



Medicare Cost Report and IRIS Update

April 29, 2025

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Agenda

- MCR Update
 - Extensions
 - Background
 - New Services by LAW
 - New Provider Type
 - Supporting Documentation
 - Updated Regulations
 - Cost Report Updates
- Electronic Signatures
 - New Report Wizard
 - Self/CFO Signatures
 - SaFE Storage
 - MCR eF
- Questions

- **While no current extension for after 12/31/2020 cost reports:**
 - 42 CFR 413.24(f)(2)(ii)
 - (ii) Extensions of the due date for filing a cost report may be granted by the contractor only when a provider's operations are significantly adversely affected due to extraordinary circumstances over which the provider has no control, such as flood or fire.

- **New Provider type - Rural Emergency Hospital (REH)**
- **Intensive Outpatient Program (IOP) costs incurred for IOP services rendered to hospital outpatients, effective for services rendered on or after January 1, 2024, in accordance with the Consolidated Appropriations Act (CAA) of 2023, §4124.**
- **Covered Marriage and Family Therapists (MFT) and Mental Health Counselors (MHC), respectively, in accordance with the CAA 2023, §4121, effective for services on or after January 1, 2024.**
- **Supporting Documentation Requirements (Exhibits)**
- **FY 2023 IPPS final rule GME Changes (Hershey changes)**
- **Sections 126, 127, 131 of the CAA 2021**
- **Sequestration Changes.**

- **Supporting Documentation Requirements (Exhibits)**
- **FFY 2019 IPPS Final Rule Supporting documents:**
 - Teaching hospitals--For teaching hospitals, the Intern and Resident Information System (IRIS) data.
 - Bad debt--Effective for cost reporting periods beginning on or after October 1, 2018, for providers claiming Medicare bad debt reimbursement, a detailed bad debt listing that corresponds to the amount of bad debt claimed in the provider's cost report.
 - DSH eligible hospitals--Effective for cost reporting periods beginning on or after October 1, 2018, for hospitals claiming a disproportionate share hospital payment adjustment, a detailed listing of the hospital's Medicaid eligible days that corresponds to the Medicaid eligible days claimed in the hospital's cost report. If the hospital submits an amended cost report that changes its Medicaid eligible days, the hospital must submit an amended listing or an addendum to the original listing of the hospital's Medicaid eligible days that corresponds to the Medicaid eligible days claimed in the hospital's amended cost report.
 - Charity care and uninsured discounts--Effective for cost reporting periods beginning on or after October 1, 2018, for DSH eligible hospitals reporting charity care and/or uninsured discounts, a detailed listing of charity care and/or uninsured discounts that corresponds to the amounts claimed in the DSH eligible hospital's cost report.
 - Home Office
 - Same fiscal year end. Effective for cost reporting periods beginning on or after October 1, 2018, for providers claiming costs on their cost report that are allocated from a home office or chain organization with the same fiscal year end, a Home Office Cost Statement completed and submitted by the home office or chain organization to its chain provider's servicing contractor that corresponds to the amounts allocated from the home office or chain organization to the provider's cost report.
 - Differing fiscal year end. Effective for cost reporting periods beginning on or after October 1, 2018, for providers claiming costs on their cost report that are allocated from a home office or chain organization with a different fiscal year end, a Home Office Cost Statement completed and submitted by the home office or chain organization to its chain provider's servicing contractor that corresponds to some portion of the amounts allocated from the home office or chain organization to the provider's cost report.

- **Supporting Documentation Requirements (Exhibits)**

- CR11644 requires documentation +/-3% for cost reports submitted on or after 12/31/2020.
- T-18 (Effective Cost Reporting Periods Beginning on or After October 1, 2022).
 - Medicare bad debt by beneficiary Exhibit 2A.
 - Exhibit 3B, listing of Charity Care Charges, to report charity care charges by patient.
 - Exhibit 3C, listing of Total Bad Debts. To report total bad debts by patient.

- **Supporting Documentation Requirements Teaching hospitals--IRIS.**

- FFY 2022 IPPS FR August 13, 2021, Federal Register
- CR12724 Mandates use of XML and begins tracing to the cost report for periods beginning October 1, 2022.

- **Home Office**

- The Home Office Cost Statement, Form CMS-287-22 Transmittal 1/2 was published by CMS, on October 28, 2022. The 287-22 is effective for cost reporting periods beginning on or after October 1, 2022.
 - Will provide for electronic submission and MAC storage

- **FY 2023 IPPS final rule GME Changes (Hershey changes)**
 - Implemented a revised DGME payment methodology that eliminates penalties for hospitals that train residents and fellows and operate over their full-time equivalent caps, according to the report.
 - Effective for CR Periods beginning on or after 10/1/2001
 - “Not a basis for reopening final settled NPRs.”
 - T-18 implements for CR periods beginning on or after 10/1/2022

- Reminder when doing GME reports that may be affected by Hershey case, you will need to pull the prior year mcrx and penultimate year mcrx files and then open S-2 Pt I and change line 68 to Y and calculate. This will make revisions to W/S E-4 which you will then need to adjust on the CY mcrx file's E-4 lines 12 and 13. You may also need to look at line 15 of the previous reports if they have new training programs whose exemption has expired.

- The FFY24 IPPS Rule also updated the CY 2022 HMO Reduction amounts shown on Worksheet E-4 line 29.01. This also was included in T22.
 - CY 2022 – 3.27%
- The FFY25 IPPS Rule updated the CY **2023** HMO Reduction amount shown on E-4 line 29.01 to **2.74%** (8-28-24 federal register page 69384). This is what you want to use for current filings.

- CMS issued CR13971 on March 13, 2025 announcing the release of the FY 2023 SSI data. We include this in the 2552-10 software in the E, Part A DSH worksheet and issue a level II edit if the amount filed on E Part A and E-3, Part III (IRF LIP) do not agree.

- One item to be aware with CMS' UCC DSH table for FFY 25, there is a new tab IFC (interim final action with comment period) which is to be used rather than the normal CN tab.

FY 2025 IPPS IFC: Implementation of Section 3133 of the Affordable Care Act- Medicare DSH- Supplemental Data														
Medicare CCN	Projected to Receive DSH in FY 2025	IHS or PR	Rural Community Hospital Demonstration	New Hospital	2019 UCC (Annualized)	Length of 2019 Reporting Period	2020 UCC (Annualized)	Length of 2020 Reporting Period	2021 UCC (Annualized)	Length of 2021 Reporting Period	Factor 3	Total Uncompensated Care Payment	Total Supplemental Payment	Estimated Per Claim Amount
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]	[10]	[11]	[12]	[13]	[14]	[15]
010001	YES	NO	NO	NO	\$25,746,956.00	365	\$25,866,530.00	366	\$27,992,560.00	365	0.000778664	\$4,442,858.96	N/A	\$996.38
010005	YES	NO	NO	NO	\$13,262,554.00	365	\$12,161,171.00	366	\$13,720,836.00	365	0.000382701	\$2,183,594.05	N/A	\$1,433.75
010006	YES	NO	NO	NO	\$7,547,149.88	366	\$8,985,968.83	365	\$9,814,185.00	365	0.000258031	\$1,472,260.91	N/A	\$419.69
010007	YES	NO	NO	NO	\$1,560,919.00	365	\$1,870,627.00	366	\$1,588,868.00	365	0.000049124	\$280,288.60	N/A	\$675.39
010008	YES	NO	NO	NO	\$879,182.00	365	\$556,399.57	276	\$1,181,623.00	365	0.000025594	\$146,033.35	N/A	\$1,216.94
010011	YES	NO	NO	NO	\$21,315,128.39	366	\$21,550,228.41	365	\$23,331,943.00	365	0.000647538	\$3,694,685.10	N/A	\$1,505.58

- See IFC reference:

80405

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 412
[CMS-1808-IFC]
RIN 0938-AV34

Medicare Program; Changes to the Fiscal Year 2025 Hospital Inpatient Prospective Payment System (IPPS) Rates Due to Court Decision

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

ACTION: Interim final action with comment period.

SUMMARY: This interim final action with comment period (IFC) implements revised Medicare wage index values for FY 2025, establishes a transitional payment exception for low wage hospitals significantly impacted by those revisions, and makes conforming changes to the hospital Inpatient Prospective Payment System (IPPS)

following address only: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-1808-IFC, Mail Stop C4-26-05, 7500 Security Boulevard, Baltimore, MD 21244-1850.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Donald Thompson and Michele Hudson, (410) 786-4487 or DAC@cms.hhs.gov.

SUPPLEMENTARY INFORMATION:
Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following website as soon as possible after they have been received: <http://www.regulations.gov>. Follow the search instructions on that website to view public comments. CMS will not post on [Regulations.gov](http://www.regulations.gov) public comments that hospital is located. If the hospital is located in Alaska or Hawaii, the nonlabor-related share is adjusted by a cost-of-living adjustment factor. This base payment rate is multiplied by the DRG relative weight.

If the hospital treats a high percentage of certain low-income patients, it receives a percentage add-on payment applied to the DRG-adjusted base payment rate. This add-on payment, known as the disproportionate share hospital (DSH) adjustment, provides for a percentage increase in Medicare payments to hospitals that qualify under either of two statutory formulas designed to identify hospitals that serve a disproportionate share of low-income patients. For qualifying hospitals, the amount of this adjustment varies based on the outcome of the statutory calculations. The Affordable Care Act revised the Medicare DSH payment methodology and provides for an additional Medicare payment beginning on October 1, 2013, that considers the amount of uncompensated care furnished by the hospital relative to all other qualifying hospitals.

If the hospital is training residents in

- If you receive UCC DSH in the interim (and not a SCH), you are to answer S-2, Part I line 22.01 (cols 1 &/or 2) as Y, then E, Part A lines 35 – 35.02 are to be zero. We will compute line 35.02 from the CMS' table. Users populate these and if different than the table, we issue a level II edit, this is due to rounding or if using the incorrect tab.

- We want to highlight the change effective with discharges on or after 10-1-2023 and how to complete L.
- If you are in an Urban CBSA the entire year and was redesignated Rural the entire year, you complete S-2, Pt I line 3, column 3 with the Urban CBSA. You also show S-2, Pt I lines 26 and 27 as 2 for Rural.

