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04/12/2023

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INSTRUCTIONS
INSTITUTIONAL COST REPORT (NYSICR)

Current Year Changes and Reminders for the 2022 ICR Submission

Email address for questions regarding the report - Hospital.ICR@health.ny.gov

Software problem resolution – Please send your "four-pack" files (CR, IC, B_, T_) to Hospital.ICR@health.ny.gov. It will then be forwarded to Health Financial Systems (HFS) for follow-up, if necessary. There may be issues if you have not downloaded and applied the most recent update to the software. Please do not attempt to apply program updates when the ICR software is running at the same time.

Updating **a hospital's** contact information used for ICR email blast notifications - The email addresses for ICR notifications are retrieved from the Health Commerce System (HCS). The email addresses are from the HCS User accounts that have access to the Hospital ICR application. To be removed from the notifications, the access to the Hospital ICR application needs to be removed or the HCS account needs to be deleted. To be added to the email notification list, the HCS User account will need to receive access to the hospital ICR application. For changes in ICR application access, please email Hospital.ICR@health.ny.gov and you will be contacted with further instructions.

In addition, if the email address associated with the HCS User account is incorrect on the HCS, the HCS User must update the email address. The Department cannot make changes to an HCS User account's email address.

Please contact the HCS helpline at 1-866-529-1890 for assistance with HCS accounts in general and to reset the HCS User Account password.

2022 Updates/New Items

New Edits - In order to improve data integrity, several new edits have been implemented. Providers must review all edits and if required make appropriate corrections to specific exhibits. If data has been correctly reported a complete explanation is required. Edits will be reviewed for appropriateness during the ICR audits. This Note has been added to the ICR Software *Edit & Calculation Report* and the Edit Report pdf :

> Note:
> Non-fatal errors (4xxxx) and Informatory messages (5xxxx) point out unusual conditions or amounts in the ICR Edit and Calculation Report (E&C).
> If any inputs for them are wrong, then correct, save and run the E&C. This may clear the Edit.
> If an edit is to remain, the Edit Report explanation is to provide insight about why the unusual situation need not be changed.

Edit Report - A limitation to the number of edits in the Edit Report pdf has been corrected.

Remainder: Working Capital - **Because the term "working capital" has accounting meanings beyond** the uses intended in offsetting interest expense with investment/interest income for the ICR, the

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ICR and its Instructions were changed to replace "working capital" with "operating" interest expense.

Exhibits 3 and 32 - Edits 43218 and 43219 have been changed to not identify a difference for separate Labor and Delivery days reporting in Exhibit 3. The difference in Medicare's Employee Discount Days and the ICR's Courtesy Days definitions may impact Edits 43218 to 43226. In some cases, Edit Report explanations are the expected response.

Cost Center Set up –

CMS has designated line 102 for the Opioid Treatment Program which was previously reported on line 90.40. The software has been set up to renumber from 90.40 to 102 automatically for cost reporting periods ending on or after January 1, 2022. Should the cost center appear out of sequence providers may restore the correct sequence by going to the Cost Center Set-up and clicking on the "Save and Exit" button. Should any other issues occur please send your 4-pack files to the Hospital.ICR@health.ny.gov.

Exhibits 12, 14 and 27 - Health Care and Mental Hygiene Worker Bonus Program (HWB) payments received by the hospital are to be reported on discrete lines 212-214 in Exhibit 27. Because these are not allowable amounts for rate-setting, make Exhibit 12 Reclassifications to Cost Center 003 from the cost centers where costs were recorded when paying the HWB to employees. Then make one or two Exhibit 14 All-payor (Class 00708) Adjustments to Cost Center 003 to remove this cost, depending on how cost was originally recorded [Lines to use : 00708/***344 (CMS 34.78 and*** 00708/***345 (CMS 34.79)]***.

Exhibits 14, 18 and 26B - Certain non-patient-care functions with both revenue and expenses require offset of one or the other value, with limitations (such as not offsetting restricted interest earnings), to reduce allowable revenue or expense to, but not below, zero.

Exhibit 23 - If the hospital has adopted FASB's Accounting Standards Update (ASU) 2016-14, the Net Assets without Donor Restrictions value is to be combined with the General Fund Balance.

COVID-19 Reporting in Exhibits 26A and 27 – For the 2021 and later ICR Report Years, hospitals should report COVID-19 Public Health Emergency (PHE) FUNDING in Exhibit 26A at Class 00037, Line 141 (CMS Line 24.50) per Form CMS 2552-10 Instructions, paragraph 4040.4, Line 24.50 described as "Enter the aggregate revenue received for COVID-19 PHE funding including both PRF and Small Business (Administration) Loan Forgiveness amounts." Should the hospital have any COVID-19 funding which is not included in Line 24.50, beginning in the 2022 Report Year, then input that(those) amount(s) in the ten discrete line(s) in Exhibit 26A, specifying the type/source of funding. The Exhibit 27, Line 090 total is repeated at Exhibit 26A, Line 23. That means that any COVID-19 amount reported in Lines 24.50 and 24.51-24.60 will not be separately included in Exhibit 27.

Exhibit 31A and ICR Schedules 1B – When the prior year cost transfer basis is Charges for a service area, related Exhibit 31A visits data cannot be input and, in ICR Schedules 1B, only the "Based on Charges" transfer information will be displayed. Related edits comparing charges to visits have been modified or deleted. Because CPEP Observation Beds is charges-based, a column is not included.

Exhibits 32, 33, 34 and 46 – Delayed determination of third-party eligibility may change the primary payor for an encounter. For example, an uninsured patient might gain retroactive Medicaid coverage.

Exhibits 32, 33, 34 and 46 - Added clarification on primary payer as Self-pay when the responsible individual informs the hospital for otherwise-covered services to bill them directly and not bill the

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third-party.

Exhibits 32, 33, 34 and 46 - Modified Edit 45204 about not using the default MSC so that it will not present in certain conditions (such as outpatient variable cost centers when using any outpatient MSC).

Exhibit 41 - Areas have been added for patient-care-related home office depreciation expense, cash capital purchases and debt service payments that are assigned or allocated to the hospital and are not in the hospital's trial balance / audited financial statements (AFS) or not presented in the hospital's portion of consolidating schedules of the system, etc. AFS.

> Note: If the ICR is to include values from a Medicare Home Office Report (Form 287), then ensure that these values will be available in order to support timely ICR submission.

Exhibit 46 - Changed the description for Line 002 to "Article 28 General Clinic, MSC 235, Visit Fees - Outpatient" to emphasize differences with: Line 013, Outpatient Visit Fees, Non-clinic; Line 014, CPEP Emergency Services; and Line 015, CPEP Observation Beds, as the point of entry for each encounter.

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General Instructions

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

The following instructions should be utilized when completing the NYSICR.

1. Due Dates

   The due date for receipt of the NYSICR (DH file-HCS electronic submission) is by close of business on Friday, June 16, 2023.

   Note: If the ICR is to include values from a Medicare Home Office Report (Form 287), then ensure that these values will be available in order to support timely ICR submission.

   Due within 5 business days of electronic submission (no later than June 23, 2023) and emailed to: AFS@health.ny.gov:

   1. Signed CFO/CEO Certification: file named with 7-digit operating certificate and "CFO" (Example: 1234567_CFO).

   2. Audited Financial Statements: file named with 7-digit operating certificate and "AFS" (Example: 1234567_AFS).

   3. Audit Fee Form: file named with 7-digit operating certificate and "AFF" (Example: 1234567_AFF).

   Timely submission of these documents is required; non-submission may delay the start of the hospital's ICR audit process. Continued non-submission will prevent the audit of the ICR from being finalized which may result in penalties.

   The ICR audit fees are due upon filing of the ICR. The audit fee levels are based on reported Total Expenses (Exhibit 11, Column 3, line 960 (Class code 00042, line 960)) from the previous year's report. The ICR Audit Fee Schedule is posted on the DOH website at: http://www.health.ny.gov/facilities/hospital/audit_fee/

   The fees should be transmitted to the DOH via an electronic fund transfer (EFT). No paper checks can be accepted and, if a wire transfer is necessary in lieu of an EFT, any additional costs will be the responsibility of the provider.

   The initial fee includes the submission of up to two versions of the ICR. Each additional submission, over two, requires a payment of 50% of the original fee. For Hospital providers, please send an email to Hospital.ICR@health.ny.gov to discuss any concerns with fees and refiling.

   For information regarding the due date of the CMS 2552, contact your Medicare Administrative

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Contractor (MAC)--questions should be directed to JK_Cost_Report_Filing@anthem.com.

2. Certification and Opinion

   Included in the certification statement is a Declaration Control Number (DCN), which allows the provider to attest to the matching cost report electronic file. The DCN is a date and time stamp which notes when the final report file was completed. The DCN will print on the provider's certification statement. The certification statement is to be submitted, in accordance with the filing instructions, no later than five business days following transmission of the electronic file.

3. Handwritten Changes

   The submitted CEO certifications must not have any handwritten changes made to the figures. If there are corrections made on any of the exhibits or ICR schedules, the cost report will be unacceptable and will be returned to the provider. The report will be considered as not received on the due date and the appropriate penalty procedures will be instituted.

4. Help

   Should a facility have questions regarding the report, please email Hospital.ICR@health.ny.gov. Please use "2020 ICR-FACILITY NAME" in your subject line and include your name and telephone number in your e-mail message.

   For Software problem resolution, please send your "four-pack" files (CR, IC, B_, T_) to Hospital.ICR@health.ny.gov. It will then be forwarded to Health Financial Systems (HFS) for follow-up, if necessary. There may be issues if you have not downloaded and applied the most recent update to the software. Please do not attempt to apply program updates when the ICR software is running at the same time.

   The four files that make up the full data sets for a single ICR include the following:

"CR"	CMS-2552 cost report data
"IC"	ICR exhibits and ICR-specific data for 2552 worksheets that are also ICR exhibits
"T"	Cost center template file, and
"B"	Cost center headings file that contains all Exhibit 46 column headings.

   Run-time errors usually can be cleared if you run the "edit/calc" again. When it persists, you can go into the CMTEMP folder (full path C:\ICR2011\CMTEMP) with Windows Explorer and delete its contents. If these steps do not clear the error, send your "four-pack" to Hospital.ICR@health.ny.gov.

5. Resubmission

   Facilities should note that all subsequent report transmissions will generate a new DCN and are subject to all certification and submission requirements. When changes to data are made and saved, the DCN number will change. Specifically:

   1) If "save changes" is selected when running the Edit and Calculate, the DCN will change.
   2) If the DH file is run and the "save changes" prompt is answered yes, the DCN will change.
   3) If changes are saved before exiting the program, the DCN will change.

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Should the hospital identify corrections needed for the ICR before the ICR Audit, decide if a resubmission should be filed in advance of that year's ICR Audit.

- We request that hospitals do not resubmit until they have their exit dashboard. If modifications are required, the hospital will have the opportunity to make these corrections with its post-audit resubmission filing. Once the audit team has been assigned to your hospital, notify them of these issues, if applicable, and provide any appropriate documentation to support these changes. (If the changes are outside the audit scope, then advance Department approval may be needed to avoid a resubmission fee.)

- If you believe the revision cannot wait until the ICR Audit, you must work with DOH to resolve this issue. Send an email to Hospital.ICR@health.ny.gov to discuss. Please note that this resubmission may require an additional submission fee.

ICR "Refiles" Post Exit Dashboard:

From the Exit Dashboard, review any proposed adjustments: Changes are to be made to the resubmitted ICR for the exhibit, column (class code) and line numbers and audited amounts in the exit dashboard. If an adjustment was not made, the provider must add an explanation to give greater context regarding why the adjustment wasn't made. Please note that these instances should be rare, as all findings and adjustments should have been discussed with your audit team during the audit.

When an adjustment made for audit findings impacts other ICR exhibits and schedules, these other ICR exhibits and schedules should be updated for consistency.

Note: If the hospital requested or was granted a waiver of part of or all unfunded depreciation, then, in Exhibit 42, the response indicating that a waiver was granted needs to be completed before resubmission along with the entering the amount of remaining penalty per the Department.

Unless your facility has not received any audit findings and has no Exhibit 42 waiver amount that require the ICR to be resubmitted, resubmit the final cost report within 30 days of receipt of the ICR Audit Exit Dashboard. For the resubmitted ICR to be considered final:

1. Resubmit the ICR electronically with only the adjustments that were proposed in the Hospital's ICR Audit Exit Dashboard (nothing more and nothing less);
2. Submit a signed CFO/CEO Certification with the DCN on the certification that matches the DCN on the ICR being refiled within five business days (see General Instructions paragraph 1 for naming); and

6. Complete Reports

Facilities must complete all applicable portions of the Institutional Cost Report. Failure to provide completed documents will result in the reports being returned to the provider. Incomplete submissions are subject to a 2% penalty in accordance with Part 86-1.2.

7. Edits

During generation of the DH file, a screen allows entry of explanations for any remaining edits.

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Note:
Non-fatal errors (4xxxx) and Informatory messages (5xxxx) point out unusual conditions or amounts in the ICR Edit and Calculation Report (E&C).
If any inputs for them are wrong, then correct, save and run the E&C. This may clear the Edit.
If an edit is to remain, the Edit Report explanation is to provide insight about why the unusual situation need not be changed.

These entries can be initialed electronically. The programmers suggest waiting until ready to submit to enter explanations. Press the "Enter" key after entry to be sure it is recognized by the program. An "ED" file will be created for the edit explanations. The electronic signature is sufficient for submission.

How to read a Data Line Error:

- ✓ Invalid Data Line Error
  II. DATA ERRORS DETECTED:
  The following line of data has an invalid column code:
  (Positions 9-12 in the data line)

X32	3004319	2000	- Exhibit 32
X32	*300*4319	2000	- Line 300
X32	300*4319*	2000	- Class Code (Column Number)*
X32	3004319	*2000*	- Value

* The "II. Data Errors Detected" section in the Edit and Calculation Report includes only the final four digits of any five-digit class code.

8. Filing

(A) Department of Health

The DOH requires the transmission of the computer-generated NYSICR (electronic file) through the Health Commerce System. Please note that submission of the hard copy of the Institutional Cost Report is no longer required.

In addition, the Department is no longer requiring the hard copy submission of the signed CEO/CFO certification. These documents, along with a complete copy of the Audited Financial Statements must be emailed in pdf format to:
AFS@health.ny.gov.

All Pdf documents should be named with the facility's seven-digit operating certificate number, underscore, and CFO or AFS to identify the facility and document.

For Example:
1234567_CFO 1234567_AFS

Note: Draft copies of the Audited Financial Statements are not acceptable. The submission is not considered to be complete until all required documents are received. Incomplete submissions are subject to a 2% penalty in accordance with Part 86-1.2.

(B) Medicare

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The CMS-2552 should be filed as directed by your Medicare Administrative Contractor (MAC).

Any questions regarding the filing of the Medicare Cost Report should be directed to JK_Cost_Report_Filing@anthem.com.

9. Penalties

It is important to note the following regarding the filing of financial and statistical report forms: The document submitted for Medicare is CMS-2552, and must be identical to that submitted for Medicaid, except as required by Title reporting regulations. If not, the ICR for Medicaid will be deemed unacceptable and may result in the application of Part 86-1.2.

- In accordance with Part 86-1.2, in the event a medical facility fails to file the required reports on or before the due dates, the Commissioner of Health shall not certify proposed rate schedules of a hospital to the state Director of the Budget for the rate year immediately following for each day the financial and statistical reports were not filed. A two percent penalty may also be applied.

- In addition, facilities which fail to complete any portion of the NYSICR will be subject to the penalty provisions of Part 86-1.2. Reports will be considered incomplete for one or more of the following:

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

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

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

10. Problem areas in reporting

The Inpatient Gross Revenue Assessment and the Health Facility Cash Assessment (formerly called the NYS Revenue Assessment) should be shown as reductions to revenue on lines 363 and 364 on Exhibit 46 of the ICR (entered as positive numbers). If the revenue is included as an expense on Exhibit 11, then it should be removed on Exhibit 14 and shown as a reconciling item of Exhibit 26. If the ICR reporting of the Assessments differs from the reporting in the Audited Financial Statements, then a reconciliation should be provided on Exhibit 28 lines 4 and 9.

Charges on Exhibit 46 and patient days and discharges on Exhibit 32, reported on a payor-specific basis, must be completed accurately as required by the instructions. This data is used in the calculation of the Disproportionate Share Cap required by the Centers for Medicare and Medicaid Services (CMS) and failure to report data accurately may result in reductions in Disproportionate Share Hospital Pool distributions.

11. Setting up the cost report

Hospitals should use the same reporting period as for Medicare. Generally, the fiscal year (Period To) ending in the named calendar year is the period used. (The exception is for the public benefit

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corporations with fiscal year end of March that use the prior calendar year name.) Providers who change their fiscal year need to be approved first by Medicare. Please contact National Government Services (NGS) to request the change. Once Medicare approves the change, DOH needs to be notified and requires a copy of the approval letter. This documentation can be sent to: Hospital.ICR@health.ny.gov.

When a New York hospital (non-surviving) is combined into another New York hospital (surviving) as of a date that is not one year after the non-survivor's prior cost report end date and subsequently provides services under the surviving hospital's operating certificate, then, for the current period, two cost reports are expected:

1. Non-surviving hospital from the start of the period through its last day of independent services; and
2. Surviving hospital services for the full period combined with any services of the non-surviving hospital from the day after its last day of independent services through the last day of the period.

If filing a cost report for more than one facility, you may wish to set up each cost report in a separate directory. If multiple cost reports are set up in the same directory, only the last report edited and calculated will be available for printing. (The reason is only one (1) set of table files is stored at a time.) The prior year's ICR software *may* be used to start keying current year data. First, download and apply the most recent update to the software, but do not attempt to apply program updates when the ICR software is running.

The prior year's cost report can serve as a template for the current year's report. The line/column structure and some other data sets can be copied from one set of CR/IC files to another without bringing any dollar amounts or statistics forward. You should then update for changes in hospital processes, if any. To maintain the cost center setup from one personal computer (PC) to another, copy all four files (CR, IC, T_, and B_) from one PC to the other. This will keep the unused cost centers from reappearing. When only the CR and IC files are available, the program falls back on the standard NGS and DOH cost center lists to create the other two files, including inserting hospital-specific cost centers found in the CR and IC files.

There have been numerous problems regarding the naming of the cost report. The file name must be cr 33_ _ _ _.YR. (Substitute the four-digit Medicare number assigned to your facility in place of the underscores, the .YR will be the 2-digit year for the filing period.) Do not add any extensions on the file name. The CR file automatically creates the IC file. These two files must be named properly to generate a dh file which is transmittable to the Department via the HCS.

12. Retaining cost report data

Facilities should keep copies of the ic, cr, B_, and T_ files (referred to as "the 4 pack") backed up on a disk after submitting the DH file to the Department of Health. A DH file cannot be loaded to the software to create a revised report; the above-named files are necessary for this purpose.

13. ICR Audit

DOH contracts for the annual audit of the ICR—KPMG was awarded the contract for the ICR 2016 through ICR 2021 audits. Part 86-1 of the Commissioner of Health's Rules and Regulations explains the review of hospital cost reports. In addition, the ICR or Medicaid cost report (Title XIX (Medicaid)) is developed utilizing the same software and data as the Medicare cost report (Title XVIII (Medicare)) and many of the same rules and regulations that apply to Medicare also apply to

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Medicaid.

To standardize and facilitate the audit process, KPMG and the DOH have developed an audit Tool. Within the Tool, there are specific thresholds to trigger further review and to request additional documentation and/or revisions. These thresholds are based on the type of procedure (percent change year-to-year; portion of the total; blank value; etc.) and nature of the specific data element (utilization; cost; FTEs; etc.). If hospital staff feel a threshold has identified an immaterial or misleading value, then the response/explanation should state why. (Note: New or discontinued services and services for which cost centers or MSCs change year-to-year often flag for zero or 100% variances.)

