(CONTINUED)

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD	FIELD SI	USAGE
Is this a Rural Hospital with a certified SNF which has fewer than 50 beds in the aggregate for both components, using the swing bed optional method of reimbursement? (Y/N)	29	1	1		X
Does this Hospital qualify as a RPCH/CAH? (Y/N)	30	1	1		X
Is this cost reporting period initial 12 month period for which the facility operated as RPCH/CAH? (Y/N)	30.01	1	1		X
If this Facility qualifies as a RPCH/CAH, has it elected the all inclusive method of payment for outpatient service? For reporting periods beginning on or after October 1, 2000 CAHs can elect the all inclusive payment for outpatient. (Y/N)	30.02	1	1		X
If this Facility qualifies as a CAH, is it eligible for cost reimbursement for ambulance services?	30.03	1	1		X
Eligiblility Determination Date (MM/DD/YY)	30.03	2	8		X
If facility qualifies as a CAH is it eligible for cost reimbursement for I&R? (Y/N)	30.04	1	1		X
Is this a rural hospital qualifying for an exception to the certified registered nurse anesthetist the CRNA fee schedule? (Y/N)	31	1	1		X
Does the RPCH have a Subprovider that qualifies for an exemption to the CRNA fee schedule? (Y/N)	31.01	1	1		X
Is this Hospital an All-Inclusive Rate Provider? (Y/N)	32	1	1		X
If yes, enter the method used: (A, B, or E only)	32	2	1		X
Is this a New Hospital under 42 CFR 412.300 PPS Capital? (Y/N)	33	1	1		X
If yes (for periods beginning on or after 10/1/2002) do you elect to be reimbursed at 100% (Y/N)	33	2	1		X
Is this a New Hospital under 42 CFR 413.40(f)(1)(i) (TEFRA)?(Y/N)	34	1	1		X
Have you established a new subprovider excluded unit under 42 CFR 413.40(f)(1)(i)?(Y/N)	35	1	1		X

T10: Line 30.04, Column 1 added.

Line 33, Column 2 added.

WORKSHEET S-2
(CONTINUED)

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Line 2, Column 5 = "P":				
Does this Hospital elect a fully prospective payment method for capital costs? (Y/N)	36	2	1	X
Does the facility qualify and receive payment for disproportionate share in accordance with 42 CFR 412.320? (Y/N/P)	36.01	2	1	X
Does this Hospital elect a hold harmless payment method for capital costs? (Y/N)	37	2	1	X
If 37 is yes, is this Hospital filing on the basis of 100% of the federal rate? (Y/N)	37.01	2	1	X
Does this Hospital have Title XIX inpatient hospital services? (Y/N)	38	1	1	X
Are Title XIX NF patients occupying Title XVIII SNF beds (dual certification)? (Y/N)	38.03	1	1	X
Does this facility operate an ICF/MR facility for purposes of Title XIX? (Y/N)	38.04	1	1	X
Are there any related organIzation or home office costs as defined in HCFA Pub. 15-I, Chapter 10? (Y/N)	40	1	1	X
If Line 40, Col 1 is 'yes' and there are home office costs and you are part of a chain, report the home office provider number	40	2	6	X
Home Office Name	40.01	1	36	X
FI/Contractor's Name	40.01	2	36	X
FI/Contractor's Number	40.01	3	5	X
Home Office Street	40.02	1	36	X
Home Office PO Box	40.02	2	9	X
City	40.03	1	36	X
State	40.03	2	2	X
Zip Code	40.03	3	10	X
Are provider based physicians' costs included in Worksheet A? (Y/N)	41	1	1	X
Are physical therapy services provided by outside suppliers? (Y/N)	42	1	1	X
Are occupational therapy services provided by outside suppliers? (Y/N)	42.01	1	1	X
Are speech therapy services provided by outside suppliers? (Y/N)	42.02	1	1	X
Are respiratory therapy services provided by outside suppliers? (Y/N)	43	1	1	X
If this Hospital is claiming cost for the renal services on Worksheet A, are they inpatient services only? (Y/N)	44	1	1	X

T7: Line 40, Column 2 added.
T16: Worksheet S-2, Lines 40.01 through 40.03 added.
T17: Line 40.01, Column 2 and 40.01, Column 3 added.

WORKSHEET S-2
(CONTINUED)

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Has this Hospital changed its cost allocation method from the previously filed cost report? (Y/N)	45	1	1	X
If 45 is yes, enter the approval date	45	2	8	X
Was there a change in the statistical basis? (Y/N)	45.01	1	1	X
Was there a change in the order of allocation? (Y/N)	45.02	1	1	X
Was there a change to the simplified cost finding method? (Y/N)	45.03	1	1	X
If this hospital participates in the NHCMQ Demonstration project (must have a hospital based SNF) during this cost reporting period, enter the phase number.	46	1	1	9
If this facility contains a provider that qualifies for an exemption from the application of the lower of costs or charges, enter 'Y' for each component and type of service that qualifies for the exemption, enter 'N' if not exempt (See 42 CFR 413.13).				
Hospital	47	1--5	1	X
Subprovider	48	1--5	1	X
SNF	49	1 & 2	1	X
HHA	50	1 & 2	1	X
Outpatient Rehabilitation Provider	51	2	1	X
Does this hospital claim expenditures for extraordinary circumstances in accordance with 42 CFR 412.348(e)? (Y/N)	52	1	1	X
If you are a fully prospective or hold harmless provider are you eligible for the special exceptions payment pursuant to 42 CFR? (Y/N)	52.01	1	1	X

T10: Line 52.01, Column 1 added.

HCRIS Specifications for the HCFA 2552-96
Table 3 - List of Data Elements with Worksheet, Line, and Column Designations

WORKSHEET S-2
(CONTINUED)

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
If this is a medicare dependent hospital (MDH), enter the number of periods MDH status in effect.	53	1	1	9
MDH beginning date	53.01-53.03	1	8	X
MDH ending date	53.01-53.03	2	8	X
Malpractice Premiums	54	1	11	9
Malpractice Paid Losses	54	2	11	9
Malpractice Self Insurance	54	3	11	9
Are Malpractice premiums and paid losses reported in other than Administrative and General cost center? (Y/N)	54.01	1	1	X
Does your facility qualify for additional prospective payment in accordance with 42 CFR 412.107? (Y/N)	55	1	1	X
Are you claiming ambulance costs? (Y/N)	56	1	1	X
If yes, enter the payment limit	56	2	11	9(9).9(2)
If Line 56, Column 1 is 'Y', is this your first year of operation for rendering ambulance services? (Y/N)	56	3	1	X
Fees	56	4	11	9
Enter subsequent ambulance payment limit	56.01-56.03	2	11	9(9).9(2)
Fees	56.01-56.03	4	11	9
Effective Date of Ambulance Limit (MM/DD/YY)	56-56.03	0	8	X
Are you claiming nursing and allied healt costs? (Y/N)	57	1	1	X

Note: Subscript Line 53.01, Columns 1 and 2 if more than 1 period is identified for this cost reporting period and enter multiple dates. HCRIS only wants this line reported up to 3 times (53.01-53.03).

WORKSHEET S-2
(CONTINUED)

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Are you an Inpatient Rehab Facility (IRF) or do you contain an IRF subprovider? (Y/N)	58	1	1	X
Have you made election for 100% Federal PPS reimbursement? (Y/N)	58	2	1	X
If Line 58, Column 1 is Yes, does the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? (Y/N)	58.01	1	1	X
Is the facility training residents in a new teaching program in accordance with FR Vol. 70, No. 156? (Y/N)	58.01	2	1	X
If Line 58.01, Column 2 is 'Y', enter 1, 2, or 3 respectively. If the current cost reporting period covers the beginning of the 4th, enter '4' or if the subsequent academic years of the new teaching program in existence, enter '5'	58.01	3	1	9
Are you a LTCH or do you contain a LTCH subprovider? (Y/N)	59	1	1	X
Have you made election for 100% Federal PPS reimbursement? (Y/N)	59	2	1	X

If column 2 is Y, enter 1, 2 or 3 respectively in column 3.
(see instructions). If the current cost reporting period covers the beginning of the fourth enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5 . (see instructions)

T10: Line 58, Column 1 - description changed.
Line 58, Column 2 added.
Line 59, Columns 1 and 2 added.

T16: Worksheet S-2, Line 58.01, Columns 1 through 3 added.
09/27/2006: Line 58.01, Column 4 removed.

WORKSHEET S-2
(CONTINUED)

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Are you an Inpatient Psychiatric Facility (IPF) or do you contain an IPF subprovider? (Y/N)	60	1	1	X
If Line 60, Column 1 is Yes, is this a new facility in accordance with CR 3752? (Y/N)	60	2	1	X
If line 60, column 1 is Y, and the facility is an IPF subprovider, were residents training in this facility in its most recent cost reportint period filed before November 15, 2004?	60.01	1	1	X
Does the facility have a new teaching program in accordance with 42 CFR? (Y/N)	60.01	2	1	X
If Line 60.01, Column is Y, enter 1, 2 or 3. If the current cost reporting period covers the beginning of the fourth enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5.	60.01	3	1	9
Is this facility a part of a Mulicampus that has one or more campuses in different CBSAs (Y/N)	61	1	1	X
If Line 61 is yes, enter the name	62	0	36	X
If Line 61 is yes, enter the County	62	1	36	X
If Line 61 is yes, enter the State	62	2	2	x
If Line 61 is yes, enter the Zip Code	62	3	10	x
If Line 61 is yes, enter CBSA	62	4	5	x
If Line 61 is yes, enter FTE count/campus	62	5	9	9(6).99
Was the cost report filed using the PS&R (either in its entirety or for total charges and days only)? Enter "Y" for yes and "N" for no in column 1.	63	1	1	X
If column 1 is "Y", enter the "paid through" date for the PS&R in column 2 (MM/DD/YY)	63	2	8	X
Did this faclity incur and report costs for implantable devices charged to patient? Enter in column 1 "Y" for yes or "N" for no.	64	1	1	X

T14: Worksheet S-2, Lines 60 and 60.01 added.
T18: Worksheet S-2, Lines 61 and 62 added. (Line 61, Column 1 was added to the front end before vendors were approved for T18 and T19. HCRIS soon be getting a business owner so it was decided to add this field so cost report extracts would not reject.)

T19: Worksheet S-2, Line 60.01, Column 1 description changed.
T19: Worksheet S-2, Line 63, Columns 1 and 2 added.
T23: Worksheet S-2, Line 64 added.
Note: Line 62 can be subscripted. HCRIS allows Lines 62.01 through 62.09.

HCRIS Specifications for the HCFA 2552-96
Table 3 - List of Data Elements with Worksheet, Line, and Column Designations

WORKSHEET S-3
PART I

	DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Part I:	For Hospital Adults & Pediatrics (Excluding Swing Beds, et al), the HMO, Hospital Adults and Pediatrics for Swing Bed SNF, Hospital Adults and Pediatrics for Swing Bed NF, Adults & Pediatrics (excluding Observation Beds), each Special Care Unit, the Nursery, in Total for the Hospital, RPCH Visits, each Subprovider, each Hospital Based SNF, each Hospital Based NF, each hospital based ICF/MR, each Hospital Based OLTC, each Hospital Based HHA, each ASC (Distinct Part), each Hospice (Distinct Part), each Hospital Based Outpatient Rehabilitation Provider, each FQHC/RHC, and in Total for entire facility:				
	Number of Beds by Department and in Total	1, 5-10,12, 14-16, 16.01, 17, 21	1	11	9
	Bed Days Available	1, 5-12, 14-16, 16.01, 17, 21	2	11	9
	Hours CAH patients spend in	1, 6-10	2.01	11	9(9).9(2)
	Title V Inpatient Days/Outpatient Visits	1, 3-16, 16.01, 18, 23, 24	3	11	9
	Title XVIII Inp Days/Outpatient Visits	1, 3, 5-10, 12-15, 18, 21, 23, 2	4	11	9
		1, 12, 14	4.01	11	9
	Title XIX Inpatient Days/Outpatient Visits	1-16, 16.01, 18, 21, 23, 24	5	11	9
	Title XVIII Inpatient Days (HMO)	2	4	11	9
	Title XIX HMO days for IRF subproviders	2.01 and subscripts	5	11	9
	Total Medicaid Observation Bed Days	26	5	11	9
	Title XIX Observation Beds Admitted	26	5.01	11	9
	Title XIX Observations Beds not Admitted	26	5.02	11	9
	Total Inpatient Days/Outpatient Visits	1, 3-16, 16.01, 17, 18, 21, 23,	6	11	9
	Observation Bed Days	26	6	11	9
	Observation Bed Days (Off Site Subprovider)	26.01	6	11	9
	Observation Bed Days (Admitted)	26	6.01	11	9
	Observation Bed Days (Not Admitted)	26	6.02	11	9
	Ambulance Trips	27	4	11	9
	Ambulance Trips (if required)	27.01-27.03	4	11	9
	Employee Discount Days	28	6	11	9
	Employee Discount Days for IRF subproviders	28.01 and subscripts	6	11	9

T10: Column 4.01 , Lines 1, 12, and 14 added.
Line 2.01, Column 5 added.
Line 28.01, Column 6 and subscripts added.

T14: Columns 5, 5.01, 5.02, Line 26 added.
Columns 6.01 and 6.02, Line 26 added.

For Internal HCRIS:

Lines 26, 26.01, and 28, Column 6 and Lines 27 and 27.01, CoL 4 are identified in the HCRIS Master as follows:

Line	HCRIS Line/Col Identifier	
26	050006200	
26	050106200	
26	050206200	
26	060006200	
26	060106200	
26	060206200	
26.01	060006201	(follow same as Line 26)
27	040006500	
27.01	040006501	
28	060006800	
29	050006900	
29	060006900	

.

WORKSHEET S-3
PART I
(CONTINUED)

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Total Interns & Residents (Approved Programs)	12, 14-16, 16.01, 17, 18, 20, 21, 2	7	11	9(9).9(2)
Less Interns and Residents Replacing Non-Phys. Anesthetists	12, 14-16, 16.01, 17, 18, 20, 21, 2	8	11	9(9).9(2)
Net Interns & Residents (Approved Programs)	12, 14-16, 16.01, 17, 18, 20, 21, 2	9	11	9(9).9(2)
Employees on Payroll	12, 14-16, 16.01, 17, 18, 20, 21, 2	10	11	9(9).9(2)
Nonpaid Workers	12, 14-16, 16.01, 17, 18, 20, 21, 2	11	11	9(9).9(2)
Title V Discharges	1, 12, 14	12	11	9
Title XVIII Discharges	1, 12, 14	13	11	9
Title XIX Discharges	1, 12, 14	14	11	9
Total Discharges	1, 12, 14, 17	15	11	9
Labor and Delivery days for Titls XIX	29	5	11	9
Labor and Delivery days in Total	29	6	11	9

T4:
Worksheet S-3, Part I - Line 16.01, Columns 7 through 11. Line 16.01 is for an ICF/MR.

T21: Worksheet S-3, Part I, Line 29, Columns 5 and 6

WORKSHEET S-3
PARTS II AND III

	DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Part II:	Hospital Wage Index Information and Overhead Costs - Direct Salaries:				
	Total Salaries as Reported	1--8, 8.01, 9-35	1	11	9
		4.01, 9.01, 9.02, 10.01, 12.01, 18	1	11	9
		5.01, 6.01	1	11	9
		19.01	1	11	9
		22.01, 26.01, 27.01	1	11	9
		9.03	1	11	9
	Reclassification of Salaries	1--8, 8.01, 9-35	2	11	-9
		4.01, 9.01, 9.02, 10.01, 12.01, 18	2	11	-9
		5.01, 6.01	2	11	-9
		19.01	2	11	-9
		22.01, 26.01, 27.01	2	11	-9
		9.03	2	11	-9
	Adjusted Salaries	1--8, 8.01, 9-35	3	11	9
		4.01, 9.01, 9.02, 10.01, 12.01, 1	3	11	9
		5.01, 6.01	3	11	9
		19.01	3	11	9
		22.01, 26.01, 27.01	3	11	9
		9.03	3	11	9
	Paid Hours Related to Salary	1--8, 8.01, 9-12, 21--35	4	11	9(9).9(2)
		4.01, 9.01, 9.02, 10.01, 12.01	4	11	9(9).9(2)
		5.01, 6.01	4	11	9(9).9(2)
		22.01, 26.01, 27.01	4	11	9(9).9(2)
		9.03	4	11	9(9).9(2)
	Average Hourly Wage	1--8, 8.01, 9-12, 21--35	5	11	9(9).9(2)
		4.01, 9.01, 9.02, 10.01, 12.01	5	11	9(9).9(2)
		5.01, 6.01	5	11	9(9).9(2)
		22.01, 26.01, 27.01	5	11	9(9).9(2)
		9.03	5	11	9(9).9(2)
Part III:	Hospital Wage Index Summary -- Net Salaries, Excluded Area Salaries, Total Salaries, Total Wage Related Costs, and Total Overhead Costs:				
	Total Salaries as Reported	1-6, 13	1	11	9
	Reclassification of Salaries	1-6, 13	2	11	-9
	Adjusted Salaries	1-6, 13	3	11	9
	Paid Hours Related to Salary	1-6, 13	4	11	9(9).9(2)
	Average Hourly Wage	1-6, 13	5	11	9(9).9(2)

T12:
Worksheet S-3, Part II, Line 9.03, Columns 1 -5 added.