Hospital and Hospital-Based Component Identification:					
		Component Name	CCN Number	CBSA Number	Provider Type
3.00	Hospital			42700	1 - General Short Term

		Urban/Rural Status	Date of Geographic Reclassification
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2	

- For Worksheet L, the column 1 will be subscribed when overlapping 10-1-23 for this change.
- Column 1 will be post 10-1 and will get capital DSH, column 1.01 will be pre-10-1 and is considered Rural and no Capital DSH.
- Worksheet L: Revised instructions to reflect revisions for providers that underwent a geographic reclassification in accordance with 42 CFR 412.103 per the FY 2024 IPPS final rule, 88 FR 59117 (August 28, 2023).

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 0001	Period	Worksheet L, Part I
		Title XVIII	From: 01/01/2023 To: 12/31/2023	PPS
			Urban Post 10/1	Rural Pre 10/1
			1.00	1.01
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		884,128	2,660,207 1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	0 1.01

- Our review of the FFY 25 IPPS Final Rural, there are many changes in County – CBSA crosswalk due to the 2020 Census that is effective 10-1-24. There are many counties that went from Urban to Rural and vice-versa. This can affect the qualification of Capital DSH so we brought up a question to CMS asking if cost report changes would be needed for this.
- We are still awaiting guidance on this.

- For the state of LA, we see Iberia County went from Lafayette CBSA 29180 and is now Rural LA. Jefferson Davis and Richland Counties went the different direction, they were Rural but effect 10-1-24 they are now under CBSAs 29340 (Lake Charles) and 33740 (Monroe) respectively.
- We pulled HCRIS data and saw 1 IPPS hospital affected (190053 – Jefferson Davis), however, CAHs may be and based on the final rule, you may need to request to continue being Rural for CAH qualification. See Federal Register dated 8-28-2024 page 69260.
- This would also be the case for SCH / MDH when applicable.

- Reminder if you are a Small Rural Hospital (under 50 beds – majority will be CAHs) with a RHC subunit. Effective 4-1-21, CMS has limited grandfathered RHC's to the PY cost multiplied by the CMS' updates (see CR12185 dated 5-4-21 for the original instruction). See following slide.

2. Provider-Based RHCs in a hospital with less than 50 beds

a. Provider-based RHCs that are Determined to be Grandfathered

Beginning April 1, 2021, provider-based RHCs that meet the criteria in section 1833(f)(3)(B) of the Act are entitled to special payment rules, as described in section 1833(f)(3)(A) of the Act.

Provider-based RHCs that meet the criteria in section 1833(f)(3)(B) of the Act are considered to be “grandfathered” into the establishment of their payment limit per visit. Meaning, those provider-based RHCs that meet the following criteria will have a payment limit per visit established (beginning with services furnished 4/1/2021) based on their AIR. A “grandfathered provider-based RHC” is an RHC that --

- As of December 31, 2020, was in a hospital with less than 50 beds and after December 31, 2020 in a hospital that continues to have less than 50 beds (not taking into account any increase in the number of beds pursuant to a waiver during the COVID-19 PHE); and one of the following circumstances:
 - As of December 31, 2020, was enrolled in Medicare (including temporary enrollment during the COVID-19 PHE); or
 - Submitted an application for enrollment in Medicare (or a request for temporary enrollment during the COVID-19 PHE) that was received not later than December 31, 2020.

With regard to the reference of the waiver during the COVID-19 PHE, CMS will take into account the policy finalized in the interim final rule with comment, published in the May 8, 2020 Federal Register (85 FR 27550-27529). Provider-based RHCs that were exempt from the statutory payment limit per visit pursuant to section 1833(f)(3)(B) whose associated hospitals have experienced temporarily added surge capacity beds will be considered “grandfathered” in accordance with the policy set out in the May 8, 2020 IFC.

A grandfathered provider-based RHC will lose this designation if the hospital does not continue to have less than 50 beds. If this occurs, the provider-based RHC will be subject to the statutory payment limit per visit applicable for such year for RHCs (that is, section B.1. of this Change Request).

Provider-based RHCs that are new beginning January 1, 2021 and after are subject to the statutory payment limit per visit applicable for such year for RHCs (that is, section B.1. of this Change Request).

- CMS also added clarification in CR13063 dated 1-26-23 which included how to handle the “base year” reports when it is a short period report. It is important to track these “base year” cost limits for future reports.
- CMS also added in T22 a change to ensure no new RHCs can be added to the list of grandfathered consolidated RHCs.

Line 13--Is this **worksheet prepared for** a consolidated **group of providers** as defined in CMS Pub. 100-02, chapter 13, §80.2? Enter “Y” for yes or “N” for no in column 1. If yes, enter in column 2, the number of providers included in **the consolidated group**, complete line 14, and complete only one M series of worksheets for the consolidated group. **If column 1, is “Y”, enter in column 3 a “G” if the consolidated group consists exclusively of grandfathered providers or an “N” if comprised exclusively of non-grandfathered providers**

Line 14--**Report the clinic/center name and CCN number filing the consolidated cost report, and subscript line 14 to report each RHC filing consolidated under the CCN reported on line 14.**

- CMS CR13667 dated 10-10-24 giving instruction to TEFRA hospitals (Cancer & Children’s) regarding CAR T-cell Therapy and handling cost exceeding the target rate.
- CMS added a new D-1 line 55.03 to identify the interim payments received (and not E-3 Pt I line 17).

Worksheet D-1, Part II

[page 40-574]

TARGET AMOUNT AND LIMIT COMPUTATION		
54	Program discharges	54
55	Target amount per discharge	55
55.01	Permanent adjustment amount per discharge	55.01
55.02	Adjustment amount per discharge (contractor use only)	55.02
55.03	CAR T-cell amount paid as an interim payment	55.03
<hr/>		
56	Target amount ((line 54 x sum of lines 55, 55.01, and 55.02) plus line 55.03)	56

4025.2. Part II - Hospital and Subproviders Only

[page 40-149]

Line 55.03--Enter the CAR T-cell amount paid to your facility that agrees with the interim payments made in advance of making a request for an adjustment to your TEFRA ceiling.

Line 56--Multiply the number of discharges on line 54 by the sum of the amounts on lines 55, 55.01, and 55.02; *plus line 55.03*, to determine the rate of increase ceiling.

- **Form CMS-2552-10 Transmittal #23 also added Level I edit 10541A. Previously, this had been a Level II edit.**
- **“Worksheet A-8-2, column 1, may only contain Worksheet A line numbers 4 through 41; line 43; lines 50 through 78; line 90 through 99; line 102; lines 105 through 111; and line 115; and subscripts of each as allowed.”**

Navigation: »No topics above this level«

4018 WORKSHEET A-8-2 - PROVIDER-BASED PHYSICIAN ADJUSTMENTS



Where several physicians work in the same department, see [CMS Pub. 15-1, chapter 21 §2182.6C](#) for a discussion of applying the RCE limit in the aggregate for the department versus on an individual basis to each of the physicians in the department.

NOTE: The RCEs are not applied to Medicare nonreimbursable or Medicare non-certified areas of the hospital and the adjustments generated from this worksheet for physician compensation are limited to the cost centers on Worksheet A, lines 4 through 41, 43, 50 through 78, 90 through 99, 102, 105 through 111, and 115, and subscripts as allowed.

- **Sections 126, 127, 131 of the CAA 2021**
 - Section 126 of the CAA, 2021, makes available an additional 1,000 Graduate Medical Education (GME) full-time equivalent (FTE) resident cap slots, phased in at a rate of no more than 200 slots per year, beginning in fiscal year 2023.
 - Section 127 made several changes affecting urban and rural hospitals that train residents in Rural Training Programs, formerly known as Rural Training Tracks.
 - Section 131 of the CAA created new opportunities for some teaching hospitals with disadvantageous PRAs and/or FTE caps to potentially get the opportunity to reset some numbers (during the time frame of December 27, 2020 to December 26, 2025).

- **Sequestration Changes**
- **Modifications**
 - §3709 of the Coronavirus Aid, Relief, and Economic Security (CARES) Act,
 - §102 of the CAA 2021, §1 of Public Law 117-7,
 - §2 of the Protecting Medicare and American Farmers from Sequester Cuts Act of 2021 (PAMA)
 - Sequestration computed
 - Prior to 5/1/2020 - 2%
 - 5/1/2020 – 3/31/2022 - 0%
 - 4/1/2022 – 6/30/2022 - 1%
 - On or after 7/1/2022 – 2%

Transmittals

- [2552-10 Transmittals](#)
- [2540-10 Transmittals](#)
- [1728-20 Transmittals](#)
- [1728-94 Transmittals](#)
- [2088-17 Transmittals](#)
- [2088-92 Transmittals](#)
- [222-17 Transmittals](#)
- [222-92 Transmittals](#)
- [224-14 Transmittals](#)
- [265-11 Transmittals](#)
- [1984-14 Transmittals](#)
- [216-94 Transmittals](#)
- [287-22 Transmittals](#)

2552-10 Hospital Transmittals

All Transmittal Information for the 2552-10

- [2552-10 T-23 HFS MCRIF32 Approval Letter](#)
- [2552-10 T-23 from CMS Website](#)

Hospital Transmittal 23

CMS issued Transmittal 23 to the 2552-10 on December 20th, 2024. Transmittal 23 has been issued with an effective date of Cost Reporting Periods Beginning on or After October 1, 2024, and implements changes including:

- Adding OMB # 0938-1473, for the Supplemental to Form CMS-2552- 10 to the Table of Contents for the Worksheet E-90 - Payment Adjustment for Domestic NIOSH-Approved Surgical N95 Respirators.
- Worksheet S-2, Part I, was modified as follows:
 - Revised the line 22.03 instructions to include geographic redesignation from urban to rural under the OMB standards for delineating statistical areas adopted by CMS.
 - Revised the line 39 instructions to extend the effective date of the temporary change in the low-volume adjustment as provided in 42 CFR 412.101.
 - Designated completion of column 8 on Exhibit 3A, Listing of Medicaid Eligible Days for a DSH Eligible Hospital, as optional.
- Worksheet S-2, Part II was modified to include revised instructions for reporting the “paid-through” dates of the PS&R used to prepare the cost report to include the “Paid Claims Verified Current As Of” date or the “Paid Dates” from the PS&R used. And to add lines 15.01 and 15.02 to report home office physician Part A administrative salaries and contract amounts and sunset line 15.
- Worksheet S-8 was revised to Clarify the instructions for reporting consolidated RHC groupings.

