INSTITUTIONAL COST REPORT (NYSICR)

Frequently Asked Questions

(for 2022 ICR)

	Question	Answer
A. Reporting Questions		
1	**Does line 24.50 include Paycheck Protection Program (PPP) amounts received (Exhibit 26A)?**	The published instructions state "Enter the aggregate revenue received for COVID-19 PHE funding including both provider relief fund (PRF) and Small Business Administration Loan Forgiveness amounts."
2	**Where should the hospital report COVID-19 revenue?**	Any COVID funding, including private donations, should be reported within Line 24.50 if it meets the CMS description for the Line. COVID funding that is not reported in Line 24.50 should be included on variable lines 131-140 in **Exhibit 26A**.
3	**What is the treatment of interest earned on PRF [CARES Act Provider Relief Fund] amounts?**	The US Department of Health and Human Services (HHS) stipulates that providers earning interest on PRF funds may either return the interest or may use the interest earned in a manner that would be compliant with the purposes of the PRF principal. For those that returned interest, the amount reported in the ICR as PRF funding would not include the returned interest or would be net of interest yet to be returned. Where PRF reporting allows the provider to retain the interest as used for the principal purpose, no interest offset would be made because this amount is to be treated as interest earned under a restricted grant.
4	**How is COVID-19 vaccination revenue to be reported in Exhibit 26A?**	The Department of Health has not established discrete cost centers for ICR reporting of COVID-19 activities, including vaccination. The site(s) of service and payment system(s) will identify the service areas that may be used. Some examples are whether the services were provided in a General Clinic versus a Rural Health Clinic and whether paid via APG or fee schedule. If the hospital wants to segregate its COVID-19 services reporting, then we suggest using variable cost centers with MSCs consistent with the service areas' underlying characters. Hospitals are expected to comply with HHS, CMS, HRSA, etc. guidance on reporting COVID-19 PHE revenue and expenses. The only specific ICR COVID-19 entry is for Exhibit 26A Line 141 which carries forward the Medicare cost report Worksheet G-3 amount on Line 24.50, COVID-19 PHE FUNDING (starting in 2020). See Medicare instructions for the line. The amounts included in Line 24.50 are not to be duplicated in Exhibit 27 (see 2021 ICR Instructions). Please keep in mind that HHS has evolving rules on reporting PRF and PPP forgiveness revenue and expense. Some examples include: • Medicare cost report Worksheet G-3 (Exhibit 26A), Line 24.50 use; • Prohibition on using PRF money to reimburse expenses or losses reimbursed from other sources or that other sources are obligated to reimburse; and • HRSA COVID Uninsured Program and vaccination program required exclusions.
5	**For Exhibits 3, 32 and 33, where do we report COVID-19 statistics?**	The reporting of statistics related to patients requiring medical care for the treatment of COVID-19 should be reported in the service area where the patient was treated/discharged from. There is no discrete reporting for these statistics. For temporary expansion COVID-19 public health emergency acute care beds, use Exhibit 3, CMS Line 34 (ICR Line 618).
6	**How is the primary payor reported for claims made to the HRSA COVID-19 Uninsured Program?**	Claims filed with the HRSA Uninsured Program for COVID-19 services are to be included in the Government Primary Payor Category.
7	**How should amounts remaining on HRSA Uninsured Program COVID-19 claims after HRSA payment be reported in the ICR?**	Report the amounts written off on HRSA Uninsured Program COVID-19 claims as Government Allowances (Exhibit 46, Line 354) since the provider is not being allowed to bill the patient.
8, Pt I	**How should payments distributed as a result of Medical Liability Mutual Insurance Company's (MLMIC) 2018 acquisition by Berkshire Hathaway be reported? Part 1 of 2 (revised 05/25/2021)**	These payments from MLMIC to eligible policyholders (or designees) are to be reported in the ICR for the period(s) during which they are received as Other Revenue and treated as investment income. The New York State Department of Financial Services (DFS), when it approved the MLMIC demutualization transaction, determined that the cash consideration received by MLMIC's policyholders in return for their equity interest in the mutual insurance company was investment income. Further, the equity interest in the demutualized company is considered investment income by the Internal Revenue Service. In addition, because the transaction did not change existing insurance policies, payments are not to be ICR-reported as returns or refunds of insurance premiums or insurance settlement payments unless documentation from MLMIC (or its representatives or successors) explicitly state that they are returns or refunds.

