

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

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 the number of times the provider resubmitted this cost report		
		4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status	6. Date Received: _____	10. NPR Date: _____	
	(1) As Submitted	7. Contractor No.: _____	11. Contractor's Vendor Code: _____	
	(2) Settled without audit	8. ☐ Initial Report for this Provider CCN	12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.	
	(3) Settled with audit	9. ☐ Final Report for this Provider CCN		
	(4) Reopened			
	(5) Amended			

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. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY 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 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 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.

(Signed) _____

Officer or Administrator of Provider(s)

Title _____

Date _____

PART III - SETTLEMENT SUMMARY

		TITLE V 1	TITLE XVIII		HIT 4	TITLE XIX 5	
			PART A 2	PART B 3			
1	HOSPITAL						1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF						5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC						10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER (Specify)						12
200	TOTAL						200

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete this information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB 15-2, SECTIONS 4003.1-4003.3)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

PROVIDER CCN: _____	PERIOD FROM _____ TO _____	WORKSHEET S-2 PART I
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18 Hospital and Hospital Health Care Complex Address:

P.O. Box:			1
State:		Zip Code:	2
		County:	

Hospital and Hospital-Based Component Identification:

		Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)		
		0	1	2	3	4	5	V	XVIII	XIX
3	Hospital							6	7	8
4	Subprovider- IPF									
5	Subprovider- IRF									
6	Subprovider- (Other)									
7	Swing Beds-SNF									
8	Swing Beds-NF									
9	Hospital-Based SNF									
10	Hospital-Based NF									
11	Hospital-Based OLTC									
12	Hospital-Based HHA									
13	Separately Certified ASC									
14	Hospital-Based Hospice									
15	Hospital-Based Health Clinic-RHC									
16	Hospital-Based Health Clinic-FQHC									
17	Hospital-Based (CMHC, CORF and OPT)									
18	Renal Dialysis									
19	Other									

Inpatient PPS Information

22	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR §412.06 (c) (2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.		22
23	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.		23

		In-State Medicaid paid days	In-State Medicaid eligible <i>unpaid</i> days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible <i>unpaid</i> days	Medicaid HMO days	Other Medicaid days
		1	2	3	4	5	6
24	<i>If this provider is an IPPS hospital</i> , enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible <i>unpaid</i> days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible <i>unpaid</i> days in col. 4, Medicaid HMO <i>paid and eligible but unpaid</i> days in col. 5, and other Medicaid days in col. 6.						24
25	<i>If this provider is an IRF</i> , enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible <i>unpaid</i> days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible <i>unpaid</i> days in col. 4 Medicaid HMO <i>paid and eligible but unpaid</i> days in col. 5 and other Medicaid days in col. 6.						25
26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.						26
27	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. <i>If applicable enter the effective date of the geographic reclassification in column 2.</i>						27

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		PROVIDER CCN: _____	PERIOD FROM _____ TO _____	WORKSHEET S-2 PART I (CONT.)		
		Program Name 1	Program Code 2	Unweighted FTEs Nonprovider Site 3	Unweighted FTEs in Hospital 4	Ratio (col. 1/ (col. 1 + col. 2)) 3
Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 + column 2). (see instructions)			1	2	66
67	Enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)					
Inpatient Psychiatric Facility PPS						
70	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			1	2	3
71	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)					70 71
Inpatient Rehabilitation Facility PPS						
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes or "N" for no.					75
76	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)					76
Long Term Care Hospital PPS						
80	Is this a Long Term Care Hospital (LTCH)? Enter "Y" for yes or "N" for no.					80
TEFRA Providers						
85	Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.					85
86	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR §413.40(f)(1)(ii)? Enter "Y" for yes or "N" for no.					86
Title V and XIX Inpatient Services						
90	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in applicable column.					90
91	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.					91
92	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.					92
93	Does this facility operate an ICFMR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.					93
94	Does title V or title XIX reduce capital cost? Enter "Y" for yes or "N" for no in the applicable column.					94
95	If line 94 is "Y", enter the reduction percentage in the applicable column.					95
96	Does title V or title XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.					96
97	If line 96 is "Y", enter the reduction percentage in the applicable column.					97

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE	PROVIDER CCN: _____	PERIOD FROM _____ TO _____	WORKSHEET S-2 Part II
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General Instruction: Enter Y for all YES responses. Enter N for all NO responses.
Enter all dates in the mm/dd/yyyy format.

COMPLETED BY ALL HOSPITALS

		Y/N 1	Date 2		
Provider Organization and Operation					
1	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)				1
		Y/N 1	Date 2	V/I 3	
2	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.				2
3	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)				3

		Y/N 1	Type 2	Date 3	
Financial Data and Reports					
4	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.				4
5	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.				5

		Y/N 1	Y/N 2	
Approved Educational Activities				
6	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?			6
7	Are costs claimed for allied health programs? If yes, see instructions.			7
8	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.			8
9	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.			9
10	Was an Intern-Resident program initiated or renewed in the current cost reporting period? If yes, see instructions.			10
11	Are GME costs directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.			11

		Y/N	
Bad Debts			
12	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		12
13	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		13
14	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		14

Bed Complement			
15	Did total beds available change from the prior cost reporting period? If yes, see instructions.		15