WORKSHEET S-4

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
County in which the HHA is located	0	1	36	X
Home Health Aide Hours				
Title XVIII	1	2	11	9
Title XIX	1	3	11	9
Other	1	4	11	9
Total	1	5	11	9
Unduplicated Census Count				
Title XVIII	2 & 2.01	2	11	9(9).9(2)
Title XIX	2 & 2.01	3	11	9(9).9(2)
Other	2 & 2.01	4	11	9(9).9(2)
Total	2 & 2.01	5	11	9(9).9(2)
Number of Hours in a Normal Work Week	3	0	11	9(9).9(2)
Number of Full Time Equivalent Employees:				
Staff	3--18	1	11	9(9).9(2)
Contract	3--18	2	11	9(9).9(2)
How many MSAs did you provide services to during reporting period?	19	1	2	9
Number of CBSAs	19	1.01	2	9
MSA Code	20.00-20.99	1	4	X
CBSA Code	20.00-20.99	1.01	5	X
Skilled Nursing Visits	21	1-7	11	9
Skilled Nursing Visit Charges	22	1-7	11	9
Physical Therapy Visits	23	1-7	11	9
Physical Therapy Visits Charges	24	1-7	11	9
Occupational Therapy Visits	25	1-7	11	9
Occupational Therapy Visits Charges	26	1-7	11	9
Speech Therapy Visits	27	1-7	11	9
Speech Therapy Visits Charges	28	1-7	11	9
Medical Social Service Visits	29	1-7	11	9
Medical Social Service Visit Charges	30	1-7	11	9
Home Health Aide Visits	31	1-7	11	9
Home Health Aide Visit Charges	32	1-7	11	9
Total Visits	33	1-7	11	9
Other Charges	34	1-7	11	9
Total Charges	35	1-7	11	9
Total Number of Episodes	36	1,3-7	11	9
Total Number of Other Episodes	37	2, 4-7	11	9
Total Medical Supply Charges	38	1-7	11	9

T8: Line 2.01, Columns 2-5 added.
Lines 21-35, and 38, Columns 1-7 added.
Line 36, Columns 1 and 3 through 7.
Line 37, Columns 2 and 4 through 7 added.

T16: Line 19, Column 1.01 added.
Lines 20-20.99, Column 1.01 added.

WORKSHEET S-5

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Renal Dialysis Statistics for Outpatient, Training, and Home Treatment:				
Number of Patients in Program at End of Cost Reporting Period	1	1--6	11	9
Number of Times Per Week Patient Receives Dialysis	2	1--6	11	9(9).9(2)
Average Patient Dialysis Time Including Setup	3	1--4	11	9(9).9(2)
CAPD exchanges Per Day	4	4, 6	11	9(9).9(2)
Number of Days in Year Dialysis Furnished	5	1--2	11	9
Number of Stations	6	1--4	11	9
Treatment Capacity Per Day Per Station	7	1--2	11	9
Utilization	8	1--2	11	9(9).9(2)
Average Times Dialyzers Re-Used	9	1--2	11	9(9).9(2)
Percentage of Patients Re-Using Dialyzers	10	1--2	11	9(9).9(2)
Transplant Information:				
Number of Patients on Transplant List	11	1	11	9
Number of Patients Transplanted During Fiscal Year	12	1	11	9
Epoietin Information:				
Net Costs of Epoietin Furnished to All Maintenance Dialysis Patients by the Provider	13	1	11	9
Epoietin amount from Worksheet A for Home Dialysis program	13.01	1	11	9
Number of EPO Units Furnished to Renal Dialysis Dept.	14	1	11	9
Number of EPO Units Furnished to Home Program Dialysis Dept.	14.01	1	11	9
Physician Payment Method:				
MCP	15	1	1	X
INITIAL METHOD	15	2	1	X
ARANESP				
Net costs of aranesp furnished to all maintenance dialysis patients by the provider	16	1	11	9
Aranesp amount from Wkst. A for Home Dialysis (see instr.)	17	1	11	9
Number of Aranesp units furnished relating to the renal dialysis department	18	1	11	9
Number of Aranesp units furnished relating to the home dialysis department	19	1	11	9

T8: Line 13.01, Column 1 added.

T16: Worksheet S-5, Line 14.01, Column 1 added.

T18: Worksheet S-5, Lines 16-19 added.

HCRIS Specifications for the HCFA 2552-96
Table 3 - List of Data Elements with Worksheet, Line, and Column Designations

WORKSHEET S-6

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Number of Hours in a Normal Work Week	1	0	11	9(9).9(2)
Number of Full Time Equivalent Employees:				
Staff	1--18	1	11	9(9).9(2)
Contract	1--18	2	11	9(9).9(2)
Is this component fully paid under established fee schedules? (Y/N)	19	1	1	X

WORKSHEET S-7

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
For each Group, Enter the Following Information:				
Rate	1--45	3 & 4	11	9(9).9(2)
Days	1--46	3.01 & 4.01	11	9
Amount	1--46	5	11	9
Rate	1-46	4.02	11	9(9).9(2)
Days	1-46	4.03	11	9
Medicare Days	7, 10, 11, 15-26 46	4.05	11	9
Days	1-46	4.06	11	9
Days	45.01-45.23	3.01	11	9

T10: Worksheet S-7, Column 4.06, Lines 1-46 added.
T15: Worksheet S-7, Lines 3, 6, 9, 12, and 14 can be subscripted.

T22: Worksheet S-7, Column 3.01, Lines 45.01-45.23.

HCRIS Specifications for the HCFA 2552-96
Table 3 - List of Data Elements with Worksheet, Line, and Column Designations

WORKSHEET S-8

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Clinic Address and Identification:				
Street	1	1	36	X
City	1.01	1	36	X
State	1.01	2	2	X
Zip Code	1.01	3	10	X
County	1.01	4	36	X
Designation (for FQHCs only) Enter R for rural or U for urban	2	1	1	X
Source of Federal Funds:				
Grant Awards:				
Community Health Center	3	1	11	9
Migrant Health Center	4	1	11	9
Health Services for the Homeless	5	1	11	9
Appalachian Regional Commission	6	1	11	9
Look-Alikes	7	1	11	9
Other	8	1	11	9
Date:				
Community Health Center	3	2	8	X
Migrant Health Center	4	2	8	X
Health Services for the Homeless	5	2	8	X
Appalachian Regional Commission	6	2	8	X
Look-Alikes	7	2	8	X
Other	8	2	8	X
Physician Information:				
Name of Physician(s) furnishing services at the clinic or under agreement	9	1	36	X
Billing Number of Physician(s)	9	2	10	X

Transmittal 4 Addition:
Worksheet S-8 is a new worksheet.

** Note: Line 9, Columns 1 and 2 can be subscripted for the reporting of physicians providing services.

WORKSHEET S-8
(CONTINUED)

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Name of Supervisory physician(s)	10	1	36	X
Hours of Supervisory physician(s)	10	2	11	9
Does the facility operate as other than an RHC or FQHC? (Y/N)	11	1	1	X
If yes to line 11, col 1, then indicate the number of other operations	11	2	2	9
Type of Operation	12.01-12.10	0	36	X
Facility hours of opertion (Hours: from/to based on a 24 hour clock)	12	1 - 14	11	9
Have you received an approval for an exception to the productivity standard? (Y/N)	13	1	1	X
Is this a consolidated cost report as defined in HCFA Pub 27, section 508(D)? (Y/N)	14	1	1	X
If yes to line 14, col 1, enter the number of providers included in this report.	14	2	2	9
Provider Name	15	1	36	X
Provider Number	15	2	6	X
Have you provided all or substantially all GME costs? (Y/N)	16	1	1	X
If yes to line 16, col 1, enter the number of Medicare visits performed by Interns and Residents for:				
Title V	16	2	11	9
Title XVIII	16	3	11	9
Title XIX	16	4	11	9
Has the hospital's bed size changed to less than 50 beds during the year for services rendered on or after 7/1/2001? (Y/N)	17	1	1	X

Notes:

Line 10, Columns 1 and 2 can be subscripted for the reporting of supervisory physicians providing services.
Line 12, Columns 1-14 can be subscripted for the hours of other operations.
Line 15, Columns 1 and 2 can be subscripted for the reporting of providers filing a consolidated cost report.

T8: Line 17, Column 1 added.

WORKSHEET S-9

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Enrollment Days:				
Continuous Home Care	1	1-6	11	9
Routine Home Care	2	1-6	11	9
Inpatient Respite Care	3	1-6	11	9
General Inpatient Care	4	1-6	11	9
Total Hospice Days	5	1-6	11	9
Census Data:				
Number of Patients Receiving Hospice Care	6	1-6	11	9
Total Number of Unduplicated Continuous Care Hours Billable to Medicare	7	1 & 3	11	9(9).9(2)
Average Length of Stay	8	1-6	11	9(9).9(2)
Unduplicated Census Count	9	1-6	11	9

T8: Worksheet S-9 added.

Worksheet S-10

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Uncompensated Care Information				
Do you have a written charity care policy? (Y/N)	1	1	1	X
Are patient write-off identified as charity? (Y/N)	2	1	1	X
If yes, is it at the time of admission? (Y/N)	2.01	1	1	X
If yes, is it at the time of first billing? (Y/N)	2.02	1	1	X
If yes, is it after collection effort has been made? (Y/N)	2.03	1	1	X
Other methods of write-offs (specify)	2.04	0	36	X
Are charity write-offs made for partial bills? (Y/N)	3	1	1	X
Are charity determinations based upon judgment without financial data? (Y/N)	4	1	1	X
Are charity determinations based upon income data only? (Y/N)	5	1	1	X
Are charity determinations based upon net worth (assets) data? (Y/N)	6	1	1	X
Are charity determinations based upon income and net worth data? (Y/N)	7	1	1	X
Does your accounting system separately identify charity from bad debt? (Y/N)	8	1	1	X
If yes, do you account for inpatient and outpatient services? (Y/N)	8.01	1	1	X
Is discerning charity from bad debt high priority in your institution? (Y/N)	9	1	1	X
If no, is it because there is not enough staff to determine eligibility? (Y/N)	9.01	1	1	X
If no, is it because there is no financial incentive to separate charity from bad debt? (Y/N)	9.02	1	1	X
If no, is it because there I no clear directive policy on charity determination? (Y/N)	9.03	1	1	X
If no, is it because your institution does not deem the distinction important? (Y/N)	9.04	1	1	X
If charity determination is based upon income data, what is the maximum income that can be earned by patient?	10	1	11	9
If charity determination is based upon income data, is the income directly tied to Federal poverty level? (Y/N)	11	1	1	X
If yes, is the percentage level less than 100% of the Federal poverty level? (Y/N)	11.01	1	1	X

Worksheet S-10

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
If yes, is the percentage level between 100% and 150% of the Federal poverty level? (Y/N)	11.02	1	1	X
If yes, is the percentage level between 150% and 200% of the Federal poverty level? (Y/N)	11.03	1	1	X
If yes, is the percentage level greater than 200% of the Federal poverty level? (Y/N)	11.04	1	1	X
Are partial write offs given higher income patients on a gradual scale? (Y/N)	12	1	1	X
Is there charity consideration given to high net worth patients who have catastrophic or other extraordinary medical expenses? (Y/N)	13	1	1	X
Is your hospital state and local government owned? (Y/N)	14	1	1	X
If yes, do you receive direct financial support from that government entity for the purpose of providing uncompensated care? (Y/N)	14.01	1	1	X
Do you receive restricted grants for rendering care to patients? (Y/N)	15	1	1	X
Are other non-restricted grants used to subsidize charity care? (Y/N)	16	1	1	X
Uncompensated Care Revenue				
Revenue related to Uncompensated Care	17	1	11	9
Gross Medicaid Revenues	17.01	1	11	9
Subsidies for charity care by state and local gov't	18	1	11	9
Revenue related to SCHIP (see instruction)	19	1	11	9
Restricted grants	20	1	11	9
Non-restricted grants	21	1	11	9
Total Gross Uncompensated Care Review	22	1	11	9
Uncompensated Care Cost				
Total charges for patients covered by state and local indigent care programs	23	1	11	9
Cost to Charge Ratio	24	1	11	9(4).9(6)
Total State and local indigent care program	25	1	11	9
Total SCHIP charges	26	1	11	9
Total SCHIP costs	27	1	11	9
Total gross Medicaid charges	28	1	11	9
Total gross Medicaid cost	29	1	11	9
Total gross uncompensated care charges	30	1	11	9
Uncompensated Care Cost	31	1	11	9
Total Uncompensated cost to the Hospital	32	1	11	9

T12:

Worksheet S-10, Line 17.01, Column 1 added.
Worksheet S-10, Line 14.02 removed from specifications because line no longer has to be completed.

HCRIS Specifications for the HCFA 2552-96
Table 3 - List of Data Elements with Worksheet, Line, and Column Designations

WORKSHEET A

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Direct Salaries by Department	5-31, 33-44, 46-61, 62.01, 63-71, 82-86, 85.01, 89, 92-10 85.02, 85.03, 46.30, 55.30	1	11	-9
Direct Salaries for ICF/MR	35.01	1	11	-9
Total Direct Salaries	101	1	11	-9
Other Direct Costs by Department	1-31, 33-61, 62.01, 63-71, 82-86, 85.01, 88-90, 92-100 85.02, 85.03, 46.30, 55.30	2	11	-9
Other Direct Costs for ICF/MR	35.01	2	11	-9
Total Other Direct Costs	101	2	11	-9
Adjustments by Department	1-31, 33-61, 62.01, 63-71, 82-86, 85.01, 88-90, 92-100 85.02, 85.03, 46.30, 55.30	6	11	-9
Adjustments for ICF/MR	35.01	6	11	-9
Total Adjustments	101	6	11	-9

Transmittal 4 Addition:
Worksheet A: Line 35.01, Columns 1, 2, and 6. Line 35.01 represents the ICF/MR.

Transmittal 6 Addition:
Worksheet A: Line 85.01, Columns 1, 2, and 6.

Trasmittal 17;
Worksheet A, Lines 85.03 added.

Transmittal 20:
Worksheet A, Lines 46.30 and 55.30 added.

HCRIS Specifications for the HCFA 2552-96
Table 3 - List of Data Elements with Worksheet, Line, and Column Designations
WORKSHEET A-7
PARTS I, II, & III

	DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Part I:	Old Capital Assets For Land, Land Improvements, Buildings and Fixtures, Building Improvements, Fixed & Movable Equipment, Reconciling Items, and in Total:				
	Beginning Balance	1--9	1	11	9
	Purchases	1--9	2	11	9
	Donations	1--9	3	11	9
	Disposals and Retirements	1--9	5	11	9
	Fully Depreciated Assets	1--9	7	11	9
Part II:	New Capital Assets For Land, Land Improvements, Buildings and Fixtures, Building Improvements, Fixed & Movable Equipment, Reconciling Items, and in Total:				
	Beginning Balance	1--9	1	11	9
	Purchases	1--9	2	11	9
	Donations	1--9	3	11	9
	Disposals and Retirements	1--9	5	11	9
	Fully Depreciated Assets	1--9	7	11	9
Part III:	Reconciliation of Capital Cost Centers For Capital-Related Costs Old and New Buildings and Fixtures; Old and New Movable Equipment; and in Total:				
	Gross Assets	1--5	1	11	9
	Capitalized Leases	1--5	2	11	9
	Gross Assets and Capitalized Leases	1--5	3	11	9
	Insurance	1--5	5	11	9
	Taxes	1--5	6	11	9
	Other Capital-Related Costs	1--5	7	11	9
	Depreciation	1--5	9	11	9
	Lease	1--5	10	11	9
	Interest	1--5	11	11	9
	Total Capital-Related Costs	1--5	15	11	9
Part IV:	Reconciliation of Amounts from Worksheet A, Columns 2, Lines 1 - 4 For Capital-Related Costs Old and New Buildings and Fixtures; Old and New Movable Equipment; and in Total:				
	Depreciation, Lease, Interest,	1-5	9, 10, 11	11	9
	and Total	1-5	15	11	9

WORKSHEET A-8

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Amount of Adjustment	1-37 and 50 38-49 and subscripts	2	11	-9

Transmittal 6 Addition:
Worksheet A-7, Part IV

Added to Specs on 06/07/2005: Will be in Transmittal 14 cost reports.
Worksheet A-8, All Lines added for Column 2.