Should the hospital have any identified ICR corrections or changes that were not reflected in the ICR data populated in the Audit Tool, notify the audit team assigned to your hospital of these issues at the start of the Audit. Provide the audit team with the updated ICR data, proposed changes to any exhibits and documentation to support these changes. (If the changes are outside the audit scope, then advance Department approval may be needed to avoid a resubmission fee.)

All hospitals will complete the desk audit portion of the Tool. A risk-based approach is used to select hospitals for field audits with additional procedures including, at least, on-site meetings and deeper review of samples of source documentation. Questions regarding documentation submission, SFTP passwords and other audit mechanics should be submitted to the KPMG ICR Mailbox: us-albadvnysdhicr@kpmg.com.

Extensions of time to complete the Tool, Exit Dashboard or ICR resubmission will be considered if requested via the Audit Tool prior to the due date for situations where the medical facility establishes reasons beyond the control of the facility. DOH will approve or deny extensions based on the information provided. Generally, 1- or 2-week extensions are granted and are considered fair and acceptable. The ICR audit contractor will be notified of any audit extensions granted so they can track accordingly. Approval of extension requests cannot guarantee that there will not be a delay in using the hospital's data in their rate development due to the late receipt of final audited data.

When, after review of the ICR data, Tool responses, documentation and explanations, a variance remains for which hospital action is indicated, KPMG works with the hospital to document a corrective action plan (CAP). These findings and CAPs are documented on the Exit Dashboard. Where, within a CAP, ICR values are to be corrected or updated, hospitals are required to resubmit the cost report including those changes. CAPs or resubmitted ICRs which do not correct or address the underlying issue of each finding may be regarded as a failure to file the required financial and statistical report and subject the hospital to the Part 86-1.3(c) penalty.

If, after the audit closing process, the exit dashboard includes a finding for which the hospital and the auditors did not agree or for which they could not agree on the CAP and the hospital wishes to appeal to mitigate the impact of the finding, then the hospital may appeal per Commissioner Regulations 86-1.4. DOH has the ultimate say in whether the finding and the hospital's response is compliant.

14. Cost Center Set Ups

For facilities that are not required by Medicare to distinctly report clinic sites, the Department requests that all costs, charges, and statistics for General Clinic services be reported in cost center 235. Facilities should no longer use NYS hard-coded clinic cost centers or variable cost centers to

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report clinic services.

In addition, hospital-based Chemical Dependency Clinic/Rehab services, including alcohol day rehabilitation, should be reported in cost center 291; outpatient renal dialysis services in cost center 240; all Cancer Treatment services, including chemotherapy and oncology clinics should be reported in cost center 472; FQHC clinic sites should be reported in cost center 474 if Worksheet "N" Series are required by CMS (otherwise use a variable outpatient cost center); and RHC clinic sites should be reported in cost centers 461-465 and 467-471.

- Cost center 473 - Child Rehabilitation Clinic is restricted to facilities billing the 2887 Medicaid rate code for Child Rehabilitation services.

- Note for 2022: CMS has designated line 102 for the Opioid Treatment Program which was previously reported on line 90.40. The software has been set up to renumber from 90.40 to 102 automatically for cost reporting periods ending on or after January 1, 2022. Should the cost center appear out of sequence providers may restore the correct sequence by going to the Cost Center Set-up and clicking on the "Save and Exit" button. Should any other issues occur please send your 4-pack files to the *Hospital.ICR@health.ny.gov*.

Cost Center Set-up- handling of services not included in rate development.

- If the hospital provides services at sites outside New York State, ensure financial and statistical information for those sites are excluded from the ICR. If included in the ICR, assign the site(s) to variable cost center(s) and final costs in Exhibit 52 to MSC 959, Non-reimbursable.

- Services for which rate codes are not listed in Appendix I are non-reimbursable for ICR reporting. They are not to be commingled with hospital-based services. For example, utilization, costs, etc. for Diagnostic and Treatment Centers associated with the hospital are considered "free-standing" and would therefore file an Ambulatory Health Care Facility (AHCF) cost report in accordance with Part 86-4.3 of the Commissioner's Rules and Regulations. If such costs, etc. are included in the ICR, use non-reimbursable cost centers.
- When a hospital offers a service outside of the Medicaid Program (i.e., before approval to use rate codes or services are grant funded, non-billable such as in the case of some Mental Health Services), the costs, charges, visits, etc. may need to be adjusted in the ICR so that remaining amounts used for rate-setting are correctly stated. Providers should reach out to the Department for guidance based on each individual hospital's circumstance.

15. ICR Instructions for DMH Programs

All DMH certified and/or funded programs are to be reported on the ICR. There are now a finite number (16) of ICR cost centers that can be used for Mental Hygiene programs. Two of these cost centers are to be used to collapse those programs not described by the other fourteen (14) program cost centers. If used, retain the details of costs, revenues and statistics for the two collapsed cost centers (All Other Mental Health Programs and All Other Alcoholism Programs) including any "discrete" program deficit financing grants. If this "program" is NOT one of the hard-coded cost centers, the program will be reported in ICR Cost Center 247 for Mental Health or Cost Center 248 for Chemical Dependency Programs not listed in Appendix I. See the Outpatient/Other Medicaid Service Code Mapping to Rate Codes Table in Appendix I for the Medicaid Service Code (MSC) for each of these ICR cost centers. The DMH program cost center configuration, as found on the ICR is as follows:

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ICR Cost Ctr #	Program Code	DMH Cost Center Description
216	1920	Extended Observation Beds (CPEP) - (Cost center 216 shall only be used by hospitals with OMH-certified CPEP programs to report the CPEP Extended Observation Beds.)
210	0030	Chemical Dependency Rehabilitation
225	0010	Sub-provider I - Psychiatric
246	0200	Mental Health Day Treatment
249	1310	Mental Health Continuing Day Treatment
253	2320	Intensive Psychiatric Rehabilitation Treatment (IPRT)
254	2200	Mental Health Partial Hospitalization
288	See Cost Center Description	Comprehensive Psychiatric Emergency Room (CPEP) - Only those Hospitals that have OMH-certified CPEP programs shall utilize this ICR cost center. This Cost Center shall only be used to report the remaining component parts of an OMH Licensed C.P.E.P.: Crisis Intervention (DMH Program Code 3130), Crisis Outreach (DMH Program Code 1680) and Crisis Residence (DMH Program Code 0910).
289	2100	Mental Health Clinic
291	0110	Chemical Dependency Clinic/Rehab (hospital-based)
301	0010	Psychiatric - Non-Exempt Unit
247*	Various	All Other MENTAL HEALTH Programs not assigned to a specific ICR Cost Center listed above, shall be reported in this Cost Center.
248**	Various	All Other Chemical Dependency Programs not assigned to a specific cost center listed above, shall be reported in this Cost Center.
420		MH Outpatient ACT Programs - shall be used to report the following programs:
	0800	Assertive Community Treatment (ACT) Teams - ACT Teams provide intensive treatment and support to people with psychiatric disabilities. The focus is on the improvement of an individual's quality of life in the community and reducing the need for inpatient care, by providing intense community-based treatment services by an interdisciplinary team of mental health professionals. Building on the successful components of the Intensive Case Management (ICM) program, the ACT program has low staff-outpatient

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ICR Cost Ctr #	Program Code	DMH Cost Center Description
		ratios, 24-hours-a-day, seven-days-per-week availability, enrollment of recipients and flexible service dollars.
	8810	ACT Team – Service Dollars - Individual services aimed at meeting basic needs of patients. These services may include emergency services as well as job coaching, education, leisure-time services and others.
421		MH Outpatient ICM Programs - shall be used to report the following programs:
	1810	Intensive Case Management (ICM) - Activities aimed at linking the client to the service system and at coordinating the various services to achieve a successful outcome. The objective of case management in a mental health system is continuity of care and service. Services may include linking, monitoring and case-specific advocacy. - Linking: The process of referring or transferring a client to all required internal and external services that include the identification and acquisition of appropriate service resources. - Monitoring: Observation to assure the continuity of service in accordance with the client's treatment plan. - Case-Specific Advocacy: Interceding on behalf of a client to assure access to services required in the individual service plan. Case management activities are expediting and coordinative in nature rather than the primary treatment services ordinarily provided by a therapist. Case management services are provided to enrolled clients for whom staff are assigned a continuing case management responsibility. Thus, routine referral would not be included unless the staff member making the referral retains a continuing active responsibility for the client throughout the system of service. ICM services are services which are operated under a fidelity structure defined in 18 NYCRR, Section 505 and a Memorandum of Understanding between OMH and the NYS Department of Health.
	2810	ICM Services Dollars Management - Direct costs of support provided by the county or agency for contracted management expenses.
	4810	Intensive Case Management (ICM) Non-Emergency Service Dollars - Services consistent with a patient's treatment plan, designed to be flexible and responsible to current individual needs. These services may include emergency services (when not immediate) and may include furnishings, utilities, tuition, job-related costs, job coaching, education, vocational services, leisure-time services and others. This program does not include agency administration.

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ICR Cost Ctr #	Program Code	DMH Cost Center Description
	5810	Intensive Case Management (ICM) Emergency Service Dollars - Individual services aimed at meeting the immediate basic needs of the patient to include transportation, medical/dental care, shelter/respite/hotel, food/meals, clothing, escort, and others. This program does not include agency administration.
422		MH Outpatient SCM Programs - shall be used to report the following programs:
	6810	Supportive Case Management (SCM) - Activities aimed at linking the client to the service system and at coordinating the various services to achieve a successful outcome. The objective of case management in a mental health system is continuity of care and service. Services may include linking, monitoring and case-specific advocacy. - Linking: The process of referring or transferring a client to all required internal and external services that include the identification and acquisition of appropriate service resources. - Monitoring: Observation to assure the continuity of service in accordance with the client's treatment plan. - Case-Specific Advocacy: Interceding on behalf of a client to assure access to services required in the individual service plan. Case management activities are expediting and coordinative in nature rather than the primary treatment services ordinarily provided by a therapist. Case management services are provided to enrolled clients for whom staff are assigned a continuing case management responsibility. Thus, routine referral would not be included unless the staff member making the referral retains a continuing active responsibility for the client throughout the system of service. SCM services are services which are operated under a fidelity structure defined in 18 NYCRR, Section 505, and a Memorandum of Understanding between OMH and the NYS Department of Health.
	7810	Supportive Case Management Services - Individual services aimed at meeting the basic needs of the client. Services may include emergency services as well as job coaching, education, leisure-time services and others.
423	6340	Comprehensive PROS (Personalized Recovery Oriented Services) with Clinic - A comprehensive recovery-oriented program for individuals with severe and persistent mental illness. The goal of the program is to integrate treatment, support and rehabilitation in a manner that facilitates the individual's recovery. Goals for individuals in the program are to: improve functioning, reduce inpatient utilization, reduce emergency services, reduce contact with the criminal justice system, increase employment, attain higher levels of education and secure preferred housing.

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ICR Cost Ctr #	Program Code	DMH Cost Center Description
		There are four service components in the program: Community Rehabilitation and Support (CRS); Intensive Rehabilitation (IR), Vocational Support (VS) and Clinic Treatment.
424	7340	Comprehensive PROS - Includes all the service components as the Comprehensive PROS with Clinic, except Clinical Treatment.
425	8340	Limited-License PROS - A PROS program that provides only Vocational Support and Intensive Rehabilitative services.
426	9340	PROS Rehabilitation and Support - Used to report PROS services rendered by subcontract providers.

* All other Mental Health program costs not reported above are to be reported in total here.

** All other Chemical Dependency programs not reported above are to be reported in total in Cost Center 248 if the programs are non-reimbursable, are paid by alternate funding such as grants, or if the program is provided in a freestanding clinic (non-hospital-based extension clinic).

Certain outpatient services cost centers which deal with Mental Health and Alcoholism outside of these **"Other"** programs are assigned specific MSCs to be used for reporting. Examples include Chemical Dependency Clinic/Rehab (ICR line 291, MSC 248) and Opioid Treatment (ICR line 262, MSC 255). For ICR 2018 and later**, there is not an "Other Outpatient OASAS Program".**

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

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16. Deleted ICR Exhibits

Exhibit	*Title of Deleted ICR Exhibit*	*For Cost Report Years After*
5	*Statement of Inclusion of Professional Services Provided*	*2008*
6	*Physician Cost*	*2012*
7	*Downstate and Mid-Hudson Hospitals Only*	*1997*
8	*Services not Covered by Blue Cross*	*1996*
21	*Balance Sheet for Computation of Return on Equity Capital of Proprietary Providers*	*1996*
22	*Computation of Return on Equity Capital of Proprietary Providers*	*1996*
29	*Notes to Financial Statements*	*2010*
31	*Statistical Data, Special Service Statistics*	*2008*
37	*Trend Factor Weights Survey*	*1999*
38	*Trend Factor Labor Sub-weights Survey*	*1999*
45	*Lease Schedule*	*1997*
47	*Disproportionate Share (DSH) Payment Limit Report*	*2010*
48	*Bad Debt and Charity Care (BD&CC) Report, Report of Charges, Collections, Write-offs & Uncollectables for SELF-PAY CASES ONLY*	*1997*

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Detailed Instructions to NYSICR

Cover Page (ICR Page 1)

Please complete the requested information. The reference number, effective date and run date are for DOH internal purposes only and do not appear on the software screens and need not be completed. Complete contact information must be provided for the individual(s) completing the report.

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

OFFICERS (ICR Page 2)

Please complete the name and address of each of the officers of the hospital. Also provide the Department with CEO and CFO contact information. This information is required as it is vital for communications from the Department.

OPINION OF PROVIDER CERTIFICATION (ICR Page 3)

Included in the certification statement is a Declaration Control Number (DCN), which will allow the administrator to attest to the matching cost report electronic file. The DCN is a date and time stamp which notes when the final report file was completed. The DCN will print on the administrator's certification statement. The certification statement is to be submitted to the DOH no later than five business days following transmission of the electronic file. A line has been added to print the name of the Officer who has signed the report certification.

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

Refer to Medicare Instructions - Section 4004.

Beginning with the 2021 ICR, If your CMS-2552-10 cost report is calculating a non-zero Title XIX settlement, be sure to do the following:

1. Enter "N" as the Title XIX Payment System code on S-2 Part I / Exhibit 1 Column 8, for the hospital and all hospital-based units listed on Lines 3-19.
2. Enter "Y" on S-2 Part I / Exhibit 1 Column 2, Line 90, if you provide Title XIX inpatient hospital services.
3. Enter "N" on S-2 Part I / Exhibit 1, Column 2, Line 91, since you are not reimbursed for Title XIX through the CMS-2552-10 cost report.

Line 164.89 - As of the last day of the ICR period, did the hospital provide ambulance services this report year? Enter "Y" for yes or "N" for no.

Ambulance services for purposes of this question are hospitals which own or operate an ambulance service, are not in contractual agreements for the service, and are eligible for reimbursement of the service through a non-comparable add-on through the APR-DRG Acute Fee-For-Service Medicaid rate.

Line 164.90 – Are any hospital Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) sites paid by New York State via APGs (Ambulatory Patient Group - methodology)? Enter "Y" for yes or

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"N" for no.

If the hospital has hospital-based (clinic site certified under the hospital's NYS operating certificate) Federal Qualified Health Centers (FQHC) or Rural Health Clinics (RHC), then identify whether New York Medicaid pays for these services via APGs.

Line 164.91 – Does this hospital provide services at any site outside of New York State? Enter "Y" for yes or "N" for no.

Identify the services provided at any site outside New York state. Check all that apply.

Line 164.92 - Clinic (including oncology) or Ambulatory Surgery
Line 164.93 - Physical Therapy, Occupational Therapy or Speech Therapy
Line 164.94 - Referred Ambulatory (including Laboratory and Diagnostic Radiology)
Line 164.95 - Home Healthcare
Line 164.96 - Inpatient hospital
Line 164.97 – Hospice
Line 164.98 - Other (briefly describe below)
Line 164.99 - Briefly describe the Other services provided outside New York State.

Exhibit 2 - Profile of Services

Inpatient Services
Indicate the number of weighted certified beds by service category for which your hospital is licensed on the NYS Operating Certificate in effect during the report period. If certified beds did not change during the period being reported, the weighted certified beds are equal to beds certified at the close of the reporting period. If certified beds changed during the reporting period, weighted beds should be calculated using the number of beds times the days in service for each different bed complement, summed and divided by 365 (366 if including February 29). Short-period reporters need to adjust for the number of days in the report period.

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

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

Teaching Status of Hospitals
Please enter a "Y" for yes in the box that applies to your hospital. Teaching status of the hospital is defined in Section 415.152 CFR as a hospital engaged in an approved GME residency program in medicine, osteopathy, dentistry, or podiatry.

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

Refer to Medicare Instructions - Section 4005.1.

Newborn discharges will be included in the total line 14 for columns 13 through 15 for NYSICR purposes.

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For any ICR periods including February 29, bed days available should be calculated using 366 days if the period is a full year.

Note: The 2021 ICR Software introduced edits for potential inconsistency in reporting patient days between Exhibit 3 and Exhibit 32. Should an edit occur please refer to the Medicare instructions – Section 4005.1 for Worksheet S-3 (Exhibit 3) and the NYS ICR instructions for Exhibit 32. Edits 43218, 43221, 43225 and 43226 may present based on differences in Exhibit 3 Employee Discount Days, Line 604, and Exhibit 32 Courtesy Days, Lines 209, when the values are correct. This is because: 1) all Lines 209 except Physical Medicine Rehabilitation, are compared to the singular Exhibit 3 Line 604; and 2) Courtesy Days may be for reasons other than hospital employee services.

Medicare instructions describe certain items (Labor and Delivery, Non-distinct Observation for those who are not admitted as inpatients) which are not "inpatient services" but are reported as "days" computed from hours of service. Hospice; SNF-level swing bed days; and similar services are reported on unique Exhibit 3 lines but are not "inpatient" hospital services for Medicare or Medicaid (even if provided in a bed that is designated as inpatient) and are paid by fee schedule or other payment systems or rate codes.

Per Medicare, Employee Discount Days, Lines 604 and 611, are to not be included in Column 8 (Class 00694), Total All Patients, on Exhibit 3 lines, including their subscripts, that total to Line 27. Line 604 and 611 should reconcile to Exhibit 32 reported Courtesy inpatient days, newborn days and ALC days.

Exhibit 4 - Certified Bed Capacity

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

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

- Neonatal Intensive Care,
- Neonatal Intermediate Care, and
- Neonatal Continuing Care.

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

The last column under the heading "Certified Bed Capacity" should reflect the certified bed days available based on the certified capacity during the period. If certified beds did not change during the period being reported, the bed days available are equal to certified beds times 365 (366 if including February 29). If certified beds changed during the reporting period, weighted certified bed days available should be calculated using the number of beds times the days in service for each different bed complement, summed and divided by 365 (366 if including February 29). Short-period reporters need to adjust for the number of days in the report period.

The provider should enter the dates of changes in certified bed capacity used in the available bed day calculation on lines 071-075 at the bottom of the page.

Exhibit 9 - Payments to and on Behalf of Owners, Stockholders, Officers, Directors and Trustees and Payments to and on Behalf of Relatives of Owners, Stockholders, Officers, Directors and Trustees

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Both sections of this Exhibit must be completed by all facilities. Report the name, position and all payments paid to and on behalf of all owners, stockholders, officers, directors and trustees of the hospital for any part of the report year in the first section. Report the name, position and all payments paid to and on behalf of all relatives of owners, stockholders, officers, directors, and trustees of the hospital for the report year in the second section, including those former officers, etc. receiving current period payments (position noted as "former").

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

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

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

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

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

Line 091 – In the software, click on the Payment column (00595), line 091 and a statement will appear at the top of the screen. Enter a "1" for "Yes" if that statement is correct.

Exhibit 10 - Compensation of the Five Highest Paid Administrative Officials of the Hospital

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

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

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

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

Refer to Medicare Instructions - Section 4013.