		Part A		Part B		
		Y/N 1	Date 2	Y/N 3	Date 4	
PS&R Report Data						
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)					16
17	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)					17
18	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file the cost report? If yes, see instructions.					18
19	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.					19
20	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments: _____					20
21	Was the cost report prepared only using the provider's records? If yes, see instructions.					21

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX
REIMBURSEMENT QUESTIONNAIRE

PROVIDER CCN:

PERIOD
FROM _____
TO _____WORKSHEET S-2
Part II (CONT.)**General Instruction:** Enter Y for all YES responses. Enter N for all NO responses.
Enter all dates in the mm/dd/yyyy format.**COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)****Capital Related Cost**

22	Have assets been relifed for Medicare purposes? If yes, see instructions.		22
23	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		23
24	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions.		24
25	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		25
26	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		26
27	Has the provider's capitalization policy changed during the cost reporting period? If yes, see instructions.		27

Interest Expense

28	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		28
29	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions.		29
30	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		30
31	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		31

Purchased Services

32	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		32
33	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		33

Provider-Based Physicians

34	Are services furnished at the provider facility under an arrangement with provider-based physicians? If "Y" see instructions.		34
35	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		35

Home Office Costs

		Y/N	Date	
		1	2	
36	Are home office costs claimed on the cost report?			36
37	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			37
38	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			38
39	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39
40	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40

Cost Report Preparer Contact Information

41	First name:	Last name:	Title:	41
42	Employer:			42
43	Phone number:	E-mail Address:		43

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX

STATISTICAL DATA

WORKSHEET S-3

PART I

Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH Hours	Inpatient Days / Outpatient Visits / Trips			Full Time Equivalents			Discharges			10		
					Title V	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII		Title XIX	Total All Patients
1 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	1
2 HMO																
3 HMO IPF <i>Subprovider</i>																2
4 HMO IRF <i>Subprovider</i>																3
5 Hospital Adults & Peds. Swing Bed SNF																4
6 Hospital Adults & Peds. Swing Bed NF																5
7 Total Adults and Peds. (exclude observation beds) (see instructions)																6
8 Intensive Care Unit																7
9 Coronary Care Unit																8
10 Burn Intensive Care Unit																9
11 Surgical Intensive Care Unit																10
12 Other Special Care																11
13 Nursery																12
14 Total (see instructions)																13
15 CAH visits																14
16 Subprovider - IPF																15
17 Subprovider - IRF																16
18 Subprovider - Other																17
19 Skilled Nursing Facility																18
20 Nursing Facility																19
21 Other Long Term Care																20
22 Home Health Agency																21
23 ASC (Distinct Part)																22
24 Hospice (Distinct Part)																23
25 CMHC																24
26 RHC/FQHC (specify)																25
27 Total (sum of lines 14-26)																26
28 Observation Bed Days																27
29 Ambulance Trips																28
30 Employee discount days (see instructions)																29
31 Employee discount days -IRF																30
32 Labor & delivery days (see instructions)																31
33 LTCH non-covered days																32
																33

HOSPITAL WAGE INDEX INFORMATION	PROVIDER CCN: _____	PERIOD FROM _____ TO _____	WORKSHEET S-3 PART II
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Part II - Wage Data

	Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (column 2 ± column 3)	Paid Hours Related to Salaries in column 4	Average Hourly Wage (column 4 ÷ column 5)	
	1	2	3	4	5	6	
SALARIES							
1 Total salaries (see instructions)							1
2 Non-physician anesthetist Part A							2
3 Non-physician anesthetist Part B							3
4 Physician-Part A - <i>Administrative</i>							4
4.01 <i>Physician-Part A - Teaching</i>							4.01
5 Physician-Part B							5
6 Non-physician-Part B							6
7 Interns & residents (in an approved program)							7
7.01 <i>Contracted interns & residents (in an approved program)</i>							7.01
8 Home office personnel							8
9 SNF							9
10 Excluded area salaries (see instructions)							10
OTHER WAGES AND RELATED COSTS							
11 Contract labor (see instructions)							11
12 <i>Contract</i> management and administrative services							12
13 Contract labor: Physician-Part A - <i>Administrative</i>							13
14 Home office salaries & wage-related costs							14
15 Home office: Physician Part A - <i>Administrative</i>							15
16 <i>Home office & Contract Physicians Part A - Teaching</i>							16
WAGE-RELATED COSTS							
17 Wage-related costs (core) Worksheet S-3, Part IV line 24							17
18 Wage-related costs (other) Worksheet S-3, Part IV line 25							18
19 Excluded areas							19
20 Non-physician anesthetist Part A							20
21 Non-physician anesthetist Part B							21
22 Physician Part A - <i>Administrative</i>							22
22.01 <i>Physician Part A - Teaching</i>							22.01
23 Physician Part B							23
24 Wage-related costs (RHC/FQHC)							24
25 Interns & residents (in an approved program)							25

HOSPITAL WAGE INDEX INFORMATION	PROVIDER CCN: _____	PERIOD FROM _____ TO _____	WORKSHEET S-3 PART II & III
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Part II - Wage Data

	Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (column 2 ± column 3)	Paid Hours Related to Salaries in column 4	Average Hourly Wage (column 4 ÷ column 5)	
	1	2	3	4	5	6	
OVERHEAD COSTS - DIRECT SALARIES							
26 Employee Benefits	4						26
27 Administrative & General	5						27
28 Administrative & General under contract (see instructions)							28
29 Maintenance & Repairs	6						29
30 Operation of Plant	7						30
31 Laundry & Linen Service	8						31
32 Housekeeping	9						32
33 Housekeeping under contract (see instructions)							33
34 Dietary	10						34
35 Dietary under contract (see instructions)							35
36 Cafeteria	11						36
37 Maintenance of Personnel	12						37
38 Nursing Administration	13						38
39 Central Services and Supply	14						39
40 Pharmacy	15						40
41 Medical Records & Medical Records Library	16						41
42 Social Service	17						42
43 Other General Service	18						43

Part III - Hospital Wage Index Summary

1 Net salaries (see instructions)							1
2 Excluded area salaries (see instructions)							2
3 Subtotal salaries (line 1 minus line 2)							3
4 Subtotal other wages and related costs (see instructions)							4
5 Subtotal wage-related costs (see instructions)							5
6 Total (sum of lines 3 through 5)							6
7 Total overhead cost (see instructions)							7

HOSPITAL WAGE RELATED COSTS	PROVIDER CCN:	PERIOD FROM _____ TO _____	WORKSHEET S-3, PART IV
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Part IV - Wage Related Cost

Part A - Core List

		Amount Reported
RETIREMENT COST		
1	401k Employer Contributions	1
2	Tax Sheltered Annuity (TSA) Employer Contribution	2
3	<i>Nonqualified Defined Benefit Plan Cost (see instructions)</i>	3
4	<i>Qualified Defined Benefit Plan Cost (see instructions)</i>	4
PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
5	401k/TSA Plan Administration fees	5
6	Legal/Accounting/Management Fees-Pension Plan	6
7	Employee Managed Care Program Administration Fees	7
HEALTH AND INSURANCE COST		
8	Health Insurance (Purchased or Self Funded)	8
9	Prescription Drug Plan	9
10	Dental, Hearing and Vision Plan	10
11	Life Insurance (If employee is owner or beneficiary)	11
12	Accident Insurance (If employee is owner or beneficiary)	12
13	Disability Insurance (If employee is owner or beneficiary)	13
14	Long-Term Care Insurance (If employee is owner or beneficiary)	14
15	Workers' Compensation Insurance	15
16	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	16
TAXES		
17	FICA-Employers Portion Only	17
18	Medicare Taxes - Employers Portion Only	18
19	Unemployment Insurance	19
20	State or Federal Unemployment Taxes	20
OTHER		
21	Executive Deferred Compensation (<i>Other Than Retirement Cost Reported on lines 1 through 4 above</i>)see instructions))	21
22	Day Care Cost and Allowances	22
23	Tuition Reimbursement	23
24	Total Wage Related cost (Sum of lines 1 -23)	24

Part B - Other than Core Related Cost

25	Other Wage Related Costs (specify) _____	25
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HOSPITAL CONTRACT LABOR AND BENEFIT COST

PROVIDER CCN:

PERIOD:

FROM _____

TO _____

WORKSHEET S-3,

PART V

Part V - Contract Labor and Benefit Cost

Hospital and Hospital-Based Component Identification:

Component		Contract Labor	Benefit Cost	
0		1	2	
1	Total facility contract labor and benefit cost			1
2	Hospital			2
3	Subprovider- IPF			3
4	Subprovider- IRF			4
5	Subprovider- (Other)			5
6	Swing Beds-SNF			6
7	Swing Beds-NF			7
8	Hospital-Based SNF			8
9	Hospital-Based NF			9
10	Hospital-Based OLTC			10
11	Hospital-Based HHA			11
12	Separately Certified ASC			12
13	Hospital-Based Hospice			13
14	Hospital-Based Health Clinic RHC			14
15	Hospital-Based Health Clinic FQHC			15
16	Hospital-Based-CMHC			16
17	Renal Dialysis			17
18	Other			18

HOSPITAL-BASED HOME HEALTH AGENCY
STATISTICAL DATA

PROVIDER CCN:

PERIOD:
FROM _____
TO _____

WORKSHEET S-4

HOME HEALTH AGENCY STATISTICAL DATA

County: _____

Description	Title V 1	Title XVIII 2	Title XIX 3	Other 4	Total 5	
1 Home Health Aide Hours						1
2 Unduplicated Census Count (see instructions)						2

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES

Enter the number of hours in your normal work week _____		Number of Employees (Full Time Equivalent)			
		Staff	Contract	Total	
		1	2	3	
3 Administrator and Assistant Administrator(s)					3
4 Director(s) and Assistant Director(s)					4
5 Other Administrative Personnel					5
6 Direct Nursing Service					6
7 Nursing Supervisor					7
8 Physical Therapy Service					8
9 Physical Therapy Supervisor					9
10 Occupational Therapy Service					10
11 Occupational Therapy Supervisor					11
12 Speech Pathology Service					12
13 Speech Pathology Supervisor					13
14 Medical Social Service					14
15 Medical Social Service Supervisor					15
16 Home Health Aide					16
17 Home Health Aide Supervisor					17
18 Other (specify)					18

