HOSPITAL COST REPORT INFORMATION SYSTEM
MINIMUM DATA SET
FROM FORM HCFA-2552-92

FOR COST REPORTING PERIODS BEGINNING ON OR AFTER
OCTOBER 1, 1991 AND BEFORE OCTOBER 1, 1995

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HOSPITAL COST REPORT DATA: MINIMUM DATA SETS

The Minimum Data Set contains cost, financial, and other information from the Medicare Hospital Cost Report (Form HCFA-2552-92) submitted by Medicare certified hospitals. These data contain extracts from as submitted, final settled, and reopened cost reports, whichever is the most current for each hospital.

Each file contains data from hospitals with cost reporting periods beginning during each Federal fiscal year.

File Name	Periods Included - Fiscal Years Beginning	Update Schedule
PPS IX	After 9/30/91 and before 10/01/92	Quarterly
PPS X	After 9/30/92 and before 10/01/93	Quarterly
PPS XI	After 9/30/93 and before 10/01/94	Quarterly
PPS XII	After 9/30/94 and before 10/01/95	Quarterly

Please review carefully the Explanatory Notes (pages 21-24). They include information which will be useful in comparisons to data from other years.

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TABLES AND EXPLANATORY NOTES

Table I: Type of Control (F26)

1	=	Voluntary Nonprofit, Church
2	=	Voluntary Nonprofit, Other
3	=	Proprietary, Individual
4	=	Proprietary, Corporation
5	=	Proprietary, Partnership
6	=	Proprietary, Other
7	=	Governmental, Federal
8	=	Governmental, City-County
9	=	Governmental, County
10	=	Governmental, State
11	=	Governmental Hospital District
12	=	Governmental, City
13	=	Governmental, Other

Table II: Type of Hospital (F27)

1	=	General Short Term
2	=	General Long Term
3	=	Cancer
4	=	Psychiatric
5	=	Rehabilitation
6	=	Other

Table III: SSA State Codes (the first two digits of the Medicare Provider Number) (F32)

01	=	Alabama
02	=	Alaska
03	=	Arizona
04	=	Arkansas
05/55	=	California
06	=	Colorado
07	=	Connecticut
08	=	Delaware
09	=	Washington, D.C.
10	=	Florida
11	=	Georgia
12	=	Hawaii

13	=	Idaho
14	=	Illinois
15	=	Indiana
16	=	Iowa
17	=	Kansas
18	=	Kentucky
19	=	Louisiana
20	=	Maine
21	=	Maryland
22	=	Massachusetts
23	=	Michigan
24	=	Minnesota
25	=	Mississippi
26	=	Missouri
27	=	Montana
28	=	Nebraska
29	=	Nevada
30	=	New Hampshire
31	=	New Jersey
32	=	New Mexico
33	=	New York
34	=	North Carolina
35	=	North Dakota
36	=	Ohio
37	=	Oklahoma
38	=	Oregon
39	=	Pennsylvania
40	=	Puerto Rico
41	=	Rhode Island
42	=	South Carolina
43	=	South Dakota
44	=	Tennessee
45	=	Texas
46	=	Utah
47	=	Vermont
49	=	Virginia
50	=	Washington
51	=	West Virginia
52	=	Wisconsin
53	=	Wyoming
99	=	Other

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Table IV: Cost Report Status (F35)

N	=	As Submitted
J	=	Settled without Audit
E	=	Settled with Audit
A	=	Reopened
O	=	Audited but not Settled

Table V: Census Divisions (F38)

0	=	National
1	=	New England
2	=	Middle Atlantic
3	=	South Atlantic
4	=	East North Central
5	=	East South Central
6	=	West North Central
7	=	West South Central
8	=	Mountain
9	=	Pacific

Table VI: HCFA Regions (F39)

1	=	Boston
2	=	New York
3	=	Philadelphia
4	=	Atlanta
5	=	Chicago
6	=	Dallas
7	=	Kansas
8	=	Denver
9	=	San Francisco
10	=	Seattle

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1. Some fields have an "X" as either the Line or Column designation. An example is the number of months in the cost reporting period (F25). Although it does not appear on the cost report, we calculate it from cost report data to ease analysis.

