



Question	Answer
<b>A. Reporting Questions</b>	
<p>1 <b>What are the primary payor categories?</b></p>	<p>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:  <b>Insured</b> 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 payment from the third-party. HFAL reductions for these accounts are reported in the primary payor's charity line.  <b>Uninsured</b> 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.  <b>Free, Charity</b> 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.</p>
<p>2 <b>Are hospitals required to distinctly report utilization and revenue for "Essential Plan 200-250" payer category for the 2025 ICR?</b></p>	<p>For hospitals that are able to identify encounters covered by third-party payors under Essential Plan 200-250, utilization and revenue should be reported within the associated primary payor's rows on Exhibits 32, 33, 34 and 46. Since it is anticipated that coverage is anticipated to revert back to the Basic Health Plan effective 7/1/2026 and not all hospitals may have updated their systems to identify this newer payor, discrete reporting under this payor category is not mandated for 2025 (or 2026).</p>
<p>3 <b>What primary payors should FIDA and FIDA-IDD dual-eligible encounters be assigned to?</b></p>	<p>Due to the change in the Medicaid DSH Cap calculation in the CMS Third Party Payor Final Rule, FIDA and FIDA-IDD dual-eligible encounters are to be assigned to the Medicare HMO primary payor in ICRs submitted for Report Year 2022 and later.</p>
<p>4 <b>To what primary payors should "Medicaid Pending", "Medicaid Applied For" or similar encounters be assigned?</b></p>	<p>Due to the change in the Medicaid DSH Cap calculation in the CMS Third Party Payor Final Rule, if an encounter has no item covered by another third-party payor and the patient has applied for but not yet been approved for Medicaid coverage for any part of the encounter, then it is to be reported within the Uninsured/Self-Pay primary payor. If Medicaid coverage is received, then see the next Question.</p>
<p>5 <b>In what circumstances, such as later coverage determination, may a change in the primary payor be appropriate?</b></p>	<p>The Primary Payor is expected to be set at the encounter start; however, there are circumstances where the hospital <u>may, but is not required to</u>, update this because the apparent payor was changed. For example, this includes: when a payor reports retroactive coverage; 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.</p>
<p>6 <b>What is the definition of expense related to an interest rate swap?</b></p>	<p>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.</p> <p>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.</p>
<p>7 <b>For Exhibit 30, Line 60, Dual-eligible, what meant by "A payor on the account"--are these Medicaid paid or Eligible for payment?</b></p>	<p>Hospitals should identify encounters with Medicaid coverage in addition to other coverage in a manner consistent with their Medicaid DSH reporting. Under the CMS change for 2021 Medicaid DSH, pending- or applied-for-Medicaid payors do not satisfy the Medicaid coverage part of dual-eligible.</p>
<p>8 <b>What approval is needed to change the ICR Schedule 1B basis from visits to charges?</b></p>	<p>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 elected within the service area on Exhibit 31A.</p>