HOME HEALTH AGENCY CBSA CODES

19	Enter the number of CBSAs where you provided services during the cost reporting period.		19
20	List those CBSA code(s) serviced during this cost reporting period (line 20 contains the first code).		20

PPS ACTIVITY

		Full Episodes		LUPA Episodes 3	PEP only Episodes 4	Total (columns 1 through 4) 5	
		Without Outliers	With Outliers				
		1	2				
21	Skilled Nursing Visits						21
22	Skilled Nursing Visit Charges						22
23	Physical Therapy Visits						23
24	Physical Therapy Visit Charges						24
25	Occupational Therapy Visits						25
26	Occupational Therapy Visit Charges						26
27	Speech Pathology Visits						27
28	Speech Pathology Visit Charges						28
29	Medical Social Service Visits						29
30	Medical Social Service Visit Charges						30
31	Home Health Aide Visits						31
32	Home Health Aide Visit Charges						32
33	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)						33
34	Other Charges						34
35	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)						35
36	Total Number of Episodes (standard/non-outlier)						36
37	Total Number of Outlier Episodes						37
38	Total Non-Routine Medical Supply Charges						38

HOSPITAL RENAL DIALYSIS DEPARTMENT
STATISTICAL DATA

PROVIDER CCN: _____

PERIOD:
FROM _____
TO _____

WORKSHEET S-5

RENAL DIALYSIS STATISTICS

DESCRIPTION	Outpatient		Training		Home		
	Regular	High Flux	Hemo-dialysis	CAPD CCPD	Hemo-dialysis	CAPD CCPD	
	1	2	3	4	5	6	
1 Number of patients in program at end of cost reporting period							1
2 Number of times per week patient receives dialysis							2
3 Average patient dialysis time including setup							3
4 CAPD exchanges per day							4
5 Number of days in year dialysis furnished							5
6 Number of stations							6
7 Treatment capacity per day per station							7
8 Utilization (see instructions)							8
9 Average times dialyzers re-used							9
10 Percentage of patients re-using dialyzers							10

TRANSPLANT INFORMATION

11 Number of patients on transplant list		11
12 Number of patients transplanted during the cost reporting period		12

EPOETIN

13 Net costs of Epoetin furnished to all maintenance dialysis patients by the provider		13
14 Epoetin amount from Worksheet A for home dialysis program		14
15 Number of EPO units furnished relating to the renal dialysis department		15
16 Number of EPO units furnished relating to the home dialysis department		16

ARANESP

17 Net costs of ARANESP furnished to all maintenance dialysis patients by the provider		17
18 ARANESP amount from Worksheet A for home dialysis program		18
19 Number of ARANESP units furnished relating to the renal dialysis department		19
20 Number of ARANESP units furnished relating to the home dialysis department		20

PHYSICIAN PAYMENT METHOD (Enter "X" for applicable method(s))

21 MCP _____ INITIAL METHOD _____	21
-----------------------------------	----

HOSPITAL-BASED COMMUNITY MENTAL HEALTH CENTER AND
OTHER OUTPATIENT REHABILITATION
PROVIDER STATISTICAL DATA

PROVIDER CCN: _____

PERIOD:
FROM _____
TO _____

WORKSHEET S-6

COMMUNITY MENTAL HEALTH & OTHER OUTPATIENT REHABILITATION PROVIDER- NUMBER OF EMPLOYEES (FULL TIME EQUIVALENT)

Check applicable box: ☐ CMHC ☐ OOT
☐ CORF ☐ OSP
☐ OPT

Enter the number of hours in your normal workweek _____

		Staff	Contract	Total (column 1 + column 2)	
		1	2	3	
1	Administrator and Assistant Administrator(s)				1
2	Director(s) and Assistant Director(s)				2
3	Other Administrative Personnel				3
4	Direct Nursing Service				4
5	Nursing Supervisor				5
6	Physical Therapy Service				6
7	Physical Therapy Supervisor				7
8	Occupational Therapy Service				8
9	Occupational Therapy Supervisor				9
10	Speech Pathology Service				10
11	Speech Pathology Supervisor				11
12	Medical Social Service				12
13	Medical Social Service Supervisor				13
14	Respiratory Therapy Service				14
15	Respiratory Therapy Supervisor				15
16	Psychiatric/Psychological Service				16
17	Psychiatric/Psychological Service Supervisor				17
18	Other (specify)				18

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	PROVIDER CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET S-7
---	------------------------	-----------------------------------	---------------

		Y/N 1	Date 2	
1	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes and do not complete the rest of this worksheet.			1
2	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.			2

	Group 1	SNF Days 2	Swing Bed SNF Days 3	TOTAL (sum of col. 2 + 3) 4	
3	RUX				3
4	RUL				4
5	RVX				5
6	RVL				6
7	RHX				7
8	RHL				8
9	RMX				9
10	RML				10
11	RLX				11
12	RUC				12
13	RUB				13
14	RUA				14
15	RVC				15
16	RVB				16
17	RVA				17
18	RHC				18
19	RHB				19
20	RHA				20
21	RMC				21
22	RMB				22
23	RMA				23
24	RLB				24
25	RLA				25
26	ES3				26
27	ES2				27
28	ES1				28
29	HE2				29
30	HE1				30
31	HD2				31
32	HD1				32
33	HC2				33
34	HC1				34
35	HB2				35
36	HB1				36
37	LE2				37
38	LE1				38
39	LD2				39
40	LD1				40
41	LC2				41
42	LC1				42
43	LB2				43
44	LB1				44
45	CE2				45
46	CE1				46
47	CD2				47
48	CD1				48
49	CC2				49
50	CC1				50
51	CB2				51
52	CB1				52
53	CA2				53
54	CA1				54