2. Inpatient Capital Reduction Rate (F29):

   NOTE: No inpatient capital reduction is now in effect. The information below will be useful for comparisons to prior years.

   The Omnibus Reconciliation Acts (OBRA) of 1986, 1987, 1989 and 1990 reduced all inpatient capital-related costs of hospitals subject to the Prospective Payment System (PPS). The effective dates with reduction percentages are as follows:

Effective Dates	Reduction Rates
10/01/87 - 11/20/87	3.5%
11/21/87 - 12/31/87	7.0%
01/01/88 - 09/30/88	12.0%
10/01/88 - 09/30/89	15.0%
10/01/89 - 12/31/89	0.0%
01/01/90 - 09/30/91	15.0%

   Hospitals apply these rates to reduce capital-related costs after step-down and post step-down adjustments, if any. They use the reduced capital-related costs for apportionment to Medicare. Refer to HCFA Forms 2552-85 and 2552-89, Worksheet D, Parts I and II, Column 4. The rates apply to cost reporting periods spanning the above dates and reduce capital related costs. Note that fields F345-F376 are net of the capital-related cost reduction, if any. Follow the example below to calculate the Medicare Inpatient Capital Related Costs before the Capital Reduction. This example illustrates the formula for calculating the Operating Room (O/R) before the Capital Reduction:

$$\frac{F351}{(1-F29)} = \text{Medicare O/R Costs before Capital Reduction}$$

3. Outpatient Capital Reduction Rate (F30)

   OBRA 90 reduced all Part B Capital-Related costs for services rendered after September 30, 1989 in PPS hospitals (other than Sole Community Hospitals). The effective dates with reduction percentages are as follows:

Effective Dates	Reduction Rates
10/01/89 - 09/30/91	15.0%
10/01/91 - 09/30/95	10.0%

   The values for fields F445, F446, F447, and F448 are net of capital-related cost reductions. Fields F445A, F446A, F447A, and F448A contain the Outpatient Capital Reduction amount to permit easy comparisons with outpatient costs from earlier periods.

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4. File Creation Date (F31) and System Identification (F31A)

These fields are primarily for internal use only. F31 represents the date that the Medicare fiscal intermediary extracted HCRIS data from the cost report. F31A enables HCFA to more quickly identify and resolve system errors.

5. Medicare Utilization Indicator (F37)

The Medicare Utilization Indicator identifies how the hospital filed its cost report. An L stands for a hospital that has low Medicare utilization an N stands for a hospital that has no Medicare utilization. This field also identifies the most common type of cost report, the Full Medicare cost report (F).

Under Section 2414.4 of the Provider Reimbursement Manual, a low or no utilization provider may file its cost report in an abbreviated form. So these reports will not contain values in most fields of the Minimum Data Set.

Data files of each of these abbreviated cost reports will contain certain identifying information and some cost report data as specified below.

The values for field F37 may be either "L," "N," or "F."

N = Medicare utilization report will have data present in up to 8 fields (F1, F23-F25, F31, and F33-F35).

L = Low Medicare utilization report will have data in up to 17 fields (F1, F23-F26, F31, F33-F35, F45, F59, F72, F82, F88, F488, F489, and F533).

F = Most of the full cost reports have normal levels of Medicare utilization. Some have either very low or no inpatient Medicare utilization at all.

6. Beds Available (F40-F46) are those available for use by patients at the end of the cost reporting period.

7. Bed Days Available (F47-F53) is based on statistics throughout the cost reporting period. It is equal to the number of beds (excluding newborn) available times the number of days.

8. For the first time, the Observation Bed Cost center is preprinted on the Medicare hospital cost report (Form HCFA-2552-92). "All Other Outpatient" fields include this cost center. This grouping has not changed since PPS year II.