> Note: An additional column, "Fringe Benefits", is for facilities that do not report total fringe benefits in the opening balance of Employee Benefits Department (cost center 003) but choose to directly assign the fringe benefits to specific cost centers. Included in Fringe Benefits are such

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payroll-related costs as FICA, SUI, vacation, holiday and sick leave, group health insurance, group life insurance, pension and retirement, workers' compensation insurance, non-payroll-related benefits such as providing day care for children of employees, and other generally accepted benefits.

Reclassify Maintenance of Personnel (MOP) to the standard MOP cost center, number 010 (CMS Line 12), instead of cost center 670 (CMS Line 194.99).

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

All certified and/or funded Mental Hygiene outpatient programs must be reported on these worksheets. If more than one skilled nursing facility is operated by the hospital, the data should not be combined into line 268. The costs and statistics must be reported separately.

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

If the hospital provides services at sites outside New York State, ensure financial and statistical information for those sites are excluded from the ICR. If included in the ICR, assign the site(s) to variable cost center(s) and final costs in Exhibit 52 to MSC 959, Non-reimbursable.

Women, Infants and Children (WIC) Program
All facilities which participate in the WIC Program must discretely report all costs and revenue associated with this program in cost center 418. Failure to establish a discrete WIC Program cost center (418) will result in a fatal edit for those facilities with designated WIC Programs. The MSC for the WIC Program is 959, Non-reimbursable.

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

Telehealth
The acquisition, installation and maintenance of telecommunication devices or systems is not reimbursable for NYS Medicaid (New York State Medicaid Update - February 2019 Vol. 35, No. 2).

Residential Health Care Facilities (RHCF)
The ICR must include all RHCF-2 (hospital-based) facilities operated by the hospital. When the hospital also operates an RHCF-4 (free-standing), that facility's information is not to be included in ICR information unless the financial statements reported in the ICR include it. In that case, the appropriate adjustments should be made so that RHCF-4 costs are not carried forward.

Exhibit 12 - (Worksheet A-6) - Reclassifications

Refer to Medicare Instructions - Section 4014.

Note: Use the column "Fringe Benefits" to specifically identify fringe benefit reclassifications.

Exhibit 13 - (Worksheet A-7, Parts I, II and III) - Analysis of Capital Assets

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Refer to Medicare Instructions - Section 4015.

If negative depreciation is reported in Exhibit 13, Part II, an edit will request that an explanation be provided.

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

Refer to Medicare Instructions - Section 4016.

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

Separate the All-Payor and Medicaid adjustments to expenses into salary and non-salary columns. These two columns will total to the existing column 00707 for Medicare purposes. Providers will enter the total adjustment in column 00707 (Amount Increase/Decrease) and the salary portion of the adjustment in column 00710 (Salary Increase/Decrease). Column 00711 (Non-Salary Increase/Decrease) will calculate the difference from column 00707 less 00710. Revenue or expense that is readily identifiable should be reported in the appropriate column. Capital (i.e., recovery of interest or depreciation) should be reported in the non-salary column. If the revenue or expense is not clearly identifiable, then the salary/non-salary proportion of that cost center's reclassified trial balance should be applied.

Health Care and Mental Hygiene Worker Bonus Program (HWB) expenses are not allowable amounts for rate-setting, therefore, make Exhibit 12 Reclassifications to Cost Center 003 from the cost centers where costs are recorded when paying the HWB to employees. Then make one or two Exhibit 14 All-payor (Class 00708) Adjustments to Cost Center 003 to remove this cost, depending on how cost was originally recorded [Lines to use : 00708/***344 (CMS 34.78 and*** 00708/***345 (CMS 34.79)]***.

System/Home Office Expenses and Revenues - Where system/home office expenses and revenues, such as interest, are passed through the hospital cost report, ensure the amounts are properly assigned or allocated to each affected hospital or other facility. Partial offsets or adjustments based on the hospital-only information should not be finalized until the allocated and assigned home office amounts are included. For example, computing the hospital's recovery of operating then capital interest expense based on unrestricted interest income should be done only after including the amounts from the home office. If patient-care-related home office depreciation expense, cash capital purchases and debt service payments are assigned or allocated to the hospital from the system/home office and are not in the hospital's trial balance/audited financial statements (AFS) or not presented in the hospital's portion of consolidating schedules of the system, etc. AFS, then all three additional amounts are to be reported in the separate areas on Exhibit 41.

Because all-payor amounts are used for rate-setting in this area, the total cost to the hospital for all payors' patients of outpatient drugs billable outside of the rate system (per the DOH list) must be removed as an adjustment to expense on line 632 as a Medicaid-only adjustment. You are required to make this adjustment whether your facility chooses to bill for them.

It is expected that if a hospital provides outpatient cancer treatment services (cost center 472 and others) that a Medicaid-only adjustment on Line 632 of Exhibit 14 to remove the applicable drug expenses relating to such services should be present, otherwise an explanation is required.

Drugs carved out for Medicaid APG rate reimbursement purposes can be identified through the APG

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Never Pay Procedures and Never Pay APG lists from the Department's APG website. These lists help identify costs that need to be removed. In addition, a consolidated list has been developed and posted to the HCS with the cost report instructions.

http://www.health.ny.gov/health_care/medicaid/rates/methodology/never_pay_procedures.htm
http://www.health.ny.gov/health_care/medicaid/rates/methodology/never_pay_list.htm

If the cost of drugs resides in any cost center other than Drugs Charged to Patient, you will need to utilize one of the "Other" lines on Exhibit 14 to remove the cost from the appropriate cost center.

Please note that if the charges related to the costs being removed are included on Exhibit 46, a negative adjustment to remove the charges should be made on Exhibit 51- Part 1A.

There is no requirement to make an adjustment to remove Inpatient drugs from expenses.

Line number 633 is utilized for the transfer of the Medicaid provider-based physician adjustment from Exhibit 17, Column 4 (less any laboratory, SNF, OMH Outpatient, FQHC (cost center 474) or RHC amounts). No entry is necessary in Exhibit 14; the software program will transfer these amounts from Exhibit 17. This adjustment will remove the professional component of physician costs from Medicaid allowable costs. Rural Health Clinics (RHC's) for New York State Medicaid are treated consistently with Federally Qualified Health Centers (FQHC's). See below for details on any manual adjustments required for FQHC/RHC services related to Physicians fees:

- Providers utilizing FQHC 474 cost center (CMS line 89) or RHC cost center (CMS line 88 or subscripts thereof)
    - Opted into NYS APGs for Medicaid reimbursement - a Medicaid-only adjustment will need to be made on Exhibit 14, line #XXX to exclude (carve-out) these physicians' costs from allowable expenses.
    - Elected the FQHC federal rate – No adjustment is required.

- Providers with FQHC/RHC utilizing a variable cost center (Subscript of CMS line 90)
    - Opted into NYS APGs for Medicaid reimbursement – No adjustment is required since these costs are automatically removed as part of the provider-based physician adjustment on line 633.
    - Elected the FQHC federal rate- a Medicaid-only adjustment will need to be made on Exhibit 14, line # XXX to add back (+) the physicians' costs to allowable expenses since these costs were automatically adjusted as part of the Medicaid provider-based adjustment on line 633.

For Article 31 hospitals only, beginning for ICR Report Year 2020, the Exhibit 17 psychiatric Professional Costs from Class 00407 reported for ICR Lines coded as 225, IPF Sub-provider, and 301, Psychiatric, are not included in the Medicaid provider-based physician adjustment on line 633. If the hospital reported any other ICR Line code in Class 00407 for psychiatric professional costs, then make manual add-backs (+) as Medicaid-only adjustments for each ICR Line Code.

Globally billed Professional Services: In reporting expenses for services that would require exclusion or offset when the technical and professional components are separately billed, adjustments or offsets of professional fees for globally billed services should be reported accordingly.

If your facility has on-call physicians that you pay a flat fee or contracted fee and you cannot fee bill, you must add back the entire amount related to the flat fee or contract as a Medicaid-only adjustment.

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If your facility opts not to fee bill, you cannot add back the physicians' professional component; it must be removed from Medicaid allowable costs.

Please note that if additional changes are made to Exhibit 14 after the completion of Exhibit 26B, the line numbers referenced in Column 4 on Exhibit 26B should be reviewed for accuracy.

A gain or loss on sale or scrapping of an asset might require an adjustment or offset based on the facts and circumstances that surround it. Factors include, but are not limited to, whether the asset was patient-care-related, whether the counterparty is related, whether the transaction is a bona fide sale, the extent of accumulated depreciation previously included in allowable costs (for a gain), the undepreciated basis (for a loss), and the extent of the asset (such as if a "medical facility" is sold).

Governmental grants MAY need to be offset depending on the purpose and use of the grant, and specific provisions of the grant document and program. Commissioner Regulations Section 86-1.8 describe one, but not the only, circumstance where ICR reporting differs from Medicare per HIM-15.

Related Party Interest - The interest expense of loans, including lines of credit or other financial facilities, which the hospital receives from a related party are not allowable costs and if included in the financial statement interest expense item(s) must be adjusted out of interest expense before computing investment income offset. If the Commissioner has approved in advance using a related party as the lender for a capital item, then the amount which does not exceed the lesser of the related party's cost of capital or the market rate when the loan was made may be allowable. Note that the NYS description of related party in Regulations Section 86.1.10 is broader than that of Medicare.

Interest Rate Swaps – New York Regulations prohibit including the costs and fees associated with setting up and maintaining Interest Rate Swaps in allowable costs. Any interest rate swap costs or fees which were included in the financial statement interest expense item(s) must be adjusted out of interest expense before computing investment income offset. To clarify what is an interest rate swap cost or fee:

- Variable-rate interest mortgages and loans (agreements) are often the vehicle available to and used by hospitals for funding. Usually, an initial low rate adjusts upward in increments stated in the agreement until the rate reaches a level that is based on an index. From that point, the rate changes up or down based on the index change with the maximum rate change as specified. Because these agreements may or may not include a prohibitive maximum rate, hospitals hedge the interest-rate risk with an interest rate swap (swap) at a fixed level somewhat less than the maximum rate.
- To establish the swap, a financial institution usually charges a fee. In addition to the fixed-rate interest expense, fees or costs are charged for maintaining the swap arrangement. When a swap is offered for "free" or at a reduced cost by a supplier (for example, a banking partner of the hospital), Statutes and Regulations require the value of the swap to be reported (as a reduction of allowable cost) if any of the supplier's payments are included in Program costs.
- Although more complicated swaps may require additional analysis, for each swap and its agreement, the hospital should determine current year costs and fees to establish and maintain the swap. Where these costs and fees are built into the loan agreement (potentially included in the interest rate or otherwise unstated built-in costs) they will need to be computed and excluded from reported costs. Support for this calculation should be available for the ICR Auditor's inspection.
- The interest expense that is allowable is the lesser of:

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- Current period swap (fixed rate) interest expense (without built-in swap costs or fees), or
- The agreement's current period interest that would have been paid if the swap was not in effect.

Exhibit 15 - (Worksheet B-2) - Post-Stepdown Adjustments

Refer to Medicare Instructions - Section 4022.

Note: Only final cost centers can be utilized on this Exhibit for Medicaid purposes since this Exhibit is intended to be utilized after the stepdown process is completed.

The first section is a summary of the adjustments to expense from the detailed schedules. No entry is required since the detail will automatically transfer.

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

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

The first four lines of the Medicaid-only post-stepdown adjustments are no longer available for the removal of Chemotherapy Drug Costs. (The removal of all Drugs Paid Outside of the rate must now be made as an Exhibit 14 recovery.)

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

Refer to Medicare Instructions - Section 4017.

For transactions with related organizations, the Net Adjustments Column (column 00707) is separated into salary and non-salary columns. The columns will total to column 00707 for Medicare purposes. Costs that are readily identifiable should be reported in the appropriate column. Capital should be reported in the non-salary column. If the costs are not clearly identifiable, then the salary/non-salary proportion of that cost center's reclassified trial balance should be applied.

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

Refer to Medicare Instructions Section 4018.

Please note that the ICR has a limit of 100 Exhibit 17 lines. We advise you to stay within the 100-line limit, entering nothing on Lines 101-199 or you will receive a data error edit. If you would exceed the 100-line limit, roll up some of your lines.

The Department received confirmation from NGS that only licensed physicians should be reported on A-8-2 (Exhibit 17). According to NGS, facilities should include all licensed physicians on this worksheet rather than recovering directly on Worksheet A-8 (Exhibit 14), especially if a portion of their time is split between Parts A and B, teaching and research.

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Services of physician extenders such as physician assistants, psychologists, and nurse anesthetists are generally 100% Part B, so any costs claimed from the trial balance on Worksheet A (Exhibit 11) should be recovered directly on Worksheet A-8 (Exhibit 14).

NGS confirmed that on-call physicians should be included on Worksheet A-8-2 (Exhibit 17). It is all Part B except for ER (potentially). Hospitals are allowed to claim Part A for ER on-call for the time that one physician is waiting for patients to arrive. This is mostly claimed by critical-access hospitals (CAHs) because they must staff the ER 24/7 but may have no or very few patients. The hospital must maintain a log of time when there are no patients in the ER vs. when there are patients. If they have 3 physicians on duty in the ER and two are working on patients, the time for the 3rd would not count for Part A; there cannot be any patients in the ER.

Please note that column 4 will transfer to Exhibit 14 as a Medicaid-only adjustment to expenses to remove the professional component of physician costs less the amounts reported for cost centers 106, 246, 247, 249, 253, 254, 268, 289, 307, 312-317, 372-373, 420-426, 461-465, 467-471 and 474. For Article 31 hospitals only, beginning for ICR Report Year 2020, the Exhibit 17 psychiatric Professional Costs from Class 00407 reported for ICR Lines coded as 225, IPF Sub-provider, and 301, Psychiatric, will not be included in the Medicaid provider-based adjustment on Exhibit 14, line 633.

For Medicare Electing Teaching Amendment (TEA or ETA) hospitals only, additional columns provide for the detail of Teaching and Part B costs.

Exhibit 18 - Detail of Specific Expenses

Administrative and General (Classes 00060, 00061, 00079 and 00062):

> Note: In the ICR software, the header titles and class numbers will be different when you **"click"** in a cell within the Administrative and General area versus the Operation and Maintenance of Plant area and some line numbers are duplicated.

Report the details of administrative and general expenses that are included in cost centers 022 through 026 and 095 of Exhibit 11 column 11, and, also, report the details of any additional administrative and general expenses that are reported elsewhere on Exhibit 11.

> Note: This section includes a column for directly assigned fringe benefits.

Malpractice insurance must be distinctly reported on line 025 if said expense is reported in the Administrative and General (A&G) cost center. For those facilities who direct charge malpractice expense (it is not in A&G after reclasses and adjustments to expense), an entry to line 081 must be made to identify the total amount of malpractice insurance expense. In class code 21030, line 082, type the Reclass Code if the Malpractice Insurance was reclassed out of A&G; if the Malpractice Insurance is direct charged, enter the 3-digit cost center(s) the malpractice insurance is reported in. (As this is a text field, separate multiple cost centers with a comma.)

Line 083, INTEREST EXPENSE-OPERATING BEFORE RECOVERIES, helps track the recovery of investment income. This line should identify the operating -interest expense after reclassifications but before recoveries; line 013 of this Exhibit should continue to identify Interest Expense-Operating after recoveries.

The Metropolitan Commuter Transportation Mobility Tax should be reported on Line 033 of the

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Administration and General part. This is a tax on employers who engage in business within the Metropolitan Commuter Transportation District (MCTD) and is based upon the salaries paid to their employees (See Tax Law, Article 23, Section 801). As this is considered a tax of doing business within the MCTD, it should be classified as an additional A&G expense and reported accordingly on this Exhibit.

Costs associated with the Language Assistance Program should be reported on line 034.

The administrative expenses associated with Health Homes should be reported on Line 035. A Health Home is a care management service model whereby all an individual's caregivers communicate with one another so that all of a patient's needs are addressed in a comprehensive manner. This is done primarily through a "care manager" who oversees and provides access to all the services the individual needs to assure that they receive everything necessary to stay healthy, out of the emergency room and out of the hospital. The health home services are provided through a network of organizations—providers, health plans and community-based organizations. Health home services will include comprehensive care management; care coordination and health promotion; transitional care including follow-up care when a patient leaves an inpatient setting; patient and family support; referral to community and social support services; and the use of health information technology to link services. All direct expenses will be reported on the cost center line where the service was provided.

Operation and Maintenance of Plant (Classes 00060, 00061, 00079 and 00062):

> Note: In the ICR software, the header titles and class numbers will be different when you "click" in a cell within the Administrative and General area versus the Operation and Maintenance of Plant area and some line numbers are duplicated.

Report the details of operation and maintenance of plant expenses that are included in cost centers 004 and 041 of Exhibit 11 column 11, and, also, report the details of any additional operation and maintenance of plant expenses that are included elsewhere in Exhibit 11.

> Note: This section includes a column for directly assigned fringe benefits.

All fuel oil should be reported on line 054.

Hospitals that operate parking facilities or have contracted for parking or have arrangements with related corporations for parking must separately identify the costs for employee parking, and the cost of parking for community convenience. These costs should be identified on lines 068 and 069 under Operation and Maintenance of Plant. The reporting of these costs should be concurrent with the reporting of parking lot receipts identified as other income on line 017 of Exhibit 26A of the ICR. Reported parking facility offset amounts are limited to the amount of parking expense or parking revenue, therefore the net amounts should not be negative.

Employee Health and Welfare Department (Classes 00063, 00064 and 00065):

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

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

Refer to Medicare Instructions - Section 4020.

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The provider may elect to change the allocation statistic basis, however, must receive approval in accordance with the Medicare instructions, Section 4020. If approval has been granted (or no response from the Medicare contractor within 60 days of a request made at least 90 days before the end of the reporting period), you may edit the basis for allocation through the Cost Center Set-Up within the ICR software.

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

Refer to Medicare Instructions - Section 4020 and Exhibit 19 Instructions.

Note: If you are transferring charges from Exhibit 46 to Exhibit 20, the charges will appear on the print, not the screen. The screen is available for additional keying if necessary.

Exhibit 23 - (Worksheet G) - Balance Sheet

Refer to Medicare Instructions - Section 4040 and HIM 15-2 Section 112.

Where the audited financial statements (AFS) include activities of more than one hospital, enter only the consolidating amounts related to this hospital.

Definitions:

CURRENT ASSETS

Cash on Hand and in Banks
The amounts on this line represent the amount of cash on deposit in banks and immediately available for use in financing activities, amounts on hand for minor disbursements and amounts invested in savings accounts and certificates of deposit. Typical accounts would be cash, general checking accounts, payroll checking accounts, other checking accounts, imprest cash funds, saving accounts, certificates of deposit, treasury bills and treasury notes and other cash accounts.

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

Notes Receivable
The amounts on this line represent current unpaid amounts evidenced by certificates of indebtedness.

Accounts Receivable
Include on this line all unpaid inpatient and outpatient billings. Include direct billings to patients for deductibles, co-insurance and other patient chargeable items if they are not included elsewhere.

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

ALLOWANCES FOR UNCOLLECTIBLE

Notes & Accounts Receivable
These are valuation (or contra-asset) accounts. Credit balances represent the estimated amounts of

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uncollectible receivables from patients and third-party payors.

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

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

FIXED ASSETS

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

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

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

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

Movable Equipment
Costs of equipment included on this line that has the following general characteristics:

1. Ability to be moved, as distinguished from fixed equipment (but not automobiles or trucks).
2. A more or less fixed location in the building.
3. A unit cost large enough to justify the expense incident to control by means of an equipment ledger and greater than or equal to $5,000.
4. Sufficient individuality and size to make control feasible by means of identification tags.

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5. A minimum life of usually three years or more.
6. Used in hospital operations.

Minor Equipment-Depreciable--Costs of equipment included on this line that has the following general characteristics:

1. Ability to be moved, as distinguished from fixed equipment.
2. A more or less fixed location in the building
3. A unit cost large enough to justify the expense incident to control by means of an equipment ledger but less than $5,000.
4. Sufficient individuality and size to make control feasible by means of identification tags.
5. A minimum life of usually three years or more.
6. Used in hospital operations.