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	PROVIDER CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET S-7 (CONT.)
---	------------------------	-----------------------------------	--------------------------

	Group 1	SNF Days 2	Swing Bed SNF Days 3	TOTAL (sum of col. 2 + 3) 4	
55	SE3				55
56	SE2				56
57	SE1				57
58	SSC				58
59	SSB				59
60	SSA				60
61	IB2				61
62	IB1				62
63	IA2				63
64	IA1				64
65	BB2				65
66	BB1				66
67	BA2				67
68	BA1				68
69	PE2				69
70	PE1				70
71	PD2				71
72	PD1				72
73	PC2				73
74	PC1				74
75	PB2				75
76	PB1				76
77	PA2				77
78	PA1				78
199	AAA				199
200	TOTAL				200

SNF SERVICES

		CBSA at Beginning of Cost Reporting Period 1	CBSA on/after October 1 of the Cost Reporting Period (if applicable) 2	
201	Enter in column 1 the SNF CBSA code, or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2 the code in effect on or after October 1 of the cost reporting period (if applicable).			201

A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)

	Expenses 1	Percentage 2	Associated with Direct Patient Care and Related Expenses? 3	
202	Staffing			202
203	Recruitment			203
204	Retention of employees			204
205	Training			205
206	Other (Specify)			206
207	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)			207

HOSPITAL-BASED RURAL HEALTH CLINIC/ FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		PROVIDER CCN: _____ COMPONENT CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET S-8
Check applicable box:	☐ RHC ☐ FQHC			

Clinic Address and Identification:

1	Street:				1
2	City:	State:	Zip Code:	County:	2
3	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				3

Source of Federal Funds:

		Grant Award	Date	
		1	2	
4	Community Health Center (Section 330(d), PHS Act)			4
5	Migrant Health Center (Section 329(d), PHS Act)			5
6	Health Services for the Homeless (Section 340(d), PHS Act)			6
7	Appalachian Regional Commission			7
8	Look-alikes			8
9	Other (specify)			9
10	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate the number of other operations in column 2.	1	2	10

Facility hours of operations (1)

	Type Operation	Sunday		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		
		from	to	from	to	from	to	from	to	from	to	from	to			
0		1	2	3	4	5	6	7	8	9	10	11	12	13	14	
11	Clinic															11

- (1) Enter clinic hours of operation on line 11 and other type operations on subscripts of line 11 (both type and hours of operation). List hours of operation based on a 24 hour clock. For example: 8:00am is 0800, 6:30pm is 1830, and midnight is 2400.

12	Have you received an approval for an exception to the productivity standard?	1	2	
13	Is this a consolidated cost report as defined in CMS Pub. 104-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			13
14	Provider name: _____ CCN number: _____			14

		Y/N	V	XVIII	XIX	Total Visits	
		1	2	3	4	5	
15	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15

HOSPICE IDENTIFICATION DATA	PROVIDER CCN:	PERIOD:	WORKSHEET S-9 PARTS I & II
	HOSPICE NO.:	FROM _____ TO _____	

PART I - ENROLLMENT DAYS

		Unduplicated Days					Total (sum of cols. 1, 2 & 5)	
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other		
		1	2	3	4	5		
1	Continuous Home Care							1
2	Routine Home Care							2
3	Inpatient Respite Care							3
4	General Inpatient Care							4
5	Total Hospice Days							5

PART II - CENSUS DATA

		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2 & 5)	
		1	2	3	4	5	6	
6	Number of Patients Receiving Hospice Care							6
7	Total Number of Unduplicated Continuous Care Hours Billable to Medicare							7
8	Average Length of Stay (line 5/line 6)							8
9	Unduplicated Census Count							9

NOTE: Parts I & II, columns 1 and 2 also include the days reported in columns 3 and 4.

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	PROVIDER CCN:	PERIOD: FROM _____ TO _____	WORKSHEET S-10
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Uncompensated and indigent care cost computation			
1	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		1

Medicaid (see instructions for each line)			
2	Net revenue from Medicaid		2
3	Did you receive DSH or supplemental payments from Medicaid?		3
4	If line 3 is yes, does line 2 include all DSH or supplemental payments from Medicaid?		4
5	If line 4 is no, enter DSH or supplemental payments from Medicaid		5
6	Medicaid charges		6
7	Medicaid cost (line 1 times line 6)		7
8	Difference between net revenue and costs for Medicaid program (line 7 minus lines 2 and 5). <i>If line 7 is less than the sum of lines 2 and 5, then enter zero.</i>		8

State Children's Health Insurance Program (SCHIP) (see instructions for each line)			
9	Net revenue from stand-alone SCHIP		9
10	Stand-alone SCHIP charges		10
11	Stand-alone SCHIP cost (line 1 times line 10)		11
12	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9). <i>If line 11 is less than line 9, then enter zero.</i>		12

