10-18 FORM CMS-2552-10 4090 (Cont.)

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050
EXPIRES 05-31-2019

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	PROVIDER CCN:	PERIOD FROM _____ TO _____	WORKSHEET S PARTS I, II & III

PART I - COST REPORT STATUS

Provider use only	1. [ ] Electronically filed cost report Date: _____ Time: _____ 2. [ ] Manually submitted cost report 3. [ ] If this is an amended report, enter number of times the provider has submitted this cost report. 4. [ ] Medicare Utilization. Enter "1" if all days for lo

Contractor use only	5. [ ] Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No.: _____ 8. [ ] Initial Report for this Provider CCN 9. [ ] Final Report for this Provider CCN	10. NPR Date: _____ 11. Contractor's Vendor Code: _____ 12. [ ] If line 5, column 1 is 4, enter number of times reopened = ___.

PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHER, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WHERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by _____{Provider Name(s) and Number(s)}for the cost reporting period beginning _____ and ending _____ and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

☐ I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent to my original signature.

(Signed) _____

Chief FinancialOfficer or Administrator of Provider(s)

What does an RHC Manager need to know about the Cost Report?

Virginia RHC Summit
June 4-5th, 2025

inQuiseek Consulting

Session Objectives

- What is the Cost Report?
- Understanding Cost-Based Reimbursement
- Understanding How the AIR is calculated
- RHC Services versus non-RHC Services
- Common Cost Report Errors that you can help avoid
- Cost Report Recordkeeping
- What should the manager or director’s involvement be in cost-report?

What is a Cost Report?

The cost report contains provider information such as facility characteristics, utilization data, cost and charges by cost center (in total and for Medicare), Medicare settlement data, and financial statement data. CMS maintains the cost report data in the Healthcare Provider Cost Reporting Information System (HCRIS).

For an RHC, the cost report is where the next calendar year's AIR is calculated, where any settlement from the last year is determined and where reimbursement for services outside the rate is established.

What are some of the key components of the cost report?

- Total Qualified Encounters (all payers)
- Total Allowable Costs
- Visits by Provider Type
- Allocation of Provider Time (RHC versus non-RHC)
- Carve outs for non-RHC services
- Medicare Immunization Expenses & Utilization
- Medicare Bad Debt

Cost-based Reimbursement Methodology

- **For traditional Medicare and Medicaid, RHCs are paid based on a cost-based methodology.**
- **We are not paid per CPT code except for a few FFS services.**
- **RHCs are paid per encounter for RHC services.**
- **For traditional Medicare, the All-Inclusive rate (AIR) is calculated on the cost report annually.**

Medicare AIR Calculation

Allowable Costs (Direct Expenses)

÷

# of Qualified Encounters (all payers)

=

AIR

All Inclusive Rate

01-22 FORM CMS-2552-10 4090(Cont.)

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	PROVIDER CCN: _____ COMPONENT CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET M-3

Check applicable boxes:	[ ] Hospital-based RHC [ ] Hospital-based FQHC	[ ] Title V [ ] Title XVIII	[ ] Title XIX