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8, Pt II	**How should payments distributed as a result of Medical Liability Mutual Insurance Company's (MLMIC) 2018 acquisition by Berkshire Hathaway be reported? Part 2 of 2 (revised 05/25/2021)**	Title 10 New York Codes, Rules and Regulations section 86-1.25(g)(3) states that "Investment income shall be defined as the aggregate net amount realized from dividends, interest, rental income, interest earned on temporary investment of withholding taxes, as well as all gains and losses." The payments for the end of MLMIC demutualization membership interests meet this definition on investment income. The regulations further require that "Interest expense shall be reduced (offset) by investment income with the exception of income from funded depreciation, qualified pension funds, trusteed malpractice insurance funds, or in instances where income from gifts or grants is restricted by donors." The description for financial statement presented amounts may differ from the ICR description. The Berkshire Hathaway acquisition resulted in MLMIC's conversion from a property and casualty mutual insurance company to a property and casualty stock insurance company with, per the DFS September 6, 2018 Decision, cash consideration was paid for extinguished members' equity according to an approved formula. The offsetable ICR investment income value is the difference in the cash consideration received from MLMIC and the hospital-specific net premiums paid during the three-year period that was used by MLMIC to calculate the hospital's share of the cash consideration pool.
9	**How do I report repayments of MLMIC demutualization payments?**	Based on the May 19, 2022 NYS Supreme Court decision, some hospitals MIGHT have to pay back or pay out some or all previously-received MLMIC demutualization distributions. Should this occur, the ICR should reflect these transactions as reduction in investment income for the ICR period in which paid out or accrued.
10	**What are the primary payor categories?**	Definitions relating to primary payor categories for reporting of Exhibits 32, 33, 34 and 46 may be found within the ICR instructions. Further clarification on specific primary payors as it relates to Exhibit 46 HFAL reductions are provided below: **Insured** means at least one provided service is covered by at least one of the patient's third-party payors. It is not necessary to collect from the third-party. HFAL reductions for these accounts are reported in the primary payor's charity line. (For 2021 ICR, Essential Plans are included as insured.) **Uninsured** means the hospital expects a patient with NO third-party coverage for ANY service provided in the account to pay at least a portion of the charges. This includes patients electing to self-pay instead of billing third parties. **Free, Charity** is for patients for whom application of the hospital financial aid policy (HFAL) results in reduction (write-off) of charges to zero. They should initially be recorded at the same value as other patients. (This determination should occur approximately when service begins, but often the determination happens during or after service—such as after receiving a charity care application.) Charity care determination or documented presumptive eligibility per HFAL Policy.
11	**In what circumstances, such as later eligibility determination, may a change in the primary payor be appropriate?**	The Primary Payor is expected to be set at the encounter start; however, there are circumstances where the hospital may, but is not required to, update this because the apparent payor was changed. For example, this includes: when a payor reports retroactive eligibility; when the hospital judges that an encounter THAT IS NOT COVERED BY A THIRD-PARTY PAYOR is fully charity care; or when the wrong payor was identified. Primary payor changes are not to occur as the account cascades from a valid primary payor to secondary payors, including self-responsible.
12	**What are the Essential Plans?**	Please refer to the Basic Health Plan Annual Reports for information about the Essential Plans: https://www.health.ny.gov/health_care/managed_care/essential/index.htm
13	**How are Essential Plans to be reported--separately or rolled into commercial HMO as in prior years? Why does the ICR require separate Essential Plan utilization reporting?**	Beginning with the 2021 ICR, Essential Plan utilization and charges may be reported separately on the discrete lines added to the ICR in Exhibits 32, 33, 34 and 46. Essential Plan utilization reporting was added to primary payor categories in order to provide for future analysis on the Essential Plans. The Essential Plan is a New York health insurance program for state residents that don't qualify for Medicaid or Child Health Plus programs. Beginning with the 2022 ICR, it will be mandatory for hospitals to report this information in the discrete lines that have been added.