Other state or local government indigent care program (see instructions for each line)			
13	Net revenue from state or local indigent care program (not included on lines 2, 5 or 9)		13
14	Charges for patients covered under state or local indigent care program (not included in lines 6 or 10)		14
15	State or local indigent care program cost (line 1 times line 14)		15
16	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13). <i>If line 15 is less than line 13, then enter zero.</i>		16

Uncompensated care (see instructions for each line)			
17	Private grants, donations, or endowment income restricted to funding charity care		17
18	Government grants, appropriations or transfers for support of hospital operations		18
19	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		19

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1	2	3	
20	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility				20
21	Cost of initial obligation of patients approved for charity care (line 1 times line 20)				21
22	Partial payment by patients approved for charity care				22
23	Cost of charity care (line 21 minus line 22)				23

24	Does the amount in line 20, column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?				24
25	If line 24 is yes, enter charges for patient days beyond an indigent care program's length of stay limit (see instructions)				25
26	Total bad debt expense for the entire hospital complex (see instructions)				26
27	Medicare bad debts for the entire hospital complex (see instructions)				27
28	Non-Medicare and non-reimbursable bad debt expense (line 26 minus line 27)				28
29	Cost of non-Medicare bad debt expense (line 1 times line 28)				29
30	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)				30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)				31

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES					PROVIDER CCN:		PERIOD: FROM _____ TO _____		WORKSHEET A	
COST CENTER DESCRIPTIONS (omit cents)		SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 + col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 + col. 6)		
		1	2	3	4	5	6	7		
GENERAL SERVICE COST CENTERS										
1	00100 Capital Related Costs-Buildings and Fixtures								1	
2	00200 Capital Related Costs-Movable Equipment								2	
3	00300 Other Capital Related Costs							-0-	3	
4	00400 Employee Benefits								4	
5	00500 Administrative and General								5	
6	00600 Maintenance and Repairs								6	
7	00700 Operation of Plant								7	
8	00800 Laundry and Linen Service								8	
9	00900 Housekeeping								9	
10	01000 Dietary								10	
11	01100 Cafeteria								11	
12	01200 Maintenance of Personnel								12	
13	01300 Nursing Administration								13	
14	01400 Central Services and Supply								14	
15	01500 Pharmacy								15	
16	01600 Medical Records & Medical Records Library								16	
17	01700 Social Service								17	
18	Other General Service (specify)								18	
19	01900 Nonphysician Anesthetists								19	
20	02000 Nursing School								20	
21	02100 Intern & Res. Service-Salary & Fringes (Approved)								21	
22	02200 Intern & Res. Other Program Costs (Approved)								22	
23	02300 Paramedical Ed. Program (specify)								23	
INPATIENT ROUTINE SERVICE COST CENTERS										
30	03000 Adults and Pediatrics (General Routine Care)								30	
31	03100 Intensive Care Unit								31	
32	03200 Coronary Care Unit								32	
33	03300 Burn Intensive Care Unit								33	
34	03400 Surgical Intensive Care Unit								34	
35	Other Special Care (specify)								35	
40	04000 Subprovider - IPF								40	
41	04100 Subprovider - IRF								41	
42	04200 Subprovider (specify)								42	
43	04300 Nursery								43	
44	04400 Skilled Nursing Facility								44	
45	04500 Nursing Facility								45	
46	04600 Other Long Term Care								46	

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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES					PROVIDER CCN:		PERIOD: FROM _____ TO _____		WORKSHEET A	
COST CENTER DESCRIPTIONS (omit cents)			SALARIES		OTHER	TOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 ± col. 6)
			1	2	3	4	5	6	7	
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room								50
51	05100	Recovery Room								51
52	05200	Labor Room and Delivery Room								52
53	05300	Anesthesiology								53
54	05400	Radiology-Diagnostic								54
55	05500	Radiology-Therapeutic								55
56	05600	Radiolisothe								56
57	05700	Computed Tomography (CT) Scan								57
58	05800	Magnetic Resonance Imaging (MRI)								58
59	05900	Cardiac Catheterization								59
60	06000	Laboratory								60
61	06100	PBP Clinical Laboratory Services-Program Only								61
62	06200	Whole Blood & Packed Red Blood Cells								62
63	06300	Blood Storing, Processing, & Transf.								63
64	06400	Intravenous Therapy								64
65	06500	Respiratory Therapy								65
66	06600	Physical Therapy								66
67	06700	Occupational Therapy								67
68	06800	Speech Pathology								68
69	06900	Electrocardiology								69
70	07000	Electroencephalography								70
71	07100	Medical Supplies Charged to Patients								71
72	07200	Implantable Devices Charged to Patients								72
73	07300	Drugs Charged to Patients								73
74	07400	Renal Dialysis								74
75	07500	ASC (Non-Distinct Part)								75
76		Other Ancillary (specify)								76
		OUTPATIENT SERVICE COST CENTERS								
88	08800	Rural Health Clinic (RHC)								88
89	08900	Federally Qualified Health Center (FQHC)								89
90	09000	Clinic								90
91	09100	Emergency								91
92	09200	Observation Beds								92
93		Other Outpatient Service (specify)								93