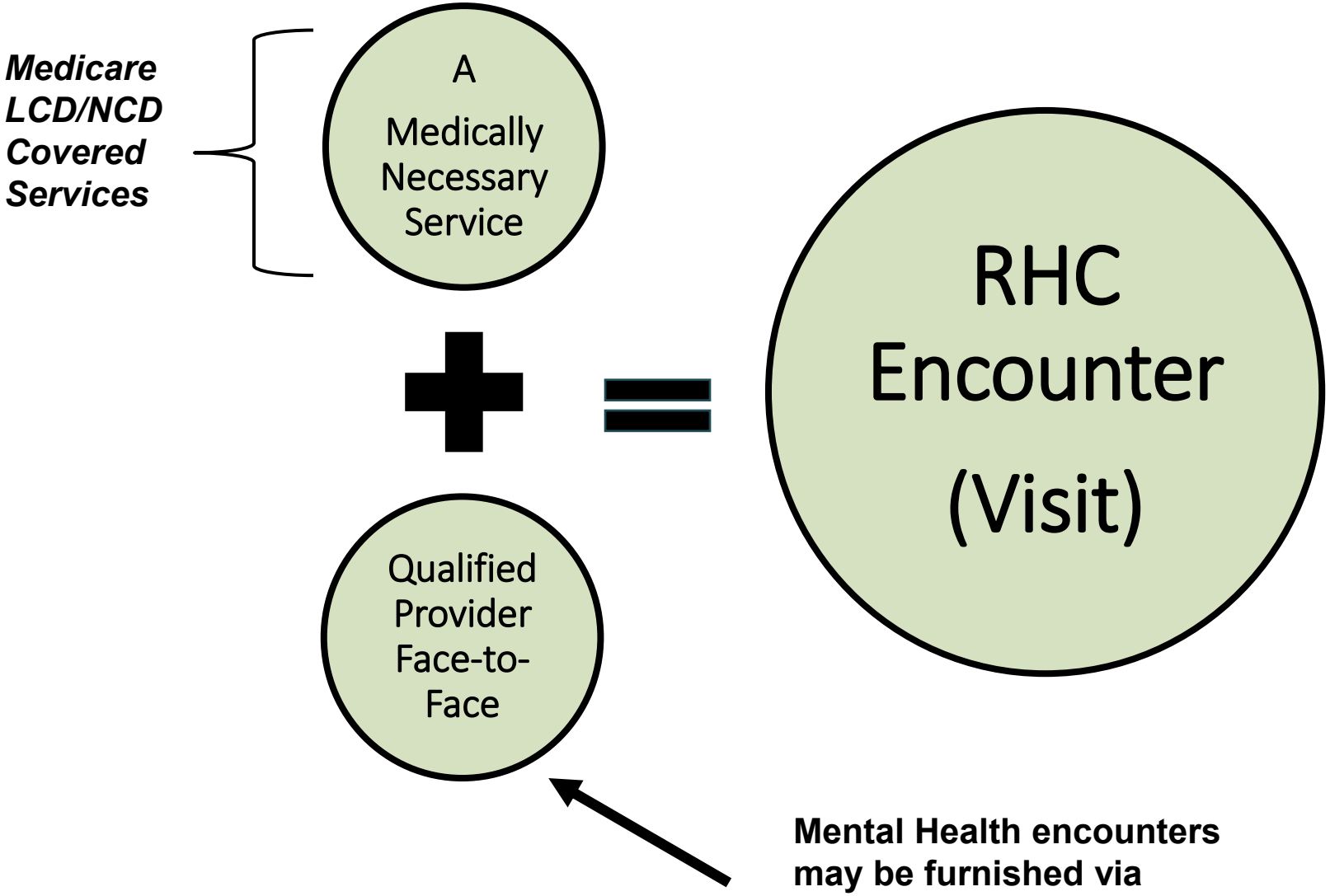
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES

1	Total allowable cost of hospital-based RHC/FQHC services (from Wkst. M-2, line 20)		1
2	Cost of injections/infusions and their administration (from Worksheet M-4, line 15)		2
3	Total allowable cost excluding injections/infusions (line 1 minus line 2)		3
4	Total visits (from Wkst. M-2, col. 5, line 8)		4
5	Physicians visits under agreement (from Wkst. M-2, col. 5, line 9)		5
6	Total adjusted visits (line 4 plus line 5)		6
7	Adjusted cost per visit (line 3 divided by line 6)		7

		Calculation of Limit (1)			
		Payment Limit Period 1	Payment Limit Period 2	Payment Limit Period 3	
		1	2	3	
8	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6, or your contractor)				8
9	Rate for Program covered visits (see instructions)				9

All-Inclusive Rate is Calculated on Worksheet M-3

What is an encounter?



Mental Health encounters may be furnished via telehealth beginning 2022 are considered face to face.

Reimbursement for an encounter is based off the All-Inclusive Rate which is calculated each year on the cost report.

CMS reimburses 80% of the AIR after the deductible is met and there is an additional patient responsibility amount/coinsurance which is 20% of the total charges.

Qualified RHC Encounter

- Face to face between a patient and a provider
- Physician, NP, PA, CNM as medical providers. Not all advanced practice nurses.
- Psychiatrist, Clinical Psychologist, LCSW, and mental health professional (Master's level, licensed with required clinical hours).
- Medically necessary per Medicare coverage determinations
- Requires the skill level of a provider
- Can be a mental health distant site telehealth encounter
- Some Medicaid programs allow encounter which are outside of what Medicare allows. These must be adjusted off the Medicare cost report.

What about nurse visits?

BP Check
Injection/Immunization Only
Bandage Change
Suture Removal

The direct expenses for performing RHC services which do not meet the encounter definition are included in the allowable costs on the cost report. Since there is no offsetting encounter, the AIR has the potential of being higher.

Medicare AIR Calculation

Allowable Costs (Direct Expenses)

÷

# of Qualified Encounters (all payers)

=

AIR
All Inclusive Rate

Includes nursing time, supplies and drugs.