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<p>9 What is expected reporting of CPEP Observation services?</p>	<p>When a patient's status includes CPEP Extended Observation, report the Number of CPEP Observation Days in Exhibit 33 00160/814 - 00160/833. Patients who receive CPEP Emergency Services AND CPEP Observation in the same encounter are to report utilization in each of the respective service areas on Exhibit 33. For Psychiatric inpatient admissions, <b>IF</b> the primary payor's billing rules are to adjust the date of admission to include those days as inpatient, then report those days as inpatient Psychiatric or Dual-Diagnosis in Exhibit 32 instead of Exhibit 33 Class 00240. <b>DO NOT REPORT THE SAME CPEP Observation DAY IN EXHIBIT 32 AND IN EXHIBIT 33.</b></p> <p>CPEP Observation routine charges are to be reported on the Exhibit 46 Line (001-015) for the area where the patient began the encounter under the Charge Code column (service area) where the discharge was billed.</p>
<p>10 Where should Hospice days reported on S-3 part I line 24.10 or another Hospice line be reported as it relates to Exhibit 32? Are Hospice Days considered ALC?</p>	<p>Hospice days 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 for "General Inpatient Care" and "Inpatient Respite Care" for Hospice services.</p> <p>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.</p>
<p>11 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?</p>	<p>Because of the Report Year 2019 change in reporting HFAL reductions, an example using Third-Party is as follows:</p> <ul style="list-style-type: none"> <li>• 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.)</li> <li>• 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.</li> <li>• 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's category and do not split among lines.</li> </ul>
<p>12 How are charges written-off (reduced) because of the hospital Financial Aid Law (HFAL) Policy to be reported in Exhibit 46?</p>	<p>If the charity care determination and HFAL Policy apply to other or future encounters of the patient/guarantor, then determine the primary payor in absence of the HFAL determination and maintain its alignment throughout ICR reporting. When the primary payor would have been Uninsured/Self-pay and ALL encounter charges are written off, then report as Free (Charity, Hill-Burton) primary payor.</p> <p>Exhibit 50 reports one application for the patient regardless of number of encounters. If presumptive eligibility for charity care applies, report one "approved" application.</p>
<p>13 Are we to report lines 382, 383, 386 and 391 based on accrual or actual write-offs?</p>	<p>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.</p>
<p>14 What changes are required for drugs paid outside the rate code?</p>	<p>At this time, for ratio-of-cost-to-charges (RCC) development, ICR Instructions only require an adjustment for drugs paid outside the rate for the amount of all patients' outpatient chemotherapy or similar drug costs, included in Exhibit 11 (Expenses) and Exhibit 51 (Charges) (Please refer to ICR instructions and the "J-code" List). Should the initial cost for Exhibit 11 expenses related to such drugs be included in a cost center other than Cost Center 123 – Drugs charged to patients, the hospital should make adjustments or reclassifications to align the cost center(s) underlying costs and charges. <b>Please note:</b> utilization of Exhibit 14, line 632 "Cost of drugs billable outside of rate system" will automatically decrease expenses of cost center 123.</p>
<p>15 What professional services may be reported within the Exhibit 50 HFAL costs (charges) and payments?</p>	<p>Professional services that are or may be 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.)</p>



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16	Are hospitals required to complete the new demographic table that was added to Exhibit 50 the 2024 ICR?	<p>Yes, those reporting changes related to demographics were based on new legislation effective October 1, 2024. Reporting demographic information on encounters prior to then is not required.</p> <p>All Article 28 general hospitals will need to complete the updated questions and Zip Code Table covering their entire reporting period in Exhibit 50.</p> <p>Exceptions: Hospitals that were Rural Emergency Hospitals for the <b>ENTIRE REPORT PERIOD</b> are not required to complete Exhibit 50, nor are Article 31 Private Psychiatric Hospitals.</p> <p>If there are questions or concerns on Exhibit 50 reporting requirements, reach out to <a href="mailto:HFAL@health.ny.gov">HFAL@health.ny.gov</a>.</p>
17	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/PPS 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.
18	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.
19	When will the 2025 RHCF-2/4 report be due?	Any questions regarding reporting or submission of the RHCF cost reports should be directed to the Bureau of Nursing Home and Long-Term Care Rate Setting at <a href="mailto:rhc-f-hcs@health.ny.gov">rhc-f-hcs@health.ny.gov</a> .
20	What should be done when the ICR software identifies a non-fatal edit?	<p>Non-fatal errors (4xxxx) and Informatory messages (5xxxx) point out unusual conditions or amounts in the ICR.</p> <p>If any inputs that caused the edit are incorrect, please correct the inputs, save and run the Calculate function. This may clear the edit.</p> <p>If an edit is to remain, the Edit Report explanation is to provide insight about why the unusual situation need not be changed. Cost reports are subject to not being accepted when inadequate explanations are given.</p>
21	How is PROS utilization to be reported on Exhibit 33 of the ICR?	<p>PROS utilization is reported as the number of <b>service months</b> of Community Rehabilitation and Support claimed (Rate Codes 4520-4524 and Rate Codes 4516-4518). The specific rate code was based on the number of allowable quarter-hours in the month. PROS pre-admission and add-on rate codes should not be counted.</p> <p>Note: Costs and revenue should be reported within the proper exhibits based on ALL PROS services.</p>
22	For ICR Exhibits 32, 33 and 34 reporting, does the Uncompensated Care Collection (UCC) amount include the uninsured HCRA surcharge?	<b>Based on the latest Department guidance and as noted in the updated 2025 ICR instructions: Uncompensated care collections may be reduced for related HCRA Surcharges received and paid to the pool administrator by the hospital. Only services that are subject to the HCRA surcharge may be adjusted. If any changes are required based on future guidance from CMS, the instructions will be updated accordingly.</b>