HCRIS Specifications for the HCFA 2552-96
Table 3 - List of Data Elements with Worksheet, Line, and Column Designations

WORKSHEET A-8-1, Part A

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Part A - For costs incurred and adjustments required as a result of transactions with related organizations:				
Worksheet A line number	1-4	1	6	9(3).99
Expense item(s)	1-4	3	36	X
Amount allowable in reimbursable cost	1-4	4	11	9
Amount included in Worksheet A	1-4	5	11	9
Net Adjustments	1-4	6	11	9
Worksheet A-7, Part III, column reference (9-14 only)	1-4	7	2	9
Costs	5	4-6	11	9

WORKSHEET A-8-1, Part B

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Part B - For each related organization:				
Type of interrelationship (A through G)	1-5	1	1	X
If type is G, description of relationship must be included.	1-5	0	36	X
Name of individual or partnership with interest in provider and related organization	1-5	2	15	X
Percent of ownership of provider	1-5	3	6	9(3).99
Name of related organization	1-5	4	15	X
Percent of ownership of related organization	1-5	5	6	9(3).99
Type of business	1-5	6	15	X

WORKSHEET A-8-2

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Provider -Based Physician Adjustments: For each Facility: Total Physician Remuneration, Fringe Benefits, Unadjusted and Adjusted RCE Limits, and Total Provider-Based Physician Disallowance	101	3-5, 7-8, 12--17	11	9

Added to Specs on 06/07/2005: Will be in Transmittal 14 cost reports and any cost reports reopened
Worksheet A-8-1, Parts A and B

WORKSHEET A-8-3
PARTS I, II, III, V, VI, and VII

	DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Part I:	General Information for Physical Therapy and Respiratory Therapy Services:				
	Number of Unduplicated HHA Visits - Supervisor or Therapist	8	1	11	9
	Number of Unduplicated HHA Visits - Therapy Assistants	9	1	11	9
	Total Hours Worked	12	1-3, 5-7, 9-11	11	9
	AHSEA	13	1-3, 5-7, 9-11	11	9(9).9(2)
	Number of Travel Hours	15	1-3, 5-7, 9	11	9
	Number of Miles Driven	16	1-3, 5-7, 9	11	9
Part II:	Salary Equivalency Computation for Supervisors and Therapists for Physical Therapy and Respiratory Therapy Services	17-29, 31, 32	1	11	9
		30	1	11	9(9).9(2)
Part III:	Standard Travel Allowance for Physical Therapy and Respiratory Therapy Services:				
	Total	40	1	11	9
Part V:	Overtime Computation for Physical Therapy and Respiratory Therapy Services:				
	Overtime Hours	52	1-3, 5-8	11	9(9).9(2)
	Overtime Rate	53	1-3, 5-7	11	9(9).9(2)
	Overtime Allowance	61	1-3, 5-8	11	9
Part VI:	Computation of Therapy for Physical Therapy and Respiratory Therapy Services:				
	Limitation and Excess Cost Adjustment	64, 66-70	1	11	9
Part VII:	Allocation of Therapy for Physical Therapy and Respiratory Therapy Services:				
	Excess Cost Over Limitation	71, 72, 77	1	11	9

Transmittal 4 Addition:

Information on Worksheet A-8-3, all parts, is to be completed for physical and respiratory therapy services furnished by outside suppliers prior to April 10, 1998. For therapy services rendered on or after April 10, 1998. Worksheet A-8-3 will no longer be reported.

For services rendered on or after April 10, 1998, therapy service data will be reported on Wksht. A-8-4.

WORKSHEET A-8-4
PARTS I, II, III, V, and VI

	DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Part I:	General Information:				
	Number of unduplicated offsite visits - supervisors or therapists	5	1	11	9
	Number of unduplicated offsite visits - therapy assistants	6	1	11	9
	For Supervisors, Therapists, Assistants, Aides, and Trainees:				
	Total hours worked	9	1-5	11	9(9).9(2)
	AHSEA	10	1-5	11	9(9).9(2)
	Number of travel hours (provider site)	12	1-3	11	9
	Number of travel hours (provider offsite)	12.01	1-3	11	9
	Number of Miles Driven (provider site)	13	1-3	11	9
	Number of Miles Driven (provider offsite)	13.01	1-3	11	9
Part II:	Salary Equivalency Computation:				
	Supervisors	14	1	11	9
	Therapists	15	1	11	9
	Assistants	16	1	11	9
	Subtotal	17	1	11	9
	Aides	18	1	11	9
	Trainees	19	1	11	9
	Total Allowance Amount	20	1	11	9
	Weighted Average rate excluding aides and trainees	21	1	11	9(9).9(2)
	Weighted Allowance excluding aides and trainees	22	1	11	9
	Total Salary Equivalency	23	1	11	9
Part III:	Standard and Optional Travel Allowance and Travel Expense Computation				
	Total Standard Travel Allowance and Standard Travel Expense at the Provider Site	28	1	11	9
Part V:	Overtime Computation:				
	For therapists, assistants, aides, trainees, and Total				
	Overtime hours worked during the reporting period	47	1-5	11	9(9).9(2)
	Overtime rate	48	1-4	11	9(9).9(2)
	Overtime allowance	56	1-5	11	9

WORKSHEET A-8-4
PARTS VII

	DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Part VI:	Computation of Therapy Limitation and Excess Cost Adjustment				
	Travel allowance and expense - offsite services	59	1	11	9
	Equipment cost	61	1	11	9
	Supplies	62	1	11	9
	Total allowance	63	1	11	9
	Total cost of outside supplier services	64	1	11	9
	Excess over limitation	65	1	11	9
Part VII:	Allocation of Therapy Excess Cost over Limitation for nonshared therapy department services				
	Cost of outside supplier services for Hospital	66	1	11	9
	Cost of outside supplier services for CORF	66.01-66.10	1	11	9
	Cost of outside supplier services for CMHC	66.11-66.20	1	11	9
	Cost of outside supplier services for OPT	66.21-66.30	1	11	9
	Cost of outside supplier services for HHA	66.31-66.40	1	11	9
	Cost of outside supplier services for OOT	66.41-66.50	1	11	9
	Cost of outside supplier services for OSP	66.51-66.60	1	11	9
	Total cost	67	1	11	9
	Total excess of cost over limitation	70	1	11	9

Transmittal 4 Addition:

Worksheet A-8-4: For services rendered on or after April 10, 1998, therapy service data is reported.

Transmittal 6 Revision:

Worksheet A-8-4: For services rendered on or after January 1, 1999, therapy services are subject to a fee schedule. Therefore, for cost reporting periods beginning on or after January 1, 1999 this form is no longer required for all hospitals except Critical Access Hospitals and complexes with hospital based home health agencies.

HCRIS Specifications for the HCFA 2552-96
Table 3 - List of Data Elements with Worksheet, Line, and Column Designations

WORKSHEET B
PART I

	DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Part I:	Allocation of General Service Costs				
	Total Costs during Cost Finding by Department, Total Reimbursable Costs	1-31, 33-61, 62.01	0-24	11	-9
	Nonreimbursable Cost Centers, and Total Costs	63-71, 82-86, 85.01, 85.02, 85.03, 92-100, 103	46.30, 55.30 0-24	11	-9
	Total Costs during Cost Finding and Total Reimbursable Costs for the ICF/MR	35.01	0-24	11	-9
	Total Post Step-Down Adjustments	103	26	11	-9
	Negative Cost Centers	102	1--24	11	-9
	Total Costs after Cost Finding and before and after Post Step-Down Adjustments, Total Reimbursable Costs, Reimbursable and Nonreimbursable Cost Centers, Negative Cost Centers, and Total Costs	25-31, 33-61, 62.01, 63-71, 82-86, 85.01, 85.02, 85.03, 92-100, 102, 46.30, 55.30	27	11	-9
	Total Costs after Cost Finding and before and after Post Step-Down Adjustments for the ICF/MR	35.01	27	11	-9

Transmittal 4 Addition:
Worksheet B, Part I: Line 35.01, Columns 0-24 and 27.

Transmittal 6 Addition:
Worksheet B, Part I: Line 85.01, Columns 0-24 and 27.

Transmittal 8:
Worksheet B, Part I: Line 85.02 added.

Transmittal 17:
Worksheet B, Part I: Line 85.03 added.

Transmittal 20:
Worksheet B, Part I, Lines 46.30 and 55.30 added.

HCRIS Specifications for the HCFA 2552-96
Table 3 - List of Data Elements with Worksheet, Line, and Column Designations

WORKSHEET B
PART II

	DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Part II:	Allocation of Old Capital Related Costs				
	Directly Assigned Old Capital Related Costs by Department	5-31, 33-44, 46-61, 62.01, 63-71, 82-86, 85.01, 92-100 85.02, 85.03, 46.30, 55.30	0, 1, 2	11	9
	Directly Assigned Old Capital Related Costs by Department	35.01	0, 1, 2	11	9
	Total Directly Assigned Old Capital Related Costs	103	0	11	9
	Old Capital Related Costs Allocated to the Hospital Based SNF	34	4A-19, 26	11	9
	Negative Cost Centers	102	1, 2	11	9
	Total Old Capital Related Costs for Buildings and Fixtures and Movable Equipment	103	1, 2	11	9
	Old Capital Related Costs after Step-down and Post Step-Down Adjustments by Department, Cross Foot Adjustments, Negative Cost Centers, and in Total	25-31, 33-44, 46-61, 62.01, 63-71, 82-86, 85.01, 92-103 85.02, 85.03, 46.30, 55.30	27	11	-9
	Old Capital Related Costs after Step-down and Post Step-Down Adjustments for the ICF/MR	35.01	27	11	-9

Transmittal 4 Addition:
Worksheet B, Part II: Line 35.01, Columns 0, 1, 2, and 27.

Addition to Specifications not resulting from Transmittal:
Worksheet B, Part II: Line 103, Columns 1 and 2

Transmittal 6 Addition:
Worksheet B, Part II: Line 85.01, Columns 0, 1, 2, and 27.

Transmittal 8:
Worksheet B, Part II: Line 85.02 added.

Transmittal 17:
Worksheet B, Part II: Line 85.03 added.

Transmittal 20:
Worksheet B, Part II, Lines 46.30 and 55.30 added.

HCRIS Specifications for the HCFA 2552-96
Table 3 - List of Data Elements with Worksheet, Line, and Column Designations

WORKSHEET B
PART III

	DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Part III:	Allocation of New Capital Related Costs				
	Directly Assigned New Capital Related Costs by Department	5-31, 33-44, 46-61, 62.01, 63-71, 82-86, 85.01, 92-100 85.02, 85.03, 46.30, 55.30	0, 3, 4	11	9
	Directly Assigned New Capital Related Costs for the ICF/MR	35.01	0, 3, 4	11	9
	Total Directly Assigned New Capital Related Costs	103	0	11	9
	New Capital Related Costs Allocated to the Hosptial Based SNF	34	4A-19, 26	11	9
	Negative Cost Centers	102	3, 4	11	9
	Total New Capital Related Costs for Buildings and Fixtures and Movable Equipment	103	3, 4	11	9
	New Capital Related Costs after Step-down and Post Step-Down Adjustments by Department, Cross Foot Adjustments, Negative Cost Centers, and in Total	25-31, 33-44, 46-61, 62.01, 63-71, 82-86, 85.01, 92-103 85.02, 85.03, 46.30, 55.30	27	11	-9
	New Capital Related Costs after Step-down and Post Step-Down Adjustments for the ICF/MR	35.01	27	11	-9

Transmittal 4 Addition:
Worksheet B, Part III: Line 35.01 , Columms 0, 3, 4, and 27.

Addition to Specifications not resulting from Transmittal:
Worksheet B, Part III: Line 103, Columns 3 and 4.

Transmittal 6 Addition:
Worksheet B, Part III: Line 85.01, Columns 0, 3, 4, and 27.

Transmittal 8:
Worksheet B, Part III: Line 85.02 added.

Transmittal 17:
Worksheet B, Part III: Line 85.03 added.

Transmittal 20:
Worksheet B, Part IIII: Lines 46.30 and 55.30 added.

HCRIS Specifications for the HCFA 2552-96
Table 3 - List of Data Elements with Worksheet, Line, and Column Designations

WORKSHEET B-1

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Statistical Basis Code (1-3)	0	1--4	1	9
Allocation Statistics for Old Buildings and Fixtures	1, 5-31, 33-44, 46-61, 62.01, 63-71, 82-86, 85.01, 92-100 85.02, 85.03, 46.30, 55.30	1	11	9
Allocation Statisitics of Old Buildings and Fixtures to the ICF/MR	35.01	1	11	9
Allocation Statistics for Old Movable Equipment	2, 5-31, 33-44, 46-61, 62.01, 63-71, 82-86, 85.01, 92-100 85.02, 85.03, 46.30, 55.30	2	11	9
Allocation Statistices of Old Movable Equipment to the ICF/MR	35.01	2	11	9
Allocation Statistics for New Buildings and Fixtures	3, 5-31, 33-44, 46-61, 62.01, 63-71, 82-86, 85.01, 92-100 85.02, 85.03, 46.30, 55.30	3	11	9
Allocation Statistics of New Buildings and Fixtures to the ICF/MR	35.01	3	11	9
Allocation Statistics for New Movable Equipment	4, 5-31, 33-44, 46-61, 62.01, 63-71, 82-86, 85.01, 92-100 85.02, 85.03, 46.30, 55.30	4	11	9
Allocation Statistics of New Movable Equipment to the ICF/MR	35.01	4	11	9
Cost to be allocated (per Wksht. B, part I)	103	1 - 24	11	9
Unit Cost Multiplier (Wksht. B, Part I)	104	1 - 24	11	9(5).9(6)

NOTE: The statistical Basis codes and meanings are as follows:
1- square feet, 2-dollar value, 3-other

Transmittal 4 Addition:
Worksheet B-1 - Line 35.01, Columns 1 - 4.

Transmittal 6 Addition:
Worksheet B-1: Line 85.01, Columns 1 - 4.

Transmittal 8:
Worksheet B-1: Line 85.02 added.

Transmittal 17:
Worksheet B-1: Line 85.03 added.

Transmittal 20:
Worksheet B-1: Lines 46.30 and 55.30 added.

WORKSHEET C
PART I

	DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Part I:	Computation of Cost to Charge Ratios for the Facility				
	Therapy Limits	49, 50, 51, 52	2	11	9
	RCE Disallowance by Department and in Total	25-31, 33-61, 63-68, 101	4	11	9
		62.01, 46.30, 55.30	4	11	9
	RCE Disallowance for the ICF/MR	35.01	4	11	9
	Total Costs	25-31, 33-68, 101-103	5	11	9
		62.01, 46.30, 55.30	5	11	9
	Total Costs	35.01	5	11	9
	Inpatient Charges by Department and in Total	25-31, 33-68, 101	6	11	9
		62.01, 46.30, 55.30	6	11	9
	Inpatient Charges for the ICF/MR	35.01	6	11	9
	Outpatient Charges by Department and in Total	37-68, 101	7	11	9
		62.01, 46.30, 55.30	7	11	9

Transmittal 4 Addition:
Worksheet C, Part I: Line 35.01, Columns 4 - 6 .

Transmittal 5 Addition:
Worksheet C, Part I: Lines 51 and 52, Column 2.

Transmittal 20:
Worksheet C, Part I: Lines 46.30 and 55.30 added.

WORKSHEET C
PARTS II AND III

	DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Part II:	Calculation of Outpatient Cost to Charge Ratios				
	Ancillary Operating Costs by Department and in Total	37-68, 101-103	3	11	9
		62.01, 46.30, 55.30	3	11	9
	Ancillary Outpatient Capital Reduction Amount by Department and in Total	37-68, 101-103	4	11	9
		62.01, 46.30, 55.30	4	11	9
	Ancillary Outpatient Operating Cost Reduction Amount by Department and in Total	37-68, 101-103	5	11	9
		62.01, 46.30, 55.30	5	11	9
	Cost Net of Capital and Operating Cost Reduction	37-68, 101-103	6	11	9
		62.01, 46.30, 55.30	6	11	9
Part III:	Computation of Total Rural Primary Care Hospital (RPCH) Inpatient Ancillary Costs				
	Total RPCH Ancillary Charges by Department and in Total	37-68, 101	2	11	9
		62.01, 46.30, 55.30			
	Total RPCH Inpatient Ancillary Charges by Department and in Total	37-68, 101	3	11	9
		62.01, 46.30, 55.30			
	Total RPCH Inpatient Cost by Department	37-68, 101	5	11	9
		62.01, 46.30, 55.30			

Trannsmittal 4 Revision:

For cost reporting periods beginning after October 1, 1997, Worksheet C, Part III will no longer be reported. CAHs will replace RPCHs and will be reimbursed on a reasonable cost based on a combined per diem of routine and ancillary costs.