Nurse Visits and Medical Telehealth Visits are NOT in the denominator,

If the services does not or would not pay the all-inclusive RHC encounter rate, it is not counted as a visit.

=

Nurse Only Visits
No provider seen
Medical Telehealth Visits
Lab or Technical Component Only Visits
Non-RHC Services

Non-RHC Services

Before you begin a new service or consider a new service, please consult your RHC tribe.

60.1 - Description of Non RHC/FQHC Services
(Rev. 13133; Issued: 03-20-25; Effective: 01-01-25; Implementation: 04-21-25)

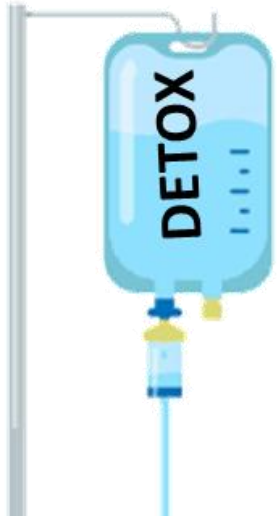
Certain services are not considered RHC or FQHC services either because they 1) are not included in the RHC or FQHC benefit, or 2) are not a Medicare benefit.

https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c13.pdf

BIOIDENTICAL HORMONES

Diet Food

Supplements/Vitamins

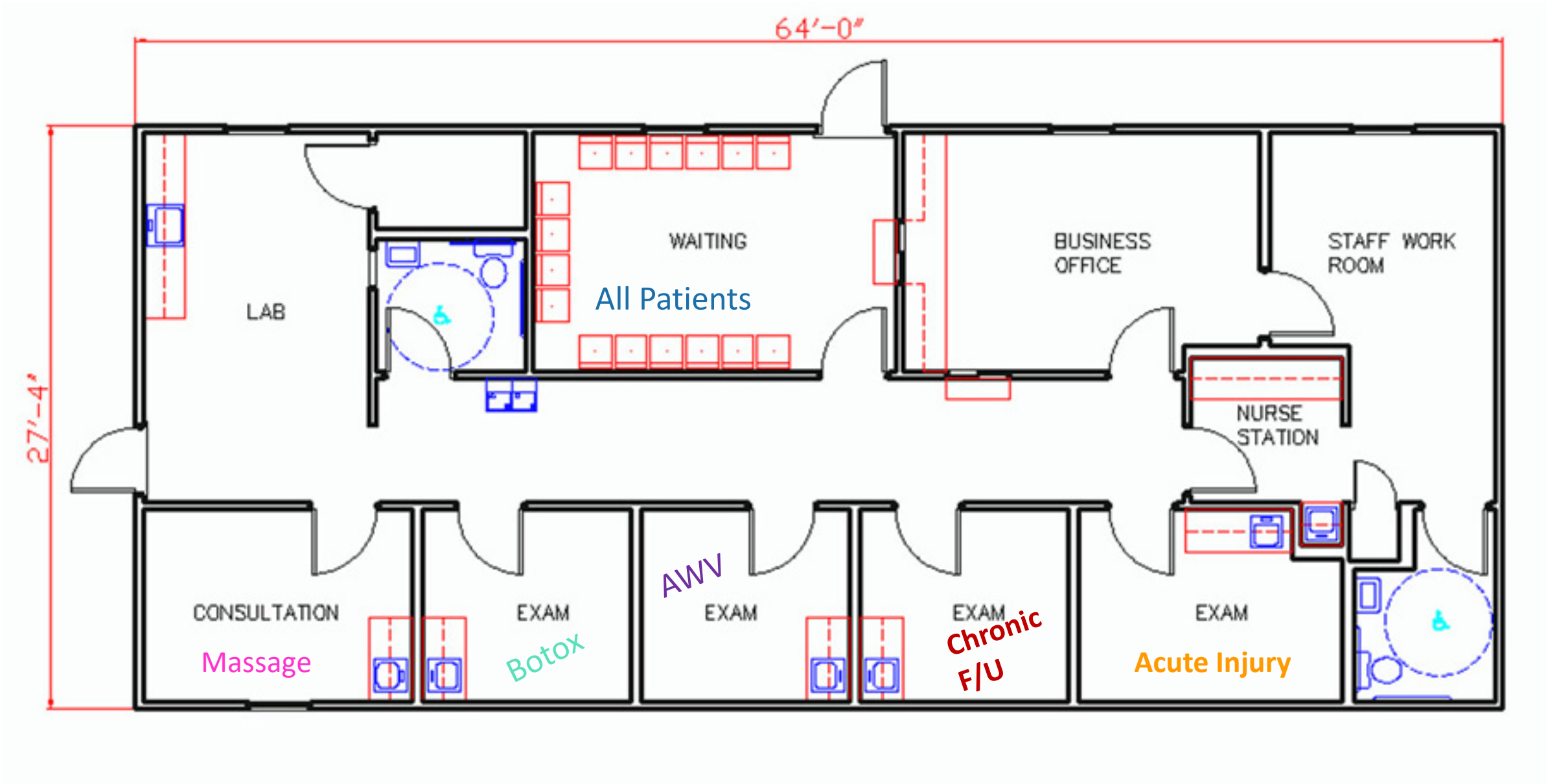


BOTOX & FILLERS

Massage Therapy


E & M Services
Preventive Services
Medically Necessary
Procedures
Allowable Expenses


BIOIDENTICAL
HORMONES
aesthetic
skin
beauty
Non-Allowable Costs



Floorplan: https://rosemedicalbuildings.com/floor-plan-category/medical-healthcare-buildings/

If you are doing all of these things at the same time, using the same rooms, using the same staff, using the same supplies and mixing it all up……

How will be able to separate RHC from Non-RHC visits and costs appropriately and accurately?

That is the problem!

You must exclude or carve out any expenses or direct costs you had that were used to perform services that were <u>non-RHC services</u>. This includes:

Drugs
Supplies
Equipment
Nursing Time
Staff Salaries
Administrative Costs

If you leave these expense in your allowable costs, then you have overstated what it cost you to perform RHC services. You inflate your cost report expense and potentially inflate your AIR.

What could be included in non-allowable costs?

Direct costs are expenses—the things that your clinic pays for while doing business: supplies, salaries, drugs, office supplies, insurance, and other operating expenses with some limitations.

These expenses, as they relate to anything that is not an RHC-service or a service does not pay the AIR (medical telehealth, care management, virtual communication services), are NOT included in the costs used to calculate the AIR.

Medicare AIR Calculation

Expenses Related to non-RHC services are excluded in the rate calculation.

Total Costs LESS non-allowable costs

÷

Total Visits LESS Visits which are not qualified encounters

=

AIR
All Inclusive Rate