Transmittals

- [2552-10 Transmittals](#)
- [2540-10 Transmittals](#)
- [1728-20 Transmittals](#)
- [1728-94 Transmittals](#)
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- [222-92 Transmittals](#)
- [224-14 Transmittals](#)
- [265-11 Transmittals](#)
- [1984-14 Transmittals](#)
- [216-94 Transmittals](#)
- [287-22 Transmittals](#)

- Worksheet S-8 was revised to clarify the instructions for reporting consolidated RHC groupings.

Worksheet D-1, Part II, was revised to add line 55.03 to report the CAR T-cell amount paid for calculating the TEFRA target rate of increase ceiling.

- Worksheet E, Part A, added line 8.28 to report the awarded FTE cap slots from section 4122 of the CAA 2023, effective beginning July 1, 2026. In addition, revised the line 35.02 instructions to clarify reporting the hospital uncompensated care payment (UCP) and revised the line 45 instructions to update the CY 2025 ESRD PPS base rate. In addition, updated the effective dates of the Medicare Dependent Hospital (MDH) program and the low-volume payment adjustment.

Revised Worksheet E-4 to add line 4.28 to report the awarded FTE cap slots from section 4122 of the CAA 2023, effective beginning July 1, 2026 and updated the instructions for line 29.01 to include the CY 2023 percent reduction to MA DGME.

- Worksheets I-2, I-3, I-4 were modified to report AKI services.
- Worksheet M-3 instructions were revised for line 21.55 for cost reporting periods ending on or after January 1, 2024, to report program IOP visits in column 1, and to calculate the total program IOP services cost for column 2 and revised the instructions for line 21.60 to include reporting deductible amounts for IOP services.

The T-23 changes were approved by CMS on January 14, 2025, and HFS will update the Hospital 2552-10 system the week of January 13, 2025.

Hospital Transmittal 22

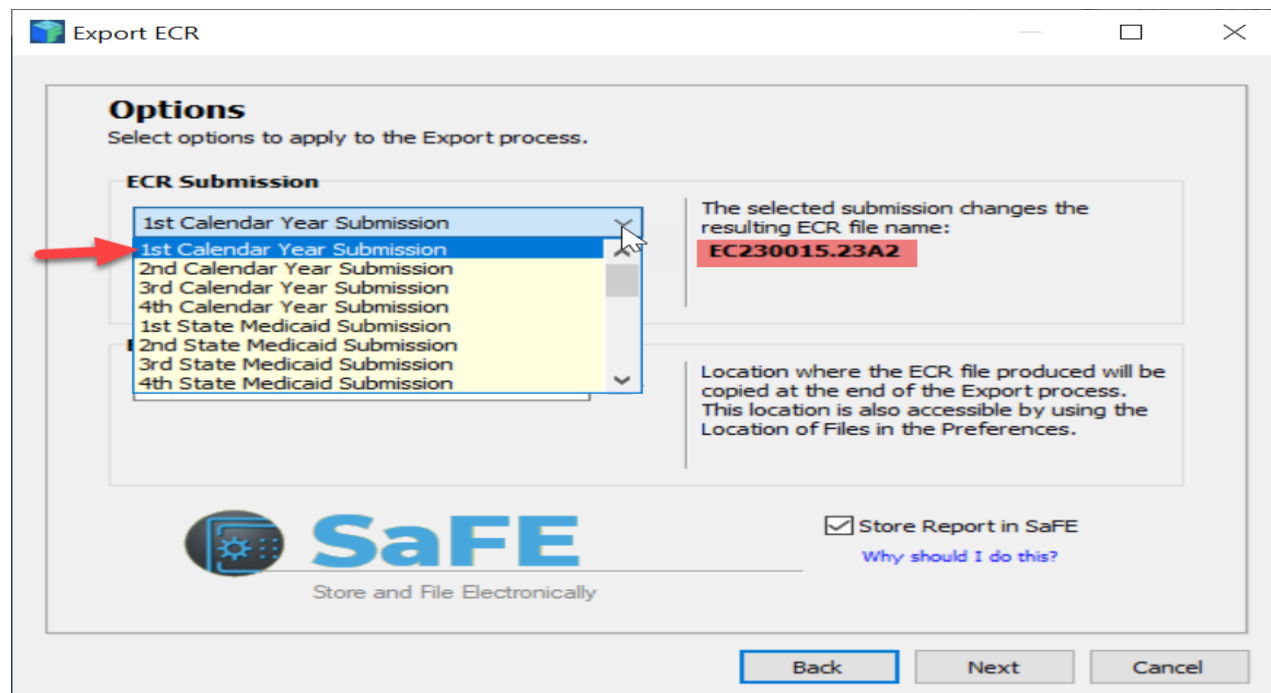
- **Amended Cost Report Clarification**

- With the S-10 amended cost reports, we noticed many users were incorrectly identifying the EC file when it is an amended cost report. When you amend a cost report, you open W/S S and select the S Part I tab and then on line 5 you change the mcr code to 5-Amended and change line 3 to 1 for 1st amended.

	A	B	C	D	E	F	G	H	I	
1	HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY					Provider CCN:	23-0015	Period		
2								From:	01/01/2023	
3								To:	12/31/2023	
4										
5								1.00	2.00	
6	PROVIDERS ONLY									
7	1.00	Electronically prepared cost report.							X	
8	2.00	Manually prepared cost report.								
9	3.00	If this is an amended report, enter the number of times the provider resubmitted this cost report.								1
10	4.00	Medicare Utilization. Enter "F" for full or "L" for low, or "N" for no.							F	
11	CONTRACTORS ONLY									
12	5.00	Cost Report Status							5 - Amended	
13	6.00	Date Received:								

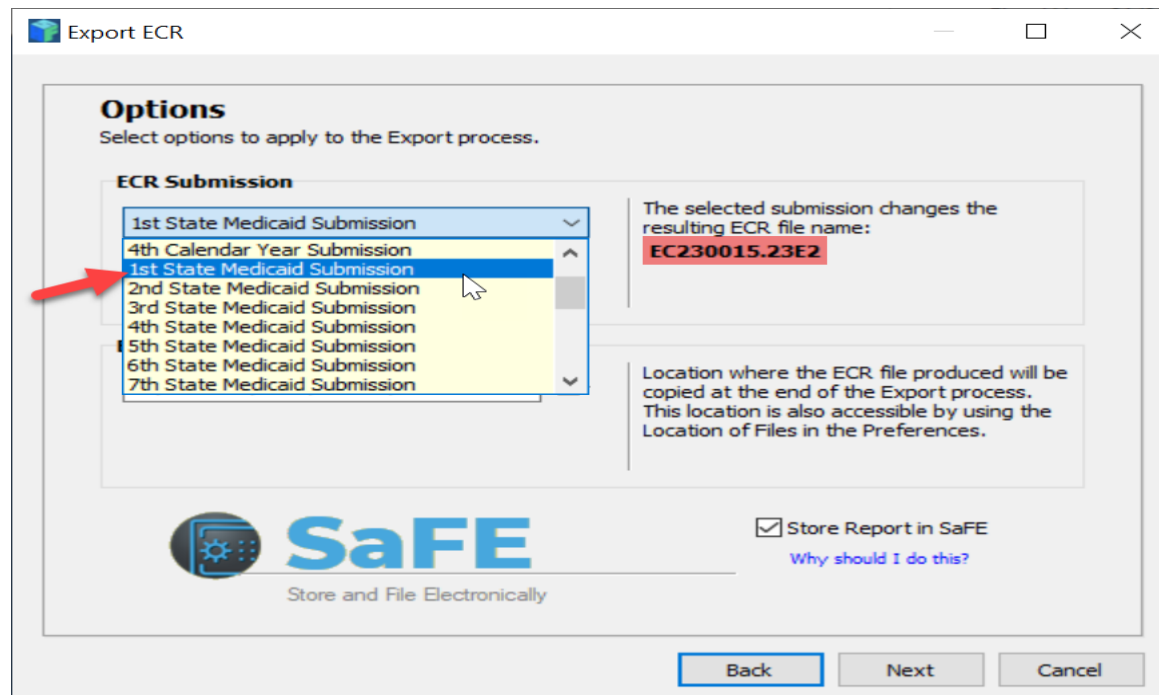
- **Amended Cost Report Clarification**

- Then when you do an ECR Export, you keep the EC Option submission still as 1st, only change this if you have 2 cost reports in the same calendar year (like a 6-30 and 12-31 due to CHOW). The EC file extension changes, like below to a 23A2.