Transmittal 20:

Worksheet C, Parts I and II: Lines 46.30 and 55.30 added.

HCRIS Specifications for the HCFA 2552-96
Table 3 - List of Data Elements with Worksheet, Line, and Column Designations

WORKSHEET C
PARTS IV & V

	DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Part IV:	Computation of Inpatient RPCH Operating Cost				
	Total Inpatient Service Cost	3	1	11	9
	Inpatient Service Cost Per Diem	5	1	11	9(9).9(2)
	Program Inpatient Service Cost				
	Title XVIII:	6	2	11	9
	Title XIX:	6	3	11	9
	Total Program Swing-Bed Inpatient Routine Costs:				
	Title V:	9	1	11	9
	Title XVIII:	9	2	11	9
	Title XIX:	9	3	11	9
Part V:	Computation of Outpatient Cost Per Visit--RPCH				
	Provider-Based Physician Adjustment by Department and in Total	37-68, 101 46.30 and 55.30	2	11	9
	Total Costs by Department and in Total	37-68, 101 46.30 and 55.30	3	11	9
	Total Outpatient Charges by Department and in Total	37-68, 101 46.30 and 55.30	5	11	9
	Total Outpatient Costs by Department and in Total	37-68, 101 46.30 and 55.30	7	11	9
	Total Outpatient Visits and Costs by Program	102	7	11	9
	Aggregate Cost Per Visit	103	7	11	9(9).9(2)

Transmittal 4 Revision:

For cost reporting periods beginning after October 1, 1997, Worksheet C, Parts IV and V will no longer be reported. CAHs will replace RPCHs and will be reimbursed on a reasonable cost based on a combined per diem of routine and ancillary costs.

Transmittal 20:

Worksheet C, Part IV: Lines 46.30 and 55.30 added.

WORKSHEET D
PARTS I, II, and III

	DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Part I:	Apportionment of Inpatient Routine Capital Costs				
	For Adults & Pediatrics, the Special Care Units, each Subprovider, the Nurseries, and in Total:				
	Swing-Bed Carve Out - Old and New Capital	25, 31	2 & 5	11	9
	Capital Reduction Amount - Old and New Capital	25-31, 33, 101	3 & 6	11	9
	Inpatient Days - in Total and Program	25-31, 33, 101	7, 8	11	9
	Inpatient Program Capital Related Costs - Old and New Capital	25-31, 33, 101	10, 12	11	9
Part II:	Apportionment of Inpatient Ancillary Service Capital Cost				
	Old Capital Cost	37-44, 46-68, 62.01, 46.30, 55.30 101	6	11	9
	New Capital Cost	37-44, 46-68, 62.01, 46.30, 55.30 101	8	11	9
Part III:	Apportionment of Inpatient Routine "Other" Pass Through Costs				
	For Adults and Pediatrics, the Special Care Units, the Nurseries, and each Subprovider, and in Total (and for the SNF , NF, and ICF/MR when Trans. 4 is in effect)				
	Nonphysician Anesthetist Costs	25-31, 33, 101	1	11	9
	Nonphysician Anesthetist Costs for the SNF, NF, and ICF/MR	34, 35, 35.01	1	11	9
	Direct Medical Education Costs	25-31, 33, 101	2, 2.01, 2.02	11	9
	Direct Medical Education Costs for the SNF, NF, and ICF/MR	34, 35, 35.01	2, 2.01, 2.02	11	9
	Swing-Bed Carve Out	25, 31	3	11	9
	Total Inpatient Days	25-31, 33, 101	5	11	9

T7: Worksheet D, Part III:

Columns 2.01 and 2.02 for Lines 25-31, 33-35.01, and 101 added. If Worksheet S-2, Line 57 is answered 'Yes', Columns 2.01 and 2.02 should be reported.

Transmittal 20:
Worksheet D, Part II: Lines 46.30 and 55.30 added.

WORKSHEET D, PART III (CONTINUED)
and Worksheet D, Part IV

	DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Part III:	Total Inpatient Days for the SNF, NF, and ICF/MR	34, 35, 35.01	5	11	9
	Inpatient Program Days	25-31, 33, 101	7	11	9
	Inpatient Program Days for the SNF, NF, and ICF/MR	34, 35, 35.01	7	11	9
	Inpatient Program Pass Through Costs	25-31, 33, 101	8	11	9
	Inpatient Program Pass Through Costs SNF, NF, and ICF/MR	34, 35, 35.01	8	11	9
Part IV:	Apportionment of Inpatient Ancillary Service Costs				
	For each Ancillary Department and in Total:				
	Nonphysician Anesthetist Costs & Outpatient CRNA Costs	37-44, 46-64, 66-68, 101 62.01, 46.30, 55.30	1 &1.01	11	9
	Direct Medical Education Costs	37-44, 46-64, 66-68, 101 62.01, 46.30, 55.30	2, 2.01, 2.02	11	9
	Costs of Administering Blood Clotting Factors to Hemophiliacs	37-44, 46-64, 66-68, 101 62.01, 46.30, 55.30	2.03	11	9
	Inpatient Program Charges	37-44, 46-64, 66-68, 101 62.01, 46.30, 55.30	6	11	9
	Inpatient Program Pass Through Costs	37-44, 46-64, 66-68, 101 62.01, 46.30, 55.30	7	11	9
	Outpatient Program Charges	37-44, 46-64, 66-68, 101 62.01, 46.30, 55.30	8	11	9
		37-44, 46-64, 66-68, 101 62.01, 46.30, 55.30	8.01 & 8.02	11	9
	Outpatient Program Pass Thru Costs	37-44, 46-64, 66-68, 101 62.01, 46.30, 55.30	9	11	9
		37-44, 46-64, 66-68, 101 62.01, 46.30, 55.30	9.01 & 9.02	11	9

T12:
Worksheet D, Part IV: Columns 8.01, 8.02, 9.01, and 9.02 added.

T14:
Worksheet D, Part IV, Column 1.01 added.

Transmittal 20:
Worksheet D, Part IV: Lines 46.30 and 55.30 added.

HCRIS Specifications for the HCFA 2552-96
Table 3 - List of Data Elements with Worksheet, Line, and Column Designations

	DESCRIPTION	WORKSHEET D, PART V LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Part V:	Apportionment of Medical and Other Outpatient Costs for the Hospital, Subprovider, SNF, NF, Swing Bed SNF, Swing Bed NF, and ICF/MR:				
	Outpatient Cost to Charge Ratios	37-68, 46.30, 55.30	1	11	9(5).9(6)
	Inpatient Part A Cost to Charge Ratios	37-68, 46.30, 55.30	1.01	11	9(5).9(6)
	Inpatient Part B Cost to Charge Ratios	37-68, 46.30, 55.30	1.02	11	9(5).9(6)
	Outpatient Ambulatory Surgery Charges and in Total	37-64, 66-68, 46.30, 55.30, 101, 102,	2	11	9
	Outpatient Ambulatory Surgery Charges and in Total	37-64, 66-68, 46.30, 55.30, 101, 10	2.01	11	9
	Outpatient Radiology Charges and in Total	37-64, 66-68, 46.30, 55.30, 101, 10	3	11	9
	Outpatient Radiology Charges and in Total	37-64, 66-68, 46.30, 55.30, 101, 10	3.01	11	9
	Other Outpatient Diagnostic Charges and in Total	37-64, 66-68, 46.30, 55.30, 101, 10	4	11	9
	Other Outpatient Diagnostic Charges and in Total	37-64, 66-68, 46.30, 55.30, 101, 10	4.01	11	9
	All Other Charges and in Total	37-68, 46.30, 55.30, 101-104 65.01, 65.02, 65.03, etc.	5	11	9
	PPS Services Charges	37-44, 46-56, 46.30, 55.30 58-63, 66-68, 101, 103, 104	5.01	11	9
	All Other Charges	37-44, 46-68, 46.30, 55.30, 101-104 65.01, 65.02, 65.03, etc.	5.02	11	9
	All Other Charges	37-44, 46-68, 46.30, 55.30, 101-104 65.01, 65.02, 65.03, etc.	5.03	11	9
	All Other Charges	37-44, 46-68, 46.30, 55.30, 101-104 65.01, 65.02, 65.03, etc.	5.04	11	9
	Outpatient Ambulatory Surgery Costs and in Total	37-64, 66-68, 46.30, 55.30, 101, 10	6	11	9
	Outpatient Ambulatory Surgery Costs and in Total	37-64, 66-68, 46.30, 55.30, 101, 10	6.01	11	9
	Outpatient Radiology Costs and in Total	37-64, 66-68, 101, 104 46.30, 55.30	7	11	9

WORKSHEET D,
PART V

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Outpatient Radiology Costs on or after 8/1/2000	37-64, 66-68, 101, 104 46.30, 55.30	7.01	11	9
Other Outpatient Diagnostic Costs and in Total	37-64, 66-68, 101, 104 46.30, 55.30	8	11	9
Other Outpatient Diagnostic Costs and in Total	37-64, 66-68, 101, 104 46.30, 55.30	8.01	11	9
All Other Costs	37-64, 66-68, 101, 102, 104 65, 65.01, 65.02, 65.03, etc 46.30, 55.30	9 9	11 11	9 9
PPS Services Costs	37-44, 46-56 58-63, 66-68, 101, 104 46.30, 55.30	9.01	11	9
All Other Costs	37-44, 46-68, 46.30, 55.30, 101, 102, 104 65.01, 65.02, 65.03, etc.	9.02	11	9
All Other Costs	37-44, 46-68, 46.30, 55.30, 101-104 65.01, 65.02, 65.03, etc.	9.03	11	9
All Other Costs	37-44, 46-68, 46.30, 55.30, 101-104 65.01, 65.02, 65.03, etc.	9.04	11	9
Hospital Inpatient Part B Charges	37-64, 66-68, 46.30, 55.30, 101-1	10	11	9
Hospital Inpatient Part B Costs	37-64, 66-68, 46.30, 55.30, 101, 10	11	11	9

T10 Changes:
Lines 65, 65.01 - 65.03, etc added for Column 9
These lines should be rolled up to Line 65, Column 9.

Note: Data for Lines 65.01, 65.02, 65.03, etc, Columns 5, 5.02-5.04, 9 and 9.02-9.04 should always be rolled up to Line 65.

For periods prior to 8/1/2000, Columns 5 and 9 are used for all other outpatient. As of 8/1/2000, Columns 5 and 9 are only for the period prior to 8/1/2000 (non-PPS), and Columns 5.01 and 9.01 are for the PPS services for the period on or after 8/1/2000. If the fy overlaps January 1 as well then Columns 5.03 and 9.03 is for PPS services on or after Jan 1. Columns 5.02 and 9.02 are for the non PPS services after 8/1/2000. CAHs are exempt from PPS and only use Columns 5 and 9.
HCRIS would like all data reported for Worksheet D, Part V..

Transmittal 20:
Worksheet D, Part V: Lines 46.30 and 55.30 added.

HCRIS Specifications for the HCFA 2552-96
Table 3 - List of Data Elements with Worksheet, Line, and Column Designations

WORKSHEET D,
PART VI

	DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Part VI:	Vaccine Cost Apportionment				
	Program Vaccine Charges prior to 8/1/2000	2	1	11	9
	Program Vaccine Charges on or after 8/1/2000	2.01	1	11	9
	Program Vaccine Costs prior to 8/1/200	3	1	11	9
	Program Vaccine Costs on or after 8/1/2000	3.01	1	11	9

WORKSHEET D-1
PART I

	DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Part I:	For the Hospital, each Subprovider, the Hospital Based NF, each Hospital Based ICF/MR, and the Hospital-Based SNF opting for Swing-Bed SNF Reimbursement:				
	Inpatient Days	1--16	1	11	9
	Medicaid Rates for Swing Bed Services	17--20	1	11	9(9).9(2)
	General Inpatient Routine Service Cost	21	1	11	9
	Swing Bed Costs	22--26	1	11	9
	Routine Service Cost, Net of Swing Bed Cost	27	1	11	9
	General Inpatient Routine Service Charges	28	1	11	9
	Private Room Charges	29	1	11	9
	Semi-Private Room Charges	30	1	11	9
	General Inpatient Routine Service Cost to Charge Ratio	31	1	11	9(5).9(6)
	Average Private and Semi- Private Room Per Diem Charge	32,33	1	11	9(9).9(2)
	Average Private and Semi-Private Room Per Diem Charge Differential	34	1	11	9(9).9(2)
	Average Private and Semi-Private Room Per Diem Cost Differential	35	1	11	9(9).9(2)
	Average Private Cost Differential	36	1	11	9
	General Inpatient Routine Service Cost, Net of the Swing-Bed and Private Room Cost Differential	37	1	11	9

T7: Worksheet D, Part VI:
Column 1, Lines 2.01 and 3.01 added. Columns 2.01 and 3.01 are reported if the period overlaps 8/1/2000. If the reporting period begins on or after 8/1/2000, columns 2.01 and 3.01 are not to be used.

HCRIS Specifications for the HCFA 2552-96
Table 3 - List of Data Elements with Worksheet, Line, and Column Designations

WORKSHEET D-1, PART II

	DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Part II:	For the Hospital and each Subprovider:				
	Adjusted General Inpatient Routine Service Cost Per Diem	38	1	11	9(9).9(2)
	Program Inpatient Routine Service Cost	39	1	11	9
	Medically Necessary Private Room Cost - Program	40	1	11	9
	Total Program General Inpatient Routine Service Cost	41	1	11	9
	For the Nursery (Title XIX only) and the Special Care Units:				
	Total Inpatient Days	42-47	2	11	9
	Average Per Diem Cost	42-47	3	11	9(9).9(2)
	Program Days	42-47	4	11	9
	Program Cost	42-47	5	11	9
	Overflow Days	42-47	6	11	9
	Program Inpatient Ancillary Service Cost	48	1	11	9
	Total Program Inpatient Costs	49	1	11	9
	Pass Through Cost Adjustments	50-53	1	11	9
	Program Discharges	54	1	11	9
	Target Amount Per Discharge	55	1	11	9(9).9(2)
	Target Amount	56	1	11	9
	Difference Between Adjusted Inpatient Cost & Target Amount	57	1	11	-9
	Incentive/ Penalty Payment // Bonus Payment	58	1	11	-9
	Lesser of lines 53/54 or 55 of 1996 cost report endi ng period updated and compounded by the market basket	58.01	1	11	9(9).9(2)
	Lesser of Lines 53/54 or 55 of prior year cost report updated by the market basket	58.02	1	11	9(9).9(2)
	See Instructions	58.03	1	11	9
	Relief Payment	58.04	1	11	9
	Allowable Inpatient Cost Plus Incentive Payment	59	1	11	9
	Allowable inpatient cost per discharge	59.01	1	11	9(8).9(2)
	Program discharges prior to July 1	59.02	1	11	9
	Program discharges after July 1	59.03	1	11	9
	Program discharges	59.04	1	11	9
	Reduced inpatient cost per discharge for discharges prior to July 1	59.05	1	11	9(8).9(2)
	Reduced inpatient cost per discharge for discharges after July 1	59.06	1	11	9(8).9(2)
	Reduced inpatient cost per discharge	59.07	1	11	9(8).9(2)
	Reduced inpatient cost plus incentive payment	59.08	1	11	9
	Program Inpatient Routine Swing Bed Cost Computation	60-65	1	11	9

T12:
Worksheet D-1, Lines 59.01 thru 59.08, Column 1 added.