Health Information Technology (HIT) Designated Assets--The amounts included here are the acquisition costs of HIT acquired assets in accordance with ARRA 2009, Section 4102. Acute care hospitals are required to depreciate such assets in accordance with their applicable depreciation schedules. CAHs are required to identify such assets on this line, but do not depreciate such assets as they will be fully expensed during the year of acquisition.

Minor Equipment - Non-depreciable--Costs of equipment included on this line that has the following general characteristics:

1. Location generally not fixed; subject to requisition or use by various departments of the hospital.
2. Relatively small size.
3. Subject to storeroom control.
4. Fairly large number in use.
5. Generally, a useful life of usually approximately three years or less.
6. Used in hospital operations.

Minor equipment includes such items as, but *is* not limited to, wastebaskets, bed pans, syringes, catheters, basins, glassware, silverware, pots and pans, sheets, blankets, ladders, and surgical instruments.

Non-depreciable Equipment
The balance in this account is used to record intangible assets. If such intangible assets are being amortized, the asset value is to be shown net of amortization. This account may also include depreciable assets not used in hospital operations.

Accumulated Depreciation or Amortization on: Land Improvements, Buildings & Fixed Equipment, Leasehold Improvements, Moveable Equipment, Minor Equipment-Depreciable, and HIT Designated Assets
The balances in these accounts reflect the amortization or depreciation accumulated on the fixed assets used in hospital operations.

ASSETS LIMITED AS TO USE

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

Deposit on Leases

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The balance in this account represents the total deposits on all leases. This includes security deposits.

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

Other Assets
This is the amount of assets not reported on the Other current assets line or as any other Asset. This could include intangible assets such as goodwill, unamortized loan costs and other organization costs.

CURRENT LIABILITIES

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

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

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

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

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

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

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

Other Current Liabilities
This line is used to record any current liabilities not reported on lines above.

LONG-TERM LIABILITIES

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

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of long-term debt.

CAPITAL ACCOUNTS

General Fund Balance
Unless the audited financial statement were prepared under ASU 2016-14, unrestricted Fund balances represent the difference between the total of Unrestricted Fund Assets and Unrestricted Fund Liabilities, i.e., the net assets of the Unrestricted Fund. Separate sub-accounts may be maintained for the above when applicable. The Transfers from Restricted Funds for Capital Outlay account should be credited for the cost of capital items purchased by the Unrestricted Fund with funds from the Plant Replacement and Expansion Fund. The fair market value of donated property, plant and equipment (at the date of donation) should be credited to the Donated Property, Plant and Equipment account. At the end of the year these accounts should be closed out to the Fund Balance account.

For audited financial statement prepared under ASU 2016-14, enter Net Assets without Donor Restrictions (combines Lines 52 and 147) to represent the difference between total Assets and Liabilities that are not subject to donor restrictions. Separate sub-accounts may be maintained for the above when applicable. The Transfers from Restricted Funds for Capital Outlay account should be credited for the cost of capital items purchased by the Unrestricted Fund with funds from the Plant Replacement and Expansion Fund. The fair market value of donated property, plant and equipment (at the date of donation) should be credited to the Donated Property, Plant and Equipment account.

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

Donor Created-Endowment Fund Balance-Restricted, Unrestricted and Governing Body Created-Endowment Fund Balance
Unless the audited financial statement were prepared under ASU 2016-14, the credit balances of these accounts represent the net amount of this restricted fund's assets available for its designated purpose. These accounts must be credited for all income earned on restricted fund assets, as well as gains on the disposal of such assets. If, however, such items are to be treated as Operating Fund income (considering legal requirements and donor intent), the Restricted Fund Balance account should be charged, and the Due to Operating Fund account credited, for such income.

For audited financial statement prepared under ASU 2016-14, enter Net Assets with Donor Restrictions to represent the net amount of the donor-restricted assets available for the designated purposes. Combine Line 147, the old "Donor created-endowment fund balance-unrestricted" with Line 52. Report the Governing Body Created-Endowment Fund Balance on Line 148.

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

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

Refer to Medicare Instructions - Section 4040.2 and HIM 15-2 Section 112.

Where the audited financial statements (AFS) include activities of more than one hospital, enter only the consolidating amounts related to this hospital.

The format for audited financial statements breaks out the Fund Balance between Unrestricted, Temporarily, and Permanently Restricted Net Assets (or between Net Assets without Donor Restrictions and Net Assets with Donor Restrictions, if the hospital has adopted ASU 2016-14). On Exhibit 24, the facility may combine them under the General Fund.

Exhibit 25 - Statement of Cash Flows

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

Where the AFS include activities of more than one hospital, enter the consolidating amounts related only to this hospital. Maintain the consolidating schedule with the AFS.

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

Refer to Medicare Instructions - Section 4040.3 and HIM 15-2 Section 112.

Where the audited financial statements include activities of more than one hospital, enter only the consolidating amounts related to this hospital.

The operating expenses are transferred from Exhibit 11, column 3 which is before reclasses and adjustments. If there is an All-Payor or Medicaid-only adjustment to expense for the NYS Health Facility Cash Assessment or patient-services Uncollectible Amounts, the same adjustment must be made on this Exhibit. (See General Instructions paragraph 10.)

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

Refer to Medicare Instructions - Section 4040.4 and HIM 15-2 Section 112.

For an amount to appear on Medicare lines 24.01, 24.02, and/or 23 (the ICR Medicaid lines are shaded), Exhibit 27 must be completed then the amounts will transfer.

COVID-19 Reporting in Exhibits 26A and 27 – For the 2020 and later ICR Report Years, hospitals should report COVID-19 Public Health Emergency (PHE) FUNDING in Exhibit 26A at Class 00037, Line 141 (CMS Line 24.50) per Form CMS 2552-10 Instructions, paragraph 4040.4, Line 24.50 described as "Enter the aggregate revenue received for COVID-19 PHE funding including both PRF and Small Business (Administration) Loan Forgiveness amounts." Should the hospital have any COVID-19 funding which is not included in Line 24.50, then input that(those) amount(s) in discrete line(s) in Exhibit 27. The Exhibit 27, Line 090 total is repeated at Exhibit 26A, Line 23. That means that any COVID-19 amount reported in Line 24.50 will not be included in Exhibit 27.

Any Health Facility Cash Assessment paid on non-patient related services or non-operating income

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should be reported on line 507 as a positive.

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

Any realized special purpose organization investment income that is donor-restricted is required to be reported on lines 020 or 503. This income is not required to be offset. Lines 121 and 502 must be used to report the realized special purpose organization investment income that is unrestricted. For Medicaid purposes, this unrestricted income should be offset first to reduce operating interest expense and then used to reduce capital interest expense. The provider reimbursement manual, CMS Pub.15-1, Section 1011.7, defines special purpose organizations as follows:

> "A provider may establish a separate, special purpose organization to conduct certain of the provider's patient-care-related or non-patient-care-related activities (e.g., a development foundation assumes the provider's fundraising activity). Often, the provider does not own the special purpose organization, and has no common governing body membership. However, such a special purpose organization is considered to be related to a provider if:
>
> a. The provider controls the special purpose organization through contracts or other legal documents that give the provider the authority to direct the special purpose organization's activities, management, and policies; or
>
> b. The provider is, for all practical purposes, the sole beneficiary of a special purpose organization's activities. The provider should be considered the special purpose organization's sole beneficiary if one or more of the three following circumstances exist:
>
> 1. A special purpose organization has solicited funds in the name of and with the expressed or implied approval of the provider, and substantially all the funds solicited by the organization were intended by the contributor or were otherwise required to be transferred to the provider or used at its discretion or direction;
>
> 2. The provider has transferred some of its resources to a special purpose organization, substantially all of whose resources are held for the benefit of the provider; or
>
> 3. The provider has assigned certain of its functions (such as operation of a dormitory) to a special purpose organization that is operating primarily for the benefit of the provider."
>
> Note: When the principal of a gift is restricted, the income may be restricted or unrestricted. For Medicaid purposes, any unrestricted realized income from gifts or grants should be offset.

When reporting Parking Lot Receipts in Line 017, ensure that, in addition to amounts collected by lot attendants, this includes any employee parking payments to the hospital such as by payroll withholding, etc.

Exhibit 26B - Income / Expense Recovery

The Other Operating Income amounts in Column 2 will automatically populate from Exhibit 26A. For all reported income amounts please indicate "Y" for Yes or "N" for No in column 3 to designate whether an adjustment to expense has been made on Exhibit 14. If Yes, indicate in column 4 (holds up to 20 characters) the Medicaid line reference number(s) utilized on Exhibit 14 where the adjustment(s) have been made. If the total amount is not offset, use Column 6 to explain.

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If No, utilize one of the reason codes provided below in the "If No" column 5. For all Income amounts not offset, an explanation is required in column 6 (holds up to 500 Characters). For Reason code #1, enter the cost center where the expense was originally reported, for reason codes #2, #3 and #4, explain why an adjustment was not required. Column 6 is also being made available for brief explanations if column 4 has a Yes entry, but the income has not been fully offset.

Reason Codes- If income not offset:

1. Non-reimbursable
2. No related expense reported on Exhibit 11
3. Non-offsettable
4. No adjustment required

Note: If additional changes are made to Exhibit 14 after the completion of Exhibit 26B, then the line numbers referenced in Column 3 on Exhibit 26B should be reviewed for accuracy.

An Example of Exhibit 26B has been provided:

REVENUE PER STATEMENT OF REVENUES & EXPENSES

OTHER OPERATING REVENUE:	*Line #*	*Exhibit 26A Amount*	*Was amount Offset? Y = Yes N= NO*	*If YES Offset on Exhibit 14 LN(s)#*	*If NO Offset, WHY? See Codes Below*	*Explanation or if # 1 Non-Reimbursable Cost Center #*
7 Income from Investments	*123*	*150,000*	*Y*	*1-4, 68 & 69*		
20 Revenue from Gifts, Flowers, Coffee Shop	*012*	*50,000*	*N*		*1*	*CC # 269*
23 Government Grants	*090*	*300,000*	*N*		*4*	*Expense recovery not required* FOR THIS GRANT

Governmental grants MAY need to be offset depending on the purpose and use of the grant, and specific provisions of the grant document and program. Commissioner Regulations Section 86-1.8 describe one, but not the only, circumstance where ICR reporting differs from Medicare per HIM-15.

Exhibit 27 - Appropriations from Special Funds

COVID-19 Reporting in Exhibits 26A and 27 – For the 2020 and later ICR Report Years, hospitals should report COVID-19 Public Health Emergency (PHE) FUNDING in Exhibit 26A at Class 00037, Line 141 (CMS Line 24.50) per Form CMS 2552-10 Instructions, paragraph 4040.4, Line 24.50 described as "Enter the aggregate revenue received for COVID-19 PHE funding including both PRF and Small Business (Administration) Loan Forgiveness amounts." Should the hospital have any COVID-19 funding which is not included in Line 24.50, then input that(those) amount(s) in discrete line(s) in Exhibit 27. The

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Exhibit 27, Line 090 total is repeated at Exhibit 26A, Line 23. That means that any COVID-19 amount reported in Line 24.50 will not be included in Exhibit 27.

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

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

Note: Indicate to what cost center the grant corresponds. If more than one cost center is applicable, enter the one cost center to which the majority of the grant pertains. The entire amount of the grant must be reported.

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

Lines 182 & 183 report payments received for Electronic Health Record (Meaningful Use) Grants. This type of grant is not offset-able. There are no restrictions on how providers can use the funds, once they are disbursed, and they are explicitly not considered reimbursement for services rendered or for expenses incurred in the procurement of the EHR system.

Lines 185 & 186 report any payments received for Delivery System Reform Incentive Program (DSRIP).

Lines 188 & 189 Interim Access Assurance Fund (IAAF) - Eliminated with the 2016 ICR.

Lines 191 & 192 report any payments received for Vital Access Provider Program (VAP).

Lines 194 & 195 report any payments received for Vital Access Provider Assistance Program (VAPAP).

Lines 197 & 198 report any payments received for Value Based Payment Quality Improvement Program (VBP QIP).

Line 207 report any lump sum payments received for Critical Access Hospital (Non-VAP) Outpatient distributions.

Line 209 report any lump sum payments received for Quality/Sole Community pool distributions from Managed Care Health Plans.

Lines 212 & 213 report any payment received for Health Care and Mental Hygiene Worker Bonus Program (HWB)—bonus and employer FICA reimbursement.

Exhibit 28 - Reconciliation to the Audited Financial Statements

This Exhibit was designed to reconcile the provider's accounting books and records to the financial statements audited by the certified public accountant. Line numbers 120 (Total Revenue), 140 (Total Expenses) and 190 (Revenue and Gains in Excess of Expenses and Losses) should agree to the Audited Financial Statements (AFS). GAAP requires Bad Debt to be reported in the AFS in the same manner it is currently being reported in the ICR--as an offset to revenue.

Exhibit 30 - Inpatient-Dual-Eligible and Swing Bed Statistics

Inpatient Statistics - Dual-Eligible

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Dual-eligible days (including ALC days) and discharges which includes all inpatient service areas for which the hospital is licensed are to be entered on line 060. (i.e., Medical Surgical, Maternity, Pediatrics, etc. inclusive of exempt units.) Include as dual-eligible days and discharges on Line 060 only those which meet CMS's definition of Inpatient Hospital services.

In the column titled "All Payor Days for Patients where Medicaid is not Primary and is a payor on the account", report total days for all dual-eligible patients that have Medicaid in conjunction with other insurance (i.e., Medicaid FFS or HMO/PHSP Medicaid are not the primary payor). All payors include, but are not limited to, Medicare, HMO and Commercial Insurers, except for Essential Plans (ineligibility for Medicaid is an Essential Plan criteria).

Any dual-eligible patient day reported here should NOT also be a Medicaid FFS (Line 014) or PHSP/HMO Medicaid (Line 200) day for Exhibit 32. Exhibit 30 lines 200, 211 and 214 exclude any Exhibit 32 utilization reported with MSCs that are not inpatient hospital services. In Exhibit 32, the day would have been reported in another payor source, that which was primary at admission. (Fully Integrated Duals Advantage (FIDA) and FIDA-IDD days are included in Exhibit 32 Lines 200 and are not to be duplicated here.)

In the column titled "All Payor Discharges for Patients where Medicaid is not Primary and is a payor on the account", report total discharges for all dual-eligible patients that have Medicaid in conjunction with other insurance (i.e., Medicaid FFS or HMO/PHSP Medicaid are not the primary payor). All payors include, but are not limited to, Medicare, HMO and Commercial Insurers.

Any dual-eligible discharge reported here should NOT also be a Medicaid FFS (Line 014) or PHSP/HMO Medicaid (Line 200) discharge for Exhibit 32. In Exhibit 32, the discharge would have been reported in another payor source, that which was primary at admission. (FIDA and FIDA-IDD discharges are included in Exhibit 32 Lines 200 and are not to be duplicated here.)

Combined Medicaid Primary and Dual-eligible Percentage of Total

For days and discharges, dual-eligible amounts reported on line 060 are summed with Exhibit 32's Medicaid FFS and HMO/PHSP Medicaid as primary payors values. The result is then divided by Exhibit 32 Totals to calculate the percentages of Medicaid days and discharges for the hospital.

Fatal edit: A fatal edit will prevent submission if the total dual-eligible days or total dual-eligible discharges reported, when added to Medicaid FFS (Lines 014) and HMO/PHSP Medicaid (Lines 200) days and discharges from Exhibit 32 exceed the inpatient total from Exhibit 32 (Lines 011).

SWING BED UTILIZATION - It should be noted that swing bed utilization is not considered an inpatient statistic; therefore, it should be reported under Swing Bed Utilization only. Qualified hospitals participating in the swing bed program established under Part 406 are required to complete the swing bed utilization schedule. Under the swing bed program, hospitals may utilize available designated beds to provide nursing home program services.

Medicaid swing bed patients, discharges and patient days should be reported by facilities that have been approved in the Department of Health's Swing Bed Utilization Program.

Exhibit 31a - Transfer Statistics

A transfer occurs when a patient enters a clinic or emergency room and is subsequently admitted into the facility to stay as an inpatient or be primarily served in another distinct outpatient service

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area. The costs associated with that patient's visit to the clinic or emergency room must be transferred to Inpatient or the other outpatient area.

If that area is visits-based for cost transfers, report the inpatient and outpatient visits by service area for Emergency Room, CPEP Emergency Service, and General Clinic. The total on line 960 should include all visits (not just transfers). Emergency Room, Class 00222, line 960 should be equal to the total visits as reported on Exhibit 33, column 00160, line 025. For CPEP Emergency Service, Class 00221, line 960 should be equal to the total visits on Exhibit 33, column 00161, line 225. General Clinic, Class 00217, Line 960, should equal the total of the visits on Exhibit 33, Class 00161, lines 025, 075, 125 and 675.

Note: Starting for the 2020 ICR, if the prior year basis was Charges, then the Exhibit 31A column for that service area will not be available and cost transfers will use Exhibit 46 charge data.

Note: Only visits are to be entered in Exhibit 31A. If visits based, ICR Schedule 1 uses this information to allocate capital and routine transfer cost. If charges-based, Exhibit 46 charges are used and input is not required for that service area. (Some hospitals are both visits- and charges-based for different areas: Clinic, CPEP Emergency Service, CPEP Extended Observation Beds and Emergency Department.)

Statistical Basis for Cost Transfers. The statistical basis for transfers of Routine Medicaid Allocated Cost and Medicaid Capital Allocated Cost related to Emergency Room, CPEP Emergency Service Visits, and General Clinic may be calculated based on routine charges or visits for those service areas reported on Exhibit 46 or 31A, respectively.

Note: Due to the change in billing rate code 4049 for Medicaid FFS effective April 1, 2020, for CPEP Extended Observation Beds, beginning with the 2020 ICR, all cost transfers are based on Exhibit 46 charges as listed on new Line 015. Therefore, Exhibit 31A does not include a column for CPEP Extended Observation Beds days.

If the hospital's basis for any of these transfer areas currently is Visits (1), then the hospital may make a one-time change to utilize charges (0) as the basis for determining transfer costs. Should the hospital elect to change from visits to charges as the basis on the submission of the ICR, then the charges basis becomes permanent for all subsequent ICR submissions.

If the hospital's basis for any of these transfer areas currently is charges (0), then the hospital must retain charges as the basis for their transfer cost calculation. A hospital cannot change from using the charges basis to visits.

Within ICR Schedules 1B only, the software computes and displays transfer costs for both bases as a reference. For a hospital currently using visits as the basis for transfers, in order to assist hospitals in determining if charges are the appropriate basis to utilize for their facility, hospitals have the ability to make a temporary change from visits to charges (from 1 to 0). This allows the hospital to view the impact on the cost distribution for ICR Schedules 1 and 3. To prevent a permanent change, reset the basis to back to Visits (1) before the initial ICR submission. By using this temporary preview of the charges basis, hospitals also have the opportunity to review charge reporting errors if the charges drive incorrect transfer cost results.

Within ICR Schedule 1B, the cost centers included to determine allocated costs are:

Cost Center

- Emergency Services

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- 236 Emergency
- 260 Observation Beds (Non-distinct Part)
- 417 Observation Beds (Distinct Part)

- CPEP Emergency Service Visits
  - 288
- CPEP Extended Observation Bed Days (charges-basis only)
  - 216
- Clinic Services
  - 235 Clinic
  - 240 Renal Dialysis
  - 250 Home Program Dialysis
  - 472 Cancer Treatment Services

Typically, a portion of the visits are not transferred from the "host" service area. If ALL visits are transferred, then enter a "0" in the Exhibit 31A ICR Line: Emergency Room, Line 00222/236; CPEP Emergency Service, Line 00221/288; or Clinic, Line 00217/235.

Exhibit 32 - Patient Days and Discharges by Source of Payment - Definitions & Specific Payor Codes

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

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

Utilization provided at sites outside of New York State is not to be included in Exhibit 32.