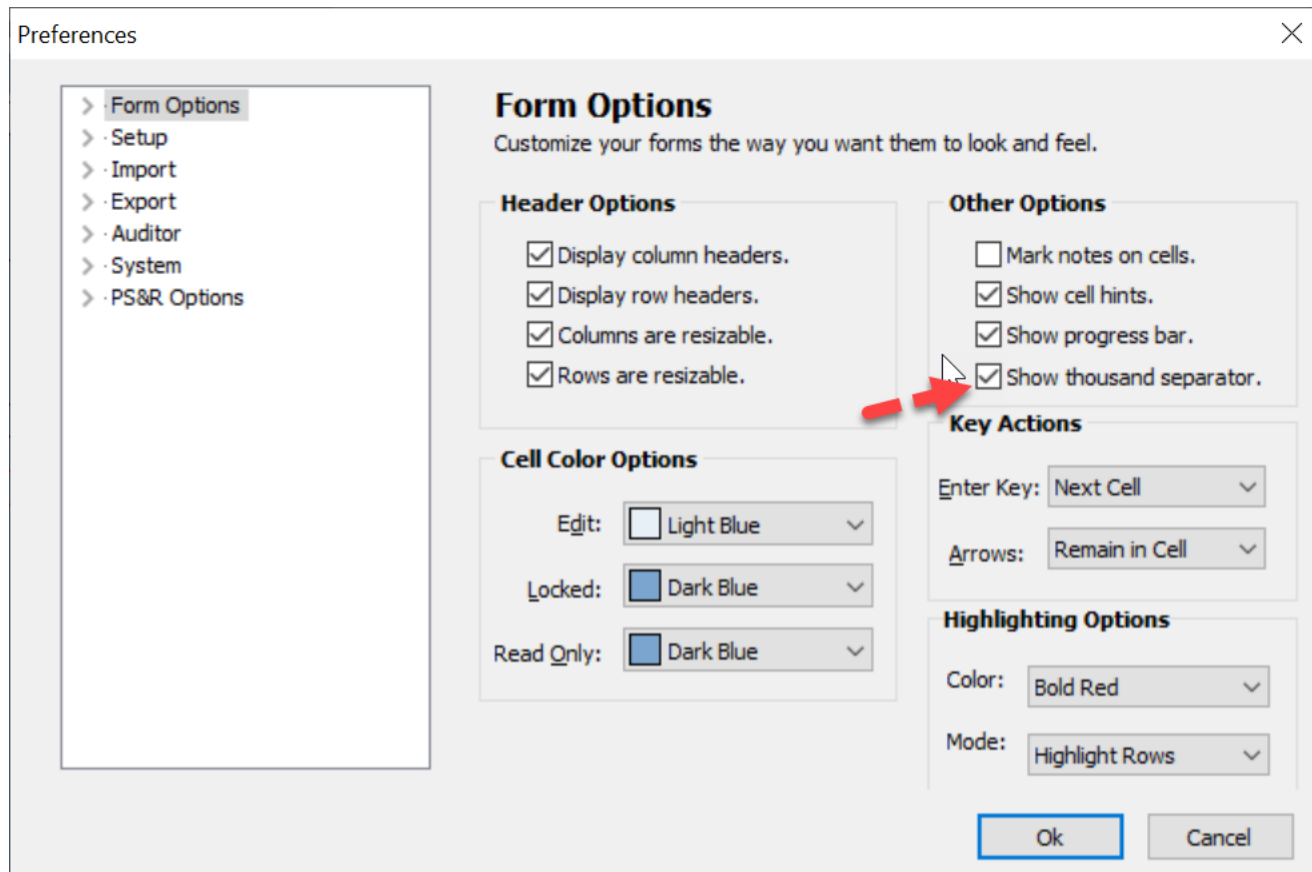
- **Amended Cost Report Clarification**

- As you can see on the prior slide, we made a change to identify State Medicaid Submissions that users may want to use, in this case it is still an Amended cost report so the 1st XIX is 23E2, 2nd would be 23F2 & we allow for 22nd XIX submission being 23Z2.



- The 287-22 Home Office Cost Statement is for Fiscal Years beginning on or after 10-1-2022.
- The 287-22 has introduced EC specifications so there is now an ECR export and electronic signature like the other cost report forms.

- One preference we have for Home Office which is beneficial due to large dollar amounts, show commas. Go to Options | Preferences.



- CMS clarified in T3 (and includes a level I edit) that only the main provider number is to be populated on Schedule S-2 Part I. You cannot include any subunits (like Psych, RHC, FQs, etc.).

Navigation: [HFS28722](#) > [4801. S SERIES](#) > [4801.30 SCHEDULE S-2 - LISTING OF COMPONENTS](#) >

4801.31 Part I - Healthcare Provider Components



Enter the information for each healthcare provider component in the HO/CO. For a Medicare-certified healthcare complex, report information for only the primary CCN.

- Schedule A-7 must be completed unless you do not have capital cost on Schedule A, line 3, column 5. CMS has a level I edit requiring this Schedule.
- Schedule A-7, Part II is not like the 2552-10 where the amounts for Other Capital works like an A-6 reclassification. With the 287-22, you are to do reclassification of Other Capital Related cost shown on Schedule A, lines 4-6 unless you allocate the cost via Direct – Schedule B.

- CMS expects the Other Capital Related cost shown on Schedule A, lines 4-6 to be allocated based on Gross Assets shown on A-7 Part II column 4.

× A-7, Parts I & II - ANALYSIS OF CAPITAL COST CENTERS

A-7, Part I A-7, Part II

	A	B	C	D	E	F	G	H	I
1	ANALYSIS OF CAPITAL COST CENTERS								
2									
3									
4	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL RELATED CO				
5			GROSS ASSETS	CAPITALIZED LEASES	GROSS ASSETS FOR RATIO	RATIO	INSURANCE PREMIUMS- OTHER CRC	TAXES & LICENSES- OTHER CRC	ALL OTHER CAPITAL REL COSTS
6			1.00	2.00	3.00	4.00	5.00	6.00	7.00
7	PART II - RECONCILIATION OF CAPITAL								
8	1.00	CRC-B&F	12,986,850	1,747,700	11,239,150	0.669552	128,939	43,365	15,935
9	2.00	CRC-ME	5,546,930	0	5,546,930	0.330448	63,636	21,402	7,865
10	3.00	Total	18,533,780	1,747,700	16,786,080	1.000000	192,575	64,767	23,800

J	K	L	M	N	O	P	Q	R
			HOME OFFICE NUMBER:	11-0981	Period			
					From:	10/01/2022	Schedule A-7, Part II	
					To:	09/30/2023		
SUMMARY OF CAPITAL								
LOCATION TOTAL	DEPRECIATION	LEASE	INTEREST	INSURANCE PREMIUMNS- OTHER CRC	TAXES & LICENSES- OTHER CRC	ALL OTHER CAPITAL REL COSTS	TOTAL	
8.00	9.00	10.00	11.00	12.00	13.00	14.00	15.00	
188,239	535,468	45,092	0	128,939	3,365	15,935	728,799	1.00
92,903	27,340	0	28,000	48,636	21,402	7,865	133,243	2.00
281,142	562,808	45,092	28,000	177,575	24,767	23,800	862,042	3.00

Purpose	287-22	287-05
Schedule S Series – Statistics/General		
- Schedule S, Part I	Cost Statement Status	N/A
- Schedule S, Part II	Certification	Schedule A, Part II
- Schedule S-1, Part I	Home Office Data	Schedule A, Part I
- Schedule S-1, Part II	Key Officer Data	Schedule A, Part I
- Schedule S-2, Part I	Healthcare Provider Components	Schedule A, Part III
- Schedule S-2, Part II	Non-Healthcare Provider Components	Schedule A, Part IV
- Schedule S-2, Part III	Region/Division Components	Schedule A, Part V

Purpose	287-22	287-05
Schedule A Series – Trial Balance of Expenses		
- Schedule A	Reclassification and Adjustments of Trial Balance of Expenses	Schedule B
- Schedule A-6	Reclassification of Expenses	Schedule B-1
- Schedule A-7	Analysis of Capital Cost Centers	Schedule B-2
- Schedule A-8	Adjustments to Expenses	Schedule C
- Schedule A-8-1	Costs of Services From Related Organizations	Schedule C

Purpose- 287-22		287-05
Schedule B – Direct Allocation of Capital Related Costs		Schedule D
- Part I	Healthcare Provider Components	
- Part II	Non-Healthcare Provider Components	
- Part III	Region/Division Components	

Purpose- 287-22		287-05
Schedule B-1 – Direct Allocation of Non-Capital Related Costs		Schedule E
- Part I	Healthcare Provider Components	
- Part II	Non-Healthcare Provider Components	
- Part III	Region/Division Components	

Purpose- 287-22		287-05
Schedule C – Functional Allocation of Capital Related Costs		Schedule F, Part I
- Part I	Healthcare Provider Components	
- Part II	Non-Healthcare Provider Components	
- Part III	Region/Division Components	

Purpose- 287-22		287-05
Schedule C-1 – Functional Allocation of Capital Related Costs - Statistics		
- Part I	Healthcare Provider Components	
- Part II	Non-Healthcare Provider Components	
- Part III	Region/Division Components	

Purpose- 287-22		287-05
Schedule D – Functional Allocation of Non-Capital Related Costs		Schedule F-1
- Part I	Healthcare Provider Components	
- Part II	Non-Healthcare Provider Components	
- Part III	Region/Division Components	

Purpose- 287-22		287-05
Schedule D-1 – Functional Allocation of Non-Capital Related Costs – Statistics		
- Part I	Healthcare Provider Components	
- Part II	Non-Healthcare Provider Components	
- Part III	Region/Division Components	

Purpose- 287-22		287-05
Schedule E –Allocation of Pooled Costs for Double Allocation Method (Stats and allocation)		Schedule G, Part I
Schedule E-1 –Allocation of Pooled Costs to Components (Stats and allocation)		Schedule G. Part II
- Part I	Healthcare Provider Components	
- Part II	Non-Healthcare Provider Components	
- Part III	Region/Division Components	44

Home Office Cost Statement 287-22 Transmittal 1/2

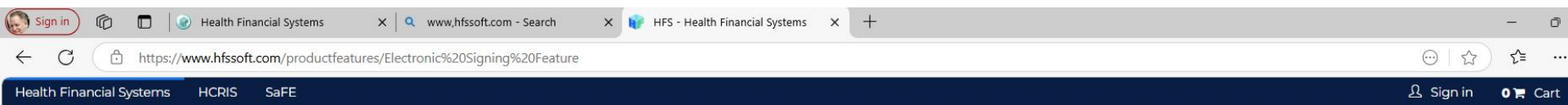
Purpose- 287-22		287-05
Schedule F Series – Summary of Cost Allocations		NA / Schedule H
Schedule F – Summary of Capital Costs		
Schedule F-1 – Summary of Non-Capital Costs		
Schedule F-2 – Summary of Interest Income		
All - Part I	Healthcare Provider Components	
All - Part II	Non-Healthcare Provider Components	
All - Part III	Region/Division Components	45

Purpose- 287-22		287-05
Schedule G – Balance Sheet		Schedule I
Schedule G-1 – Statement of Revenues and Expenses		Schedule J