14	**What if an Essential Plan 3,4 patient has a Medicaid ID number? Can this be considered Medicaid?**	The Essential Plan is not available to individuals eligible for Medicaid. Therefore, for the provider patient accounting system to list a Medicaid number for an Essential Plan patient, this number either: applies to dates of service before or after having Essential Plan coverage; or the patient was enrolled in the Essential Plan in error. The provider should use the Electronic Medicaid Eligibility Verification System (EMEVS) for each date of service and establish the correct payor(s). Essential Plan covered services are NOT considered Medicaid because an Essential Plan requirement is not being eligible for Medicaid. Therefore, no Essential Plan inpatient admission should be dual eligible for Exhibit 30.

	Question	Answer
15	**What is the definition of expense related to an interest rate swap?**	As with any hedge, interest rate swap contracts vary. Financial institutions incur costs in making and providing these swaps, therefore, hospitals encounter initiation and ongoing maintenance fees and costs for the hedge (swap). These costs may include interest at the fixed-rate that is in excess of the floating (variable) rate, especially early in the arrangement while the variable rate is temporarily frozen or has not risen much. When a financial arrangement includes an interest rate swap, the hospital is expected to identify the costs of the swap and report them properly in any Federal healthcare program cost report. In addition to excluding stated fees and costs and additional interest expense when the fixed-rate exceeds the variable rate, this may require the hospital to adjust reported costs with the implicit value of the swap arrangement, if not explicitly stated in the contract. Hospitals' methods for recording transactions also vary, therefore there is not a single approach to how and where within the financial reporting system they are reported. The Department suggests that the controller or CFO can provide insight into the local method(s) applied and underlying contracts.
16	**For Exhibit 30, Line 60, Dual-eligible, what meant by "A payor on the account"--are these Medicaid paids or Eligible for payment?**	Hospitals should identify encounters with Medicaid coverage in addition to other coverage in a manner consistent with their Medicaid DSH reporting.
17	**What approval is needed to change the ICR Schedule 1B basis from visits to charges?**	If a provider has utilized visits as a transfer basis statistic in the prior year, they may change to charges in the current year with no prior approval. Once an ICR has been submitted with charges used as the basis to determine transfer costs, the provider will no longer be permitted to change back to visits. The change is made for the service area on Exhibit 31A.
18	**If the 2021 Software indicates that, for a service area (Emergency, CPEP Emergency Service, CPEP Observation Beds or Clinic), "Charges" was the prior-year allocation basis, what options are available?**	ICR Schedules 1B compute the amount of routine and capital costs transferred to and from four outpatient service areas. The three historical service areas (Emergency, CPEP Emergency Service and Clinic) computed in ICR Schedules 1B are based on either the Exhibit 31A visits or Exhibit 46 charges reported in the ICR. During 2020, CPEP Observation Beds transitioned to an outpatient service only (Exhibit 33 reporting) and an ICR Schedule 1B was established for which all hospitals' bases are charges. If the previous year basis was charges, then for that service area in the 2020 and later ICR: Exhibit 31A will not be available and ICR Schedule 1B will only present transfers based on charges.
19	**Where should Hospice days reported on S-3 part I line 24.10 be reported as it relates to Exhibit 32? Are Hospice Days considered ALC?**	No, they are not considered ALC. Hospice is a program that provides care to terminally ill individuals that focuses on easing symptoms rather than treating disease. The hospice benefit is not an Inpatient Hospital Service unless the patient is admitted as a hospital (not Hospice) inpatient. Therefore, Exhibit 32 should not include days paid under Hospice rate codes "General Inpatient Care" and "Inpatient Respite" care. NYCRR Title 10, Section 86 -1.15 (h) defines Alternate Level of Care services as "those services provided by a hospital to a patient for whom it has been determined that inpatient hospital services are not medically necessary, but that post-hospital extended care services are medically necessary, consistent with utilization review standards, and are being provided by the hospital and are not otherwise available." Third-party payers often term these “custodial care” services.