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9. Reimbursement for Interns & Residents (I&R)

Effective with cost reporting periods beginning after June 30, 1985, Medicare reimburses for I&R prospectively under the Graduate Medical Education (GME) regulations. See 42 CFR 413.86. Medicare will continue to pay hospitals for the nursing school and paramedical education on a reasonable cost basis. So, if F478A and F501A are less than one, Medicare paid the teaching hospital for any I&R services at reasonable cost. If F478A and F501A are greater than zero, Medicare paid the hospital for any I&R services prospectively.

For cost reports filed under the new GME rule, Medicare DME fields (F409-F440, F473B, and F474B) will exclude the reasonable cost of Interns and Residents. If the hospital has either a nursing school or allied health, these fields may still be greater than zero. These values will represent the remainder of the DME Pass Through Costs still reimbursed at reasonable costs (nursing school, allied health, or both).

NOTE: The prospective GME cost reports will affect many fields, making comparison to pre-GME reports very difficult. This will affect the following fields to varying degrees: F222-F243, F245, F247-F263, F318-F344, F377-F408, F445, F446, F447, F448, F449-F456, F458, F460, F473, F474, F484, F488, F492, F497, F499, and F504.

For example, total costs after step-down (F222-F243, F245, and F247-F263) exclude I&R costs. For valid comparison to prior years, I&R costs (F142-F180) must be added.

Finally, there are two fields of prospective reimbursement for I&R services (F478A and F501A). They represent the total Medicare reimbursement to the hospital and **all** hospital-based providers (subproviders, SNFs, etc.). Medicare still reimburses I&R costs associated with End Stage Renal Disease services (F504) at reasonable cost.

10. As required by §1886(g) of the Social Security Act, Medicare now pays hospitals differently for capital-related costs. Until this change, Medicare paid for hospital capital-related costs on a reasonable cost basis. For cost reporting periods beginning after September 30, 1991, Medicare pays PPS hospitals prospectively for capital-related costs.

There are three payment methods under this system. These methods are the Fully Prospective Method, the Hold Harmless Method, and the Reasonable Cost Method. Under the Hold Harmless Method, hospitals must split the capital-related costs associated with old and new capital assets. All capital costs in the Minimum Data Set are in total. That is, they include both Old and New Capital-Related Costs. As a result, the content of the capital data elements is consistent with previous Minimum Data Sets.

11. Outpatient Operating Cost Reduction

P.L. 101-58 (Section 4151 of OBRA 90) reduced operating costs for Part B services. This is a 5.8% reduction for services rendered from 11/1/90 through 12/31/95. Fields F445B, F446B, F447B and F448B contain the amounts of this reduction for use in longitudinal studies.

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12. In the Part A Settlement Summary (F470-F491), Worksheet E, Part A pertains only to PPS hospitals. Supplemental Worksheet E-3, Part I applies only to hospitals subject to the Tax Equity and Fiscal Responsibility Act of 1983 (TEFRA) limits. Supplemental Worksheet E-3, Part II applies to hospitals reimbursed at reasonable cost, that is either PPS or TEFRA.

13. The Sequestration Adjustments under Part A (F489) and Part B (F505) are reductions of Medicare reimbursement. They are provisions of the Balanced Budget and Emergency Deficit Control Act of 1985 (P.L. 99-177 Gramm-Rudman-Hollings). P.L. 101-58 (Section 4158 of OBRA 90) mandated an additional payment reduction for Part B services rendered from 11/1/90 through 12/31/90. The applicable reduction percentages and time periods are as follows:

A.Part A Inpatient Hospital Services:

03/01/86 - 09/30/86	1.000%
11/21/87 - 03/31/88	2.324%
10/17/89 - 12/31/89	2.092%

B.Other Part A Services:

11/21/87 - 12/31/88	2.324%

C.Part B Services:

03/01/86 - 09/30/86	1.000%
11/21/87 - 03/31/88	2.324%
10/17/89 - 03/31/90	2.092%
04/01/89 - 09/30/90	1.400%
11/01/90 - 12/31/90	2.000%

14. The Hospital Wage Index Information must be provided by hospitals and subproviders subject to PPS or any hospital that would be subject to PPS if not granted a waiver.