Flow of Costs	287-22
Schedule A	<ul style="list-style-type: none">- Summary of Direct Allocations in Column 6- Identify Functional Allocations by cost Center in Column 7- Remaining costs allocated "Pooled"

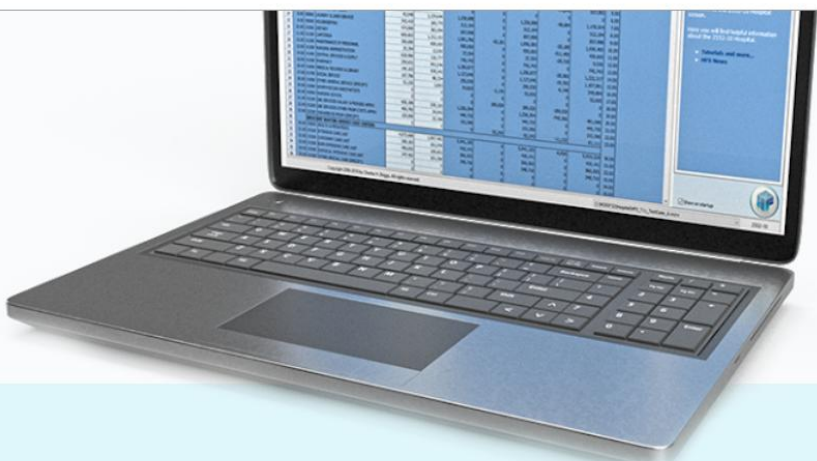
- **Electronic Signature Process begins at ECR export**
- **Three options**
 - “Wet” signature
 - Preparer completes electronic signature
 - Preparer forwards to Administrator/CFO (via email)

- <https://www.hfssoft.com/productfeatures/Electronic%20Signing%20Feature>



Export process.

HFS has incorporated the ability to electronically sign an MCR into the ECR Export process. As CMS updates the form sets and HFS is approved users will be offered this ability in their software. Users are given the option to sign the MCR themselves (if they meet the CMS criteria of CFO or Administrator) or they can give contact information for the signer and the HFS SaFE site will facilitate the signing.



Features


It's easy to use and documented for the preparer and signer at every step.

The HFS shows the complete CMS certification to the statement along with the ability to view the report and any other information the preparer adds to the 'signing package'.

If the signer is not an HFS user they are NOT required to register with our system.

- See How to Sign Electronically
- [Demo of preparation of submission for CFO signature](#)
- [Demo of CFO Signature](#)
- [Demo of Self Signature](#)

Mock-up with Upcoming Changes



Medicare Cost Report e-Filing System (MCR eF)

Home Accessibility User Manual Logout
 User ID: Sample User
 Wednesday, February 14, 2024

[Home](#)

[Bulk e-File](#)

Home

Filters

Quick Search

Fiscal Year End
 From To
mm/dd/yyyy

CR Status

FYE Not Elapsed (1)

Pending Receipt (1)

Processing (1)

Reopening/Appeal (0)

Complete (5)

Bulk e-Filing Issue(s)

Warning (0)

Error (0)

[Clear Filters](#)

Show entries
 [Export To Excel](#)
[Download PS&Rs \(3\)](#)

Provider #	Provider Name	FYE	PS&R Download	Cost Report Status	Action
12-3456	College Hospital	09/30/2024	(Not Yet Available in MCR eF)	FYE Not Elapsed	
12-3456	College Hospital	09/30/2023	↓ (02/12/2024)	Pending Receipt	E-File CR
12-3456	College Hospital	09/30/2022	↓ (01/30/2024)	Processing	E-File CR
12-3456	College Hospital	09/30/2021	↓ (11/17/2022)	Complete	
12-3456	College Hospital	09/30/2020	(Only Available in PS&R)	Complete	
12-3456	College Hospital	09/30/2019	(Only Available in PS&R)	Complete	
12-3456	College Hospital	09/30/2018	(Only Available in PS&R)	Complete	
12-3456	College Hospital	09/30/2017	(Only Available in PS&R)	Complete	

Showing 1 to 8 of 8 entries (filtered from 8 total entries)

[Previous](#) [Next](#)

[Load More](#)

Updated Individual e-Filing Process

CMS
Home Accessibility Help Logout
User ID: Sample
Monday, April 19, 2021

Home
Bulk e-File

[Back to Search Results](#)

e-File Cost Report Materials


[Printer Friendly Version](#)

* Indicates Required Field
+ Indicates a newly added or updated file

Provider [ⓘ]	11-1111 Test Provider	Fiscal Year End [ⓘ]	09/30/2019
Medicare Utilization [ⓘ]	Full <input type="text"/>	First Cost Report Submission [ⓘ]	Yes (No cost report submission has been previously recorded for this Provider and Fiscal Year End.)

Cost Report Materials [ⓘ]

Do not encrypt or password-protect uploaded files (including files within ZIP/archive files). This website is a secure portal for transmission of MCR materials (including PII/PHI).
Required Files: ECR, Print Image, Signed Certification Page



File Category [▲]	File
There are currently no files within the Cost Report Materials Table. To add one or multiple files, please click on the "Add File(s)" button above.	

* I acknowledge that this represents an official submission of my Medicare cost report to my servicing Medicare Administrative Contractor (MAC) and the Centers for Medicare and Medicaid Services (CMS), subject to all rules and regulations pertaining to Medicare cost report submissions (e.g. filing deadlines).

Note: Once "Submit" is clicked, this transaction cannot be stopped. Closing the browser window or navigating to another webpage will not cancel this e-filing.

[Back to Search Results](#)

Updated Individual e-Filing Process

[Back to Search Results](#)

e-File Cost Report Materials

[Printer Friendly Version](#)

* Indicates Required Field
+ Indicates a newly added or updated file

Provider

Medicare Utiliza

Cost Report M
Do **not** encry
Required File

Add

* I acknowle
for Medicare a

Choose File to Upload

Documents > PS&R-STAR > MCRRef Slots > Training > CR-Materials

Name	Date modified	Type	Size
A111111_2019-09-30.DBF	4/19/2021 7:19 PM	DBF File	1 KB
Additional CR Material.png	4/6/2020 10:46 PM	PNG File	15 KB
Crosswalk.doc	1/15/2020 11:57 AM	Microsoft Word 97 - 200...	627 KB
EC111111.19A1	4/18/2021 8:49 PM	19A1 File	68 KB
ExpenseRevenueGrp.doc	1/15/2020 11:57 AM	Microsoft Word 97 - 200...	627 KB
FinancialStatements.xlsx	9/23/2014 5:55 PM	Microsoft Excel Worksh...	84 KB
M111111_2019-09-30.DBF	4/18/2021 8:54 PM	DBF File	1 KB
PI111111.19A1.pdf	1/15/2020 11:57 AM	Microsoft Edge PDF Do...	627 KB
SIGPAGE111111.19A1.pdf	1/15/2020 11:57 AM	Microsoft Edge PDF Do...	627 KB
WorkingTrialBalance.xlsx	9/23/2014 5:55 PM	Microsoft Excel Worksh...	84 KB

File name: "A111111_2019-09-30.DBF" "Additional CR Material.png" "Crosswalk.doc" "EC111111.19A1" All Files (*.*)

Note: Once 'submit' is clicked, this transaction cannot be stopped. Closing the browser window or navigating to another webpage will not cancel this e-filing.

[Back to Search Results](#)

Updated Individual e-Filing Process

Provider 11-1111 Test Provider **Fiscal Year End** 09/30/2019
Medicare Utilization Full **First Cost Report Submission** Yes
 (No cost report submission has been previously recorded for this Provider and Fiscal Year End.)

Cost Report Materials
 Do **not** encrypt or password-protect uploaded files (including files within ZIP/archive files). This website is a secure portal for transmission of MCR materials (including PII/PHI).
 Required Files: [ECR](#), [Print Image](#), [Signed Certification Page](#)

File Category ▲	File	
Acceptability Documents		
ECR	EC111111.19A1 (67 KB)	<input type="button" value="Remove"/>
Print Image	PI111111.19A1.pdf (627 KB)	<input type="button" value="Remove"/>
IRIS	A111111_2019-09-30.DBF (1 KB)	<input type="button" value="Remove"/>
IRIS	M111111_2019-09-30.DBF (1 KB)	<input type="button" value="Remove"/>
Other Documents		
Other	Additional CR Material.png (15 KB)	<input type="button" value="Remove"/>
Other	Crosswalk.doc (627 KB)	<input type="button" value="Remove"/>
Other	ExpenseRevenueGrp.doc (627 KB)	<input type="button" value="Remove"/>
Supporting Documents		
Adjustment to Expenses	alStatements.xlsx (83 KB)	<input type="button" value="Remove"/>
Bad Debt Collection Policy	se111111.19A1.pdf (627 KB)	<input type="button" value="Remove"/>
Bed Available	gTrialBalance.xlsx (83 KB)	<input type="button" value="Remove"/>
CAH - ER Availability		
CHOW Documentation		
<input checked="" type="checkbox"/> Expense/Revenue Groupings		
Financial Assistance Policy		
Financial Statements or Justification		
Home Office Cost Statement		

* I am a Medicare cost report to my servicing Medicare Administrative Contractor (MAC) and the regulations pertaining to Medicare cost report submissions (e.g. filing deadlines).

Note: Once 'Submit' is clicked, this transaction cannot be stopped. Closing the browser window or navigating to another webpage will not cancel this e-filing.

[Back to Search Results](#)



Part A cost report audit

21st Century Cures Act Mid-Build Audits

Electronic Cost Report Exhibit Templates

Medicare Cost Report Electronic Filing (MCReF)

Health Information Technology for Economic and Clinical Health (HITECH) Audits

Provider Statistical & Reimbursement Report (PS&R)

End-Stage Renal Disease (ESRD) Special Audits

Intern and Resident Information System (IRIS)

Electronic Cost Report Exhibit Templates

In support of efforts to streamline the Medicare Cost Report (MCR) process for participating providers, CMS is supplying optional electronic versions for key MCR exhibits. Utilizing these optional electronic versions will aid MACs in reviewing supporting data from providers, and reduce the need for rejections, amendments, and follow-up communication about MCR submissions. When used in combination with the [Medicare Cost Report e-Filing system \(MCReF\)](#), providers will also receive additional pre-emptive feedback about potential issues with the information in their exhibits.