20	**What basis should be used to split the real estate tax and insurance expense on Exhibit 40 between 'Buildings and Fixtures' and 'Major Moveable Equipment'?** **Should a similar allocation be done on Exhibit 13?**	Generally, insurance documents provide detail of elemental premiums which should be followed. Where a policy does not provide details of premiums for Buildings and Fixtures (including Land) versus Moveable Equipment, the hospital may make a reasonable allocation and must make that supporting documentation available for ICR Audit review. The Exhibit 13 and Exhibit 40 entries are not linked, but are expected to be similar or the same. As Worksheet A-7, Exhibit 13 is required for Medicare cost reporting.
21	**Are we to carve the amounts on Exhibit 46 lines 382, 386, 383 and 391 out of the allowances where they would normally be reported under primary insurance?**	Because of the Report Year 2019 change in reporting HFAL reduction, an example using Third-Party is as follows: • If application of the HFAL 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.

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22	**How are charges written-off (reduced) because of the hospital Financial Aid Law (HFAL) Policy to be reported in Exhibit 46?**	Because of the Report Year 2019 change in reporting HFAL reduction, an example using Third-Party is as follows: • If application of the HFAL 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 NEW 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 NEW 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 NEW Line 382, 383 or 386. Use the primary payor category and do not split among lines.
23	**Are we to report lines 382, 383, 386 and 391 based on accrual or actual write-offs?**	The Department expects the accounting basis of amounts reported on lines 382, 383, 386 and 391 to be consistent with that for the remainder of Exhibit 46.
24	**How can I view Exhibit 53 or the ICR Schedules while preparing the ICR?**	To view Exhibit 53, ICR Schedules 1, 1A, 1B, 2, 2A, 3 or 4 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 exhibit, stepdown, or schedule within the Software.
25	**What changes are required for drugs paid outside the rate code?**	At this time, for ratio-of-cost-to-charges (RCC) development, ICR Instructions require adjustment as paid outside the rate only of the amounts of all patients' outpatient chemotherapy drug costs in Exhibit 11 and charges in Exhibit 51 (Please refer to ICR instructions).
26	**What professional services may be reported within the Exhibit 50 HFAL costs (charges) and payments?**	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. (Services 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.)
27	**Since Rural Health Clinics (RHCs) are paid under the all inclusive rate and professional cost is left in allowable expenses, do professional charges need to be backed out on Exhibit 51?**	If the provider has elected to be reimbursed the NYS Medicaid FQHC rate for their RHC(s) (reported on CMS line 88 and subscripts thereof) and the provider has included the professional charges on Exhibit 46 then no adjustment is required on Exhibit 51.
28	**Do school of nursing non-comparable costs include other allied health education programs? For example, school of radiology or pharmacy residency program.**	No, although Medicare reporting for Nursing Programs (Schools of Nursing) and allied health education programs are similar, NY State only computes non-comparable amounts for Schools of Nursing.
29	**When will the 2021 RHCF-2/4 report be due?**	Any questions regarding reporting or submission of the RHCF cost reports should be directed to the Bureau of Residential Health Care Reimbursement at rhcf-hcs@health.ny.gov.
30	**What should be done when the ICR Software identifies a non-fatal edit?**	Non-fatal errors (4xxxx) and Informatory messages (5xxxx) point out unusual conditions or amounts in the ICR Edit and Calculation (E&C) Report. 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.
31	**How should the Health Care and Mental Hygiene Worker Bonus Program (HWB) be reported?**	The amounts received by **ALL** Hospitals for the HWB Program are to be reported at Exhibit 27, Lines 212-214. (This might require an Exhibit 28, Reconciliation to the Audited Financial Statements entry.) Because these are not allowable amounts for rate-setting, make Exhibit 12 Reclassifications to Cost Center 003 from the cost centers where recorded when paying the HWB to employees. Then make one or two Exhibit 14 All-payor Adjustments to Cost Center 003 to remove this cost, depending on how cost was recorded. **If the hospital included HWB payments in the balance sheet, ensure there are no amounts in the Exhibit 11 trial balance, after adjustments.**

	Question	Answer
32	**For ICR Exhibits 32, 33 and 34 reporting, does the Uncompensated Care Collection (UCC) amount include the uninsured HCRA surcharge?**	Based on the latest Department guidance, provided for the 2019 Medicaid DSH Audit, that "Per the Preamble to the 2008 DSH Final Rule regarding provider health care taxes, the Department of Health (DOH)'s position for the Medicaid DSH Audits has historically been that payment amounts cannot be offset by the amount of the HCRA surcharge. Therefore, hospitals should not reduce their payments amounts by the HCRA surcharge.", the reported UCC should include the HCRA surcharge. **Note**: The Department and CMS are discussing this issue. Should that discussion come to a change, then the Department will promulgate further guidance including which ICR periods to which the change is to be applied.