Patient days and discharges are defined as follows:

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

PATIENT DAYS - the number of days during which a patient remains in acute care or exempt unit status. This is computed according to the following guidelines:
(1) each day begins at midnight and continues for twenty-four hours;
(2) the day of admission is counted as a full day; and,
(3) the day of death, transfer, or discharge is not counted. If discharge, transfer or death occurs on the same day as admission, the length of stay is considered to be one patient day.

Note: Ancillary Labor & Delivery (L&D) Days and Non-distinct Observation Days preceding admission or for those who are not admitted as inpatients, for Worksheet S-3, CMS Line 32 (Exhibit 3 Lines 024 and 612), are not considered inpatient days for purposes of Exhibit 32.

ALC DAYS - the number of days that services were provided by a hospital to a patient for whom it

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has been determined that inpatient hospital services are not medically necessary, but that post-hospital extended care services are medically necessary, consistent with utilization review standards, and are being provided by the hospital and are not otherwise available.

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

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

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

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

Services are defined as follows:

ACUTE - for this section of the ICR, the category "Acute", in addition to medical/surgical, shall include areas such as ICU, CCU, pediatrics, maternity, routine nursery (newborn), neonatal, approved premature nursery, as well as any services for which the hospital did not receive exempt unit status and any similar corresponding separate rates. Chemical Dependency Detoxification programs certified by OASAS should not be reported in this section but must be reported separately. (Department-approved Critical Access Hospitals use the Critical Access Hospital area.)

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

CHEMICAL DEPENDENCY REHABILITATION - any patient days/discharges/ALC patient days incurred in providing daily bedside care to Chemical Dependency Rehabilitation patients. The hospital must also employ specially trained personnel to staff this unit, and at least one psychiatrist on the medical staff.

DUAL-DIAGNOSIS PSYCHIATRIC - (Only if approved for Rate Code 4608) - any patient utilization incurred in providing daily bedside care for specialized hospital-based inpatient psychiatric units, certified by the Office of Mental Health, solely dedicated to the treatment of adults with diagnosis of both developmental disability and either serious mental illness or serious emotional disturbance.

OTHER (SPECIFY) - any patient days/discharges/ALC days incurred in providing daily bedside care for the patients specified. This section should not be used if the utilization should be reported under Acute described above. This cost center should be as specified in Title 10 NYCRR and entered in place of "Specify".

PHYSICAL MEDICAL REHAB - any patient days/discharges/ALC days incurred in providing daily bedside care for the Medical Rehabilitation patients for rehabilitation services. Individualized, goal-oriented, comprehensive and coordinated services will be designed to minimize the effects of physical, mental, social and vocational disadvantages and to affect a realization of the patient's

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potential for useful and productive activity while ensuring the health and safety of the patient.

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

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

CHEMICAL DEPENDENCY DETOX – any patient days/discharges/ALC days incurred in providing daily bedside care for those inpatients in Chemical Dependency Detox programs certified by OASAS.

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

Primary Payor Source

Payor source is the primary payor for the patient at time of admission, unless found to be in error (such as without any coverage for any provided service by that payor on the date of admission) and the source should be maintained for the entire admission regardless of from whom payment is received or is currently being billed. The determination of insured or uninsured (including Charity primary payor) is made once per inpatient stay or outpatient encounter including all services provided. If any of the provided services are covered by insurance, then the stay or encounter is **"insured". Do not change an otherwis**e insured encounter to uninsured or Charity based on:

- Denial of payment because of administrative error (i.e., late billing or lack of pre-authorization;
- Reaching a coverage limit or benefits exhaustion DURING the stay or encounter; or
- Inability to pay significant self-responsible amounts after the insurer settles. (For 2019, lines have been added to Exhibit 46 to enter these amounts.)

"Directly submitted" within these descriptions includes claims made though clearinghouse services where the clearinghouse functions only as an information conduit (even with some built-in front-end edits). Should the payor source category for the primary payor change during the cost report period (for example, a not-for-profit medical indemnity insurance company became a commercial indemnity insurance company), then characterize each patient account with the payor source **applicable as of the claim's date of discharge or service.** Payor sources are described as follows:

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

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

NON-PROFIT MEDICAL INDEMNITY INSURANCE - utilization for patients for which billing for services

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

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

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

HMO/PHSP MEDICAID - utilization for Medicaid patients whose services are covered under a premium policy with a Health Maintenance Organization or NYS-licensed Prepaid Health Service Plan (PHSP) which has been billed directly for services rendered. This would include patients covered by the Family Health Plus program and Children's Medicaid (not Children's Health Plus). Fully Integrated Duals Advantage (FIDA) and FIDA-IDD are included here.

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

ESSENTIAL PLAN 1, 2 – utilization for patients whose services are covered under an Essential Plan who: meet certain income requirements; are not eligible for Medicaid or Child Health Plus; and do not have access to affordable employer coverage.

ESSENTIAL PLAN 3, 4 – utilization for patients whose services are covered under an Essential Plan who: meet certain income requirements; are not eligible for Medicaid or Child Health Plus due to immigration status; and do not have access to affordable employer coverage.

SELF-INSURED - any utilization for patients whose services are covered by a self-insured fund which is either self-administered or administered by a third-party agent to process claims on such fund's behalf.

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

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

UNINSURED/SELF-PAY - utilization for patients having no third-party or other insurance coverage and are thus solely responsible for payment of the charges, whether in full or in part, for the services rendered. In cases where the patient is insured but the service provided is completely uncovered by the insurer, the case is to be considered a self-pay case. Self-pay includes encounters for which the patient/guarantor has informed the provider that the individual is not seeking for a

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claim to be filed with the third-party plan or coverage for an otherwise covered service. Conversely, if the service provided is partially covered by a third-party insurance carrier the case should not be designated as self-pay and should be reported in accordance with the definitions established for the other payor category that applies as described herein.

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

Payment by **Foreign Embassy** or **Government** - Based on who has the fiscal responsibility to pay for the medical encounter and not merely who made the payment or negotiated the amount.

- For self-responsible portions when Health Care Coverage is via a US carrier (Blues, GHI, etc.), use that carrier's payor source;
- For foreign carriers, use the payor source that aligns with the type of carrier: not-for-profit, commercial indemnity, HMO, etc.;
- Unless paid by an insurance carrier, if the individual is "*protected under their diplomatic mission*," use **Government**;
- When the foreign agency is acting as a conduit for the individual's payment and the individual is responsible, use **Uninsured/Self-Pay**; or,
- When the foreign government has a Nationalized Health Plan that includes the individual or pays directly from government resources, use **Government**.

FREE (Charity, Hill-Burton) - utilization provided to a patient free of charge because of a patient's indigent income status or the hospital's charity care policy when the patient encounter is not reportable within any other primary payor category. This will include free care provided to cases in compliance with obligations entered into under the Hill-Burton Program as well as other forms of care provided consistent with this definition. The determination that the hospital expects no or very little collections is usually made around the time of admission or registration. If an application is made later, then follow the hospital's Financial Aid Policy.

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

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

Note: NET uncompensated care collections are entered as positive amounts.

INPATIENT MEDICAID SERVICE CODE (MSC) MAPPING - The purpose of Medicaid Service Code mapping is to assist in the alignment of a hospital's costs, visits, charges, and Medicaid billing rate codes. For each service reported on this Exhibit, enter the MSC associated with the Medicaid rate code(s) billed. Selection of Medicaid Service Codes has been limited to inpatient MSCs for Exhibit 32. The Non-reimbursable MSC can also be applied. (Assignment of a Non-reimbursable MSC indicates that the service area's costs and utilization are either non-reimbursable or may not be used for developing

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hospital rates by the bureau that utilizes the ICR for rate development. These services may be paid under other departments' rate codes.) Hospitals with exempt units should report the services provided in the exempt units under the specific MSC and not roll them up to MSC 201 or MSC 216. A comprehensive list of MSCs is located as Appendix I to these Instructions.

Please note, before assigning Medicaid Service Codes on this Exhibit you must complete the Medicaid Service Code assignments on Exhibit 52. Exhibit 52 will form the list of available Medicaid Service Codes for use on Exhibit 32.

Note: The 2021 ICR Software introduced edits for potential inconsistency in reporting patient days between Exhibit 3 and Exhibit 32. Should an edit occur please refer to the Medicare instructions – Section 4005.1 for Worksheet S-3 (Exhibit 3) and the NYS ICR instructions for Exhibit 32. Edits 43218, 43221, 43225 and 43226 may present based on differences in Exhibit 3 Employee Discount Days, Line 604, and Exhibit 32 Courtesy Days, Lines 209, when the values are correct. This is because: 1) all Lines 209 except Physical Medicine Rehabilitation, are compared to the singular Exhibit 3 Line 604; and 2) Courtesy Days may be for reasons other than hospital employee services.

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

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

The provider should complete those outpatient services statistics which are applicable to the hospital. Utilization should be reported only for hospital-based services and exclude any with rate codes not listed in Appendix I, even with the same or similar names. (For example, utilization, costs, etc. for Diagnostic and Treatment Centers associated with the hospital are considered "free-standing." If such costs, etc. are included in the ICR, you may use non-reimbursable cost centers.) Utilization provided at sites outside of New York State is not to be included in Exhibit 33.

Both columns, "Number of Visits" and "Visits Excluding Inpatient Admissions" must be completed even if the amounts are the same. For Ambulatory Surgery, the unit of service is Procedures (see below). For PROS, the unit is service is Months. Opioid Treatment Program (formerly MMTP) – the statistics should be visits, do not report weekly claims.

The categories for the reporting of outpatient utilization have been revised to agree with the cost centers rolled up into Clinic: General Clinic (cost center 235), Renal Dialysis (cost center 240), Home Program Dialysis (cost center 250) and Cancer Treatment Services (cost center 472). A section is designated for Child Rehabilitation Clinic utilization (cost center 473).

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

PROS Monthly (OMH) – Continue to report billed months of service, however, for Medicaid include only the billed months for PROS Community Rehabilitation and Support (rate codes 4520 – 4524). Do not report monthly claiming for any other PROS Medicaid rate codes. Do continue to report revenues and expenditures for all PROS Medicaid rate codes in relevant exhibits (e.g., 11, 26). For non-Medicaid payors, continue to report months of service.

The statistic for Ambulatory Surgery is procedures, not visits. A procedure is defined as a unit of measure for those types of services customarily provided because of a complete service requiring multiple visits. For reimbursement purposes, all the visits related to a procedure, regardless of the number of visits, are to be considered and counted as part of the one procedure and are not billable as

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separate visits. The term "procedure" does not mean the count of the number of "procedure codes" on ambulatory surgery claims.

Outpatient Comprehensive Psychiatric Emergency Program (CPEP), Extended Observation Beds - Provided after March 31, 2020 - Beds operated by the Comprehensive Psychiatric Emergency Program which are in or adjacent to the emergency room of a CPEP and are available 24 hours per day, seven days per week to provide extended assessment and evaluation as well as a safe and humane environment for up to 72 hours for those presenting to the CPEP provider. This program is one of four program components which, when provided together, form the Office-of-Mental-Health-licensed Comprehensive Psychiatric Emergency Program (CPEP). Extended Observation Beds utilize ICR Cost Center 216. Providers licensed by OMH to operate a CPEP must have the Extended Observation Beds and should be reflecting costs (cost center 216) and days associated with this portion of the service. Psychiatric and CPEP Observation Beds utilization should not include the same day, etc. and should reconcile to Exhibit 3 Psychiatric, Sub-provider-IPF and CPEP Observation Beds (PSYCH) (for services before 4/1/2020).

Chemical Dependency Clinic/Rehab (for 2020 and later ICRs) – These variously named clinics may be billed and paid for under differing rate-setting protocols by the Department (DOH), OMH and OASAS.

- Chemical Dependency Clinic/Rehab services which are "free-standing" with rates not included in Appendix I are not included in Exhibit 33 reporting. If these clinics' costs are included in the ICR, the final costs must be separate from "hospital-based" clinics and assigned to MSC 959, Non-reimbursable, for ICR purposes.
- Only those Chemical Dependency Clinic/Rehab services with rate codes 1528, 1552, 1558 and 1561 are to be reported in Exhibit 33. The Medicaid Service Code for these services is to be MSC 248. (They are no longer to be combined into MSC 235.)

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

Note: NET uncompensated care collections are entered as positive amounts.

OUTPATIENT MEDICAID SERVICE CODE (MSC) MAPPING – The purpose of MSC mapping is to assist in the alignment of a hospital's costs, visits, charges, and Medicaid billing rate codes.

Note: Before assigning MSCs on this Exhibit, you must complete the MSC assignments on Exhibit 52. Exhibit 52 will form the list of available Medicaid Service Codes for use on Exhibit 33.

For each service reported on this Exhibit, enter the MSC associated with the Medicaid rate code(s) billed. Selection of MSCs has been limited to outpatient MSCs for Exhibit 33. The Non-reimbursable MSC can be applied to any service area. Assignment of a Non-reimbursable MSC indicates that the area's costs and utilization are not used for developing hospital rates by DOH. These services may be paid under rates set by other offices or departments. A comprehensive list of MSCs is located as Appendix I to these Instructions.

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

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

Detail visits by payor source for approved Home Health Services provided by the hospital during the reporting period. (Refer to Exhibit 32 instructions for definitions of Payor Sources.) These services would include Nursing, Physical Therapy, Speech Therapy, and Occupational Therapy. All corresponding charges are to be reported distinctly on Exhibit 46.

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

Utilization provided at sites outside of New York State is not to be included in Exhibit 34.

Report on line 108 the total number of criminal history record checks performed in accordance with provisions of Part 402 of Title 10 of the Codes, Rules and Regulations of the State of New York (NYCRR).

Report on line 109 the total expenses, fees, and related administrative costs associated with the criminal history record checks reported on the previous line.

UNCOMPENSATED CARE COLLECTIONS - Report on line 110 the sum of payments collected from all uninsured/self-pay and free patients. Do not include co-pays and deductibles that insured patients pay. As you are reporting the collections on a cash basis, include all cash collected during the current year, whether it pertains to the current year or a prior year.

Note: NET uncompensated care collections are entered as positive amounts.

It is not necessary to report on line 161 the Medicaid Service Code associated with the Medicaid rate code(s) billed for Home Health Services as this will automatically be assigned once data has been entered to this Exhibit.

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

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

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

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

Line 111 - Worker Recruitment and Retention Revenue (WRR) - report all revenue accrued from the

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rate add-on calculated in accordance with the Public Health Law Article 3614, Section 8.
Line 112 – Worker Recruitment, Training and Retention Revenue (RTR) – report all revenue accrued from the rate add-on calculated in accordance with the Public Health Law Article 3614, Sections 9 and 10.

Lines 113 through 123 – identify the HHA expenses associated with the funds received for Worker Recruitment and Retention and Worker Recruitment, Training and Retention. Allowable costs for HHA services shall not include expenses funded by the WRR and RTR add-ons, therefore it is important that these expenses are reported properly. For any amounts reported on lines 119 through 123 of this Exhibit, a description of the expenses must be provided.

Line 131 – Accessibility, Quality and Efficiency Revenue – report all revenue accrued from the rate add-on calculated in accordance with the Public Health Law Article 3614, Section 11.

Lines 132 through 143 - identify the HHA expenses associated with funds received for AQE. Allowable costs for HHA services shall not include expenses funded by the AQE add-on, therefore it is important that these expenses are reported properly. For any amounts reported on lines 139 through 143 of this Exhibit, a description of the expenses must be provided.

Lines 151 through 155 – please provide the breakdown of the total WRR, RTR and AQE expenses by service. These amounts will be used to adjust allowable costs for Therapy and Aides on your facility's Home Health Agency rate exhibit. Please note that the total add-on expenses (Line 160) should equal Line 130 + Line 150.

Exhibit 35 - Hospital Personnel Wage Survey

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

Note: Columns 1 and 2 are to one decimal place.

Column 1 To compute full time equivalents, divide the total paid hours (including vacation, sick leave and overtime) for all employees in each title by the number of hours in the standard workweek, then divide by the number of weeks in the report period. If different classifications of employees within each title (i.e., part-time, union, non-union) have different standard workweek hours, compute the full-time equivalent employees for each classification separately and combine the result. If employees are paid for unused sick leave or "sell back" other leave, exclude these hours from the calculations. Do not include on-call hours. Did not include hours for "add-ons" such as shift differentials or other items which are paid per-hour but do not increase the number of actual hours worked.

Note: Where the hospital is accommodating the payroll of a different organization whose activity is not reported otherwise in the ICR; the fully-weighted cost of payroll is reimbursed to the hospital; and the payroll and payroll-related expenses are offset from the ICR, do not include the statistics in Exhibit 35.

Column 2 Enter standard number of hours in the work week for each title. Please note that this should be for one work week and is generally greater than 30 hours and less than or equal to 40 hours.

Note: Columns 3 to 8 are whole numbers only.

Column 3 Enter total hours paid exclusive of on-call hours (straight time plus overtime as recorded

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on your payroll records).

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

Column 6 Enter the total payroll dollars paid exclusive of retroactive pay which was for hours worked in a previous cost reporting period. Include pay for on-call hours.

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

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

The following is a brief description of selected job titles:

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

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

Accountants, Auditors and Other Financial Specialists
Plans and administers accounting services, provides advice on tax and accountancy problems, conducts audits, and plans and administers other financial activities, such as budget analysis, credit review and reimbursement.

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

Social Workers Including but not limited to the following titles:

- Social Workers, Medical and Psychiatric (Drug or Alcohol Addiction Counselors; Medical Caseworkers; etc.)
  Counsels and aids individuals and families with problems that may arise during or following the recovery from physical or mental illness by providing supportive services designed to help people understand, accept, and follow medical recommendations. Includes Chemical Dependency Counselors.
- Social Workers (Caseworkers; Community Organization Workers; etc.)
  Counsels and aids individuals and families requiring social service assistance. Includes Community Organization Social Workers who plan, organize and work with community groups to solve problems.

Post-Graduate Trainees
Interns, residents and fellows providing patient care services as part of a medical training program approved by the ACGME, AOA, or an equivalent accrediting program approved by the New York State Education Department.

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Respiratory Therapists (Inhalation Therapists, etc.)
Sets up and operates various types of equipment, such as iron lungs, oxygen tents, resuscitators, and incubators, to administer oxygen and other gases to patients.
Occupational Therapists (Industrial Therapists, etc.)
Plans, organizes, and participates in medically oriented occupational program to rehabilitate patients who are physically or mentally ill.

Physical Therapists (Physiotherapists; Pediatric Physical Therapists; Pulmonary Physical Therapists; etc.)
Applies techniques and treatments that help relieve pain, increase the patient's strength, and decrease or prevent deformity and crippling.

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

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

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

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

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

Nurse Supervisor
Supervises and coordinates activities of nursing personnel engaged in specific nursing services, such as obstetrics, pediatrics or surgery, or for two or more patient care units. Supervises Head Nurses in carrying out their responsibilities in the management of nursing care. Evaluates performance of Head Nurses and nursing care as a whole and suggests modifications. Inspects unit areas to verify that patient needs are met.

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

Physician's Assistants (Ophthalmic Medical Assistants; Orthopedic Physician's Assistants; Surgeon's Assistants; Gynecological Assistants; Pediatric Physician's Assistants; etc.; excludes Nurses)
Provides patient services under direct supervision and responsibility of a Doctor of Medicine or Osteopathy. Elicits detailed patient histories and does complete physical examinations. Reaches tentative diagnoses and orders appropriate laboratory tests. Requires substantial educational

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preparation, usually at colleges or junior colleges.

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

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

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

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

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

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

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

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

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

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

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

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

All Protective Occupations
Stands guard at entrance gate or walks about premises of hospital to prevent theft, violence, or infractions of rules; monitors property against fire, theft, vandalism, and illegal entry; directs patrons or employees and answers questions relative to services of establishment; and controls traffic to and from buildings and grounds.

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

Physical and Corrective Therapy Assistants and Aides
Prepares patients and/or administers physical therapy treatment such as massages, heat, light and sound treatment, and traction. Instructs, motivates, and assists patients with learning and improving functional activities. Normally works under the direction of a Physical or Corrective Therapist.