The MCR instructions include the definitions of and requirements for exhibits supporting various reimbursements being claimed in the cost report. These exhibit instructions include a visual layout of the requested information, as well as definitions of the expected fields and rules that the recorded information is required to follow.

In support of these exhibits, CMS provides optional electronic specifications for creating digital versions of the exhibits that enable enhanced troubleshooting and accelerated cost report processing if filing through MCReF. These specifications contain file naming conventions that will enable MCReF to automatically identify what kind of file is being submitted, as well structure and label information to construct a spreadsheet file (.xlsx or xlsx format) that fulfills all of the requirements of the exhibits in the MCR instructions.

By submitting files in accordance with the specifications, MCReF is able to check the files for adherence to the cost reporting instructions and give providers feedback about potential problems with their documentation. The utilization of this standardized electronic format also enables accelerated cost report acceptance and tentative settlement.

Each specification includes an identifier to be placed at the top of each tab, the necessary field labels for conforming to the exhibit, and the specific spreadsheet locations to place those labels and corresponding data. For each field, the specifications also include whether that field is required to be populated on each row, what type of information to enter (date, number, etc.), and any other rules the recorded information must follow.

In addition to these optional electronic specifications, CMS has created pre-made templates that are arranged according to the specifications. These are blank spreadsheets with all of the appropriate worksheet identifiers and all of the field labels in the specified locations, ready for data entry.

Medicare Bad Debt Listing

The Medicare Bad Debt Listing specification has three variations, depending on the MCR version the listing is being submitted with.

- A general specification shared across the following MCR versions and exhibits
 - 222-17 – Exhibit 1
 - 2088-17 – Exhibit 1
 - 224-14 – Exhibit 1
 - 265-11 – Exhibit 1
 - 2540-10 – Exhibit 1
- MCR Version 1728-20 – Specifying the layout for Exhibit 1
- MCR Version 2552-10 – Specifying the layout for Exhibit 2A

Medicaid Eligible Days

The Medicaid Eligible Days specification is designed to accommodate the completion of Exhibit 3A of the 2552-10 Medicare Cost Report.

Charity Care Charges

The Charity Care Charges specification is designed to accommodate the completion of Exhibit 3B of the 2552-10 Medicare Cost Report.

Total Bad Debt

The Total Bad Debt specification is designed to accommodate the completion of Exhibit 3C of the 2552-10 Medicare Cost Report.



Downloads

[RHC, CMHC, FQHC, ESRD, SNF Exhibit 1 Medicare Bad Debt Specification \(PDF\)](#)

[MedicareBD RHC, CMHC, FQHC, ESRD, SNF Exhibit 1 Template \(XLSX\)](#)

[1728-20 \(HHA\) Exhibit 1 Medicare Bad Debt Specification \(PDF\)](#)

[MedicareBD 1728-20 \(HHA\) Exhibit 1 Template \(XLSX\)](#)

[2552-10 \(Hospital\) Exhibit 2A Medicare Bad Debt Specification \(DOCX\)](#)

[MedicareBD 2552-10 \(Hospital\) Exhibit 2A Template \(XLSX\)](#)

[2552-10 \(Hospital\) Exhibit 3A Medicaid Eligible Days Specification \(DOCX\)](#)

- We have added a New Report Wizard with ability for you to pull in information from your PY report. The Template feature is still there but we have expanded this for the user, please look through this and we would love to have feedback on possible additional items.
- This is under File | New Report Wizard.

With SaFE, you will need to log in.

New Report Wizard

New Report Wizard - SaFE - Select Previous Report

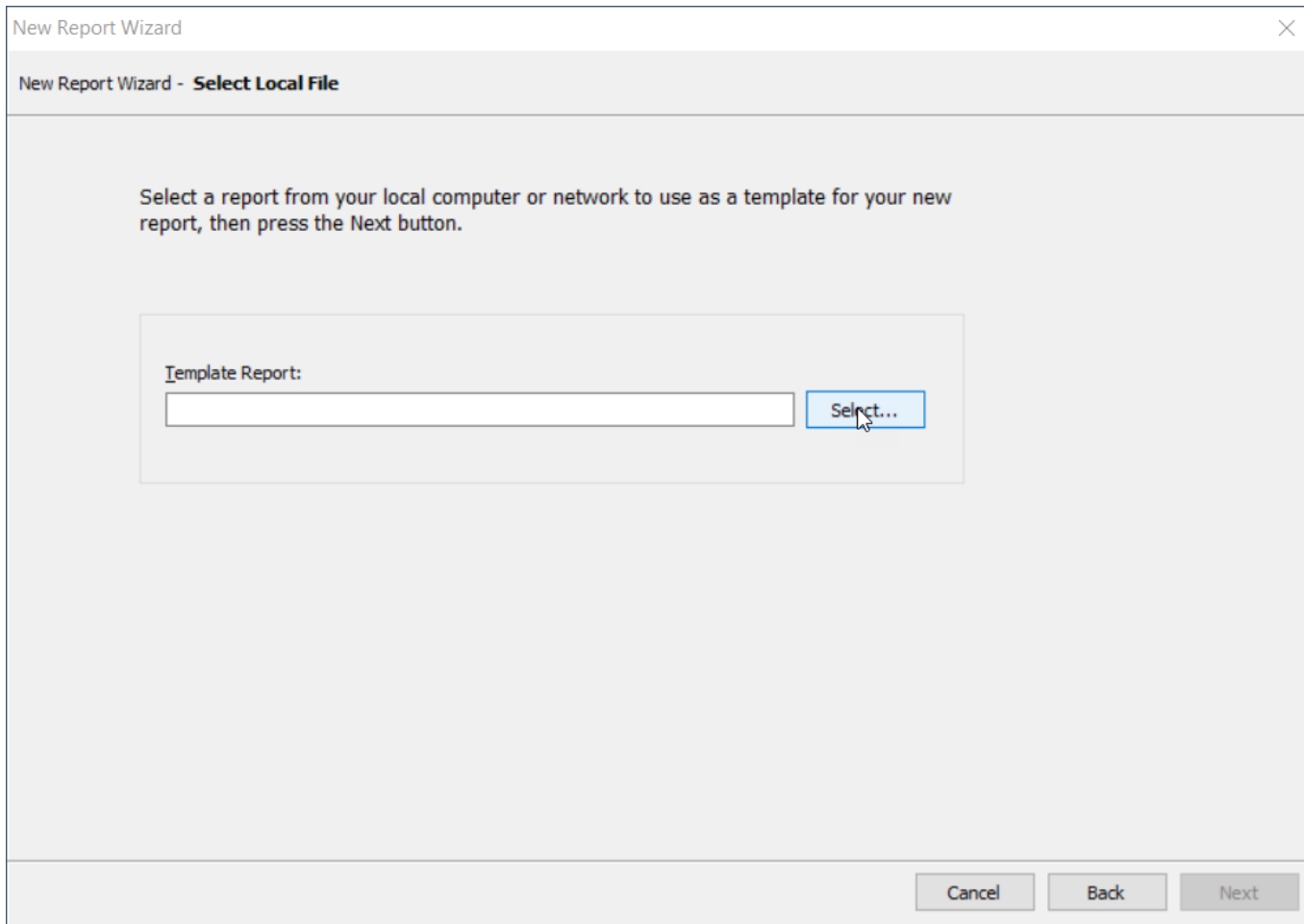
Company: Health Financial Systems Display reports stored

Users: Since: / /

Provider	FYB	FYE	Provider Name	Form	Date Stored
10-1311	10/01/2019	09/30/2020	MADISON MEMORIAL HOSPITAL	2552-10	3/22/2021 5:37:54 AM
10-0330	02/04/2020	09/30/2020	MEDICAL CENTER OF DELTONA	2552-10	3/31/2021 9:20:05 AM
10-0330	02/04/2020	09/30/2020	MEDICAL CENTER OF DELTONA	2552-10	3/31/2021 9:43:34 AM
10-0330	02/04/2020	09/30/2020	MEDICAL CENTER OF DELTONA	2552-10	3/31/2021 11:40:21 AM
55-2573	01/01/2019	12/31/2019	AZUSA DIALYSIS CENTER	265-11	4/13/2021 5:27:35 AM
26-0040	10/01/2019	09/30/2020	COXHEALTH	2552-10	4/13/2021 5:33:02 AM
32-7181	01/01/2020	12/31/2020	FRONTIER MEDICAL HOME CARE, I...	1728-20	4/13/2021 5:39:13 AM
55-2573	01/01/2019	12/31/2019	AZUSA DIALYSIS CENTER	265-11	4/13/2021 6:57:28 AM
26-7195	01/01/2020	12/31/2020	SAINT LUKE'S HOME CARE & HOSPICE	1728-20	6/18/2021 10:12:34 AM
19-3870	01/01/2020	12/31/2020	ST. JAMES PRIMARY CARE-GRAME...	222-17	7/1/2021 8:44:29 AM
19-3875	01/01/2020	12/31/2020	ST. JAMES PRIMARY CARE-LAPLACE	222-17	7/1/2021 8:47:01 AM
14-0065	01/01/2020	12/31/2020	ADVENTIST LAGRANGE MEMORIAL ...	2552-10	7/27/2021 10:30:48 AM
14-0065	01/01/2020	12/31/2020	ADVENTIST LAGRANGE MEMORIAL ...	2552-10	7/27/2021 11:01:02 AM
41-5042	01/01/2020	12/31/2020	WATERVIEW VILLA REHAB/HLTH CA...	2540-10	8/2/2021 11:29:59 AM
94-1045	01/01/2020	12/31/2020	NEIGHBORCARE HEALTH AT THE M...	224-14	8/4/2021 11:31:28 AM

10-1311: MADISON MEMORIAL HOSPITAL
10/01/2019 to 09/30/2020

If getting PY file from PC, you will see the following:



✕

New Report Wizard - Cost Report Options

What will be the fiscal year of your new report?