HCRIS Specifications for the HCFA 2552-96
Table 3 - List of Data Elements with Worksheet, Line, and Column Designations

WORKSHEET D-1
PARTS III & IV

	DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Part III:	For the Hospital-Based SNF not Claiming Optional Swing-Bed SNF Reimbursement and the Hospital Based NF, and each Hospital Based ICF/MR:				
	SNF/NF/ ICF/MR Routine Service Cost	66	1	11	9
	Adjusted General Inpatient Routine Service Per Diem Cost	67	1	11	9(9).9(2)
	Program Routine Service Cost	68	1	11	9
	Medically Necessary Private Room Days Applicable to Program	69	1	11	9
	Total Program General Inpatient Service Routine Costs	70	1	11	9
	Capital-Related Cost - Inpatient Routine Service Costs	71	1	11	9
	Per Diem Capital Related Costs	72	1	11	9(9).9(2)
	Program Capital Related Costs	73	1	11	9
	Inpatient Routine Service Cost	74	1	11	9
	Aggregate Charges to Beneficiaries for Excess Costs	75	1	11	9
	Total Program Routine Service Costs for Comparison	76	1	11	9
	Inpatient Routine Service Cost Per Diem Limitation	77	1	11	9(9).9(2)
	Inpatient Routine Service Cost Limitation	78	1	11	9
	Reasonable Inpatient Routine Service Costs	79	1	11	9
	Program Inpatient Ancillary Services	80	1	11	9
	Utilization Review - Physician Compensation	81	1	11	9
	Total Program Inpatient Operating Costs	82	1	11	9
Part IV:	For the Hospital - Computation of Observation Bed (Non-Distinct Part) Pass Through Cost:				
	Total Observation Bed Days	83	1	11	9
	Adjusted General Inpatient Routine Cost Per Diem	84	1	11	9(9).9(2)
	Observation Bed Cost Calculation	85	1	11	9
	Observation Bed Pass Through Old Capital-Related Cost	86	5	11	9
	Observation Bed Pass Through New Capital Related Cost	87	5	11	9
	Observation Bed Pass Through Non Physician Anesthetist Cost	88	5	11	9
	Observation Bed Pass Through Direct Medical Education Cost	89	5	11	9

WORKSHEET D-2
PARTS I AND II

	DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Part I:	Title XVIII Part B Program Cost	9, 10, 12	9	11	9
	Title XIX Program Cost	9, 10, 12, 13	10	11	9
Part II:	Title XVIII Part B Inpatient Cost	34, 35, 37, 38	7	11	9

WORKSHEET D-4

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
For Each Component Under Titles XVIII and XIX:				
Ratio of Cost to Charges	37-64,46.30, 55.30, 66-68 62.01	1	11	9(5).9(6)
Inpatient Part A Charges for Inpatient Routine Service Cost Centers by Department	25-30	2	11	9
Charges for Subprovider	31	2	11	9
Inpatient Part A Ancillary Charges by Department and in Total	37-64, 46.30, 55.30, 66-68, 101 62.01	2	11	9
PBP Clinical Lab - Program Only Charges	102	2	11	9
Net Program Charges	103	2	11	9
Inpatient Part A Ancillary Costs by Department and in Total	37-64, 46.30, 55.30, 66-68, 101 62.01	3	11	9

T12:
Worksheet D-4, Line 31, Column 2 added.

Transmittal 20:
Worksheet D-4, Lines 46.30 and 55.30 added.

WORKSHEET D-6
PARTS I, III, AND IV

	DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Part I:	Medicare Organ Acquisition Days	1--7	3	11	9
Part III:					
	Routine and Ancillary Organ Acquisition Cost	48	1	11	9
	Direct Costs for Organ Acquisition	51	1	11	9
	Total Costs	53	1	11	9
	Total Usable Organs	54	2	11	9
	Medicare Usable Organs	55	2	11	9
	Revenue for Organs Sold	58	1	11	9
	Net Organ Acquisition Costs and Charges	61	1,2	11	-9
	Part A Charges	48-53, 57-61	3	11	9
	Part B Charges	60-61	4	11	9
Part IV:					
	Statistics for Living Organ Acquisition Only:				
	Organs Excised at Provider	62	1	11	9
	Organs Purchased from Other Transplant Hospitals	63	1	11	9
	Organs Purchased from Non-Transplant Hospitals	64	1	11	9
	Organs Purchased from OPOs	65	1	11	9
	Total Organs Acquired	66	1	11	9
	Organs Transplanted	67	1	11	9
	Organs Sold to Other Hospitals	68	1	11	9
	Organs Sold to OPOs	69	1	11	9
	Organs Sold to Transplant Hospitals	70	1	11	9
	Organs Sold to Military or VA Hospitals	71	1	11	9
	Organs Sold Outside the U.S.	72	1	11	9
	Organs Sold Outside the U. S. (no revenue received)	73	1	11	9
	Organs Used for Research	74	1	11	9
	Unusable or Discarded Organs	75	1	11	9
	Total Organs Sold, Used for Research or Discarded	76	1	11	9

Added on January 30, 2003
Worksheet D-6, Part III (for all organs) Columns 3 and 4

WORKSHEET D-6
PART IV (CONTINUED)

	DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Part IV: Continued	Statistics for Cadaveric Heart, Liver, Lung, Kidney , Pancreas, and Intestine Acquisitions:				
	Organs Excised at Provider	62	2	11	9
	Organs Purchased from Other Transplant Hospitals	63	2	11	9
	Organs Purchased from Non-Transplant Hospitals	64	2	11	9
	Organs Purchased from OPOs	65	2	11	9
	Total Organs Acquired	66	2	11	9
	Organs Transplanted	67	2	11	9
	Organs Sold to Other Hospitals	68	2	11	9
	Organs Sold to OPOs	69	2	11	9
	Organs Sold to Transplant Hospitals	70	2	11	9
	Organs Sold to Military or VA Hospitals	71	2	11	9
	Organs Sold Outside the U.S.	72	2	11	9
	Organs Sold Outside the U.S. (no revenue received)	73	2	11	9
	Organs Used for Research	74	2	11	9
	Unusable or Discarded Organs	75	2	11	9
	Total Organs Sold, Used for Research or Discarded	76	2	11	9
	Revenue for Hearts, Livers, Lungs, Kidneys, Pancreas, and Intestines Tansplanted into Non-Medicare Patients:				
	Organs Transplanted	67	3	11	9
	Organs Sold to Other Hospitals	68	3	11	9
	Organs Sold to OPOs	69	3	11	9
	Organs Sold to Transplant Hospitals	70	3	11	9
	Organs Sold to Military or VA Hospitals	71	3	11	9
	Organs Sold Outside the U.S.	72	3	11	9

HCRIS Specifications for the HCFA 2552-96
Table 3 - List of Data Elements with Worksheet, Line, and Column Designations

WORKSHEET E
PART A

	DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Part A:	Part A Settlement Data for the Hospital and Each Subprovider Under Title XVIII PPS	1, 1.01 - 1.06, 2, 2.01, 3.03, 3.21 - 3.24, 4.04, 5, 5.01, 5.03, 5.06, 6, 7 - 21, 22, 23, 24, 25, 26, 27 - 30	1 , 1.01, 1.02	11	-9
		24.99	1 , 1.01, 1.02	11	-9
		1.07, 1.08	1, 1.01, 1.02	11	9
		3.15 & 3.16	0	1	9
		4.03	0	1	9(6).9(4)
		3.17	0	1	9(9).9(2)
		3, 3.01, 3.02, 3.04 - 3.17 5.02, 5.05	1, 1.01, 1.02	11	9(9).9(2)
		4, 4.01-4.03	1, 1.01, 1.02	11	9(6).9(4)
		11.01	1, 1.01, 1.02	11	9
		21.01	1, 1.01, 1.02	11	9
		21.02	1, 1.01, 1.02	11	9
		3.18 - 3.20, 5.04	1, 1.01, 1.02	11	9(5).9(6)
		28.01, 11.02, 7.01	1, 1.01, 1.02	11	9
		24.94	1, 1.01, 1.02	11	9
		24.95	1, 1.01, 1.02	11	9
		24.96	1, 1.01, 1.02	11	9
		24.97	1	11	9
		24.98	1	11	-9
		24.99	1	11	-9
		50 and subscripts	1, 1.01, 1.02	11	-9
		51 and subscripts	1, 1.01, 1.02	11	-9
		52 and subscripts	1, 1.01, 1.02	11	-9
		53 and subscripts	1, 1.01, 1.02	11	-9
		54 and subscripts	1, 1.01, 1.02	11	9(8).9(2)
		55 and subscripts	1, 1.01, 1.02	11	-9
		56 and subscripts	1, 1.01, 1.02	11	-9
	Note: The new column 1.01 (lines 1 - 6 only) is for SCH and MDH providers that have a change in SCH/MDH status during the cost reporting period, Column 1.01 is used for the period in which the provider did not retain SCH/MDH status.	1-6	1, 1.01, 1.02	11	9

Added to Specs on 12/15/2004
E, Part A, Column 0, Line 4.03

T12: Worksheet E, Part A, Line 21.02, Column 1 and subscripts added.
T14: Worksheet E, Part A, Lines 50 through 53 added.
T16: Worksheet E, Part A, Line 3.17, Column 0 added.
T16: Worksheet E, Part B, Line 30.99, Column 1 added.
T17: Worksheet E, Part A, Line 24.99 and 54-56 added and Line 52 changed from a decimal to a whole number
T19: Worksheet E, Part A, Lines 24.98 and 24.99 added.
T19: Worksheet E, Part A, Lines 50-53 and 55-56 usages changed to -9. Line 54 usage changed to -9(8).9(2).
T22: Worksheet E, Part A, Line 24.97 added.
T23: Worksheet E, Part A, Lines 24.94-24.96

HCRIS Specifications for the HCFA 2552-96
Table 3 - List of Data Elements with Worksheet, Line, and Column Designations

WORKSHEET E
PART B

DESCRIPTION		LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Part B:	Part B Settlement Data for the Hospital,				
	Each SNF and Each Subprovider	1--12, 14- 27			
	Under Title XVIII	27.01, 28 - 36	1, 1.01, 1.02	11	-9
		1.01	1, 1.01, 1.02	11	9
		1.02	1, 1.01, 1.02	11	9
		1.03	1, 1.01, 1.02	11	9(8).9(3)
		1.04	1, 1.01, 1.02	11	9
		1.05	1, 1.01, 1.02	11	9(8).9(2)
		1.06	1, 1.01, 1.02	11	9
		1.07	1, 1.01, 1.02	11	9
		13	1, 1.01, 1.02	11	9(5).9(6)
		17.01, 18.01	1, 1.01, 1.02	11	9
		27.02, 34.01	1, 1.01, 1.02	11	9
		30.99	1	11	9
		50	1	11	-9
		51	1	11	-9
		52	1	11	9(8).9(2)
		53	1	11	-9
		54	1	11	-9

T12: Worksheet E, Part B, Line 27.02, Column 1 and subscripts added.

Transmittal 20:
Worksheet E, Part B: Lines 50-54 added.

HCRIS Specifications for the HCFA 2552-96
Table 3 - List of Data Elements with Worksheet, Line, and Column Designations

WORKSHEET E
PARTS C, D, AND E

	DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Part C:	Part B Settlement Data for Outpatient Ambulatory Surgery	1--9, 11-19			
		21	1	11	-9
		10	1	11	9(5).9(6)
		1, 3, 5-9, 11-14, 16-21	1.01	11	-9
		10	1.01	11	9(5).9(6)
Part D:	Part B Settlement Data for Outpatient Radiology	1--9, 11-19	1	11	-9
		21	1	11	-9
		10	1	11	9(5).9(6)
		1, 2, 5 - 9, 11 - 14, 16 - 21	1.01	11	-9
		10	1.01	11	9(5).9(6)
Part E:	Part B Settlement Data for Outpatient Diagnostic Procedures	1--9, 11-19	1	11	-9
		10	1	11	9(5).9(6)
		21	1	11	-9
		1, 2, 5 - 9, 11 - 14, 16 - 21	1.01	11	-9
		10	1.01	11	9(5).9(6)

Transmittal 4 Revision:
Worksheet E, Parts C, D, and E:

** For cost reporting periods that end on or before 9/30/97, Column 1 should only be reported.

** If a cost reporting period overlaps 10/1/97, both Columns 1 and 1.01 should be reported to accomodate the change in payment methodology regarding the application of deductibles and coinsurance.
For cost reporting periods that overlap October 1, 1997 data should be reported reported as follows:
1. For services rendered prior to October 1, 1997, report in Column 1.
2. For services rendered on or after October 1, 1997, report in Column 1.01.

*** If a cost reporting period begins on or after 10/1/97 and ends before 9/30/98 only Column 1.01 should be reported. This would be a short period cost report, for example 10/1/97-6/30/98.

*** For cost reporting periods ending on or after September 30, 1998, only Column 1.01 should be reported.

HCRIS Specifications for the HCFA 2552-96
Table 3 - List of Data Elements with Worksheet, Line, and Column Designations

WORKSHEET E-1

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
For the Hospital, each Subprovider, each SNF, and each Swing-Bed SNF - Title XVIII Only:				
Total Interim Payments Paid to Provider	1	2 & 4	11	9
Interim Payments Payable	2	2 & 4	11	9
Retroactive Adjustments:				
Program to Provider-Date (MM/DD/YY)	3.01-3.49	1 & 3	8	X
Program to Provider - Amount	3.01-3.49	2 & 4	11	9
Provider to Program - Date (MM/DD/YY)	3.50-3.98	1 & 3	8	X
Provider to Program - Amount	3.50-3.98	2 & 4	11	-9
Subtotal Retroactive Payments	3.99	2 & 4	11	-9
Total Interim Payments	4	2 & 4	11	-9
Tentative Settlement Payments:				
Program to Provider - Date (MM/DD/YY)	5.01-5.49	1 & 3	8	X
Program to Provider - Amount	5.01-5.49	2 & 4	11	9
Provider to Program - Date (MM/DD/YY)	5.50-5.98	1 & 3	8	X
Provider to Program - Amount	5.50-5.98	2 & 4	11	9
Subtotal Tentative Settlement	5.99	2 & 4	11	-9
Net Settlement:				
Program to Provider - Date (MM/DD/YY)	6.01	1 & 3	8	X
Program to Provider - Amount	6.01	2 & 4	11	-9
Provider to Program - Date (MM/DD/YY)	6.02	1 & 3	8	X
Provider to Program - Amount	6.02	2 & 4	11	9
Total Medicare Program Liability	7	2 & 4	9	9

WORKSHEET E-2

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Swing-Bed SNF and NF Settlement Data for :				
Swing-Bed SNF Under Title XVIII, Part A and Title XIX	1, 3, 5-13, 15-22	1	11	-9
	4	1	11	9(9).9(2)
	20.01	1	11	9
	17.01	1	11	9
Swing-Bed SNF Under Title XVIII, Part B	1, 3, 5, 6, 8 - 22	2	11	-9
	4	2	11	9(9).9(2)
	20.01	2	11	9
	17.01	2	11	9
Swing-Bed NF Under Title XIX	2, 3, 5-13, 15-22	1	11	-9
	4	1	11	9(9).9(2)
	20.01	1	11	9
	17.01	1	11	9

T12:
Worksheet E-2, Line 17.01, Columns 1 and 2 added.

WORKSHEET E-3
PART I

	DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Part I:	Inpatient hospital services	1	1	11	9
	Hospital Specific amount	1.01	1	11	9
	IRF PPS Payments (for cost reporting periods beginning on or after 1/1/2002 excluding LIP and Outlier Payments)	1.02	1 & 1.01	11	9
	Medicare SSI ratio (IRF PPS only)(see instructions)	1.03	1	7	9(2).9(4)
	IRF LIP Payments	1.04	1 & 1.01	11	9
	IRF Outlier Payments	1.05	1	11	9
	Total PPS Payments	1.06	1	11	9
	Nursing and Allied Health Managed Care Payment	1.07	1	11	9
	Inpatient Psychiatric Facility Lines 1.08-1.24	1.08 - 1.10	1	11	9
		1.11 - 1.15	1	6	9(3).9(2)
		1.16 - 1.17	1	11	9(4).9(6)
		1.18 - 1.23	1	11	9
	Inpatient Rehabilitation Facility Lines 1.35-1.42	1.35-1.39	1	11	9(8).99
		1.40	1	11	9(4).9(6)
		1.41	1 and 1.01	11	9(4).9(6)
		1.42	1 and 1.01	11	9
	Organ Acquisition	2	1	11	9
	Cost of teaching physicians	3	1	11	9
	Subtotal	4	1	11	9
	Primary payer payments	5	1	11	9
	Subtotal	6	1	11	9
	Deductibles - Part A	7	1	11	9
	Subtotal	8	1	11	9
	Coinsurance (see instructions)	9	1	11	9
	Subtotal	10	1	11	9
	Reimbursable bad debts (see instructions)	11	1	11	9
	Reimursable bad debt adjustment	11.01	1	11	9
	Reimbursable bad debts for dual eligible beneficiaries	11.02	1	11	9
	Subtotal	12	1	11	9
	Direct Graduate Medical Education Payment	13	1	11	9
	Other Pass Through Costs	13.01	1	11	9
	Recovery of excess depreciation	14	1	11	9
	Other adjustment (see instructions) (specify)	15	1	11	9
	Amount applicable to prior periods - asset disposition	16	1	11	9
	Total Amount Payable to Provider	17	1	11	9
	Sequestration adjustment	18	1	11	9
	Interim Payments	19			
	Tentative settlement	19.01	1	11	9
	Balance Due Provider / Program	20	1	11	9
	Protested amounts	21	1	11	9
	Original Outlier Amount	50 and subscripts	1	11	-9
	Outlier Reconciliation Amount	51 and subscripts	1	11	-9
	Interest Rate	52 and subscripts	1	11	-9(8).9(2)
	Time Value of Money	53 and subscripts	1	11	-9

T12: Worksheet E-3, Part I, Lines 1.07 and 11.02, Column 1 added.
T14: Worksheet E-3, Part I, Lines 1.08 through 1.23 added. And Line 13.01 added.