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

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

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

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Maintenance Workers
Excludes stationary engineers who should be reported under category "All Other". Includes workers who repair, maintain and adjust motor vehicles, equipment, machines and tools including such work as machinery repair, auto repair and communications equipment repair. Workers may also install, as well as repair, equipment and machinery. Repair work may be performed on or off premises. Includes but not limited to the following titles:

- Air Conditioning and Refrigeration Mechanics
- Electro-medical and Bio-medical Equipment Repairers
- General Heating
- Machinery Maintenance Mechanics (Power Plant Mechanics, etc.)
- Maintenance Repairers

Exhibit 36 - Hospital Personnel and Contracted FTE's

The number of employees reported on this Exhibit must be consistent with the salaries as reported on Exhibit 11, column 1 (class code 00040) plus or minus salary reclasses from Exhibit 12, class 00701. To compute full-time equivalents (FTEs), divide the total annual paid hours (including vacation, sick leave and overtime) for all employees in each cost center by the number of hours in the standard workweek, then divide the rest by 52. If different classifications of employees within each cost center (i.e., part-time, union, non-union) have different standard workweek hours, compute the full-time equivalent employees for each classification separately and combine the result. If employees are paid for unused sick leave or "sell back" other leave, exclude these hours from the calculations. If a sampling technique is utilized, the number of full-time equivalent employees must be computed for a minimum of one day period per quarter.

Note: Where the hospital is accommodating the payroll of a different organization whose activity is not reported otherwise in the ICR; the fully-weighted cost of payroll is reimbursed to the hospital; and the payroll and payroll-related expenses are offset from the ICR, do not include the statistics in Exhibit 36.

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

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

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

Exhibit 39 - Union Affiliation Representation

Question 1 must be completed with a Y or N as appropriate. If yes, the code number must be entered to indicate union affiliation for each unit as defined in the recognition clause of the labor agreement. Other union affiliations not listed must be identified by name and union affiliation on the "Other Union - Please Specify" lines.

If the recognition clause covers more than one unit, data for each unit must be provided. For example, the recognition clause covers non-professional employees including housekeeping, dietary, aides,

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orderlies, maintenance and clerical. The housekeeping, dietary, and orderlies would be reported on the "service" line 02, the maintenance employees on line 06, and the clerical employees on line 06.

Union Codes:

01 District 1199	National Union of Hospital & Health Care Employees
02 Local 144	Hotel, Hospital, Nursing Home & Allied Services - SEIU
03 Local 200	Hotel, Hospital, Nursing Home & Allied Services - SEIU
04 Local 721	Licensed Practical Nurses of NYC, Affil. With SEIU
05 Local 1115	Joint Board of Nursing & Hospital Employees
06 Local 4	Medical and Health Employees Union
07 Local 810	International Brotherhood of Teamsters
08 Local 30	International Union of Operating Engineers
09 Local 907	International Union of Operating Engineers
10 Buffalo & Western	New York Hospital & Nursing Home Council
11 SNA	New York State Nurses Association
12 CSEA	Civil Service Employees Association
13 Council 66	Amer. Fed of State, County, & Municipal Employees
14 District Council 37	Amer. Fed of State, County, & Municipal Employees
15 Committee of Interns & Residents	
16 American Physical Therapy Association	
17 Other Union - Please Specify	

The Bargaining/Negotiation Units are as follows:

Service, Maintenance, Technical, Pharmacy, Clerical, LPN, RN, Supv Nurses, Social Workers, Physical Therapy, Security, Perfusionists, Occupational Therapists, Professional Dieticians, and Other.

The bargaining unit line should be left blank for any group of workers who are either not represented by a union, or not on the facility payroll.

Exhibit 40 - Details of Specific Capital Expenses

This Exhibit captures the detail of capital reported on Exhibit 11, Column 11, "Medicaid Costs for Allocation." The first two columns are for the detail of Buildings and Fixtures and Movable Equipment after reclassifications.

The Reclassified Trial Balance is the sum of the first two columns and no data entry is allowed. If any Exhibit 14 recoveries were made to capital cost centers, they must be entered on the appropriate line in the "All Payor and Medicaid Adjustments" column. The amounts of property tax and property insurance are to be reported separately for Buildings and Fixtures or Movable Equipment. Report property tax and insurance related to Building & Fixtures on line 004 and 005, respectively. Report property tax and insurance related to Movable Equipment on lines 088 and 089, respectively.

The Direct Charge Capital must agree with the total capital direct charged on Exhibit 44, which is also after recoveries.

The Total Capital Related Costs (Column 8, Line 090), should now tie to the "Capital Related Cost to be Allocated", Column 3A, Line 960 of the Medicaid Capital Cost Allocation in the ICR software.

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

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Funding of allowable depreciation by voluntary hospitals is required in the provisions of Section 86-1.25(f)(2) of the Commissioner of Health's Administrative Rules and Regulations. Such funds may be used for other than capital expenditures only with approval. Funding for plant and fixed equipment shall mean the transfer of monies to the funded accounts that occurs by the end of the fiscal period in which the depreciation is recorded. Board-designated funds and the accrual of liabilities to the funded depreciation accounts (due to/from accounts) shall not be recognized as funding of depreciation. Deposits to the funded depreciation accounts must remain in such accounts to be considered as valid funding transactions unless expended for an allowable capital purpose. The Exhibit requires identification of investment income attributable to the depreciation fund (the number entered must be greater than or equal to zero).

Note: The premise of funded depreciation is to limit the age of plant and equipment by requiring capital expenditures to equal or exceed depreciation and amortization and, when expenditures are less, to set aside the deficit for future capital spending.

Amounts should reconcile to the AFS or its hospital consolidating information from health system consolidated financial statements. Since some AFS values include non-allowable items or the value differs between the AFS and Exhibit 41, and some hospitals separately report components of capital purchases and capital debt in the statement of cash flows (SOCF), the hospital should provide the reconciling schedule for its ICR audit. If patient-care-related home office depreciation expense, cash capital purchases and debt service payments are assigned or allocated to the hospital from the system /home office and are not in the hospital's trial balance/audited financial statements (AFS) or not presented in the hospital's portion of consolidating schedules of the system, etc. AFS, then all three additional amounts are to be reported in the separate areas on Exhibit 41.

Specific instructions include:

- Note: For any element in Lines 001 through 007 (or 031 through 037 and 041 through 047) where the SOCF amount is reported in more than one line, the response to edits for Exhibit 41 should include that explanation and amounts.

- Lines 001, 031, 041 – Include total depreciation and Property, Plant, and Equipment amortization (i.e., leasehold improvements) expense on allowable capital costs only.
  - Where depreciation expense is adjusted to exclude the expense of non-allowable activities, the capital purchases (Lines 002-005, 032-035 and 042-045) and capital debt payments (Lines 007, 037 and 047) for non-allowable items should be excluded as well, if any payments were related to these activities.
- Lines 002-005, 032-035, 042-045 – Include purchases of allowable capital. Enter as positive. Do not include HIT for CAHs, if fully expensed.
  - Cash payments for patient-care-related capital items which satisfy the requirements of capital leases or finance leases under ASC 842 are included.
  - Do not include depreciation expense in capital purchases on Lines 0x2-0x5.
- Lines 004, 034, 044 – Disbursements for capital purchases from the Depreciation Fund should correlate to changes in the Depreciation Fund balances in Lines 008-018.
- Lines 007, 037, 047 – Enter only payments to reduce capital debt for allowable patient-related services. Enter as positive. If refinancing debt, the amounts included here should be the payments which reduced debt outside of the refinancing. Do not net against increases in capital debt.
- Line 008-010 and 016-018 – Enter as positive (as negative values indicate the underlying assets are not solely to be maintained for funding depreciation). When the depreciation fund is not uniquely identified within the chart of accounts and Exhibit 23, the hospital should maintain a schedule of the amounts it sets aside.

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  - Asset values included in Lines 008-010 and 016-018 are those set aside for the Depreciation Fund that are not intended to be converted to non-capital use. Per HIM 15 Section 226, use for other purposes, especially shortly after year-end, renders the converted amounts as not funded depreciation.
  - Per NYS Regulation, 'due to'/'due from' amounts on Lines 010 and 018 are not considered for satisfaction of depreciation funding requirements.
- *Line 011, Prior Reporting Period Depreciation Fund Balance is equal to the value in the Prior Year ICR Class 00054, Line 019, the ending Depreciation Fund Balance.*
- Line 024 - Investment income attributable to funded depreciation (must be greater or equal to zero).

Failure to fully fund depreciation, to the extent not waived by the Commissioner, will result in a reduction in allowable capital used for future rate-setting.

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

When Exhibit 41 is prepared and shows that depreciation is not fully funded (an amount on Line 022), then, if your facility is requesting a waiver, state the reason why a waiver should be granted.

The hospital has a Regulatory requirement to request a depreciation funding waiver in order for one to be considered. If the hospital is requesting a funded depreciation waiver, a complete request, which includes specific details why the waiver should be considered, is required to be entered on Exhibit 42 in the text box. The details for the Commissioner to consider a waiver are submitted in the ICR and approval is required before any waiver relief, including application of Exhibit 42 (the alternate depreciation schedule and waiver eligibility calculation) can be applied. The Department will consider the waiver request during the audit of the ICR and provide the final unfunded depreciation penalty before the ICR is resubmitted to the Department that includes all other audit findings (the "refile").

Note: The ICR Software interprets entering the reason(s) for requesting a funding waiver in the Exhibit 42 text box as a request for waiver consideration.

Depreciation Funding Schedule - If a voluntary hospital has not fully funded depreciation (Exhibit 41), then an alternate Depreciation Funding Schedule will be presented (Exhibit 42, Sections A & B). This schedule calculates using ICR values from Exhibit 40 (Depreciation), Exhibits 25 & 41 (Funding), and also allows for adjustments of Other Depreciation and Other Cash Flow amounts. If the hospital has reported depreciation and amortization on other or variable lines, then enter these amounts in section A8 -A10 (Other Depreciation). If the hospital has allowable cash flow (capital purchases or capital debt payments) on other or variable lines, then enter these amounts in section B(5) Line 004 (Other Cash Flow). All manual entries must have a supporting schedule for audit.

Waiver Eligibility Calculation- If, after computing the alternate Depreciation Funding Schedule (Exhibit 42, Sections A & B), a potential penalty remains, then the Waiver Eligibility Calculation (Exhibit 42, Section D) assesses whether the hospital's cash position qualifies it for a reduction in the penalty. For hospitals whose Audited Financial Statements do not separately state salaries payable or related payroll taxes payable, or where salaries payable or payroll taxes payable were not explicitly reported in Exhibit 23, these amounts may be entered in Section D. Again, a schedule reconciling the entries to the audited financial statement liabilities should be prepared and provided to the auditors.

Even though the Exhibit 42 calculations may automatically reduce or eliminate the unfunded depreciation penalty transferred to ICR Schedule 3, they will not be considered unless the hospital provides a complete justification for a waiver in the text box on Exhibit 42. Further, in order to

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request an additional waiver of any remaining penalty after the Exhibit 42 calculations, also provide justification in the text box. The Department will consider the request and provide the final unfunded penalty amount during the audit of the ICR before the ICR is resubmitted by the hospital that includes the audit findings.

Exhibit 43 - Rent and Equity

This Exhibit is required for all facilities.

This Exhibit identifies cost centers where rental expense is reported for arm's-length/non-arm's-length arrangements.

Exhibit 44 - Direct Charged Capital

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

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

If there is a capital direct charge to a cost center, there should be an amount equal to or greater than the direct-charge amount reported in that cost center in the opening balance of the stepdown.

Any capital direct charged to hospital-based nursing home cost centers must be correctly reflected on the capital lines in the RHCF-2 to be included in the capital calculation.

Exhibit 46 - Hospital Service Revenue

Purpose
This schedule is meant to provide a breakdown into the components of revenue by routine and ancillary service, and allowances and other deductions from revenue by payor.

Definitions
Gross Charges - full established rates for services rendered undiminished by related deductions except corrections. This includes the reporting of full charges for Free/Charity Care patients.

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

The "summary" columns will automatically total amounts for Total All Services, Inpatient, SNF and LTC, Outpatient, Home Health Agency, Mental Health, and All Other by the Medicaid Service Code assignments on Exhibit 52. No data should be entered on Line 099 (Medicaid Service Code mapping), as these are transferred from Exhibit 52 (effective for 2016).

Incorrect mappings will cause the charge summaries to be incorrect.

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

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

This Exhibit requires the reporting of gross charges by Payor. In addition, allowances and patient-services uncollectible amounts detail should be reported by primary payor (as described for Exhibit 32 in these Instructions). This data is needed to identify net payor revenues and must be reported. Failure to correctly and completely report may result in the report being determined incomplete and unacceptable.

ROUTINE SERVICES

Similar to Exhibit 11 costs, when completing this worksheet do not combine the inpatient areas into line 201. If the hospital operates and is licensed for separate patient units (i.e., medical/surgical, ICU, pediatrics, etc.), then the charges must be reported separately under each patient area's class code for each applicable line as listed below to permit the alignment with and allocation of costs by service area.

There are separate cost centers for Observation Beds Non-distinct and Observation Beds Distinct into which patient charges would be entered, if active for the hospital. For observation patients receiving care in other hospital areas, the observation charges will be entered for those units' lines.

Globally billed Professional Charges

In reporting charges and payments for services that would require exclusion or offset when the technical and professional components are separately billed, adjustments or offsets for globally billed services should be reported accordingly. If these charges were reported within Exhibit 46, then adjust for the professional component at Exhibit 51, Part 1A.

Daily Care - Inpatient

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

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

Article 28 General Clinic, MSC 235, Visit Fees - Outpatient - Line 002

This line is used to report the routine gross charges earned from services provided in the hospital's general clinic service areas (Clinic- 235, Renal – 240, Cancer Treatment – 472, and any variable outpatient cost center considered a general clinic which has been assigned Medicaid Service Code 235.)

Additionally, on line 002 for any non-general clinic areas, routine charges would only be reported if the services were initiated in a general clinic and the patient was then transferred to the non-clinic service area in which they were discharged from.

These charges are used to compute the transfer of clinic costs. (See MSC 235 in APPENDIX I, Medicaid Service Code Mapping to Rate Codes for general clinic service areas.)

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

Outpatient Visit Fees – Other than General Clinic- Line 013 – includes all Mental Hygiene Clinics or programs, OPWDD, OASAS, OTP, HIV Clinics, Oncology Clinics, Federally Qualified Health Centers, Rural Health Clinics, and other services outside of general clinics.

This line is used to report the routine gross charges earned from services begun in these areas and provided to patients that were not admitted to a bed. (Except for transfers into these areas, General Clinic, Emergency Service, CPEP Emergency Services, CPEP Extended Observation Beds, Ambulance, and Home Health Agency Fees should not be reported on Line 013 as there are specific lines for reporting charges for these services.)

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

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

Note: Urgent care (or similar) services provided in hospital areas outside of the Emergency Department are considered general clinic services for rate setting and should be reported on Line 002.

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

CPEP Extended Observation Bed Fees
This line is used to report the routine gross charges earned from OMH-certified CPEP Extended Observation Bed Service for up to three days after the date of a CPEP Emergency Service visit.

Variable Routine Charges - Lines 008-012
Exhibit 46, Lines 008-012, are to be used only when a hard-coded "default" cost center for the services is not established. See the current Cost Center Setup Cross References Table (the Matrix) for the list and coding of ICR hard-coded and variable cost centers. For example, there are two available hard-coded Observation Services ICR Cost Centers: Observation Beds (Non-distinct Part), ICR Cost Center 260, Exhibit 46 Charge Code 00030 and Observation Beds (Distinct Part), ICR Cost Center 417, Exhibit 46 Charge Code 04846. Observation services, regardless of where provided, are to be reported in the appropriate column of these two cost centers.

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

Note: Medicaid "Acute" hospitals, that are not Medicaid Critical Access Hospitals, and that provide ambulance services may be eligible for an ambulance add-on per Medicaid FFS discharge. If the primary service of the hospital is "excluded" or "specialty," then the hospital is not eligible. "Providing ambulance services" means that, for the reporting period, the hospital was DOH-authorized to and did operate an ambulance service and was not merely paying ambulance companies for billed fees. The Exhibit 52 MSC for Ambulance Services should be MSC 201 if the hospital is providing ambulance services as described above and MSC 237 if not providing ambulance

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service but incurring allowable ambulance costs.

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

GROSS CHARGES BY PAYOR
These lines should be used to report all gross charges, routine and ancillary, by primary payor, including full charges for Free/Charity Care patients.

ALLOWANCES AND OTHER SPECIFIC DEDUCTIONS (ADDITIONS)

ALLOWANCES should be reported in the same category as the gross charges for each patient (i.e., with the primary payor). Any amounts reported in the *Charity Care Reductions per Health Financial Aid Law (HFAL) policy* area, Lines 382, 386, 391 and 383, are not to be reported as Allowances.

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

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

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

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

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

HMO/Medicare

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

HMO/PHSP Medicaid
Report allowances for Medicaid patients' services which have been billed directly to a Health Maintenance Organization or NYS-licensed Prepaid Health Service Plan for patients covered under such premium policies. Fully Integrated Duals Advantage (FIDA) and FIDA-IDD are included here.

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

Essential Plan 1, 2
Report allowances for patients' services which have been billed directly to Essential Plan 1 and 2 under such premium policies.

Essential Plan 3, 4
Report allowances for patients' services which have been billed directly to Essential Plan 3 and 4 under such premium policies.

Self-Insured
Report allowances for patient services which are covered by a self-insured fund which is either self-administered or administered by a third-party agent to process claims on behalf of such funds.

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

No Fault
Report allowances for patient services which have been billed directly to an insurance carrier for services rendered to patients for illness or injury arising from the use or maintenance of a motor vehicle.

Uninsured/Self Pay
Report allowances for any patient having no third-party or other insurance coverage and who individually or whose guarantor is thus solely responsible for payment of the charges, whether in full or in part, for the services rendered. In cases where the patient is insured but ALL services provided are completely uncovered by the insurer, the case is to be considered a self-pay case. Self-pay includes encounters for which the patient/guarantor has informed the provider that the individual is not seeking for a claim to be filed with the third-party plan or coverage for an otherwise covered service. Conversely, if the service provided is partially covered by a third-party insurance carrier, the case should not be designated as self-pay and should be reported in accordance with the definition established for the other patient category.

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

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Free (Charity, Hill-Burton)
Report allowances for services to patients for whom the hospital expects to be provided free of charge or at a reduced charge because of the hospital's charity care policy when the patient encounter is not reportable within any other primary payor category. This should include obligations entered into under the Hill-Burton Program as well as charity care.

Note: Reporting of Free payor category allowances would rarely occur. See the *Charity Care Reductions per Health Financial Aid Law (HFAL) policy* discussion below.

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

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

If you have contractual adjustments relating to prior periods relating to Third-Party Payors, for other than Medicare and Medicaid, please report these adjustments under the respective payor under "Allowances, Other Deductions/Additions" for the current period.

Employee Discounts
All employee discounts should be shown as courtesy allowances.

OTHER DEDUCTIONS (ADDITIONS) TO CHARGES

DISPROPORTIONATE SHARE AND SUPPLEMENTAL MEDICAID PAYMENTS - entries in this section should typically be negative since they represent increases to revenue.

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

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

Intergovernmental Transfer Revenue
This line item should be used by public hospitals to report uncompensated care payments (Medicaid Disproportionate Share Hospital payments) associated with intergovernmental transfers.

Note: Intergovernmental payments associated with upper payment limit (UPL) payments should not be reported on this line; they are to be reported as Inpatient/Outpatient Medicaid Gross Charges.