Visits for non-RHC services are excluded in the visit count/productivity standard.

OTHER ISSUES WITH NON-RHC SERVICES

- Remember that you are a CMS facility type with a specific clinical footprint and physical address.
- **LOOP IN YOUR COST REPORT PREPARER OR CONSULTANT BEFORE YOU BEGIN ANY NEW SERVICE LINE. JUST ASK!**
- **You may need additional bookkeeping or record-keeping processes to separate RHC from non-RHC services.**
- If you run RHC and non-RHC services concurrently, you may need a separate door or distinct treatment areas. All situations are different.
- Monitor your productivity standards and allowable costs.
- Having non-RHC hours is probably the cleanest way to do some of these things.
- Do your providers have adequate training for new services? Do you have adequate malpractice?
- Be careful about marketing and advertising. You cannot have a clinic within a clinic. You are one RHC. You can have hours or appointment types for different services. Social media and web advertising can raise questions.

Non-RHC Services and Cost Reporting

- The visits for non-RHC services are not included on the cost report in either the productivity standard or the rate calculation.
- Any cost (direct operating expenses, bills you pay, etc.) related to a non-RHC service is not included in allowable costs used in the rate calculation. These are carved out.
- Even the direct expenses of the services which you split-bill are removed from allowable costs.
- Anything that you aren't paid your AIR for are also removed—Medicare medical telehealth (G2025), CCM (G0511), Virtual Communication (G0071).
- Reducing allowable costs could negatively impact your rate.
- Reducing encounters could also negatively impact your rate.

RHC Hours versus Non-RHC Hours

- You may designate non-RHC hours.
- These are hours that the clinic is not operating as an RHC.
- This must be disclosed to the patients.
- No RHC services are done at all during non-RHC hours. All providers must operate the same RHC versus non-RHC hours.
- Services are billed as fee-for-service during non-RHC hours.
- ALL COSTS ARE NON-ALLOWABLE
- AVOID LOOKING LIKE SWISS CHEESE
- PATIENTS WILL HAVE A DIFFERENT COST SHARE

Record-Keeping for Cost Reporting

Healthcare Business Specialists
Electronic Request List
Items Needed for Cost Report Preparation

The Below listing details all items we need to begin the cost report preparation process. The more complete the data that is submitted up front, the quicker and easier we will be able to process that data and produce a draft of the report.