From: / / To: / /

Choose the previous report information you would like to use in the new report:

- Facility Information (most of S-2, including sub-facilities; Y/N answers; Home Office information; etc.)
- Cost Center Structure Reimbursement Questionnaire
 - Statistical Allocation Methodology Square Feet (and override) Statistics
- Hospital Statistical Data (number of beds)
- Reclassifications Structure (A-6; structure without amounts)
- Adjustments Structure (A-8; structure without amounts)
- Related Organization Interrelationships (A-8-1; structure without amounts)
- Fund Balance at end of prior report period (becomes beginning Fund Balance)
- Total allowable FTE count for the prior year (E, Part A, line 12 in prior report becomes E, Part A, line 13 in new report)
- Prior year resident to bed ratio (E, Part A, line 19 in prior report becomes E, Part A, line 20 in new report)
- SSI Percentage (E, Part A, line 30)
- Carryover of accumulated capital minimum payment level over capital payment
(L, Part III, line 14 in prior report becomes L, Part III, line 11 in new report.)

New Report Wizard ✕

New Report Wizard - **Cost Report Options**

Fiscal Year: 07/01/2021 to 06/30/2022

Choose previous report sub-facility statistical data you would like to retain in the new report:

Statistical Data

SNF (S-7, line 2 and CBSAs)

HHA (County and CBSAs)

Renal Dialysis (ESRD PPS and ESAs)

CMHC and Other Rehab (Hours in normal workweek)

RHC (facility information, hours of operation, etc.)

Choose previous report sub-facility statistics you would like to retain in the new report:

Statistics

HHA CMHC and Other Rehab

Hospice

If the previous report contains FQHC information, choose the information you would like to retain in the new report:

Retain FQHC and FQHC Participant identification information.

Note: The statistics options are only available if the Hospital Statistical Allocation Methodology option is also selected.

Cancel Back Next

New Report Wizard

New Report Wizard - **Location and Name of New Report**

The last thing we need to know is the location where you would like your new report created, and the name you would like to give that report.

In what folder should we create your new report?

What should we name your new report?

.mcrx

- CMS has moved to an xml file for submission of IRIS with the cost reports rather than the M & A dbf.
- The XML is required for FYB 10-1-2021 so we have it set up to only export with these FYBs.
- The reason for this change is to be able to compute the FTEs from the XML import and trace this to the cost report.

- CMS has added the following new fields to IRIS:
 - Non-IRPS Year One – Simultaneous Match
 - Non-IRPS Year One – Prelim. – Transitional
 - IRF % and IPF % - for time spent at subprovider
 - Non-Provider Site %
 - New Program – True or False
 - Displaced Resident – True or False
 - **New Program GME exclusions (NEW)**

- CMS' definitions of the new fields:

New Fields

Except for one field being removed (which is addressed in a subsequent section below), the new XML format will contain the same fields as the old DBF format plus the following new fields:

1. **Assignment IPF Percentage (Psych):** The percentage of the Intern/Resident(IR)'s rotational assignment time period the hospital provider is allowed to count in its total number of FTE residents for Psych in the 2552-10 Cost Report's Worksheet E-3 Part II.
2. **Assignment IRF Percentage (Rehab):** The percentage of the IR's rotational assignment time period the hospital provider is allowed to count in its total number of FTE residents for Rehab in the 2552-10 Cost Report's Worksheet E-3 Part III.
3. **Assignment Non-Provider Site Percentage:** The percentage of the IR's rotational assignment time that was spent in allowable non-provider site settings. See 2552-10 cost report worksheet S2 Lines 66 & 67.
4. **Assignment Displaced Resident (True/False):** Indicates whether the IR is an allowable displaced resident for which the hospital may receive a temporary cap adjustment. See 2552-10 worksheet E-4 line 16 (DGME) and worksheet E Part A line 17 (IME). Note that IRIS will track the raw number of displaced resident FTEs while what gets recorded in the cost report is an adjustment whose calculation, among other things, takes into account free cap slots. The displaced resident assignments recorded in IRIS do NOT directly sum to the displaced resident FTEs recorded in the cost report.

- **CMS' definitions of the new fields (continued):**

5. **Assignment New Program (True/False):** Indicates whether the resident is in the “initial years of a program that meets the exception to the rolling average rules” as per the cost report instructions. See 2552-10 worksheet E-4 Line 15 (DGME), worksheet E Part A Line 16 (IME), worksheet E-3 Part II Line 7 (Psych), and worksheet E-3 Part III Line 8 (Rehab).
6. **Resident Non-IRP Year One Residency:** For IRs that either participated in a preliminary/transitional year or a simultaneous match, this records the code for the residency type they were enrolled in during their first year as well as a ‘type’ value indicating whether it was a preliminary year or a simultaneous match.
7. **Creation Software Name:** Simple text field for recording the name of the software or vendor used to create the IRIS submission. This is meant to help CMS debug issues with specific files by identifying their source.

Removed Field

The XML format will not include an equivalent of the DBF master file Residency Years Completed (RESYEAR). This field was removed due to being redundant because the same value was already being tracked in a more granular and useful way at the assignment level (ARESYEAR in the assignment file).

- CMS' definitions of the new fields (continued) – the latest addition:

<p><u>New Program</u> <u>IME Exception</u></p>	<p>Assignment</p>	<p>imeException</p>	<p>For residents included in New Programs per the field above where the program is not eligible to be counted as a GME New Program, indicates which IME subcategory (IPPS, IPF, or IRF) the program is eligible to count as a New Program for. (Multiple values can be included.)</p> <p>This is generally for providers reclassifying from Urban to Rural or providers with new IPF or IRF teaching programs without a previously established cap.</p> <p>Possible values: "IPPS" "IPF" "IRF"</p>
--	-------------------	---------------------	---

- Cost Reporting periods beginning on or after 10-1-2021 requires IRIS files to be submitted in XML format rather than the M & A dbf files.
- Beginning with CR periods beginning on or after 10-1-2022, CMS requires the cost report to trace to the computed FTEs from the IRIS file uploaded into CMS' IRIS system.

- CMS did issue CR12724 which instructs the use of XML but also states the tracing to the cost report will be CR beg 10-1-22:

Number	Requirement	Responsibility				
		A/B MAC		D M E		
		A	B	H H H	M A C	
12724.1	The MACs shall ensure that the IRIS data for all accepted teaching providers' cost reports with fiscal year beginning on or after October 1, 2021 are filed using the XML IRIS format.	X				
12724.3	The MACs shall reject all cost reports with fiscal year beginning on or after October 1, 2022 that the total unweighted GME and IME FTEs reported on the IRIS do not match the total unweighted GME and IME FTEs reported on the cost report. Note: See attachment B for the Medicare cost report worksheets and line references for the total unweighted GME and IME FTEs.	X				
12724.3.1	The MACs shall allow a variance of two percent between the total GME and IME FTEs reported on IRIS and the as-filed cost reports before rejecting the cost reports.	X				

- Below is Attachment B and the fields to be compared at acceptance.

Attachment B

Total Unweighted GME FTEs– IPPS Teaching Providers

- Worksheet E-4 Line 6: Unweighted resident FTE count for allopathic and osteopathic programs for the current year.
- Worksheet E-4 Line 10.01, Column 2: Unweighted dental and podiatric resident FTE count for the current year.
- Worksheet E-4 Line 15.01 Columns 1 & 2: Unweighted adjustment for residents in initial years of new programs.
- Worksheet E-4 Line 16.01 Columns 1 & 2: Unweighted adjustment for residents displaced by program or hospital closure.

Total Unweighted IME FTEs

- Worksheet E Part A line 10: FTE count for allopathic and osteopathic programs in the current year from your records.
- Worksheet E Part A line 11: FTE count for residents in dental and podiatric programs.
- Worksheet E Part A line 16: Adjustment for residents in initial years of the program.
- Worksheet E Part A line 17: Adjustment for residents displaced by program or hospital closure.
- Worksheet E-3 Part II line 6 (Inpatient Psychiatry Facility): Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program".
- Worksheet E-3 Part II line 7 (Inpatient Psychiatry Facility): Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program".
- Worksheet E-3 Part III line 7 (Inpatient Rehabilitation Facility): Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program".
- Worksheet E-3 Part III line 8 (Inpatient Rehabilitation Facility): Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program".

- CMS has their own IRIS system included in STAR that MACs load all IRIS data into it.
- This will enable the IRIS database to accumulate historical info for each resident to determine the initial residency and number of years the residents have completed.
- The other major issue is running overlaps; therefore, **it is vital to have discussions between the hospitals if residents rotate to other hospitals.**

- CMS has updated the IRIS website with the XML information; the residency code table is now published but edits are missing which we asked for.