T16: Worksheet E-3, Part I, Column 1.01 added for Lines 1.02 and 1.04 and Lines 1.35 through 1.42 added.
9/27/06: changed Lines 1.40 and 1.41 from 2 to 6 decimal places.

T17:
Worksheet E-3, Part I: Lines 50-53 added.

T19: Worksheet E-3, Part I, Line 52 usage changed to -9(8).9(2). And Lines 50, 51, and 53 changed to a usage of -9.

T21: Worksheet E-3, Part I, Line 1.41 and 1.42, Column 1.01 added.

HCRIS Specifications for the HCFA 2552-96
Table 3 - List of Data Elements with Worksheet, Line, and Column Designations

WORKSHEET E-3
PART II and III

	DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Part II:	Settlement Data for the Hospital, each Subprovider, and Each SNF Reimbursed for Medicare Part A Services at Reasonable Cost	1--13, 15-25, 25.01, 26-34	1	11	-9
		14	1	11	9(5).9(6)
		32.01	1	11	9
	Nursing and Allied Health Managed Care Payments	1.01	1	11	9
	Reimbursable bad debts for dual eligible beneficiaries	25.02	1	11	9
Part III:	Settlement Data for the Hospital, each Subprovider, each SNF, and the NF for Title XIX	1-18, 20-38, 38.01, 39, 40 49-55, 57-59	1	11	-9
		19	1	11	9(5).9(6)
		57.01	1	11	9
	SNF Under Title XVIII PPS	2, 6, 7, 9, 11, 16-18, 20-24, 28-30, 32-36, 38, 38.01, 39-44, 46-52 55-59	2	11	-9
		19	2	11	9(5).9(6)
		45	2	11	9(5).9(6)
		57.01	2	11	9
	Reimbursable bad debts for dual eligible beneficiaries	38.02	2	11	9
	Adjusted reimbursable bad debts for periods ending on or after 10/01/05	38.03	1 & 2	11	9

T12:
Worksheet E-3, Part II, Lines 1.01 abd 25.02, Column 1 added.
Worksheet E-3, Part III, Line 38.02, Column 2 added.

T16: Worksheet E-3, Part III, Line 38.03, Columns 1 and 2 added.

WORKSHEET E-3,
PARTS IV & V

	DESCRIPTION		LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Part IV:	Direct Graduate Medical Education and ESRD					
	Direct Medical Education Costs		3, 4, 5, 7, 8, 10-20, 23, 23.01, 24, 25 3.24, 3.25 6.01-6.03, 6.05, 6.06, 6.08	1	11	-9
		Prior to FYB 10/01/2001	3.21	1	11	9
		On or after FYB 10/01/2001	3.21	1	11	9(9).9(2)
		Prior to FYB 10/01/2001	3.18	1	11	9(9).9(2)
		On or after FYB 10/01/2001	3.18	1	11	9
			6, 9, 21, & 22	1	11	9(5).9(6)
			1, 1.01, 2, 2.01 3.01 -3.17, 3.19, 3.20 6.04, 6.07	1	11	9(9).9(2)
		Prior to FYB 10/01/2001	3.22, 3.23	1	11	9
		On or after FYB 10/01/2001	3.22, 3.23	1	11	9(9).9(2)
			3.07, 3.08. 3.11	0	11	9(9).9(2)
			3.12	0	11	9(9).9(2)
			3.13 & 3.14	0	1	9
			3.16, 3.22	0	11	9(9).9(2)
Part V:	Calculation of NHCMQ Demonstration Reimbursement					
	Settlement		1--6, 9--18, 22-25	1	11	-9
			8	1	11	9(9).9(2)
			19-21	1	11	9(5).9(6)

T10: Worksheet E-3, Part IV: Usage for Lines 3.21, 3.22, and 3.23 changed from 9 to 9(9).9(2) for reporting periods beginning on or after 10/0/2001. Usage for Line 3.18 changed from 9(9).9(2) to 9 for periods beginning on or after 10/01/2001.

T16: Worksheet E-3, Part IV, Lines 3.16 and 3.22, Column 0 added.

WORKSHEET E-3
PART VI

	DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Part VI:	Direct graduate medical education (GME) and indirect medical education (IME) payments related to redistribution of unused residency slots				
	Enter the ratio of the number of days from July1, 2005 to the end of the cost reporting period) divided by the total number of days in the cost reporting period.	1	1	8	9.9(6)
	Enter the adjusted GME FTE resident cap for allopathic and osteopathic for a hospital whose direct GME FTE was reduced	2	1	6	9(3).99
	Enter the Unadjusted Direct GME FTE Cap (Wkst E-3, Part IV, sum of lines 3.01 and 3.02)	3	1	7	9(4).99
	Enter the Prorated Reduced Direct GME FTE Cap (see instructions)	4	1	6	9(3).99
	Enter the number of unweighted allopathic and osteopathic direct GME FTE resident cap received	5	1	6	9(3).99
	Prorated Direct GME FTE Cap	5.01	1	6	9(3).99
	Enter the GME FTE Resident count over Cap (see instructions)	6	1	6	9(3).99
	Enter the lower of line 5 or line 6 if the amount on line 6 is greater than -0- (see instructions for cost reporting periods straddling July 1, 2005)	7	1	6	9(3).99
	Enter the locality adjusted national average per resident amount (see instructions)	8	1	11	9(8).99
	Enter the product of line 7 times line 8	9	1	11	9(8).99
	Enter the Medicare program patient load from Wkst E-3 Part IV, line 6	10	1	8	9.9(6)
	Enter the Direct GME payment for non-managed care days (multiply line 9 times line 10) [(line 6.02 + 6.06)/line5]	11	1	11	9
	Enter the Direct GME payment for managed care days (multiply line 10 by Wkst E-3, Part IV [(line 6.02 + 6.06)/line5]	12	1	11	9
	Adjusted IME FTE resident cap for allopathic and osteopathic for a hospital whose direct IME FTE was reduced	13	1	11	9
	Unadjusted IME FTE Cap (Wkst E, Part A, sum of lines 3.04 and 3.05)	14	1	11	9(8).99

T15:
Worksheet E-3, Part VI added.
8/05/06: Added Line 5.01

WORKSHEET E-3
PART VI

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Prorated Reduced allowable IME FTE Cap	15	1	11	9(8).99
Enter the number of allopathic and osteopathic IME FTE resident cap slots the hospital received.	16	1	6	9(3).99
IME FTE Resident Count Over Cap (see instructions)	17	1	11	-9(8).99
If the count on Line 17 is greater than zero, enter the lower of Line 16 or Line 17	18	1	6	9(3).99
Resident to bed count(divide line 18 by line 3 of Wkst E, Part A)	19	1	8	9.9(6)
IME Adjustment Factor (see instructions)	20	1	8	9.9(6)
DRG other than outlier payments for discharges on or after July 1, 2005.	21	1	11	9
Simulated Medicare managed care payments for discharges on or after July 1, 2005	22	1	11	9
Additional IME payments attributable to section 422 of MMA	23	1	11	9

T15: Worksheet E-3, Part VI added.

T16: Worksheet E-3, Part VI, Line 18 description changed.

HCRIS Specifications for the HCFA 2552-96
Table 3 - List of Data Elements with Worksheet, Line, and Column Designations

WORKSHEET G

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
For all Hospitals or Hospital Complexes:				
Balance Sheet Accounts, Including Old and New Asset, and Accumulated Depreciation	1-44, 51, 52	1	11	-9
For Hospitals or Hospital Complexes Using Fund Accounting:				
Specific Purpose Fund Account Balances	1-32, 34-43, 45 51, 52	2	11	-9
Endowment Fund Account Balance	1-32, 34-43, 46-48 51, 52	3	11	-9
Plant Fund Account Balance	1-32, 34-43, 49-52	4	11	-9

WORKSHEET G-2
PARTS I & II

	DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Part I:	Revenue for General Inpatient Routine Care Services	1--9	1	11	9
	Intensive Care Type Inpatient Hospital Services	10--15	1	11	9
	Total Revenues for Routine and Special Care	16	1	11	9
	Inpatient Ancillary Services Revenue	17	1	11	9
	Outpatient Services in Inpatient Setting	18	1	11	9
	Inpatient Revenues for Ambulance (associated with admissions), ASC, Hospice, and Other Inpatient Services	20, 22-24	1	11	9
	Outpatient Revenues for the Home Health Agency, Ambulance, CMHC, CORF, ASC, Hospice, and Other Outpatient Services	17-24	2	11	9
	Patient Revenue - Inpatient, Outpatient, and in Total	25	1--3	11	9
Part II:	Total Operating Expenses from Worksheet A	26	2	11	9
	Increases to Operating Expenses Reported on Worksheet A	33	2	11	9
	Decreases to Operating Expenses Reported on Worksheet A	39	2	11	9
	Total Operating Expenses	40	2	11	9

WORKSHEET G-3

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Total Patient Revenues	1	1	11	9
Contractual Allowances and Discounts on Patients' Accounts	2	1	11	-9
Net Patient Revenues	3	1	11	9
Total Operating Expenses	4	1	11	9
Net Income from Service to Patients	5	1	11	-9
Other Revenues	6--24	1	11	9
Total Other Income	25	1	11	9
Total Revenue Before Other Expenses	26	1	11	-9
Other Expenses	27-29	1	11	9
Total Other Expenses	30	1	11	9
Net Income	31	1	11	-9

WORKSHEET H

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
For each Home Health Agency (HHA) - Analysis of HHA Costs:				
Transportation Costs by Department and in Total	1--24, 23.50	3	11	9
Other Costs by Department and in Total	1--24, 23.50	5	11	9
Adjustments by Department and in Total	1--24, 23.50	9	11	-9
Salaries	3-24, 23.50, 13.20	1	11	9
Employee Benefits	3-24, 23.50, 13.20	2	11	9
Contracted/Purchased Services	3-24, 23.50, 13.20	4	11	9
Total	1-24, 23.50, 13.20	6	11	9
Reclassifications	1-24, 23.50, 13.20	7	11	-9
Reclassified Trial Balance	1-24, 23.50, 13.20	8	11	9
Net Expenses for Allocation	1-24, 23.50, 13.20	10	11	9

WORKSHEET H-1

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
For each Home Health Agency (HHA) - Analysis of Compensation of Salaries and Wages by Department and in Total:				
Administrators	3--12, 15--24, 23.50	1	11	9
Directors	3--12, 15--24, 23.50	2	11	9
Supervisors	3--12, 15--24, 23.50	4	11	9
Nurses	3--12, 15--24, 23.50	5	11	9
Therapists	3--12, 15--24, 23.50	6	11	9
Aides	3--12, 15--24, 23.50	7	11	9
All Other	3--24, 23.50	8	11	9
Total Salaries and Wages for Administrators, Directors, Supervisors, Nurses, Therapists, Aides, and All Other for Each Department and for Entire HHA	3--24, 23.50	9	11	9

T8:
Worksheet H: Line 23.50, Columns 3, 5, and 9 added.
Worksheet H-1: Line 23.50, Columns 1 through 9 added.

T17: Worksheet H: Line 13.20 added.

Added on February 22, 2007: Worksheet H, Columns 1, 2, 4, 6, 7, 8, and 10, all Lines.

WORKSHEET H-2

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
For each Home Health Agency (HHA): Analysis of Compensation of Employee Benefits (Payroll Related) by Department and in Total:				
Administrators	3--11, 15--24, 23.50	1	11	9
Directors	3--11, 15--24, 23.50	2	11	9
Supervisors	3--11, 15--24, 23.50	4	11	9
Nurses	3--11, 15--24, 23.50	5	11	9
Therapists	3--11, 15--24, 23.50	6	11	9
Aides	3--11, 15--24, 23.50	7	11	9
All Other	3--24, 23.50	8	11	9
Total Benefits for Administrators, Directors, Supervisors, Nurses, Therapists, Aides, and All Other for Each Department and for Entire HHA:	3--24, 23.50	9	11	9

WORKSHEET H-3

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
For each Home Health Agency (HHA): Analysis of Compensation of Purchased/Contracted Services by Department and in Total:				
Administrators	3--11, 15--24, 23.50	1	11	9
Directors	3--11, 15--24, 23.50	2	11	9
Consultants	3--11, 15--24, 23.50	3	11	9
Supervisors	3--11, 15--24, 23.50	4	11	9
Nurses	3--11, 15--24, 23.50	5	11	9
Therapists	3--11, 15--24, 23.50	6	11	9
Aides	3--11, 15--24, 23.50	7	11	9
All Other	3--24, 23.50	8	11	9
Total Cost of Contracted/Purchased Services for Administrators, Directors, Consultants, Supervisors, Nurses, Therapists, Aides, and All Other for Each Department and for the Entire HHA:	3--24, 23.50	9	11	9

WORKSHEET H-4,
PARTS I AND II

	DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Part I:	For each HHA: Allocation of General Service Costs	1--24, 23.50, 13.20	0	11	9
	Total Costs during Cost Finding by Department	1, 3-24, 23.50, 13.20	1	11	9
	and in Total	2-24, 23.50, 13.20	2	11	9
		3-24, 23.50, 13.20	3	11	9
		4-12, 14-24, 23.50, 13.20	4	11	9
		5-24, 23.50, 13.20	5	11	9
		6-24, 23.50, 13.20	6	11	9
Part II:	For each HHA : Cost Allocation Statistical Basis				
	Total Cost to be Allocated	25	1-4, 5	11	9
	Unit Cost Multiplier	26	1-4, 5	11	9(5).9(6)

T8:
Worksheet H-2: Line 23.50, Columns 1 through 9 added.
Worksheet H-3: Line 23.50, Columns 1 through 9 added.
Worksheet H-4, Part I: Line 23.50, Columns 0 through 6 added.

T17: Worksheet H-4, Part I: Line 13.20 added.

WORKSHEET H-5
PART I

	DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Part I:	Allocation of General Service Costs to Home Health Agency Cost Centers: HHA Trial Balance by HHA Cost Center and in Total	2--20, 19.50, 9.20	0	11	9
	Total Costs During Cost Finding by Department and in Total	1--20, 19.50, 9.20	1--27	11	9
	Total Costs After Allocation by Department and in Total for Entire HHA	2--20, 19.50, 9.20	29	11	9
	Allocated HHA A&G	2-20, 19.50, 9.20	28	11	9
		21	28	11	9(5).9(6)

WORKSHEET H-5
PART II

	DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Part II:	For each HHA: Cost Allocation Statistical Basis				
	Total Cost to be Allocated	21	1--5, 6-24	11	9
	Unit Cost Multiplier	22	1--5, 6-24	11	9(5).9(6)
	Buildings &Fixtures - Old Capital	1-20, 9.20	1	11	9
	Movable Equipment - Old Capital	1-20, 9.20	2	11	9
	Buildings &Fixtures - New Capital	1-20, 9.20	3	11	9
	Movable Equipment - New Capital	1-20, 9.20	4	11	9
	Employee Benefits	1-20, 9.20	5	11	9
	Reconciliation	1-20, 9.20	6A	11	9
	Administrative &General	1-20, 9.20	6	11	9
	Maintenace & Repairs	1-20, 9.20	7	11	9
	Operation of Plant	1-20, 9.20	8	11	9
	Laundry and Linen Service	1-20, 9.20	9	11	9
	Housekeeping	1-20, 9.20	10	11	9
	Dietary	1-20, 9.20	11	11	9
	Cafeteria	1-20, 9.20	12	11	9
	Maintenace of Personnel	1-20, 9.20	13	11	9
	Nursing Administration	1-20, 9.20	14	11	9
	Central Services & Supply	1-20, 9.20	15	11	9
	Pharmacy	1-20, 9.20	16	11	9
	Medical Records & Library	1-20, 9.20	17	11	9
	Social Service	1-20, 9.20	18	11	9
	Other General Service	1-20, 9.20	19	11	9
	NonPhysician Anesthetists	1-20, 9.20	20	11	9
	Nursing School	1-20, 9.20	21	11	9
	Interns & Residents Salary and Fringes	1-20, 9.20	22	11	9
	Program Costs	1-20, 9.20	23	11	9
	Paramedical Education	1-20, 9.20	24	11	9

T8: Worksheet H-5, Part I: Line 19.50, Columns 0, 1-27, and 29 added,

T17: Worksheet H-5, Part I and II: Line 9.20 added.