1 We need at least one of the following items to determine total expenses paid by the clinic during the cost reporting period. These reports should be for the entire accounting period which matches the cost reporting period (typically 12 months)
a Trial Balance
b Financial Statement from Accountant or QuickBooks
c Federal Tax Return for the Practice (only if the clinic's cost reporting period matches the calendar year)

2 Please provide a CPT report matching the cost reporting period broken down by provider so that we can accurately count all relevant encounters for the period.

3 We will need either a payroll summary for the appropriate period or a complete set of W-2s. In both cases, please indicate the job title for each employee as well as the hours each employee worked through the year. If the total of salaries and wages does not match the total shown on the provided expense listing, please provide a brief explanation of the variance.

4 Please provide us with a PS&R report for the period or the appropriate access to pull the report ourselves. If you are unsure whether we have that access, please check in with us to verify as this is also critical to ensuring we are able to file the report.

5 Please complete the clinic information tab.

6 Please complete the Provider FTE Tab

7 Please complete the Malpractice information tab

8 How many hours were worked by all nursing staff and Medical Assistants during the period?

Your cost report preparer should give you a list of items they need and the format in which the data needs to be given. It is important to know in advance what recordkeeping is needed. It is difficult to reconstruct or recreate some data if it has not been collected all year. You need a relationship with your cost report preparer.

Cost Report Recordkeeping: Visits

- Total number of unique visits by financial class: This can be a difficult number to find depending on if your EHR can pull this. Sometimes an ad hoc report must be created and then reconciled to some other source document.

- Sometimes managers are keeping a monthly reconciliation of visits by provider or payer, but no one asks them for their data. Instead, someone from administration or corporate runs system reports, often with the wrong parameters. The result can be an inaccurate number of unique qualified visits.

- Total number of non-RHC visits/services. Track medical telehealth, care management, virtual communication services, lab or imaging services. The number of services should not be in the visit count on the cost report. The associated direct expenses should be removed from allowable costs.

- Allocation of expenses and provider time for non-RHC services. ER Visits, deliveries, surgeries, inpatient acute rounding, administrative time and PTO hours.

- Total number of mental health distant site telehealth encounters is included in the visit count since it reimburses at the RHC AIR.

Cost Report Recordkeeping: Provider Time

- Time Allocation or Time Studies for Provider Time spent out of the clinic for surgery, inpatient acute rounding, ER call, administrative time.
- Provider roster and time worked per provider

Provider Time Allocation

PROVIDER TIME ALLOCATION SHEET								
For the Two Weeks Ending:						Provider Name:		
						Facility/Clinic:		
Week/Weekday	**Total Hours**	**Clinic Patient Care Hrs**	**Clinic Admn Hours**	**Hospital Inpatient**	**ER/ED Hours**	**Other Hospital Dept Hrs**	**Hospital Admn Hrs**	**Comments**
Week 1								
Monday	8	6.5		1.5				
Tuesday	6	3	2	1				Work on Annual Eval
Wednesday	8	5	1	1	0.5		0.5	Trauma in ER; Chart Catch up
Thursday	9	7		1			1	
Friday	4	4						
Saturday	0							
Sunday	0							
Total Hours	**35**	**25.5**	**3**	**4.5**	**0.5**	**0**	**1.5**	
% of Time	**100.0%**	**72.9%**	**8.6%**	**12.9%**	**1.4%**	**0.0%**	**4.3%**	
Week 2								
Monday	10	7	1	1	0.5		0.5	Review NP Charts
Tuesday	0							Off/CME

Productivity Standard Ends

- For RHCs with fiscal year ends 12/31, the current cost report is the last one to report visits for the purpose of meeting the productivity standard.

- For RHC with fiscal year ends into 2025, the next cost report will be the last one to report visits for the purpose of meeting the productivity standard.

- HOWEVER, as far as we know visits will still be reported as a utilization standard.

