Diamond State Hospital Cost Review Board
Patient Revenue Summary
DRAFT 2026.08.11

Instructions
Complete cells shaded in yellow. The Total column and total rows sum from the completed inputs.

Section 1 reports revenue by payer: Gross Patient Revenue is built from the cost-center category rows, and Net Patient Revenue is entered by payer. Section 2 reconciles Total Gross Patient Revenue to Net Patient Revenue through the deduction and adjustment lines; enter deductions as positive amounts and the capitation and value-based lines as signed amounts. The reconciled Net Patient Revenue must tie to the Section 1 Net Patient Revenue total, so the Variance should be zero.

Definitions provides additional detail and Cost Center Mapping lists representative cost centers for each category.

Reporting Entity

Hospital	
Medicare CCN	
Reporting Period	
Preparer / Title	
Date	

Section 1. Patient Revenue by Payer

Revenue Category	Medicare (Original / FFS)	Medicare Advantage	Medicaid (FFS)	Medicaid Managed Care	Commercial	Self-Pay	Other	Total
Inpatient Routine								
Ancillary								
Outpatient Service								
Other Reimbursable								
Special Purpose								
Total Gross Patient Revenue								
Net Patient Revenue								

Section 2. Reconciliation of Gross to Net Patient Revenue (Total)

Total Gross Patient Revenue	
Less: Contractual Adjustments	
Less: Charity Care	
Less: Implicit Price Concessions	
Net Charge-Based Patient Revenue	
Add / (Less): Capitation and Risk-Based Revenue	
Add / (Less): Value-Based and Incentive Payments	
Net Patient Revenue (reconciled)	
Net Patient Revenue (reported by payer, Section 1)	
Variance (reconciled less reported; should be zero)	

Cost Center Mapping

Each revenue category corresponds to a grouping of CMS Form 2552-10, Worksheet A cost centers. Representative cost centers are listed below; the list is not exhaustive. The Hospital maps its own Worksheet A cost centers to these categories per the Form 2552-10 instructions, regardless of its Medicare payment classification (IPPS or TEFRA). Inpatient Routine, Ancillary, and Outpatient Service are Reportable Cost Center categories; Other Reimbursable and Special Purpose are disclosed for reconciliation only.

Category	Worksheet A Lines	Representative Cost Centers
Inpatient Routine	30 to 46	Adults & Pediatrics (general routine care); Intensive Care Unit; Coronary Care Unit; Burn Intensive Care Unit; Surgical Intensive Care Unit; Other Special Care; Psychiatric subprovider (IPF); Rehabilitation subprovider (IRF); Nursery; Skilled Nursing Facility; Nursing Facility / Other Long-Term Care
Ancillary	50 to 76	Operating Room; Recovery Room; Labor & Delivery Room; Anesthesiology; Radiology - Diagnostic; Radiology - Therapeutic; CT Scan; MRI; Cardiac Catheterization; Laboratory; PBP Clinical Laboratory Services; Blood Storing, Processing & Transfusion; Intravenous Therapy; Respiratory Therapy; Physical Therapy; Occupational Therapy; Speech Pathology; Electrocardiology (EKG); Electroencephalography (EEG); Medical Supplies Charged to Patients; Implantable Devices Charged to Patients; Drugs Charged to Patients; Renal Dialysis
Outpatient Service	88 to 93	Rural Health Clinic; Federally Qualified Health Center; Clinic; Emergency (line 91); Observation Beds (distinct part, line 92.01); Outpatient Services / Ambulatory Surgery
Other Reimbursable	94 to 101	Home Health Agency; Ambulance Services; Outpatient Rehabilitation Provider (CORF / OPT / OSP); Durable Medical Equipment - Rented; Durable Medical Equipment - Sold
Special Purpose	105 and following	Organ acquisition cost centers (kidney, heart, liver, lung, pancreas, intestinal, islet); other special-purpose cost centers identified in the Form 2552-10 instructions

Definitions

Capitation and Risk-Based Revenue	Fixed periodic payments (e.g., per-member-per-month) received for providing or arranging covered services, recognized under ASC 606 by the payment rather than by charges.
Charity Care	Charges for services provided to patients who qualify under the hospital's financial assistance policy.
Commercial	Health insurance coverage provided by a private insurer, including employer-sponsored plans, individual market plans, and self-insured employer plans.
Contractual Adjustments	Explicit price concessions: the difference between established charges and amounts payable under contract with a payer.
Cost Center	A discrete operational unit identified by line number on Worksheet A of CMS Form 2552-10, including subscripted lines per Form 2552-10 instructions.
Gross Patient Revenue (GPR)	Total established charges for services rendered during the reporting period, before contractual adjustments, charity care, and price concessions.
Implicit Price Concessions	The portion of charges the hospital does not expect to collect.
Medicaid (Fee-for-Service)	The joint federal-state health insurance program. Captures payments made directly by the State on a fee-for-service basis. Excludes payments made through managed care organizations.
Medicaid Managed Care	Payments received from managed care organizations (MCOs) that contract with the State to provide or arrange for Medicaid-covered services.
Medicare Advantage	Private health insurance plans approved by CMS to provide Medicare Part A and Part B benefits. Reported separately from original Medicare.
Medicare (Original / Fee-for-Service)	Payments made directly by the State on a fee-for-service basis and excluding payments made through managed care organizations.
Net Charge-Based Patient Revenue	Gross Patient Revenue less contractual adjustments, charity care, and implicit price concessions. Reflects revenue derived from charges before non-charge-based payments.
Net Patient Revenue (NPR)	Net Charge-Based Patient Revenue plus capitation and risk-based revenue and value-based and incentive payments.
Other [Payment Source]	Workers' compensation programs, TRICARE, CHAMPVA, Indian Health Services, and any other payments not otherwise classified (e.g., other third-party liability).

Primary Payer	The payer financially responsible as the first source of payment for an encounter, determined as of the date of discharge for inpatient encounters and the date of service for outpatient encounters. Each encounter is assigned to one and only one Primary Payer among the following categories: Medicare (Original / FFS), Medicare Advantage, Medicaid (FFS), Medicaid Managed Care, Commercial, Self-Pay, or Other.
Reportable Cost Center	A Cost Center in the inpatient routine service, ancillary service, or outpatient service categories. General service, special purpose, and non-reimbursable Cost Centers are not Reportable Cost Centers, but their charges may be disclosed for reconciliation.
Self-Pay	Amounts billed to patients who do not have coverage for the service or who are responsible for a balance not covered by a third-party payer, including deductibles, copayments, and coinsurance not subject to a charity care write-off.
Value-Based and Incentive Payments	Shared-savings distributions, quality and pay-for-performance incentives, withhold returns, and risk-pool or risk-contract settlements that adjust patient service revenue outside the charge structure.