Added on February 22, 2007: Worksheet H-5, Part I, Column 28, all Lines.
Added on February 22, 2007: Worksheet H-5, Part II, Columns 1-24, Lines 1-20.

HCRIS Specifications for the HCFA 2552-96
Table 3 - List of Data Elements with Worksheet, Line, and Column Designations

WORKSHEET H-6
PART I

	DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Part I:	Apportionment of HHA Cost Centers Computation of the Lesser of Aggregate Medicare Cost or the Aggregate of the Medicare Limitation				
	Cost Per Visit Computation				
	Shared Ancillary Costs by Department and in Total	2	2	11	9
		3	2	11	9
		4	2	11	9
		7	2	11	9
	Total HHA Costs by Department and in Total	1	3	11	9
		2	3	11	9
		3	3	11	9
		4	3	11	9
		5	3	11	9
		6	3	11	9
		7	3	11	9
	Total HHA Visits by Department and in Total	1	4	11	9
		2	4	11	9
		3	4	11	9
		4	4	11	9
		5	4	11	9
		6	4	11	9
		7	4	11	9
	Average Cost Per Visit by Department	1	5	11	9(9).9(2)
		2	5	11	9(9).9(2)
		3	5	11	9(9).9(2)
		4	5	11	9(9).9(2)
		5	5	11	9(9).9(2)
		6	5	11	9(9).9(2)
	Part A Program Visits by Department and in Total	1	6 & 6.01	11	9
		2	6 & 6.01	11	9
		3	6 & 6.01	11	9
		4	6 & 6.01	11	9
		5	6 & 6.01	11	9
		6	6 & 6.01	11	9
		7	6 & 6.01	11	9

T8: Column 6.01 added.

WORKSHEET H-6
PART I
(CONTINUED)

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Part B Program Visits - Not Subject to Deductibles and Coinsurance by Department and in Total	1	7 & 7.01	11	9
	2	7 & 7.01	11	9
	3	7 & 7.01	11	9
	4	7 & 7.01	11	9
	5	7 & 7.01	11	9
	6	7 & 7.01	11	9
	7	7 & 7.01	11	9
Part A Cost of Services by Department and in Total	1	9 & 9.01	11	9
	2	9 & 9.01	11	9
	3	9 & 9.01	11	9
	4	9 & 9.01	11	9
	5	9 & 9.01	11	9
	6	9 & 9.01	11	9
	7	9 & 9.01	11	9
Part B Cost of Services - Not Subject to Deductibles and Coinsurance by Department and in Total	1	10 & 10.01	11	9
	2	10 & 10.01	11	9
	3	10 & 10.01	11	9
	4	10 & 10.01	11	9
	5	10 & 10.01	11	9
	6	10 & 10.01	11	9
	7	10 & 10.01	11	9
Total Program Cost by Department and in Total	1	12 & 12.01	11	9
	2	12 & 12.01	11	9
	3	12 & 12.01	11	9
	4	12 & 12.01	11	9
	5	12 & 12.01	11	9
	6	12 & 12.01	11	9
	7	12 & 12.01	11	9

T8: Columns 7.01, 9.01, 10.01, and 12.01 added.

WORKSHEET H-6
PART I
(CONTINUED)

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Limitation Cost Computation				
MSA Code	8.00-8.99	1	4	X
	9.00-9.99	1	4	X
	10.00-10.99	1	4	X
	11.00-11.99	1	4	X
	12.00-12.99	1	4	X
	13.00-13.99	1	4	X
Program Cost Limits by Department	8.00-8.99	5	11	9(9).9(2)
	9.00-9.99	5	11	9(9).9(2)
	10.00-10.99	5	11	9(9).9(2)
	11.00-11.99	5	11	9(9).9(2)
	12.00-12.99	5	11	9(9).9(2)
	13.00-13.99	5	11	9(9).9(2)
Part A Cost of Services by Department and in Total	8.00-8.99	9 & 9.01	11	9
	9.00-9.99	9 & 9.01	11	9
	10.00-10.99	9 & 9.01	11	9
	11.00-11.99	9 & 9.01	11	9
	12.00-12.99	9 & 9.01	11	9
	13.00-13.99	9 & 9.01	11	9
	14	9 & 9.01	11	9
Part B Cost of Services - Not Subject to Deductibles and Coinsurance by Department and in Total	8.00-8.99	10 & 10.01	11	9
	9.00-9.99	10 & 10.01	11	9
	10.00-10.99	10 & 10.01	11	9
	11.00-11.99	10 & 10.01	11	9
	12.00-12.99	10 & 10.01	11	9
	13.00-13.99	10 & 10.01	11	9
	14	10 & 10.01	11	9
Total Program Cost by Department and in Total	8.00-8.99	12 & 12.01	11	9
	9.00-9.99	12 & 12.01	11	9
	10.00-10.99	12 & 12.01	11	9
	11.00-11.99	12 & 12.01	11	9
	12.00-12.99	12 & 12.01	11	9
	13.00-13.99	12 & 12.01	11	9
	14	12 & 12.01	11	9

T8: Columns 9.01, 10.01, and 12.01 added.

WORKSHEET H-6
PART I
(CONTINUED)

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Supplies and Equipment Cost Computation				
Shared Ancillary Costs by Department	15, 15.01, 16, 16.01, 16.20	2	11	9
Total Ancillary Costs by Department	15, 15.01, 16, 16.01, 16.20	3	11	9
Total Charges by Department	15, 15.01, 16, 16.01, 16.20	4	11	9
Ratio of HHA Cost to Charges	15, 15.01, 16, 16.01, 16.20	5	11	9(5).9(6)
Part A Medicare Covered Charges	15, 15.01, 16, 16.01, 16.20	6 & 6.01	11	9
Part B Medicare Covered Charges - Not Subject to Deductibles and Coinsurance	15, 15.01, 16, 16.01, 16.20	7 & 7.01	11	9
Part B Medicare Covered Charges - Subject to Deductibles and Coinsurance	15, 15.01, 16, 16.01, 16.20	8	11	9
Part A Cost of Services	15, 15.01, 16, 16.01, 16.20	9 & 9.01	11	9
Part B Cost of Services - Not Subject to Deductibles and Coinsurance	15, 15.01, 16, 16.01, 16.20	10 & 10.01	11	9
Part B Cost of Services - Subject to Deductibles and Coinsurance	15, 15.01, 16, 16.01, 16.20	11	11	9
Program unduplicated census amount	17.00-17.99	2	11	9
Per beneficiary cost limitation amount	18.00-18.99	2	11	9(9).9(2)
Per beneficiary cost limitation total amount	19	2	11	9

Revision to specs on 06/06/2004.
This was issued with the Transmittal 12 changes, but it is not a T12 addition.
Worksheet H-6, Part I, Columns 6.01, 7.01, 9.01, and 10.01 have been subscripted for Lines 15 and 16.

T17:
Worksheet H-6, Part I: Line 16.20 added.

WORKSHEET H-6,
PARTS II AND III

	DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Part II:	Apportionment of Cost of HHA Services Furnished by Shared Hospital Departments				
	Total HHA Charges by Department	1--5	2	11	9
Part III:	Outpatient Therapy Reduction Computation				
	Physical, Occupational, Speech Average Cost per Visit	1-3	2	11	9(9).9(2)
	Number of Program Visits rendered for Physical, Occupational, and Speech therapies prior to January 1, 1998.	1 - 4	2.01	11	9
	Number of Program Visits rendered for Physical, Occupational, and SpeechTherapies from 1/1/98 through 12/31/98	1-4	3	11	9
	Program Costs of Physical, Occupational, and Speech therapy services rendered prior to January 1, 1998	1--4	3.01	11	9
	Program Costs of Physical, Occupational, and Speech therapy services from 1/1/98 through 12/31/98	1-4	4	11	9
	Program visits on or after 1/1/99	1-4	5	11	9

T7: Worksheet H-6, Part III:

Columns 3 and 4 are for services rendered from 1/1/98 through 12/31/98.
Added Column 5, Lines 1-4

HCRIS Specifications for the HCFA 2552-96
Table 3 - List of Data Elements with Worksheet, Line, and Column Designations

WORKSHEET H-7
PARTS I AND II

	DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Part I:	Computation of the Lesser of Reasonable Costs or Customary Charges:				
	Part A	1-4, 6-9	1	11	9
	Part B Not Subject to Copayments	1-4, 6-9	2	11	9
	Part B Subject to Copayments	1-4, 6-9	3	11	9
	Ratio of Amounts Collected to Amounts Collectible	5	1--3	11	9(5).9(6)
Part II:	Computation of HHA Reimbursable Settlement:				
	Part A	10, 12-14, 16-27, 25.01	1	11	-9
	Part B	10--27, 25.01	2	11	-9
	Total PPS Reimbursement Part A	10.01 - 10.14	1	11	9
	Reimbursable bad debts for dual eligible beneficiaries	17.01	1	11	9
	Total PPS Reimbursement Part B	10.01 - 10.14	2	11	9
	Reimbursable bad debts for dual eligible beneficiaries	17.01	2	11	9

WORKSHEET H-8

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
For each Home Health Agency (HHA):				
Total Interim Payments to Provider	1	2 & 4	11	9
Interim Payments Payable	2	2 & 4	11	9
Retroactive Adjustments:				
Program to Provider - Date (MM/DD/YY)	3.01-3.49	1 & 3	8	X
Program to Provider - Amount	3.01-3.49	2 & 4	11	9
Provider to Program - Date (MM/DD/YY)	3.50-3.98	1 & 3	8	X
Provider to Program - Amount	3.50-3.98	2 & 4	11	-9
Subtotal Retroactive Payments	3.99	2 & 4	11	-9
Total Interim Payments	4	2 & 4	11	-9
Tentative Settlement Payments:				
Program to Provider - Date (MM/DD/YY)	5.01-5.49	1 & 3	8	X
Program to Provider - Amount	5.01-5.49	2 & 4	11	9
Provider to Program - Date (MM/D/YY)	5.50-5.98	1 & 3	8	X
Provider to Program - Amount	5.50-5.98	2 & 4	11	9
Subtotal Tentative Settlement	5.99	2 & 4	11	-9
Net Settlement:				
Program to Provider - Date (MM/DD/YY)	6.01	1 & 3	8	X
Program to Provider - Amount	6.01	2 & 4	11	-9
Provider to Program - Date (MM/DD/YY)	6.02	1 & 3	8	X
Provider to Program - Amount	6.02	2 & 4	11	9
Total Medicare Program Liability	7	2 & 4	9	9

T12:
Worksheet H-7, Part II, Line 17.01, Columns 1 and 2 added.

HCRIS Specifications for the HCFA 2552-96
Table 3 - List of Data Elements with Worksheet, Line, and Column Designations

WORKSHEET I-1

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
For Renal Dialysis & Home Program Dialysis Departments:				
Total Direct Costs by Cost Center and in Total	1--33	1	11	9
Paid Hours	1--6	3	11	9(9).9(2)
Statistics	30, 31, 32	3	11	9
FTE's Per 2080 Hours	1--6	4	11	9(9).9(2)

WORKSHEET I-2

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Allocation of Renal Department Costs to Treatment Modilities for Renal Dialysis and Home Program Dialysis:				
Total Costs During Cost Finding by Department and in Total	1--13, 15, 16	1-5, 8-10	11	9
	1--16	6 & 7	11	9
Total Cost After Cost Allocation	1--18	11	11	9
ARANESP	14.01	6	11	9

WORKSHEET I-3

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Direct and Indirect Renal Dialysis Cost Allocation-Statistical Basis:				
Number of Inpatient Dialysis Treatments	12	0	11	9
Direct Patient Care Salary:				
RN Hours	2-13, 15	3	11	9(9).9(2)
Other Hours	2-13, 15	4		9(9).9(2)
Total Statistical Basis	16	3 & 4	11	9

2/27/2002: The usage for I-3, Columns 3 and 4, Lines 2-13 and 15 changed to 9(9).9(2).

T18: Worksheet I-2, Line 14.01, Column 6 added.

WORKSHEET I-4

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
For Renal Dialysis & Home Program Dialysis Departments:				
Statistics by Type of Service and in Total:				
Number of Treatments and in Total	1--8, 10, 11	1	11	9
Number of Patient Weeks	9	1 & 4	11	9
Average Cost of Treatments	1--10	3	7	9(9).9(2)
Number of Program Treatments	1--8, 10, 11	4	11	9
Number of Program Treatments	1-11	4.01	11	9
Total Program Expenses	11	5	11	9
Payment Rate	1--10	6	6	9(9).9(2)
Payment Rate	1-10	6.01	6	9(3).9(2)
Total Program Payment	1--11	7	11	9

T14: Worksheet I-4, Columns 4.01 and 6.01 added.

WORKSHEET I-5

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Data for Calculation of Reimbursable Bad Debts, Title XVIII, Part B	1--9	1	11	-9
Reimbursable bad debts for dual eligible beneficiaries	5.01	1	11	9

WORKSHEET J-1
PART I

	DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Part I:	Allocation of General Service Costs to Component Cost Centers for each CMHC, CORF, OPT, OOT, and OSP:				
	Net Expenses for Cost Allocation	1--22	0	11	-9
	Allocation of General Service Costs to Component Cost Centers	1--22	1--5, 6--27	11	-9
	Total Cost After Cost Allocation	2--22	29	11	-9

WORKSHEET J-2
PART I

	DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Part I:	Apportionment of Cost Centers for Each CMHC, CORF, OPT, OOT, and OSP:				
	Component Charges and in Total	2--20	2	11	9
	Title XVIII Charges	2--20	6 & 6.01	11	9
	Title XVIII Costs	2-20	7 & 7.01	11	9
	Title XIX Charges	2--20	8	11	9
	Title XIX Costs	2--20	9	11	9

T12:
Worksheet I-5, Line 5.01, Column 1 added.

HCRIS Specifications for the HCFA 2552-96
Table 3 - List of Data Elements with Worksheet, Line, and Column Designations

WORKSHEET J-2
PART II

	DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Part II:	Computation of Unit Cost Multiplier for Allocation of Component Administrative and General Costs for each CMHC, CORF, OPT, OOT, and OSP:				
	Title XVIII Charges	21-27	6 & 6.01	11	9
	Title XVIII Costs	21--28	7 & 7.01	11	9
	Title XIX Charges	21- 27	8	11	9
	Title XIX Costs	21- 28	9	11	9

WORKSHEET J-3

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Title XVIII and Title XIX Settlement Data for	1--6, 8--29	1	11	-9
each CMHC, CORF, OPT, OOT, OSP	7	1	11	9(5).9(6)
	27.01	1	11	9
Reimbursable bad debts for dual eligible beneficiaries	19.01	1	11	9
Title XVIII Settlement Data	1--6, 8--29	1 & 1.01	11	-9
for Each CMHC if the reporting period	7	1 & 1.01	11	9(5).9(6)
overlaps August 1, 2000	27.01	1 & 1.01	11	9
Reimbursable bad debts for dual eligible beneficiaries	19.01	1.01	11	9
Title XVIII for CMHC	1.01	1 & 1.01	11	9
for services on or after August 1, 2000	1.02	1 & 1.01	11	9
	1.03	1 & 1.01	11	9(8).9(2)
	1.04	1 & 1.01	11	9
	1.05	1 & 1.01	11	9(8).9(2)
	1.06	1 & 1.01	11	9

T12:
Worksheet J-3: Line 19.01, Columns 1 and 1.01 added.