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

OMH/OASAS Disproportionate Share
This adjustment represents accrued disproportionate share hospital (DSH) payment in accordance with Chapter 119 of the Laws of 1997. These payments replace Office of Mental Health and/or Office of Addiction Services and Supports (formerly Office of Alcoholism and Substance Abuse Services) (OASAS)

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approved net deficit financing in certain Article 28 voluntary hospitals effective April 1, 1997. These payments must be reported within the appropriate mental health or alcoholism and substance abuse program.

Supplemental Medicaid (UPL) Payments
This line item should be used to report Medicaid payments received as supplemental (Upper Payment Limit) payments.

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

Public Goods Surcharge
This line item should be used to report all payments made to the Public Goods Pool pursuant to Public Health Law Section 2807j (HCRA Surcharge Payments).

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

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

UNCOLLECTIBLE AMOUNTS FOR PATIENT SERVICES

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

HOSPITAL FINANCIAL AID POLICY DEDUCTIONS

Charity Care Reductions per Health Financial Aid Law (HFAL) policy

When the patient has third-party coverage for any of the services in the stay or encounter and applying the hospital Financial Aid Policy results in any write-off as "charity care", report the value of charges written off to "charity care" on lines 382, 386, 391 and 383.

Examples using Third-Party payors include:

- If application of the HFAL policy results in write-off of ALL charges for an account with NO services covered by ANY third-party payor, report full charges under Primary Payor Free (Charity, Hill-Burton) on Line 313 and Line 391. (Line 355, Allowances for the Free Primary Payor, would rarely be used, but, if used, the Line 355 amount would not also be reported in Line 391.)
- For an account with NO services covered by ANY third-party payor where some payment is expected from/for the patient, report full charges under Primary Payor Uninsured/Self-Pay on Line 311 and HFAL write-off on Line 391.
- For accounts with at least one service covered by a third-party payor, report full charges under the applicable primary payor category and HFAL write-offs on Line 382, 383 or 386. Use the primary payor category and do not split among lines 382, 383, 386 or 391.

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

Refer to Medicare Instructions – Section 4012.

Note: All hospitals filing an ICR must complete and submit this Exhibit even if not required to be completed by Medicare.

Exhibit 50 - Patient Financial Aid Report

Line 1: This line represents total hospital costs incurred rendering services to uninsured patients. The reported amounts should be in accordance with generally accepted accounting principles.

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

Uninsured expenses reported shall apply to inpatient (including exempt units) and outpatient hospital services, including referred ambulatory services. Do not report Skilled Nursing Facility expenses. For exempt hospitals and exempt units of hospitals whose inpatient payments are on a per diem basis, there may be instances where some units of services (days) are insured and others are not, e.g., lengths of stay during which benefits are fully exhausted. Those units of service (days) occurring after the exhaustion of benefits will be deemed uninsured for the purposes of this report. This treatment does not apply to non-exempt, per discharge payments.

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

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

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

Professional services that are discretely billed are to be excluded from Exhibit 50 costs/charges and payments. If the hospital billed a global charge and it could have billed the professional and technical components separately, then the charges (costs) and payments for the professional component are to be excluded from Exhibit 50. (Service paid under the FQHC and RHC fee schedules are generally exceptions because the professional component cannot be separately billed for providers that receive the full FQHC/PPS rate.)

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

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

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

Lines 3a and 3b: On these lines, report hospital costs incurred (3a) and uncollected amounts for deductibles and coinsurance (3b) in rendering services to patients with insurance or other third-party payor coverage found to be eligible for financial aid assistance pursuant to the hospital's financial aid policy. Costs for these lines shall mean the patient liability for hospital charges. Facilities do not need to convert the charges to cost. If an amount is written off and is not a patient responsibility, it will not be considered in either line. If your hospital does not provide financial aid to insured patients, as described, enter a zero in the appropriate line(s) and respond to the corresponding affirmation questions on Lines 3c **and 3d with a "Y" for yes.**

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

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

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

Example 2: (3a) If the charges are $20,000 and the patient's insurance is 80/20, the charity care policy reduction is 50%, report the patient's liability which is 20% of the $20,000 or $4,000.

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

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

Lines 3c and 3d: If your hospital does not provide financial aid to insured patients, as described, enter a zero in the appropriate lines. You must also affirm this to be correct by entering a Y response to Questions 3c and 3d.

Line 4: This section represents the number of patients (New York State residents) organized by U.S. zip codes (5 digits only, no text or 4-digit extensions) who submitted applications for financial assistance and the results of those applications as of the close of this reporting period.

- The Applied column (class code 04932) represents the number of patients who applied for financial assistance for this reporting period and will be the sum of the subsequent 4 columns.
- The Approved column (class code 04933) represents the number of patients approved for this reporting period.
- The Denied column (class code 04934) represents the number of patients denied for financial assistance during this period.
- The Pending column (class code 04935) represents the number of applications for financial

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assistance that are still pending at the end of the reporting period.

- The Incomplete column (class code 04936) represents the number of applications that are incomplete at the end of the reporting period due to the patient not providing required data.

The last line under the zip code section, Line 356, reads "Not NYS". Both out-of-country and out-of-state patients would be reported in aggregate on this line.

Enter the number of appeals submitted, approved, and denied during the reporting year by zip code.

*NOTE - Instructions for importing patient/appeals by zip code are available within the software.

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

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

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

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

Line 5: This line represents the reimbursement received from the Indigent Care Pool. Report all cash received during the reporting period from the Indigent Care and High Need Pools, both Section 2807-k and Section 2807-w of the Public Health Law. This includes all components (regular, high need, rural and GME components). Do not include UPL payments on this line.

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

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

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

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

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

Line 8: This line represents the financial losses resulting from services provided under Medicaid. Enter the number as a negative.

Medicaid losses include losses from both Medicaid fee-for-service and Medicaid Managed Care (i.e., HMO-Medicaid and Family Health Plus Medicaid). Revenues must include 100% of any payments made to hospitals related to UPL, Upper Payment Limits (voluntary non-for-profit and public hospitals).

Medicaid revenue and expenses used to calculate these losses shall include all inpatient services (including exempt units) and hospital outpatient services, including referred ambulatory. DO NOT INCLUDE SKILLED NURSING FACILITY DATA IN THIS CALCULATION.

Medicaid revenues for inpatient and outpatient services should not include indigent care pool payments, public indigent care adjustment payments, OMH/OASAS disproportionate share payments and intergovernmental-transfer DSH payments.

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

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

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

Line 8a: If no amount is entered on line 8, you must affirm this to be correct by entering a Y response on this line.

Line 9: Enter Y if the hospital places liens on primary residences of patients, or N if not. If the response is Y, proceed to line 9a and enter the number of liens. If the response is N, you must affirm this to be corrected with a "Y" response to Questions 9b and 9e.

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

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

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from any further actions of the collection agency and would not be expected to report any liens the agency is placing on the patient.

Line 9b: If no liens are placed on primary residences, you must affirm this to be correct by entering a Y response to this question.

Line 9c: Enter Y if the hospital was awarded any court-ordered judgments against patients (excluding primary residence liens), or N, if not. If the response is Y, proceed to Line 9d and enter the number of court-ordered judgments (excluding primary residence liens). If the response is N, you must respond to 9e.

Line 9d: This line represents the number of court-ordered judgments awarded to the hospital (excluding primary residence liens) for the reporting period. Most likely the judgments will apply to prior periods, i.e., by the time the hospital has gone through the entire process, it will most likely occur in a different reporting period then when the patient was hospitalized.

Example: While the law speaks solely of liens on the primary residences, there are other instances where a judgment can be attached to other property owned by a patient (e.g., other real estate such as a secondary house, condo, land; and personal property such as jewelry, art, antiques, and other valuables). These types of judgment awards would apply to this question. Consistent with Question (9), the hospital is expected to exercise "due diligence" in obtaining this information if the matter is in the control of a collection agency. It is our expectation that the collection agency would be required to notify the hospital if the collection agency is awarded a judgment from the court against a patient on behalf of the hospital regarding a patient's outstanding account. If the hospital has sold an account to a collection agency and as a result, will not receive any additional payment, then the hospital is considered removed from any further actions of the collection agency and would not be expected to report any court-ordered judgments the agency is awarded.

Line 9e: If there are no court-ordered judgments through the collection process of the hospital, you must affirm this to be correct by entering a Y response to this question.

Line 11: Line 072 was added for cost reporting periods ending on and after June 30, 2015. This is a "Yes/No" question for the Patient Financial Assistance Asset Test Survey. This question must be completed, or your facility will not be able to submit the NYSICR. This question on Exhibit 50 does not replace the audit tool for Patient Financial Assistance but does replace the patient financial assistance attestation that has been previously sent to hospitals separately.

Exhibit 51 - Ratio of Cost to Charges

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

There are 83 CCGs that will be used to map ICR Cost Centers and Revenue Codes with the numbers ranging from 3 to 89. These CCGs are displayed at the end of the instructions for Exhibit 51. The Table displays 3 items for each CCG: the CCG Number, the type of CCG [AC (Accommodation) or AN (Ancillary)] and the CCG Name/Description. Some of the CCGs that are currently not used are not displayed in the table.

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

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PART I: ICR Cost Center to Cost Center Group Mapping:
Line 001: This line pertains to the list below. If a hospital meets either of the following it should enter a Y on this line.

- Article 31 hospitals are hospitals that are licensed by the NYS Office of Mental Health.
- It may be determined that Exhibit 51 should not be submitted by the hospital. Hospitals will be advised by the Department if this flag should be set for the non-submission of Exhibit 51. Except for Article 31 hospitals, do NOT set a Y for this instance unless the Department has specifically directed the hospital to do so. This directive is expected to be used infrequently and will be provided in writing by the Department for documentation and the ICR auditors advised accordingly.

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

If a variable ICR cost center is used and the standard CCG mapping displayed is highlighted in Red, the hospital is required to assign this ICR cost center to a CCG Number. Users will not be able to complete Parts II and III until all ICR cost centers have been assigned in Part I.

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

PART IA: RCC by Cost Center:

This Part displays the cost centers in seven (7) different sections of services: Ancillary Service, Inpatient Service, Outpatient Service, Other Reimbursable, Special Purpose, Reimbursable with No RCC Calculated, and Non-Reimbursable. They do not follow the ICR matrix, however, some sections are identical.

The CCG mapping provided on Part I will be brought forward to Part IA and will be used for the summation of the ICR cost and charges by ICR Cost Center into the CCGs on Part IC.

"Accumulated Routine Costs" are from the Stepdown and are the costs after the Routine Costs have been stepped down but prior to Ancillary costs being stepped down. The post stepdown adjustments from Exhibit 15 are also reflected in these costs.

"Post Stepdown Adjustments Reported on Exhibit 15" are for positive or negative adjustments the provider must enter to adjust the RCC for the proper alignment of costs and charges, if necessary.

"Final Accum Routine Costs used for RCC" is a summation of the Accumulated Costs, and any post stepdown adjustments entered by the hospital. An edit will alert when the "Final Accumulated Routine Costs Used for RCCs" for any cost center is negative in Class Code 45110.

"Total All Svcs Charges Directly Reported" is the routine and ancillary charges from Exhibit 46 that can be directly identified for placement to a specific cost center. The Routine Charges on Exhibit 46 for lines 001, 002 and 008 thru 013 that cannot be identified for direct placement to a cost center will be displayed in the three Routine columns. Refer to the Part IB instructions for the cost center assignment.

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The ADJUSTMENTS TO CHARGES column allows providers to key charges as positive or negative to appropriately align costs and charges. "Drugs Paid Outside of the Rate" and "Physicians Professional Component" are now removed from costs on Exhibit 14. If the related charges are included in Exhibit 46, they must be entered as negative adjustments to charges on Exhibit 51 to properly align cost and charges for RCC purposes. Edits will alert when any positive charge adjustment is entered in Class Code 45137 (unless a negative adjustment of the same value is entered), or if there is not a negative charge adjustment for DRUGS CHARGED TO PATIENTS at 45137/123 when the hospital otherwise reported cancer treatment services.

"Total All Services Charges" is the summation of the directly assigned charges, the routine assigned charges, and the adjustments to charges columns. This column, less the Adjustment to Charges column, must agree with the "Total All Services" charges on Line 200 of Exhibit 46. An edit will alert when Total All Service Charges for any cost center is negative in Class Code 45140.

The "Costs and Chgs Do Not Agree" flag is designed to direct a hospital's attention to cost centers that have costs but no charges or charges but no costs. Hospitals are required to review their data and, if it is inaccurate, to revise the data. A flag for "Costs and Chgs Do Not Agree" on Part IA will not result in a fatal edit.

"RCC by Cost Center" is the actual RCC ratio that results from the Cost Center cost and charge comparison. This RCC will NOT be used to generate RCC costs and is supplied as information for a hospital's review of its cost and charge comparisons. Any negative value RCC should be investigated to ensure that the hospital has correctly entered adjustments and has aligned the costs and the charges when reporting services in other than their initial cost centers.

> Note: Although the ICR will allow submission of a "negative" RCC for a cost center, these RCC's and supporting values may be adjusted or disregarded when using ICR information for developing payment rates.

"Total Inpatient Charges" is the inpatient charges based on the directly identified cost centers and the hospital's routine charges cost center placement. The summation of these charges may differ from the "Total Inpatient Services" charges on Exhibit 46, class code 00023, line 200.

PART IB: Routine Charge Assignments:

Part IB allows hospitals to move charges reported on Lines 001, 002 and 008 thru 013 of Exhibit 46, where the cost center cannot be directly identified, to properly align the charges with the costs for RCC purposes.

Exhibit 46, Line 001: For Inpatient cost centers; the charges on line 001 can be directly identified to a cost center and are directly posted. For cost centers OTHER THAN Inpatient cost centers, the charges on line 001 are displayed in the first section of Part IB and are, by default, coded to cost center 201. If a hospital's charges for a specific cost center for line 001 should not be coded to cost center 201, the hospital can type over the 201 to change it to the appropriate cost center. The charges on this screen will then be summed into the appropriate cost center on Part IA. If the 201 is deleted and a cost center is not typed in its place, this will result in a fatal edit.

Exhibit 46, Lines 002 & 013: For Outpatient cost centers; the charges on lines 002 and 013 can be directly identified to a cost center and are directly posted. For cost centers OTHER THAN outpatient cost centers, the charges on lines 002 and 013 are displayed in the second section of Part IB and are, by default, coded to cost center 237. If a hospital's charges for a specific cost center for lines 002 and

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013 should not be coded to cost center 237, the hospital can type over the 237 to change it to the appropriate cost center. The charges on this screen will then be summed into the appropriate cost center on Part IA. If the 237 is deleted and a cost center not typed in its place, this will result in a fatal edit.

Exhibit 46, Lines 008 thru 012: Since these lines on Exhibit 46 are variable routine charge lines, the charges cannot be directly identified to a cost center. If there are charges for a cost center for these lines, the charges will display in the third section of Part IB, however, there is no default cost center established for these charges. The cost center displays as an "XX" and the hospital needs to type over the "XX" with the cost center number where these charges should be displayed. The charges on this screen will then be summed into the appropriate cost center on Part IA. If there are charges with an "XX" and the "XX" is not replaced with a cost center or is deleted and a cost center not typed in its place, this will result in a fatal edit. When coding charges from these Lines for Exhibit 51, Part 1B, consider the nature of the service. The service itself and where routine costs reside should be considered when assigning a cost center to these charges in order to maintain the integrity of the ratios-of-cost-to-charges (RCC). This may require an additional adjustment within Exhibit 51.

PART IC: RCC by Cost Center Group:

Part IC displays the summation by CCG of the by cost center "Final Accum Routine Costs", "Total All Services Charges" and "Total Inpatient Charges" in Part IA.

The "Costs and Chgs Do Not Agree" flag is designed to direct a hospital's attention to CCGs that have costs but no charges or charges but no costs. Hospitals are required to review their data and, if it is inaccurate, to revise the data. A flag for this comparison will result in a fatal edit.

The "RCC by Cost Center Group" is the actual RCC ratio that results from the cost and charge comparison by cost center group. This RCC will be used to generate RCC costs.

This part also contains a flag for comparing the CCG calculated RCC to the Medicare RCC ceiling of 1.604. If the CCG RCC is over the ceiling, an "XX" will display and the hospital should review their data for accuracy. In some cases, the high RCC is due to a misalignment of costs and charges. In this situation, the provider should review their cost center groups to see if any should be combined for a better matching of costs and charges. A flag for this comparison will not result in a fatal edit for Part 1C.

PART ID: RCC by Cost Center Group is over Ceiling:

If a CCG RCC is flagged in Part IC as being over the ceiling, the hospital is required to provide an acceptable comment in Part ID explaining the reason for the CCG RCC being above the Medicare ceiling of 1.604. If a comment is not provided on Part ID, this will result in a fatal edit. Acceptable comments explain why, after including proper charges high enough to spread the cost of providing the service over the actual volume and costs in the CCG, the ratio remains high, such as: "The local market would not bear".

> Note: When a high RCC is identified, consider whether costs for more than one cost center have been reported together while the related charges are not, or vice versa. For example, if the Maternity service cost includes the costs of Nursery services but the charges are split, consider assigning both cost centers to the predominate cost center group on Part I. This would also require that revenue codes associated with both services be assigned to the same cost center group on Part II.

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When the RCC is between 1.000 and 1.604, explanations will be requested during the ICR audit. Please note that the comments will be reviewed to determine whether a waiver of the (CCG RCC ≤ 1.000) ceiling is appropriate or not. A statement to the effect that costs were higher than charges without further explanation, or that the cause is an error in reporting costs or charges which has not been corrected in the ICR, would not be adequate. If a waiver is not approved, the facility's average RCC will be applied to that CCG. Examples of comments that would not be approved, as they indicate that the costs and charges have not been properly aligned through the consolidation of the appropriate cost centers and charges into a CCG are as follows:

RESPIRATORY THERAPY CHARGES ARE CODED TO M&S
COST IS IN DIFFERENT CATEGORY THAN CHARGES
PART OF DELIVERY CHARGE IS IN ROOM/BOARD
CHARGES COMBINED IN CLINIC
REVENUE CO-MINGLED WITH MED/SURG
SHARED CC BETWEEN ASU AND OR
CHARGES APPEAR UNDER MED SURG IP
COST INCLUDED IN MATERNITY
CHARGES MAY BE INCLUDED IN P.T.
CHARGES ARE COMBINED WITH EKG
CHARGES ARE IN THE OPERATING ROOM.

If unable to access Exhibit 51 Part 1D to explain high RCCs, take the following steps:

1) Start the ICR software and open the data file.
2) Run the full Edit and Calculation to rebuild the structure for the Exhibit 51 Part 1D screen. For now, the fatal edit will display.
3) When the edit list displays, click the "CLOSE HERE" button.
4) Use the "Worksheets" button to restore the side menu of worksheets and exhibits.
5) Open Exhibit 51 Part 1D.
6) Enter the appropriate explanation for the CCG in question. Be sure to press the ENTER key after keying the explanation so that it will be retained.
7) Close the window for Exhibit 51 and rerun the full Edit and Calculation. Be sure to click "YES" when asked if you want to save the data file.
8) The Edit and Calculation should run cleanly this time.

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

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

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

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

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

Note: The software will allow you to copy the inpatient charge code mappings to the outpatient charge code mapping exhibit. Providers who choose this option are only required to enter any additional outpatient charge code mappings that are used.