Provider Statistical & Reimbursement Report

Provider Statistical and Reimbursement (PS&R) System

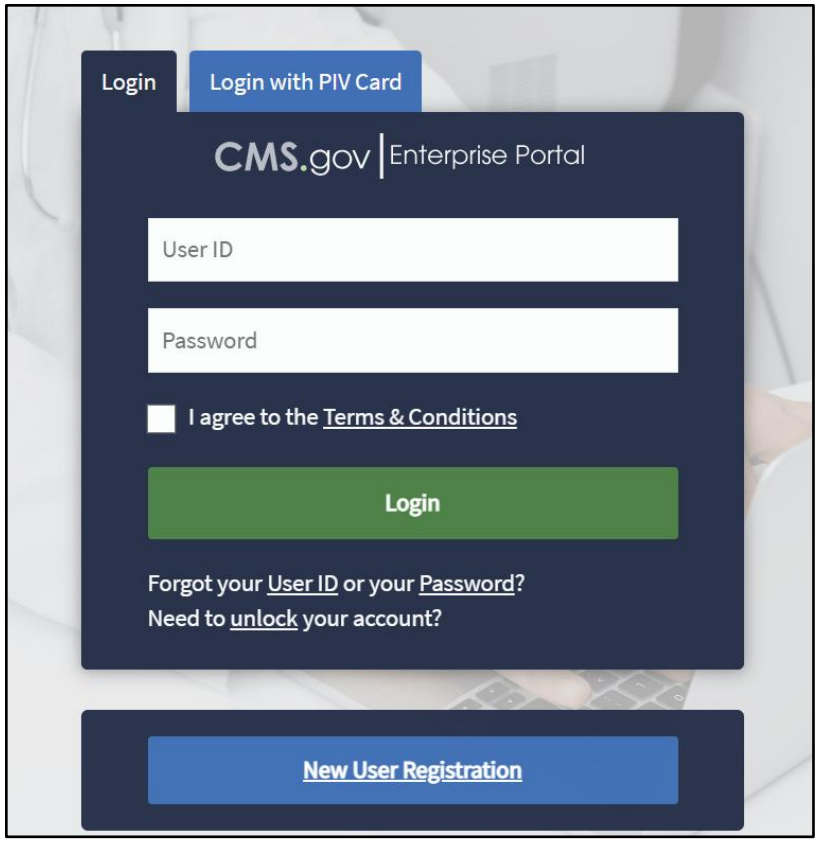
The Provider and Statistical Reimbursement (PS&R) System is a key tool for institutional healthcare providers, Medicare Administrative Contractors (MACs) and CMS. The system accumulates statistical and reimbursement data applicable to the processed and finalized Medicare Part A claims. This data is summarized in various reports, which are used by providers to prepare Medicare cost reports, and by MACs during the audit and settlement process.

The CMS has redesigned the PS&R system and the new system (PS&R Redesign) is a web-based, centralized system, housed at CMS. The previous PS&R (Legacy PS&R) is housed at each MAC. The PS&R Redesign shall be utilized to file and settle all cost reports with fiscal years ending January 31, 2009 and later. All cost reports with fiscal years ending prior to January 31, 2009 will continue to be filed and settled using data from the Legacy PS&R. The PS&R Redesign will only contain the data needed to file January 31, 2009 cost reports, and later. All data needed prior to that period must continue to be requested from the MAC.

Prior to accessing the PS&R system, users will first need to register for a user ID and password in CMS' Enterprise Identity Management system (EIDM). EIDM is the CMS identification and authentication system used to access CMS web-based applications. EIDM allows users to obtain one ID and password needed to access multiple web-based systems, one of which is the PS&R system. Links to the EIDM user guides and other helpful EIDM information are located on this page.

https://www.cms.gov/data-research/statistics-trends-and-reports/provider-statistical-reimbursement-report

https://portal.cms.gov/portal/



Financial Data

Cost Report Recordkeeping: Financial Data

- Trial Balance for the RHC/RHC Cost Centers
- RHC and non-RHC direct expenses
- Bad Debt Log for Medicare deductibles and coinsurance written off in the cost report period.
- Other statistical data
- P S & R report

No.	Account Name	Trial Balance		Adjustments		Adjusted trial balance	
		Dr	Cr	Dr	Cr	Dr	Cr
100	Cash	10000			420	9580	
112	Prepaid Insurance	2500			210	2290	
113	Supplies	3000			1320	1680	
120	Land	50000				50000	
122	Building	100000				100000	
123	Accumulated Deprication-Building				420		420
130	Furniture	24000				24000	
131	Accumulated Deprication-Furniture				350		350
200	Accounts Payable		7000				7000
212	Rent Rev. Recd in advance		6000	2100			3900
220	Mortgage payable		60000		600		60600
300	Share capital		90000				90000
400	Rent revenue		33100		2100		35200
505	Advertising Expense	800				800	
506	Depreciation Expense			770			770
510	Electricity Expense	1500				1500	
512	Insurance Expense			210			210
515	Interest Expense			600			600
525	Salaries Expense	4300		420		4720	
530	Supplies Expense			1320			1320
	TOTAL	**196100**	**196100**	**5420**	**5420**	**194570**	**200370**

Bad Debt Allowance

- Traditional Medicare Unpaid Deductibles and Coinsurance
- After a reasonable collection effort
- Dual eligible patients are deemed indigent after the Medicaid claim is file
- Not given to a collection agency
- Taken in the year they are written off
- Must Have a Bad Debt Log
- Reimburses .65 on the unpaid $