WORKSHEET J-4

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
For each CMHC, CORF, OPT, OOT, and OSP, Title XVIII:				
Total Interim Payments Paid to Provider	1	2	11	9
Interim Payments Payable	2	2	11	9
Retroactive Adjustments:				
Program to Provider - Date (MM/DD/YY)	3.01-3.49	1	8	X
Program to Provider - Amount	3.01-3.49	2	11	9
Provider to Program - Date (MM/DD/YY)	3.50-3.98	1	8	X
Provider to Program - Amount	3.50-3.98	2	11	-9
Subtotal Retroactive Payments	3.99	2	11	-9
Total Interim Payments	4	2	11	-9
Tentative Settlement Payments:				
Program to Provider - Date (MM/DD/YY)	5.01-5.49	1	8	X
Program to Provider - Amount	5.01-5.49	2	11	9
Provider to Program - Date (MM/DD/YY)	5.50-5.98	1	8	X
Provider to Program - Amount	5.50-5.98	2	11	9
Subtotal Tentative Settlement	5.99	2	11	-9
Net Settlement:				
Program to Provider - Date (MM/DD/YY)	6.01	1	8	X
Program to Provider - Amount	6.01	2	11	-9
Provider to Program - Date (MM/DD/YY)	6.02	1	8	X
Provider to Program - Amount	6.02	2	11	9
Total Medicare Program Liability	7	2	9	9

HCRIS Specifications for the HCFA 2552-96
Table 3 - List of Data Elements with Worksheet, Line, and Column Designations

WORKSHEET K

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
For each Hospice - Analysis of Hospice Costs:				
Transportation Costs by Department	1-34	3	11	9
and in Total	10.20, 18.20, 20.30, 20.31, 20.3	3	11	9
Other Costs by Department	1-34	5	11	9
and in Total	10.20, 18.20, 20.30, 20.31, 20.3	5	11	9
Adjustments by Department	1-34	9	11	9
and in Total	10.20, 18.20, 20.30, 20.31, 20.3	9	11	9

WORKSHEET K-1

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
For each Hospice - Analysis of Compensation of Salaries and Wages by Department and in Total:				
Administrators	3-19, 22-34, 10.20, 18.20	1	11	9
Directors	3-19, 22-34, 10.20, 18.20	2	11	9
Social Services	3-19, 22-34, 10.20, 18.20	3	11	9
Supervisors	3-19, 22-34, 10.20, 18.20	4	11	9
Nurses	3-19, 22-34, 10.20, 18.20	5	11	9
Therapists	11-13, 34	6	11	9
Aides	3-19, 22-34, 10.20, 18.20	7	11	9
All Other	3-19, 22-34, 10.20, 18.20	8	11	9
Total	3-19, 22-34, 10.20, 18.20	9	11	9

WORKSHEET K-2

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
For each Hospice: Analysis of Compensation of Employee Benefits (Payroll Related) by Department and in Total:				
Administrators	3-19, 22-34, 10.20, 18.20	1	11	9
Directors	3-19, 22-34, 10.20, 18.20	2	11	9
Social Services	3-19, 22-34, 10.20, 18.20	3	11	9
Supervisors	3-19, 22-34, 10.20, 18.20	4	11	9
Nurses	3-19, 22-34, 10.20, 18.20	5	11	9
Therapists	11-13, 34	6	11	9
Aides	3-19, 22-34, 10.20, 18.20	7	11	9
All Other	3-19, 22-34, 10.20, 18.20	8	11	9
Total	3-19, 22-34, 10.20, 18.20	9	11	9

T8: The K Series of Worksheets for Hospice added

T17:
Worksheet K: Lines 10.20, 18.20, 20.30, 20.31, and 20.32 added.
Worksheet K-1: Lines 10.20 and 18.20 added.
Worksheet K-2: Lines 10.20 and 18.20 added.

WORKSHEET K-3

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
For each Hospice: Analysis of Compensation of Purchased/Contracted Services by Department and in Total:				
Administrators	3-19, 22-34, 10.20, 18.20	1	11	9
Directors	3-19, 22-34, 10.20, 18.20	2	11	9
Social Services	3-19, 22-34, 10.20, 18.20	3	11	9
Supervisors	3-19, 22-34, 10.20, 18.20	4	11	9
Nurses	3-19, 22-34, 10.20, 18.20	5	11	9
Therapists	11-13, 34	6	11	9
Aides	3-19, 22-34, 10.20, 18.20	7	11	9
All Other	3-19, 22-34, 10.20, 18.20	8	11	9
Total	3-19, 22-34, 10.20, 18.20	9	11	9

WORKSHEET K-4
PARTS I AND II

	DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Part I:	For each Hospice: Allocation of General Service Costs	1-34, 10.20, 18.20, 20.30-20.32	0	11	9
	Total Costs during Cost Finding by Department	1-34 10.20, 18.20, 20.30-20.32	1	11	9
	and in Total	2-34 10.20, 18.20, 20.30-20.32	2	11	9
		3-34 10.20, 18.20, 20.30-20.32	3	11	9
		4-34 10.20, 18.20, 20.30-20.32	4	11	9
		5-34 10.20, 18.20, 20.30-20.32	5	11	9
		7-33 10.20, 18.20, 20.30-20.32	6	11	9
		7-34 10.20, 18.20, 20.30-20.32	7	11	9
Part II:	For each Hospice: Cost Allocation Statistical Basis				
	Total Cost to be Allocated	34	1-5, 6	11	9
	Unit Cost Multiplier	35	1-5, 6	11	9(5).9(6)

T10: Worksheet K-4, Part I, Line 34, Column 6 has been removed from the specs. It is now closed on the worksheet form.

T17:
Worksheet K-3: Lines 10.20 and 18.20 added.
Worksheet K-4, Part I: Lines 10.20, 18.20, 20.30, 20.31, and 20.32 added.

WORKSHEET K-5
PART I

	DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Part I:	Allocation of General Service Costs to Hospice Cost Centers:				
	Hospice Trial Balance by Hospice Cost Center	2-29 5.20, 13.20, 15.30, 15.31, 15.3	0	11	9
	Total Costs During Cost Finding by Department and in Total	1-29 5.20, 13.20, 15.30, 15.31, 15.3	1-27	11	9
		1-29 5.20, 13.20, 15.30, 15.31, 15.3	5A	11	9
	Total Costs After Allocation by Department and in Total for Entire Hospice	2-29 5.20, 13.20, 15.30, 15.31, 15.3	29	11	9

WORKSHEET K-5
PART II

	DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Part II:	For each Hospice Cost Allocation Statistical Basis				
	Total Cost to be Allocated	30	1-5, 6-24	11	9
	Unit Cost Multiplier	31	1-5, 6-24	11	9(5).9(6)

WORKSHEET K-5
PART III

	DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Part III:	Computation of Total Hospice Shared Costs				
	Total Hospice Charges	1-10	2	11	9
	Hospice Shared Ancillary Costs	1-11	3	11	9

T8: The K Series of Worksheets for Hospice added

T17: Worksheet K-5, Part I, Lines 5.20, 13.20, and 15.30, 15.31, and 15.32 added.

WORKSHEET K-6

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Calculation of Hospice Per Diem Cost				
Title XVIII Computation of Per Diem Cost	4, 5, 8, 9	1	11	9
Title XIX Computation of Per Diem Cost	6, 7, 10, 11	2	11	9
Other Computation of Per Diem Cost	12, 13	3	11	9
Total Cost	1	4	11	9
Total Unduplicated Days	2	4	11	9
Average cost per diem	3	4	11	9(9).9(2)

T8:
The K series of worksheets added.

WORKSHEET L
PARTS I, II, III, AND IV

	DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
	For the Hospital and Each Subprovider - Titles XVIII and XIX:				
Part I:	Capital Payments - Fully Prospective Method	1, 2, 4.03, 5.04, 6	1	11	9
	Capital Payments for services rendered before 10/01/1997	3	1	11	9
	Captial Payments for services rendered on or after 10/01/1997	3.01	1	11	9
		4, 4.01	1	11	9(9).9(2)
		5, 5.01, 5.02, 5.03	1	6	9.9(4)
		4.02	1	6	9(3).9(2)
Part II:	Capital Payments - Hold Harmless Method	1--3, 5, 7-10	1	11	9
		4	1	11	9(5).9(6)
		6	1	11	9(9).9(2)
Part III:	Capital Payments - Reasonable Cost Method	1-3, 5	1	11	9
		4	1	11	9(9).9(2)
Part IV:	Capital Payments - Exception for Extraordinary Circumstances	1--3, 5, 7-14	1	11	-9
		4 & 6	1	11	9(9).9(2)
		15, 16, 17	1	11	9

T10:
Worksheet L, Part I: Usage for Lines 4.02, 5 and 5.01-5.03 changed from 2 decimal fields to 4 decimal fields. This is effective for cost reporting periods ending on or after April 30, 2003.

Transmittal 20:
Worskheet L, Part I: Usage for Line 4.02 and 5-5.03 corrected.

WORKSHEET L-1
PART II

	DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Part II:	For Facilities Claiming Capital Related Costs Due to Extraordinary Circumstances:				
	Total Routine Capital Related Costs by Department and in Total	25-31, 33, 101	1	11	9
	Total Routine Capital Related Costs, Reduced by the Swing-Bed Adjustment, by Department and in Total	25-31, 33, 101	3	11	9
	Total Inpatient Days by Department and in Total	25-31, 33, 101	4	11	9
	Inpatient Program Days	25-31, 33, 101	6	11	9
	Inpatient Program Capital Cost	25-31, 33, 101	7	11	9

WORKSHEET L-1
PART III

	DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Part III:	Computation of Program Inpatient Ancillary Service Capital Costs for Extraordinary Circumstances:				
	Total Ancillary Capital Related Costs by Department and in Total	37-44, 46-68, 46.30, 55.30, 10	1	11	9
	Program Ancillary Capital Related Costs by Department and in Total	37-44, 46.30, 55.30, 46-68, 10	5	11	9

Transmittal 20:
Worksheet L-1, Part III: Lines 46.30 and 55.30 added.

HCRIS Specifications for the HCFA 2552-96
Table 3 - List of Data Elements with Worksheet, Line, and Column Designations

WORKSHEET M-1

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
For RHC/FQHC:				
Compensation by Department and in Total	1 - 32	1	11	-9
Other Costs by Department and in Total	1 - 32	2	11	-9
Adjustments by Department and in Total	1 - 32	6	11	-9
Net Expenses for Allocation	1 - 32	7	11	-9

Transmittal 4 Addition:
Worksheet M-1 is a new worksheet.

WORKSHEET M-2

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Number of FTE Personnel for the following:				
Physicians	1	1	11	9(9).9(2)
Physician Assistants	2	1	11	9(9).9(2)
Nurse Practitioners	3	1	11	9(9).9(2)
Subtotal	4	1	11	9(9).9(2)
Visiting Nurse	5	1	11	9(9).9(2)
Clinical Psychologist	6	1	11	9(9).9(2)
Clinical Social Worker	7	1	11	9(9).9(2)
Total FTEs and Visits	8	1	11	9(9).9(2)
Total Visits for the following:				
Physicians	1	2	11	9
Physician Assistants	2	2	11	9
Nurse Practitioners	3	2	11	9
Subtotal	4	2	11	9
Visiting Nurse	5	2	11	9
Clinical Psychologist	6	2	11	9
Clinical Social Worker	7	2	11	9
Total FTEs and Visits	8	2	11	9
Physician Services Under Agreement	9	2	11	9
Productivity Standard for the following:				
Physicians	1	3	11	9
Physician Assistants	2	3	11	9
Nurse Practitioners	3	3	11	9
Minimum Visits for the following:				
Physicians	1	4	11	9
Physician Assistants	2	4	11	9
Nurse Practitioners	3	4	11	9
Subtotal	4	4	11	9
Total costs of health care services	10	1	11	9
Total nonreimbursable costs	11	1	11	9
Cost of all services excluding overhead	12	1	11	9
Ratio of RHC/FQHC services	13	1	11	9(5).9(6)
Total facility overhead	14	1	11	9
Parent provider overhead allocated to facility	15	1	11	9
Total overhead	16	1	11	9
Allowable GME overhead	17	1	11	9
Line 17 minus Line 16	18	1	11	9
Overhead applicable to RHC/FQHC services	19	1	11	9
Total allowable cost of RHC/FQHC services	20	1	11	9

Transmittal 4 Addition:
Worksheet M-2 is a new worksheet.

HCRIS Specifications for the HCFA 2552-96
Table 3 - List of Data Elements with Worksheet, Line, and Column Designations

WORKSHEET M-3

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Determination of Rate for RHC/FQHC Services				
Total allowable cost of RHC/FQHC services	1	1	11	9
Cost of Vaccines and their Administration	2	1	11	9
Total allowable cost excluding vaccine	3	1	11	9
Total FTE and VIsits	4	1	11	9
Physicians visits under agreement	5	1	11	9
Total adjusted visits	6	1	11	9
Adjusted cost per visit	7	1	11	9(9).9(2)
Per visit payment limit	8	1 ,2,& 3	11	9(9).9(2)
Rate for Program covered visits	9	1 ,2,& 3	11	9(9).9(2)
Calculation of Settlement				
Program covered visits excluding mental health services	10	1 ,2,& 3	11	9
Program cost excluding costs for mental health services	11	1 ,2,& 3	11	9
Program covered visits for mental health services	12	1 ,2,& 3	11	9
Program covered cost from mental health services	13	1 ,2,& 3	11	9
Limit adjustment for mental health services	14	1 ,2,& 3	11	9
Graduate Medical Education Pass Through Cost	15	2	11	9
Total Program cost	16	2	11	9
Primary Payer Amounts from your records	16.01	2	11	9
Beneficiary deductible	17	2	11	9
Net Program cost excluding vaccines	18	2	11	9
Reimbursable cost of RHC/FQHC services, excluding vaccine	19	2	11	9
Program Cost of Vaccines and their Administration	20	2	11	9
Total Reimbursable Program Cost	21	2	11	9
Reimbursable bad debts	22	2	11	9
Reimbursable bad debts for dual eligible beneficiaries	22.01	2	11	9
Other Adjustments	23	2	11	9
Net reimbursable amount	24	2	11	9
Interim Payments	25	2	11	9
Tentative Settlement	25.01	2	11	9
Balance due component/program	26	2	11	9
Protested amounts	27	2	11	9

**** Lines 8 through 14, Column 1 calculate the cost limit for services rendered before January 1, 1998.
**** Lines 8 - 19 and 21 -27, Column 1 calculate the cost limit for services rendered on or after January 1, 1998.

**** For Lines 8 through 14, Columns 1 and 2 are used by providers who are fiscal year providers.
**** For Lines 8 through 14, Column 2 is used by providers who are calendar year providers.

T12:
Worksheet M-3, Line 22.01, Col 2 added.

WORKSHEET M-4

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
Computation of Pneumococcal and Influenza				
Health Care Staff Cost	1	1, 2, 2.01, 2.02	11	9
Ratio of vaccine staff time to total health care staff time	2	1, 2, 2.01, 2.02	11	9(5).9(6)
Vaccine health care staff cost	3	1, 2, 2.01, 2.02	11	9
Medical supplies cost	4	1, 2, 2.01, 2.02	11	9
Direct cost of vaccine	5	1, 2, 2.01, 2.02	11	9
Total direct cost of the facility	6	1, 2, 2.01, 2.02	11	9
Total overhead	7	1, 2, 2.01, 2.02	11	9
Ratio of vaccine direct cost to total direct cost	8	1, 2, 2.01, 2.02	11	9(5).9(6)
Overhead cost	9	1, 2, 2.01, 2.02	11	9
Total vacine cost and its administration	10	1, 2, 2.01, 2.02	11	9
Total number of vaccine injections	11	1, 2, 2.01, 2.02	11	9
Cost per vaccine injection	12	1, 2, 2.01, 2.02	11	9(9).9(2)
Number of vaccine injections administered to program beneficiaries	13	1, 2, 2.01, 2.02	11	9
Program cost of vaccine and its administratino	14	1, 2, 2.01, 2.02	11	9
Total cost of vaccine and its administration	15	1, 2, 2.01, 2.02	11	9
Total program cost of vaccine and its administration	16	1, 2, 2.01, 2.02	11	9

T8:
Worksheet M-4 reinstated.

Flash Report - Nov 2009 - Worksheet M-4, Columns 2.01 added for H1N1 and Column 2.02 added for Combination.

WORKSHEET M-5

DESCRIPTION	LINE(S)	COLUMN(S)	FIELD SIZE	USAGE
For each RHC/FQHC, Title XVIII:				
Total Interim Payments Paid to Provider	1	2	11	9
Interim Payments Payable	2	2	11	9
Retroactive Adjustments:				
Program to Provider - Date (MM/DD/YY)	3.01-3.49	1	8	X
Program to Provider - Amount	3.01-3.49	2	11	9
Provider to Program - Date (MM/DD/YY)	3.50-3.98	1	8	X
Provider to Program - Amount	3.50-3.98	2	11	-9
Subtotal Retroactive Payments	3.99	2	11	-9
Total Interim Payments	4	2	11	-9
Tentative Settlement Payments:				
Program to Provider - Date (MM/DD/YY)	5.01-5.49	1	8	X
Program to Provider - Amount	5.01-5.49	2	11	9
Provider to Program - Date (MM/DD/YY)	5.50-5.98	1	8	X
Provider to Program - Amount	5.50-5.98	2	11	9
Subtotal Tentative Settlement	5.99	2	11	-9
Net Settlement:				
Program to Provider - Date (MM/DD/YY)	6.01	1	8	X
Program to Provider - Amount	6.01	2	11	-9
Provider to Program - Date (MM/DD/YY)	6.02	1	8	X
Provider to Program - Amount	6.02	2	11	9
Total Medicare Program Liability	7	2	9	9

Transmittal 4 Addition:
Worksheet M-5 is a new worksheet.