COST CENTER GROUPS					
Cost Center Group	**AN or AC**	**Department Description**	**Cost Center Group**	**AN or AC**	**Department Description**
3	AC	AIDS	46	AN	Oncology
4	AN	Ambulance Services	47	AN	Operating Room Services
5	AN	Ambulatory Surgical Care	48	AN	Organ Acquisition
6	AN	Anesthesiology	49	AN	Osteopathic Services
7	AN	Audiology	50	AN	Other Diagnostic Services
8	AN	Blood	51	AN	Other Donor Bank
9	AN	Blood Storing & Processing	52	AC	Other Intensive Care
10	AC	Burn Intensive Care	53	AC	Other Room & Board
11	AN	C.A.T. Scan	55	AN	Other Therapeutic Services
12	AN	Cardiology	56	AN	Outpatient Services/Clinic
13	AN	Cast Room	57	AN	Outpatient Special Residence
14	AC	Coronary Intensive Care	58	AN	Patient Convenience Items
15	AN	Delivery Room and Labor Room	59	AC	Pediatric Acute
16	AC	Detoxification	60	AC	Pediatric Intensive Care
17	AN	Diagnostic Radiology/Other Imaging Services	61	AN	Pharmacy/Drugs Requiring Specific Identification
18	AN	Durable Medical Equipment (Other than Renal)	62	AN	Physical Therapy
19	AN	EEG (Electroencephalography)	63	AC	Premature Nursery
20	AN	EKG/ECG (Electrocardiogram)	64	AN	Preventive Care Services
21	AN	Emergency Room Services	65	AN	Professional Fees
22	AC	Epilepsy	66	AC	Psychiatric Acute
23	AN	Free-Standing Clinic	67	AN	Psychiatric/Psychological Treatments/Services
24	AN	Gastro-Intestinal Service	68	AN	Pulmonary Function
25	AN	Home IV Therapy Services	69	AN	Recovery Room
26	AN	Home Health	70	AC	Rehabilitation - Medical Acute
27	AC	Hospice	71	AC	Rehabilitation - Alcohol & Drug
28	AN	Hospice Service	72	AN	Respiratory Therapy
29	AN	Incremental Nursing Charge Rate	73	AC	Room & Board/Other Service
30	AN	Inpatient/Outpatient/Home Dialysis	74	AC	Self-Care
31	AN	Intravenous Therapy	76	AC	Skilled Nursing Facility
32	AN	Invalid / Non-Reimbursable	77	AN	Special Charges
33	AN	Laboratory/Pathological Laboratory	78	AN	Speech-Language Pathology
34	AC	Leave of Absence	79	AC	Sterile Environment
35	AN	Lithotripsy	80	AN	Telemedicine Services

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COST CENTER GROUPS					
Cost Center Group	**AN or AC**	**Department Description**	**Cost Center Group**	**AN or AC**	**Department Description**
36	AN	Magnetic Resonance Technology	81	AN	Therapeutic Radiology
37	AC	Maternity	82	AN	Treatment or Observation Room
39	AC	Medical/Surgical Acute	83	AC	CPEP
40	AC	Medical/Surgical Intensive Care	84	AC	SNF – Vent
41	AN	Medical/Surgical Supplies and Devices	85	AN	Other Outpatient
42	AC	Neonatal Intensive Care	87	AN	Medical Implants Charged to Patients
43	AC	Newborn Nursery	88	AN	Reserved for Internal Payor/National/State Use
44	AN	Nuclear Medicine	89	AN	Referred Ambulatory
45	AN	Occupational Therapy			

Exhibit 52 - Medicaid Allocated Cost Service Code Assignment

The purpose of the MSC assignment on this Exhibit is to assist in the alignment of a hospital's costs, charges, net revenue and Medicaid billing rate codes. This Exhibit is populated based on your facility's final cost center set-up, therefore if you are no longer using a specific final cost center, please delete it from your cost center set-up within the software*. For each service reported on this Exhibit, select the MSC provided in the list which is appropriate for that cost center. A comprehensive list of MSCs is located as Appendix I to these instructions.

See General Instructions paragraph 14 when providing services without any Medicaid Rate Code assigned to the hospital by the Department or for which a Medicaid Rate Code is not listed in the Medicaid Service Code Mapping to Rate Codes Table, Appendix I.

**All providers with maintenance of personnel (MOP) must report costs using the appropriate General Service cost center consistent with Medicare (CMS line number 12 / Medicaid 010 and any subscripts). Providers must also set up the Final Non-reimbursable Medicaid cost center 670 (CMS line no 194.99) as these costs are considered non-allowable for Medicaid. Do not include MOP costs in the opening balance of cost center 670. The NYS ICR software will automatically allocate all costs from cost center 010 to cost center 670 on the Medicaid Stepdown only.*

It is important that the proper MSCs be assigned to the cost center as these assignments will be used to calculate the summary of charges on Exhibit 46 and the summary report on Exhibit 53. Ensure that all cost centers with any of the following: utilization (patient days, visits, procedures, months or hours), costs, capital costs, charges or net patient service revenue are coded, including applying MSC 959, Non-Reimbursable / Non-Billable, when applicable. Every cost center with any amount reported in Class 10200, Routine Medicaid Allocated Cost, or 11200, Medicaid Capital Allocated Cost, must have an MSC assigned. If the cost center is non-reimbursable or its reimbursement is determined outside of ICR data, MSC 959 should be assigned. (A Fatal edit may occur as a result of an MSC assignment to an ICR cost center which bear no logical relationship. For example, ICR cost center 269 - Gifts, Flower, etc. to MSC 269- Adult Day Care.)

Hospitals are to report cost center 250, Home Program Dialysis, with MSC 235.

*Please Note: when assigning Medicaid Service Codes within the software you must complete Exhibit 52 prior to completing the MSC assignments on Exhibits 32 & 33. An edit will identify when more than one long-term-care area is assigned the same MSC.

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Exhibit 53 - Service Code Assignment Summary

This Exhibit provides the opportunity to review the alignment of overall cost, charges, net revenue and utilization statistics for Medicaid Service areas based on Medicaid Service Code assignments. It should be used as a guide to verify proper reporting within the ICR as well as appropriate assignment of Medicaid Services Codes within Exhibits 32, 33 and 52. If Exhibit 53 indicates any error or misalignment of revenue, costs, and utilization, then identify and correct the amounts and coding in the supporting Exhibits: 32, 33, 34, 46 and 52, or in the other exhibits on which they are based.

The presentation of utilization has been updated to include all Medicaid Service Codes which may be entered for Exhibits 32, 33 and 34. The Totals now include all utilization carried into the Exhibit. Omission of the MSC in Exhibits 32 and 33 areas where utilization was reported will result in a Fatal edit.

> Note: To view Exhibit 53 and ICR Schedules 1, 1A, 1B, 2 or 3, within the ICR Software, select the Print Cost Report Icon, then select from the ICR Exhibits Menu, the exhibit or ICR schedule (use the Control key to select multiple items). To display, select Preview/Print or to create a pdf select Print to PDF. This option will allow you to save a pdf copy which can then be stored and/or printed outside of the software. These steps will work for any exhibits, stepdown, or schedules within the Software.

ICR Schedules 1, 2, 3 and 4

All ICR Schedules are calculated based on proper assignment of Medicaid Service Codes (MSCs) from Exhibits 32, 33, 46 & 52. Please review all ICR schedules for accuracy. Should a correction be required the hospital must go to the ICR exhibit(s) which drive(s) the ICR schedule(s) in order to make the necessary correction(s).

ICR Schedule 1 - Calculates and provides the total allowable costs by MSC. The calculation includes summing of Final Stepdown Costs with Post Step Down Adjustments for All Programs and Medicaid Only, then adjusting for costs associated with Emergency Room (ER), Certified Psychiatric Emergency Program (CPEP ER), CPEP Extended Observation Beds (CPEP OBS) and Clinic Transfers (ICR Schedules 1A & 1B) to determine Total Allowable Costs.

ICR Schedule 1A - Transfer Summary - Provides a summary of all calculated transfer costs from ICR Schedules 1B.

ICR Schedules 1B - Transfers by Service - Using visits or charges to determine transfer costs, ICR Schedules 1B distribute allocated costs to other service areas from Emergency Services, Clinic Services, CPEP Extended Observation Beds and CPEP Emergency Visits which are aggregated on ICR Schedule 1A. The resulting routine cost transfers are applied to final stepdown cost in ICR Schedule 1 to calculate Total allowable cost.

*Please refer to Exhibit 31A for more information on transfer statistics.

Note: Starting with the 2020 ICR, if the prior year basis was Charges, then the ICR Schedule 1B "Based on Visits" transfer cost area will be blank.

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ICR Schedule 2 – Utilization – Summary of utilization by Medicaid Service Area as reported in Exhibits 32, 33 and 34 by the primary payor.

- Outpatient visits from Exhibit 33, *Excluding Inpatient Admissions* (Columns 00240-00242).
- Inpatient days and discharges from Exhibit 32.
- Swing bed utilization for Medicare FFS and Medicaid FFS from Exhibit 30.
- Home health services from Exhibit 34.

Inpatient summary totals include exempt service units.

Outpatient service summary totals are provided for outpatient, clinic and other (referred ambulatory and non-reimbursable). Adult Day Care services and Opioid Treatment Program computed weekly amounts are presented but not included in totals.

ICR Schedule 2A – Combines Uncompensated Care Collection and Uninsured/Charity utilization information from Exhibits 32, 33 and 34 that are used in the Indigent Care Pool (ICP) Model to compute Medicaid DSH payment levels.

ICR Schedule 3 – Capital Costs - accumulates capital and capital-related costs from Exhibits 11, 40, 41 or 42, and 44. Total reported capital costs is reduced by property taxes & insurance, a 44% major movable reduction, and any unfunded depreciation penalty to arrive at an allowable Capital amount. The Distribution page of ICR Schedule 3 allocates allowable capital plus transfer capital (ICR Schedule 1) to all service areas based on the Medicaid capital cost allocation percentages.

Note: The limitation on major moveable equipment does not apply to Article 31 hospitals.

Capital Cost Distribution Total Reported Rounding Differential are expected to be small amounts (less than 10). Should a larger rounding differential be present, the hospital should attempt to reduce it. The following suggestions may address the rounding differential:

- Capital and Capital-related cost centers, CMS Line numbers 1 and 2, may use subscripts up to **".49"**. Verify that Lines 1 and 2 subscripts are within the stated range. The Total Capital-Related Costs on the Capital Costs page exclude amounts subscripted to ".50" or higher.
- Allocation Code "0000" assigned in Exhibit 11 to General Service Cost Centers in addition to: CMS Line 3, Other Capital Related Costs; and CMS Line 23.56, Other Admin. & General, may interfere with allocation of the Other Admin. & General costs, even if the other cost center has no reported costs for the current ICR.
- When the allocation basis, for example: Gross Charges, is very large compared to the cost center total costs, the relative values may be too small to display some costs. This can be addressed by replacing Exhibit 19 Statistical Basis actual amounts with relative percentages (100% = 10000 as Line 200, Total).

ICR Schedule 4 – Calculates hospital-specific non-comparable costs as well as an indirect medical education teaching factor which may be included for Acute reimbursement when the associated base year report is used for updating the cost base. These areas include:

- Ambulance Services
- Schools of Nursing
- Indirect Medical Education (IME) Factor

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APPENDIX I
Medicaid Service Code Mapping to Rate Codes

Inpatient Medicaid Service Code Mapping to Rate Codes (1 of 2)
To be Used for Exhibits 32, 46 & 52

Medicaid Service Code	Medicaid Service Code Description	Service Description	Rate Codes
201	Inpatient Acute Care	Acute (including Hospital Operated Ambulance Svc, Organ Acquisitions, Swing Beds, HIV & ALC)	2290, 2946, 2992, 2950, 2951
202	Psychiatric Care	Psychiatric Certified Unit, Private Psychiatric Hospital, CPEP Extended Observation Beds (including ALC)	2852, 2858, 2962, 2963
203	Chemical Dependency Detoxification	Chemical Dependency Detoxification Certified Unit	4800, 4801, 4802, 4803
204	Dual-Diagnosis (Psychiatric)	Psychiatric Dual-diagnosis Unit (*only authorized hospitals*)	4608
205	Specialty Hospital	Specialty Acute, & Children's Hospital (including ALC)	2947, 2949, 2954, 2955, 2959
210	Chemical Dependency Rehabilitation	Chemical Dependency Rehabilitation Certified Unit (Including ALC)	2957, 2966, 2967, 2993, 3118, 3119
216	Critical Access Hospital	Critical Access Hospital (Including ALC)	2968, 2969, 2992, 2999
218	Medical Rehabilitation	Physical Medical Rehabilitation Certified Unit (Including ALC) and Medical Rehabilitation Hospital	2853, 2948, 2970, 2971
268/271-273	Skilled Nursing Facility 1 thru 4 (SNF/RHCF 1 thru 4)	Skilled Nursing Facility (SNF) [If multiple facilities, use multiple service codes]	3810, 3812, 3838, 3839, 2862, 2863
266	RHCF - Long Term Ventilator Dependent	Skilled Nursing Facility Vent	3759, 3760, 3775, 3776, 3770, 3771, 3760, 3759
267	RHCF – Neurobehavioral	Skilled Nursing Facility Neurobehavioral	3754, 3845, 3753, 3844
275	Specialty Pediatric SNF	Skilled Nursing Facility Pediatrics	3762, 3763, 3846, 3847
276	AIDS SNF	Skilled Nursing Facility AIDS	3755, 3756, 3766, 3767, 3848, 3849

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Inpatient Medicaid Service Code Mapping to Rate Codes (2 of 2) To be Used for Exhibits 33, 46 & 52			
Medicaid Service Code	**Medicaid Service Code Description**	**Service Description**	**Rate Codes**
959	Not Included in Rate Development	Non-Reimbursable / Non-Billable / Not included in Rate Development	As Applicable Article 31 Outpatient services with rates set by OMH. **Transitional Care Unit**

Outpatient/Other Medicaid Service Code Mapping to Rate Codes (1 of 3)

To be Used for Exhibits 33, 46 & 52

Medicaid Service Code	Medicaid Service Code Description	Service Description	Rate Codes
235	Clinic Services (including Renal Dialysis and Home Dialysis), Oncology	APG Clinic & Episode	1400, 1432
		APG MR/DD/TBI & Episode	1501, 1489
		APG SBHC & Episode	1444, 1450
		MOMS	1604
236	Emergency Department	APG ED	1402
239	Ambulatory Surgery	APG Ambulatory Surgery	1401
248	Chemical Dependency Clinic/ Rehab	Chemical Dependency Clinic/Rehab (hospital-based)	1082, 1528, 1552, 1558, 1561
254	Rehabilitation Clinic	Children's Rehabilitation not paid thru APGs	2887
255	OTP (formerly MMTP)	Opioid Treatment Program (OTP) formerly Methadone Maintenance Treatment Program (MMTP), Buprenorphine Fees	1090, 1120, 1555, 1567, 2531, 2532, 2533, 2534
269/270	Adult Day Care 1 and 2	Adult Day Care [If facilities have more than one adult day care service, use multiple service codes.]	2800, 3800, 3833, 3834
287	Federally Qualified Health Center (FQHC) / Rural Health Clinic (RHC)	FQHC, FQHC School Based Health Centers, FQHC HIV	2973, 4011, 4012, 4013, 4014, 4015, 4017, 4018, 4019, 4020, 4021, 4022, 4023, 4024, 4025, 4032, 4033, 4034, 4035, 4036, 4301, 4303, 4306, 4273, 4274, 4275, 4276, 4277, 4278 [**FQHC that opts into APG**: 1400, 1432, 1444, 1450, 1489, 1501, 1604]
261	OPWDD Clinic	OPWDD Clinic	1534, 1546

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Outpatient/Other Medicaid Service Code Mapping to Rate Codes (2 of 3) To be Used for Exhibits 33, 46 & 52			
Medicaid Service Code	**Medicaid Service Code Description**	**Service Description**	**Rate Codes**
250	Mental Health Clinic	Mental Health Clinic	1122, 1140, 1516, 1519, 1522, 1525, 1576, 1582, 1588, 1591
290	MH Continuing Day Treatment	Mental Health Continuing Day Treatment	4310, 4311, 4316, 4317, 4325, 4331, 4337, 4346
243	MH Day Treatment	Mental Health Day Treatment	4060, 4061, 4062, 4063, 4064, 4065, 4066, 4067
264	PROS - Personalized Recovery Oriented Services	Mental Health Service - PROS	For utilization reporting, report billed months only for rate codes 4520 – 4524. For revenue and expenditure reporting, report dollars for 4520 – 4524, as well as 4510, 4525, 4526, 4527, 4528, 4529, 4531, 4532, 4533, and 4534
289	Emergency Psychiatric (CPEP)	Mental Health Service – CPEP	4007, 4008, 4009, 4010, 4049
293	CPEP Observation Beds (Psychiatric)	CPEP Extended Observation Beds (Psychiatric) provided after 3/31/2020	4049
291	MH Intensive Psych Rehab (IPRT)	Mental Health Intensive Psych Rehabilitation	4364, 4365, 4366, 4367, 4368
292	MH Partial Hospital (O/P)	Mental Health Partial Hospitalization	4349, 4350, 4351, 4352, 4353, 4354, 4355, 4356, 4357, 4358, 4359, 4360, 4361, 4362, 4363
258	All Other MH Programs	All Other OMH Programs (Intensive Case Management, Supportive Case Management, Blended Case Management, Assertive Community Treatment, Adult Voluntary Community Residence, Children's Voluntary Community Residence, Collaborative Care)	5200, 5250, 5255
			5205, 5206, 5254, 5259
			5251, 5252, 5253, 5256, 5257, 5258
			4508, 4509, 4511, 4512
			4369, 4370, 4371, 4500, 4501, 4502, 4503, 4504, 4005
			4383, 4384, 4385
			5246, 5247, 5248, 5249
237	Referred Ambulatory	Referred Ambulatory (including Contracted Ambulance Svcs)	Fee Billed

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Outpatient/Other Medicaid Service Code Mapping to Rate Codes (3 of 3) To be Used for Exhibits 33, 46 & 52			
Medicaid Service Code	**Medicaid Service Code Description**	**Service Description**	**Rate Codes**
959	Not Included in Rate Development	Non-Reimbursable / Non-Billable / Not included in Rate Development	As Applicable
RESTRICTED FOR USE			
263	Poison Control	*Designated poison control centers:* University Hospital SUNY Health Science Center Bellevue Hospital Center	
241	Oncology Clinic	Oncology Clinic (ONLY FQHC providers which have opted out of APGs, not reimbursable through FQHC rate)	

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Home Health Agency Medicaid Service Code Mapping to Rate Codes

To be Used for Exhibits 34, 46 & 52

Medicaid Service Code	Medicaid Service Code Description	Service Description	Rate Codes
238	Home Health Agency	Home Health Agency (Aides & Therapy)	2841, 2878, 2499, 2842, 2844, 2845, 2847
		Telehealth: Certified Home Health Agencies	2560, 2561, 2562, 2563
277	Long Term Home Care	Long Term Care Home Health Care Services	2685, 2689, 2809 thru 2818, 2821, 2822, 2824, 2825, 2826, 2827, 2828, 2829, 2830, 2831, 2832, 2834, 2835, 2836, 2837, 2864, 3143, 3826, 3827, 9981, 9993, 9994, 9995
		Telehealth: Long Term Home Health Care Programs	2544, 2545, 2546, 2547
238 or 277	Home Health Episodic or Long-Term Home Care (see **Note**)	Home Health Episodic rate codes that may be used for certified HHA (MSC 238) or LTHHC (MSC 277). **Note**: Use of MSC 238 requires the hospital also have billable rates codes for Home Health Agency (included above under MSC 238).	4810, 4811, 4812, 4813, 4814, 4815, 4816, 4817, 4818, 4819, 4820, 4821, 4822, 4823, 4824, 4826, 4827, 4828, 4829, 4830, 4831, 4832, 4833, 4834, 4835, 4836, 4837, 4838, 4839, 4840, 4841, 4842, 4843, 4844, 4845, 4846, 4847, 4849, 4850, 4851, 4852, 4853, 4854, 4855, 4856, 4857, 4858, 4859, 4860, 4861, 4862, 4863, 4864, 4865, 4866, 4867, 4868, 4869, 4870, 4871, 4872, 4873, 4874, 4875, 4876, 4877, 4878, 4879, 4880, 4881, 4882, 4883, 4884, 4885, 4886, 4887, 4888, 4889, 4890, 4891, 4892, 4893, 4894, 4895, 4896, 4897, 4898, 4899,4900, 4901, 4902, 4903, 4904, 4905, 4906, 4907, 4908, 4910, 4911, 4912, 4913, 4914, 4915, 4916, 4917, 4919, 4920