Someone should ask for this

Bad Debt Logs

Data Fields (with label locations)

Column Label	Expected Location	Required?	Data Validation Rules
Beneficiary Name	A13	Yes	Free text
MBI or HICN	B13	Yes	Free text
Dates of Service - From	C13	Yes	Date
Dates of Service - To	D13	Yes	Date, must be on or after Dates of Service - From
Medicaid No.	E13	No	Free text
Deemed Indigent	F13	No	Equal to "Y" or "N"
Remittance Advice Date - Medicare	G13	When Allowable Bad Debts is positive.	Date
Date First Bill Sent to Bene	H13	When Allowable Bad Debts is positive and Deemed Indigent is blank or 'N'.	Date or "QMB"
Collect. Efft. Cease Date	I13	When Allowable Bad Debts is positive.	Date
Medicare Deductible and Coinsurance Amounts - Deductible	J13	At least one of Deductible or Coinsurance must be populated when the provider is not an FQHC/RHC and when Allowable Bad Debts is positive.	Dollar amount
Medicare Deductible and Coinsurance Amounts - Coins.	K13	At least one of Deductible or Coinsurance must be populated when the provider is not an FQHC/RHC and when Allowable Bad Debts is positive.	Dollar amount
Allowable Bad Debts	L13	Yes	Dollar amount; sum total needs to match amount in cost report

https://www.cms.gov/files/document/rhc-cmhc-fqhc-esrd-snf-exhibit-1-medicare-bad-debt-specification.pdf

	A	B	C	D	E	F	G	H	I	J	K	L
1	**Supporting Exhibit**	Medicare Bad Debt Listing										
2												
3	**Provider Name**											
4	**Provider Number (CCN)**											
5	**FYE**											
6	**Bad Debts For (Choose One)**											
7	**Prepared By**											
8	**Date Prepared**											
9	**Subprovider**											
10												
11												
12	***Totals***									$0	$0	$0
13	**Beneficiary Name**	**MBI or HICN**	**Dates of Service - From**	**Dates of Service - To**	**Medicaid No.**	**Deemed Indigent**	**Remittance Advice Date - Medicare**	**Date First Bill Sent to Bene**	**Collect. Efft. Cease Date**	**Medicare Deductible and Coinsurance Amounts - Deductible**	**Medicare Deductible and Coinsurance Amounts - Coins.**	**Allowable Bad Debts**
14	1	2	3	4	5	6	7	8	9	10	11	12
15												
16												
17												
18												
19												
20												
21												

Downloads

RHC, CMHC, FQHC, ESRD, SNF Exhibit 1 Medicare Bad Debt Specification (PDF)

MedicareBD RHC, CMHC, FQHC, ESRD, SNF Exhibit 1 Template (XLSX)

https://www.cms.gov/medicare/audits-compliance/part-a-cost-report/electronic-cost-report-exhibit-templates

4090(Cont.) FORM CMS-2552-10 01-22

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	PROVIDER CCN: _____ COMPONENT CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET M-4

Check applicable boxes: [ ] Hospital-based RHC [ ] Hospital-based FQHC [ ] Title V [ ] Title XVIII [ ] Title XIX

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1	2	2.01	2.02	
1	Health care staff cost (from Worksheet M-1, column 7, line 10)					1
2	Ratio of injection/infusion staff time to total health care staff time					2
3	Injection/infusion health care staff cost (line 1 x line 2)					3
4	Injections/infusions and related medical supplies costs (from your records)					4
5	Direct cost of injections/infusions (line 3 plus line 4)					5
6	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, column 7, line 22)					6
7	Total overhead (from Worksheet M-2, line 19)					7
8	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)					8
9	Overhead cost - injection/infusion (line 7 x line 8)					9
10	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)					10
11	Total number of injections/infusions (from your records)					11
12	Cost per injection/infusion (line 10/line 11)					12
13	Number of injection/infusion administered to Program beneficiaries					13
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees					13.01
14	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)					14
15	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Worksheet M-3, line 2)					15
16	Total Program cost of injections/infusions and their					16

VACCINE COSTS REPORTED ON WORKSHEET M-4

Cost Report Recordkeeping: Vaccines

- Flu Vaccine Log
- Pneumococcal Vaccine Log
- COVID-19 Vaccine Log
- Hep B
- Invoices for private stock vaccine
- Total number of private vaccines (above) given
- Total number of Medicare vaccines given (tied to logs)