## B. Software Questions

23	What is the username and password to download the ICR Software?	The 2024 ICR Software is available to download from the Health Financial Systems (HFS) website. The link is available within the Hospital ICR application of the Health Commerce System (HCS) secure website.
24	We have already started entering the new report year 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 HFS software updates related to the new report year have been applied using its Report Wizard. Please note that where the ICR Instructions, entry or Exhibit definitions have been modified, the hospital should verify that previously entered amounts are still accurate and properly reflect the revised ICR.
25	What ICR software should be used?	All ICR submissions must use the HFS MCRIF32 Software. The Department will communication which software versions should be used for annual submissions and any resubmissions related to audits.

## C. Audit Fee Questions



Question	Answer
<p>26 What are the fees associated with submitting an ICR?</p>	<p>The ICR audit fees are based on Exhibit 11, column 3, line 960 <b>total expenses</b> at Class code 00042, line 960 of the previous year's report. The audit fee schedule scale is posted on the DOH website at: <a href="http://www.health.ny.gov/facilities/hospital/audit_fee/index.htm">http://www.health.ny.gov/facilities/hospital/audit_fee/index.htm</a>, however DOH will post hospital-specific fees to the Health Commerce System (HCS) within the Hospital Institutional Cost Report Application.</p> <p>The current fee scale is as follows:            &lt;\$50 million = \$ 5,000            \$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            &gt;\$1.5 billion = \$40,000</p>
<p><b>D. General Questions</b></p>	
<p>27 How is the information in cost reports used by the Department?</p>	<p>The data in the report is used by the Department for data analysis, rate development, the Upper Payment Limit calculation, Disproportionate Share calculation, Directed Payment Templates, development of fund distributions, etc. Certain data elements in the ICR are also used by other NYS Agencies, as well as various outside stakeholders that have access to the reports through HealthDataNY or the Freedom of Information Law process.</p>
<p>28 Will the DOH accept an electronic CEO signature page at some point like the Medicare Report does?</p>	<p>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 in PDF format until further notice.</p>
<p>29 Who should I contact with ICR related questions? Other contacts?</p>	<p><b>ICR questions can be answered using the following emails:</b>            General ICR Questions: <a href="mailto:Hospital.ICR@health.ny.gov">Hospital.ICR@health.ny.gov</a>            Audited Financial Statements must be emailed in pdf format to: <a href="mailto:AFS@health.ny.gov">AFS@health.ny.gov</a>            HFAL Exhibit 50 reporting requirements: <a href="mailto:HFAL@health.ny.gov">HFAL@health.ny.gov</a>            KPMG ICR Audit Contact: <a href="mailto:us-albadvnysdhicr@kpmg.com">us-albadvnysdhicr@kpmg.com</a></p> <p><b>Other resources include:</b>            Hospital Inpatient or Outpatient Article 28 rates: <a href="mailto:HospFFSUnit@health.ny.gov">HospFFSUnit@health.ny.gov</a>            Hospital Outpatient Services for Article 32 (OASAS), Article 31 (OMH) &amp; Article 16 (OPWDD) providers or rates: <a href="https://www.health.ny.gov/health_care/medicaid/rates/contacts/">https://www.health.ny.gov/health_care/medicaid/rates/contacts/</a>            Hospital Financial Aid Law questions: <a href="mailto:HFAL@health.ny.gov">HFAL@health.ny.gov</a>            Medicaid Managed Care Premiums and Rates: <a href="mailto:bmcr@health.ny.gov">bmcr@health.ny.gov</a>            Residential Health Care Cost Reports: <a href="mailto:rhc-f-hcs@health.ny.gov">rhc-f-hcs@health.ny.gov</a>            Accounts Receivables and Recoupment: <a href="mailto:bimamail@health.ny.gov">bimamail@health.ny.gov</a>            HCRA and Cash Assessment: <a href="mailto:hcraprov@health.ny.gov">hcraprov@health.ny.gov</a>            DSH or Indigent Care questions: <a href="mailto:dshaudits@health.ny.gov">dshaudits@health.ny.gov</a>            Establishment of locations on eMedNY: <a href="mailto:providerenrollment@health.ny.gov">providerenrollment@health.ny.gov</a>            Billing questions: eMedNY Call Center: 1-800-343-9000</p>