B. Software Questions		
33	**What is the username and password to download the ICR Software?**	The 2021 ICR Software is available to download from the Health Financial Systems (HFS) website. The link/URL and password are available within the Hospital ICR application of the Health Commerce System (HCS) secure website.
34	**We have already started entering 2021 data. Will we have any problems saving our work once the updated software is installed?**	There should not be any problems with saving work once the 2021 software updates have been applied. Please note that where entry or Exhibit definitions have been modified, the hospital should verify that previously entered amounts are still accurate and properly reflect the revised ICR.
C. Audit Fee Questions		
35	**What are the fees associated with submitting an ICR?**	The ICR audit fees are based on Exhibit 11, column 3, line 960 **total expenses** at Class code 00042, line 960 of the previous year's report. The audit fee levels are posted on the DOH website at: http://www.health.ny.gov/facilities/hospital/audit_fee/index.htm For cost report audits for years 2021 and prior, the audit fee payments have been based on the above costs at the following fee amounts: <$50 million = $ 5,000 fee $50 - $100 million = $ 7,500 $100 - $300 million = $10,000 $300 - $700 million = $15,000 $700 - $1 billion = $20,000 $1 - $1.5 billion = $30,000 >$1.5 billion = $40,000
D. ICR Audit Questions		
36	**Is the Hospital Financial Assistance Law (HFAL) questionnaire used solely to determine compliance? Are hospitals field audited on HFAL compliance?**	All hospitals' questionnaire responses are used to determine HFAL compliance and are used during the ICR desk audit process. Hospitals selected for ICR field audits have additional procedures performed to complete the HFAL compliance determination.
37	**If a hospital is not found to be in substantial compliance with the HFAL, how long does it have to correct the issue?**	As with any ICR Audit finding, for an HFAL non-compliance finding, the hospital is to provide a corrective action plan (CAP) with a "completed-by" date for the Final Audit Dashboard. The Department has the final determination in whether this CAP results in compliance and its timing is appropriate.
E. General Questions		
38	**How is the information in cost reports used by the Department?**	The data in the report is used by the Department for data analysis, rate development, the Upper Payment Limit calculation, Disproportionate Share calculation and development of fund distributions. Certain data elements in the ICR are also used by other Agencies.
39	**Will the DOH accept an electronic CEO signature page at some point like the Medicare Report does?**	There are internal discussions on the possibility of moving to an electronic certification. However, at this time, we will continue to collect signed CFO certifications and Edits in pdf format.

	Question	Answer
40	**Who should I contact with ICR related questions?**	**ICR questions can be answered using the following emails:** General ICR Questions**:** Hospital.ICR@health.ny.gov KPMG ICR Audit Contact: us-albadvnysdhicr@kpmg.com. Audited Financial Statements must be emailed in pdf format to: AFS@health.ny.gov **Other resources include:** Hospital Inpatient or Outpatient Article 28 rates: HospFFSUnit@health.ny.gov Hospital Outpatient Services for Article 32 (OASAS), Article 31 (OMH) & Article 16 (OPWDD) providers or rates: https://www.health.ny.gov/health_care/medicaid/rates/contacts/ Medicaid Managed Care Rates: bmcr@health.ny.gov Residential Health Care Cost Reports: rhcf-hcs@health.ny.gov Accounts Receivables and Recoupment: bimamail@health.ny.gov. The payoff or collection process for a liability balance: mfm@health.ny.gov HCRA and Cash Assessment: hcraprov@health.ny.gov Establishment of locations on eMedNY: providerenrollment@health.ny.gov Billing questions: eMedNY Helpline Number: 1-800-343-9000