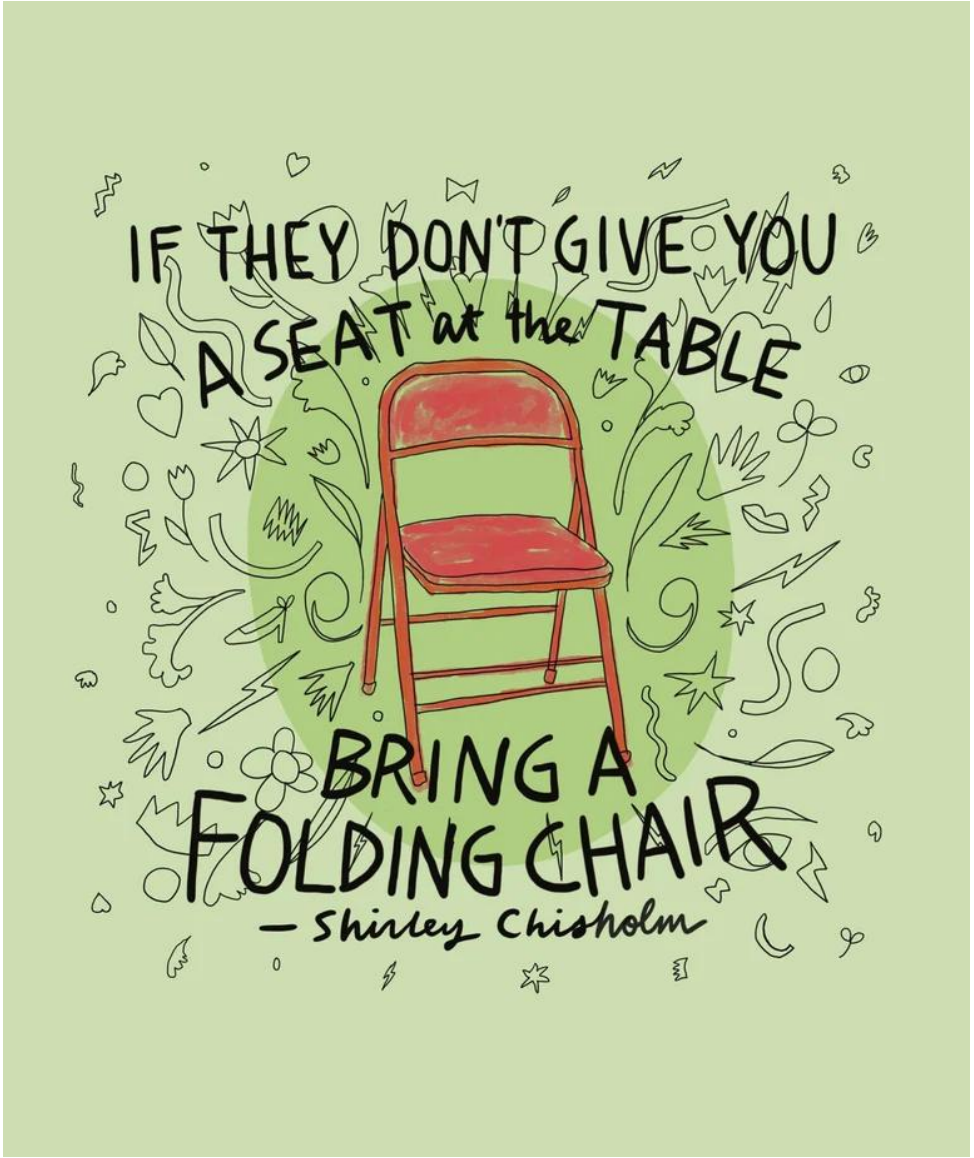
Only Traditional Medicare Captured on Cost Report

Changes in Vaccines beginning July 1, 2025

- They may be reported on the UB-04 claim for a partial FFS payment.
- Still reconciled on the cost report.
- Still need logs
- Still need total number of vaccine from private stock
- Still need total number of RW&B Medicare immunizations
- Do not report MA immunizations on cost report
- CMS has issued a Change Request to the MACs, but we have no details on how to put on the claim.

- ☐ Number of Qualified Unique RHC Encounters
- ☐ Remove nurse visits and non-RHC services
- ☐ Remove medical telehealth and care management
- ☐ Remove Medicaid visits which do not align with Medicare
- ☐ Medicare Preventive Services
- ☐ Number of Visits by Provider Type
- ☐ P S & R report
- ☐ Allocation of Provider Time/non-RHC hours
- ☐ Bad Debt Log
- ☐ Medicare Vaccine Log, Invoices, Total #

Who will know where to get data and validate the numbers better than you?



Questions & Comments

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