<https://www.cms.gov/medicare/audits-compliance/part-a-cost-report/intern-and-resident-information-system-iris>



Downloads

[IRIS XML General Instructions \(PDF\)](#)

[IRIS XML FTE Calculations \(PDF\)](#)

[IRIS XML Format and Duplicate Interns and Residents FTEs Review \(Presentation\) \(PDF\)](#)

[IRIS XSD \(ZIP\)](#)

[IRIS Residency Types Reference Table 04-2024 \(PDF\)](#)

[IRIS Medical School Codes List 04-2024 \(PDF\)](#)

- In the HFS IRIS, you can see the Residency Code table in the Data Management tab and can select the headers to sort codes:

Home Data Management Interns Reports Help

Import/Export Data

- Import IRIS Data
- Export CMS IRIS Data
- Export Special Export
- Import OIG
- Change Database

View Data

- Error Codes
- Providers
- Residency Code**
- School Code
- Track Changes
- Event Log

Delete Data

- Deleted Assignments
- Delete Providers

Residency Codes

Print

Residency Code	Primary Description	Secondary Description	ResYearLimit	GeriFellow	PrimaryC
1050	ALLERGY & IMMUNOLOGY	GENERAL	5	<input type="checkbox"/>	<input type="checkbox"/>
1051	ALLERGY & IMMUNOLOGY	DIAGNOSTIC LABORATORY IMMUNOLOGY	5	<input type="checkbox"/>	<input type="checkbox"/>
1052	ALLERGY & IMMUNOLOGY	CLINICAL IMMUNOLOGY	5	<input type="checkbox"/>	<input type="checkbox"/>
1100	ANESTHESIOLOGY	GENERAL	4	<input type="checkbox"/>	<input type="checkbox"/>
1101	ANESTHESIOLOGY	CRITICAL CARE MEDICINE	5	<input type="checkbox"/>	<input type="checkbox"/>
1102	ANESTHESIOLOGY	PAIN MEDICINE	5	<input type="checkbox"/>	<input type="checkbox"/>
1103	ANESTHESIOLOGY	PEDIATRIC ANESTHESIOLOGY	5	<input type="checkbox"/>	<input type="checkbox"/>
1104	ANESTHESIOLOGY	ADULT CARDIOTHORACIC ANESTHESIOLOGY	5	<input type="checkbox"/>	<input type="checkbox"/>
1105	ANESTHESIOLOGY	OBSTETRIC ANESTHESIOLOGY	5	<input type="checkbox"/>	<input type="checkbox"/>
1106	ANESTHESIOLOGY	HOSPICE & PALLIATIVE MEDICINE	5	<input type="checkbox"/>	<input type="checkbox"/>
1107	ANESTHESIOLOGY	SLEEP MEDICINE	5	<input type="checkbox"/>	<input type="checkbox"/>
1108	ANESTHESIOLOGY	CLINICAL INFORMATICS	6	<input type="checkbox"/>	<input type="checkbox"/>
1109	ANESTHESIOLOGY	ADDICTION MEDICINE	5	<input type="checkbox"/>	<input type="checkbox"/>
1150	COLON AND RECTAL SURGERY	GENERAL	6	<input type="checkbox"/>	<input type="checkbox"/>
1200	DERMATOLOGY	GENERAL	4	<input type="checkbox"/>	<input type="checkbox"/>
1201	DERMATOLOGY	DERMATOPATHOLOGY	5	<input type="checkbox"/>	<input type="checkbox"/>
1202	DERMATOLOGY	CLINICAL & LAB'Y DERM'L IMMUNOLOGY	4	<input type="checkbox"/>	<input type="checkbox"/>
1203	DERMATOLOGY	DERMATOLOGICAL MICROGRAPHIC SURGERY	5	<input type="checkbox"/>	<input type="checkbox"/>
1204	DERMATOLOGY	PROCEDURAL DERMATOLOGY	5	<input type="checkbox"/>	<input type="checkbox"/>
1250	EMERGENCY MEDICINE	GENERAL (SEE NOTE 4 IN HELP SCREEN)	3	<input type="checkbox"/>	<input type="checkbox"/>
1251	EMERGENCY MEDICINE	PEDIATRIC EMERGENCY MEDICINE	5	<input type="checkbox"/>	<input type="checkbox"/>
1252	EMERGENCY MEDICINE	EMERGENCY MEDICAL SERVICES	4	<input type="checkbox"/>	<input type="checkbox"/>
1253	EMERGENCY MEDICINE	SPORTS MEDICINE	4	<input type="checkbox"/>	<input type="checkbox"/>
1254	EMERGENCY MEDICINE	MEDICAL TOXICOLOGY	5	<input type="checkbox"/>	<input type="checkbox"/>

- You can print to csv or can also change the column width and header sort which is helpful:

Residency Codes

Residency Code	Primary Description	Sec	Re	GeriFellow	Prima	Prev	Dental	Podiatry	OBC	SimultaneousMatch	InvalidIRP
1100	ANESTHESIOLOGY	GEN	4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
1200	DERMATOLOGY	GEN	4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1250	EMERGENCY MEDICI	GEN	3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1300	EMERGENCY MEDICI	GEN	3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1325	EMERGENCY MEDICI	GEN	3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1326	Emergency Medicine	GEN	6	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1350	FAMILY MEDICINE	GEN	3	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1400	INTERNAL MEDICINE	GEN	3	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1450	INTERNAL MEDICINE	GEN	4	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1455	INTERNAL MED. & D.	GEN	4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- You want to be aware of 2 specific columns – the InvalidIRP and SimultaneousMatch columns.
- CMS requires the master record to contain what residency code the resident was in for their 1st year of residency. This establishes the years allowed prior to GME weighting. If the box InvalidIRP is checked off, this means the resident did not start in this program in year 1 so it should not be identified in the Master.

Health Financial Systems

SSN: XXXXX3542 | Last Name: DOE | First Name: JOHN | M.I.: | FMG Cert Date: | FMG Cert ID: | Med Grad Date: 5/1/2020 | Last Updated: | CHGME ID: |

Medical School and Location: 00511 | Stanford University School of Medicine | Stanford | CA

Intern Primary Residency Information: 1662 | NEUROLOGY | Active: | Category: | Yrs Limit: 5

Secondary Residency/Potential Simultaneous Match: | | | 0

Prov#	Adj	Asgn Begin	Asgn End	Yr Comp	Res	Residency Description	Wgt	Time % #	GME % #	IME % #	UW GME #	IRF% #	IPF% #	NonProv% #	NewProg D				
111111		1/1/2022	6/30/2022	0	1662	Neurology HOSPITAL	1	100	0.4959	100	0.4959	100	0.4959	0	0	0	0	0	<input checked="" type="checkbox"/>
111111		7/1/2022	12/31/2022	0	1662	Neurology HOSPITAL	1	100	0.5041	100	0.5041	100	0.5041	0	0	0	0	0	<input checked="" type="checkbox"/>

Buttons: Provider Summary, Add Assignment Records

- The SimultaneousMatch code identifies there is a possibility the resident identified to go into this program in year 2 and if this is the case, CMS now wants the year one code to be identified. The example below is 3650 General Surgery.

A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U
SSN	FNAME	MNAME	LNAME	EMPLOYEF	RESTYPCODE	nonIRPyr1SimCode	nonIRPyr1preTran	MEDSCHO	MSGRADD/	FORCERT	PROVNUN	FYBEGIN	FYEND	TIMEPERC	IMEPERC	GMEPERC	ASGNBEGI	ASGNENDDAT	ARESYEAR	ARESTYPE
U3334	SIMULT		SURGERY	HOSPITAL	1100	3650		401	6/10/2021		111111	1/1/2022	12/31/2022	100	100	100	1/1/2022	6/30/2022	0	3650
U3334	SIMULT		SURGERY	HOSPITAL	1100	3650		401	6/10/2021		111111	1/1/2022	12/31/2022	100	100	100	7/1/2022	12/31/2022	0	1100






- CMS has identified a table of possible year 1 Broad-Based programs allowed when simultaneous match, the edit kicking out by CMS' IRIS is shown below.

Errors/Informational Messages Detail						
<u>Category</u>	<u>Severity</u>	<u>Resident</u>	<u>SSN</u>	<u>Assignment Start</u>	<u>Assignment End</u>	<u>Additional Info</u>
Year One Residency Code Was Not Valid For Broad Based Initial Training	Error	NIMER, RYAN LYNN	XXXXXX2246			A Simultaneous Match was recorded, but the resident's claimed Year One Residency Code (3650 - GENERAL SURGERY - GENERAL) is not valid for Broad Based Initial Training. Residency Type Code (1406) is different than the previous Assignment's



- CMS stated this was a fatal edit but have reduced it to a warning. We have the table in the new v6.40.0.0.

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Import/Export Data

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-  Export CMS IRIS Data
-  Export Special Export
-  Import OIG
-  Change Database

View Data

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-  Providers

Error Codes

Print
Print Broad Based Initial

Code	Description
701	The Social Security Number must begin with a `U` for United States Social Security Number (SSN) or a `C` for Canadian Social In
702	The Foreign Certification Date is required with school code of 99999. Otherwise it must be blank. When used it may not be lat
703	Assignment Dates must be within the Fiscal Period.
704	Invalid Medical School Code.
705	Missing or invalid Residency Type Code in the master record.
706	Assignment End Date may not be earlier than Assignment Begin Date and both dates must be present.
707	No Master Record was found for Assignment Record. These assignments will be rejected.
708	No Assignment Records found for master record. Master will be rejected from the import data.
709	Assignment Residency Year must be within 1 year of the Master Residency Year.
710	Overlapping Assignments - dates may need to be changed.
711	Physician's First and Last Name are required. Also, first and last name has a character limit of 25 while the middle name has a l
712	F/T, GME and IME percentages must be between 0 and 100.

- The list of possible Broad-Based Initial Training codes are shown below:

Residency Codes - Possible Valid Codes for Broad-Based Initial Training

Type	PrimDescription	SecDescription	Gerifellow	PrimaryCare	PreventMed	ResYea
1250	Emergency Medicine	General (See Note 4 In Help Screen)	False	False	False	3.00
1350	Family Medicine	General	False	True	False	3.00
1400	Internal Medicine	General	False	True	False	3.00
1450	Internal Medicine /Pediatrics	General	False	True	False	4.00
1505	Internal Medicine/Family Medicine	General	False	True	False	4.00
1515	Internal Medicine/Preventive Med.	General	False	True	False	4.00
1750	Obstetrics & Gynecology	General	False	False	False	4.00
2000	Pediatrics	General	False	True	False	3.00
2150	Preventive Medicine	General	False	True	True	3.00
2450	Surgery	General	False	False	False	5.00
2525	Transitional Year (Allopathic Med.)	General	False	False	False	1.00
2550	Preliminary Medicine	General	False	False	False	1.00
2600	Preliminary Surgery	General	False	False	False	2.00
3600	Family Medicine	General	False	True	False	3.00
3650	General Surgery	General	False	False	False	5.00
3900	Internal Medicine	General	False	True	False	3.00
4450	Obstetrics & Gynecology	General	False	False	False	4.00
5250	Pediatrics	General	False	True	False	3.00
5400	Preventive Medicine	General	False	True	True	3.00
5425	Public Health & Preventive Medicine	General	False	True	False	3.00
6350	Internal Medicine/Pediatrics	General	False	True	False	4.00

Type	PrimDescription	SecDescription
6400	Trad'l Rot'g Intern'p (Osteo. Med.)	General



August 21 - 22, 2025
The Westin New York at
Times Square

- Questions?
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