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES					PROVIDER CCN:	PERIOD: FROM _____ TO _____		WORKSHEET A	
COST CENTER DESCRIPTIONS (omit cents)		SALARIES 1	OTHER 2	TOTAL (col. 1 + col. 2) 3	RECLASSIFI- CATIONS 4	RECLASSIFIED TRIAL BALANCE (col. 3 + col. 4) 5	ADJUSTMENTS 6	NET EXPENSES FOR ALLOCATION (col. 5 + col. 6) 7	
	OTHER REIMBURSABLE COST CENTERS								
94	09400 Home Program Dialysis								94
95	09500 Ambulance Services								95
96	09600 Durable Medical Equipment-Rented								96
97	09700 Durable Medical Equipment-Sold								97
98	Other Reimbursable (specify)								98
99	Outpatient Rehabilitation Provider (specify)								99
100	10000 Intern-Resident Service (not appvd. rchg. prgm.)								100
101	10100 Home Health Agency								101
	SPECIAL PURPOSE COST CENTERS								
105	10500 Kidney Acquisition								105
106	10600 Heart Acquisition								106
107	10700 Liver Acquisition								107
108	10800 Lung Acquisition								108
109	10900 Pancreas Acquisition								109
110	11000 Intestinal Acquisition								110
111	11100 Islet Acquisition								111
112	Other Organ Acquisition (specify)								112
113	11300 Interest Expense							- 0 -	113
114	11400 Utilization Review-SNF							- 0 -	114
115	11500 Ambulatory Surgical Center (Distinct Part)								115
116	11600 Hospice								116
117	Other Special Purpose (specify)								117
118	SUBTOTALS (sum of lines 1-117)								118
	NONREIMBURSABLE COST CENTERS								
190	19000 Gift, Flower, Coffee Shop, & Canteen								190
191	19100 Research								191
192	19200 Physicians' Private Offices								192
193	19300 Nonpaid Workers								193
194	Other Nonreimbursable (specify)								194
200	TOTAL (sum of lines 118-199)				- 0 -				200

RECLASSIFICATIONS

WORKSHEET A-6

PROVIDER CCN: _____

PERIOD:
FROM _____
TO _____

EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES			DECREASES			OTHER	Wkst. A-7 Ref.
		COST CENTER 2	LINE # 3	SALARY 4	COST CENTER 6	LINE # 7	SALARY 8		
1									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34
35									35
500	Total reclassifications (sum of columns 4 and 5 must equal sum of columns 8 and 9)								500

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.

Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

RECONCILIATION OF CAPITAL COSTS CENTERS

PROVIDER CCN: _____

PERIOD:
FROM _____
TO _____WORKSHEET A-7,
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES

Description	Beginning Balances	Acquisitions		Disposals and Retirements	Ending Balance	Fully Depreciated Assets
		Purchases	Donation			
1 Land	1	2	3	5	6	7
2 Land Improvements						1
3 Buildings and Fixtures						2
4 Building Improvements						3
5 Fixed Equipment						4
6 Movable Equipment						5
7 HIT-designated Assets						6
8 Subtotal (sum of lines 1-7)						7
9 Reconciling Items						8
10 Total (line 7 minus line 9)						9
						10

PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 AND 2

Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)
	9	10	11	12	13	14	15
* 1 Capital Related Costs-Buildings and Fixtures							1
2 Capital Related Costs-Movable Equipment							2
3 Total (sum of lines 1-2)							3

(1) The amount in columns 9 through 14 must equal the amount on Worksheet A, column 2, lines 1 and 2. Enter in each column the appropriate amounts including any directly assigned cost that may have been included in Worksheet A, column 2, lines 1 and 2.

* All lines numbers are to be consistent with Worksheet A line numbers for capital cost centers.

PART III - RECONCILIATION OF CAPITAL COSTS CENTERS

Description	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL			
	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)
1	1	2	3	4	5	6	7	8
* 1 Capital Related Costs-Buildings and Fixtures								1
2 Capital Related Costs-Movable Equipment								2
3 Total (sum of lines 1-2)				1.000000				3

Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)
	9	10	11	12	13	14	15
* 1 Capital Related Costs-Buildings and Fixtures							1
2 Capital Related Costs-Movable Equipment							2
3 Total (sum of lines 1-2)							3

(2) The amounts on lines 1 and 2 must equal the corresponding amounts on Worksheet A, column 7, lines 1 and 2. Columns 9 through 14 should include related

Worksheet A-6 reclassifications, Worksheet A-8 adjustments, and Worksheet A-8-1 related organizations and home office costs. (See instructions.)

FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTIONS 4015)

ADJUSTMENTS TO EXPENSES	PROVIDER CCN:	PERIOD: FROM _____ TO _____	WORKSHEET A-8
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1	DESCRIPTION (1)	BASIS/CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		Wkst. A-7 Ref.	
				COST CENTER	LINE #		
				3	4		
1	Investment income - buildings and fixtures (chapter 2)			Buildings and Fixtures	1		1
2	Investment income - movable equipment (chapter 2)			Movable Equipment	2		2
3	Investment income - other (chapter 2)						3
4	Trade, quantity, and time discounts (chapter 8)						4
5	Refunds and rebates of expenses (chapter 8)						5
6	Rental of provider space by suppliers (chapter 8)						6
7	Telephone services (pay stations excluded) (chapter 21)						7
8	Television and radio service (chapter 21)						8
9	Parking lot (chapter 21)						9
10	Provider-based physician adjustment	Worksheet A-8-2					10
11	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Worksheet A-8-1					12
13	Laundry and linen service						13
14	Cafeteria-employees and guests						14
15	Rental of quarters to employee and others						15
16	Sale of medical and surgical supplies to other than patients						16
17	Sale of drugs to other than patients						17
18	Sale of medical records and abstracts						18
19	Nursing school (tuition, fees, books, etc.)						19
20	Vending machines						20
21	Income from imposition of interest, finance or penalty charges (chapter 21)						21
22	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments						22
23	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	Worksheet A-8-3		Respiratory Therapy	65		23
24	Adjustment for physical therapy costs in excess of limitation (chapter 14)	Worksheet A-8-3		Physical Therapy	66		24
25	Utilization review - physicians' compensation (chapter 21)			Utilization Review - SNF	114		25
26	Depreciation - buildings and fixtures			Buildings and Fixtures	1		26
27	Depreciation - movable equipment			Movable Equipment	2		27
28	Non-physician Anesthetist			Nonphysician Anesthetist	19		28
29	Physicians' assistant						29
30	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	Worksheet A-8-3		Occupational Therapy	67		30
31	Adjustment for speech pathology costs in excess of limitation (chapter 14)	Worksheet A-8-3		Speech Pathology	68		31
32	CAH HIT Adjustment for Depreciation						32
33	Other adjustments (specify) ⁽³⁾						33
50	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200)						50

- (1) Description - all chapter references in this column pertain to CMS Pub. 15-1
- (2) Basis for adjustment (see instructions)
- A. Costs - if cost, including applicable overhead, can be determined
- B. Amount Received - if cost cannot be determined
- (3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	PROVIDER CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET A-8-1
---	------------------------	-----------------------------------	-----------------

**A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS
OR CLAIMED HOME OFFICE COSTS:**

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount included in Wkst. A column 5	Net Adjustments (col. 4 minus col. 5) *	Wkst. A-7 Ref.	
	1	2	3	4	5	6	7	
	1							1
	2							2
	3							3
	4							4
	5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.						5

* The amounts on lines 1 through 4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which have not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

	Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office			
				Name	Percentage of Ownership	Type of Business	
	1	2	3	4	5	6	
6							6
7							7
8							8
9							9
10							10

(1) Use the following symbols to indicate interrelationship to related organizations:

- FORM CMS-255
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
 - B. Corporation, partnership, or other organization has financial interest in provider.
 - C. Provider has financial interest in corporation, partnership, or other organization.
 - D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
 - E. Individual is director, officer, administrator, or key person of provider and related organization.
 - F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.
 - G. Other (financial or non-financial) specify _____

PROVIDER-BASED PHYSICIANS ADJUSTMENTS

PROVIDER CCN:

PERIOD:
FROM
TO

Wkst. A Line #	Cost Center/ Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit
1	2	3	4	5	6	7	8	9
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
200	TOTAL							200

Wkst. A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment
10	11	12	13	14	15	16	17	18
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
200	TOTAL							200

REASONABLE COST DETERMINATION FOR THERAPY SERVICES
FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3,
PARTS III & IV

PROVIDER CCN: _____
PERIOD:
FROM _____
TO _____

Check applicable box: ☐ Occupational ☐ Physical ☐ Respiratory ☐ Speech Pathology

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

Standard Travel Allowance	
24 Therapists (line 3 times column 2, line 11)	24
25 Assistants (line 4 times column 3, line 11)	25
26 Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	26
27 Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	27
28 Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	28
Optional Travel Allowance and Optional Travel Expense	
29 Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	29
30 Assistants (column 3, line 10 times column 3, line 12)	30
31 Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	31
32 Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	32
33 Standard travel allowance and standard travel expense (line 28)	33
34 Optional travel allowance and standard travel expense (sum of lines 27 and 31)	34
35 Optional travel allowance and optional travel expense (sum of lines 31 and 32)	35

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

Standard Travel Expense	
36 Therapists (line 5 times column 2, line 11)	36
37 Assistants (line 6 times column 3, line 11)	37
38 Subtotal (sum of lines 36 and 37)	38
39 Standard travel expense (line 7 times the sum of lines 5 and 6)	39
Optional Travel Allowance and Optional Travel Expense	
40 Therapists (sum of columns 1 and 2, line 9 times column 2, line 10)	40
41 Assistants (column 3, line 9 times column 3, line 10)	41
42 Subtotal (sum of lines 40 and 41)	42
43 Optional travel expense (line 8 times the sum of columns 1-3, line 13)	43
Total Travel Allowance and Travel Expense - Offsite Services: Complete one of the following three lines 44, 45, or 46, as appropriate.	
44 Standard travel allowance and standard travel expense (sum of lines 38 and 39) (see instructions)	44
45 Optional travel allowance and standard travel expense (sum of lines 39 and 42) (see instructions)	45
46 Optional travel allowance and optional travel expense (sum of lines 42 and 43) (see instructions)	46

REASONABLE COST DETERMINATION FOR THERAPY SERVICES
FURNISHED BY OUTSIDE SUPPLIERSWORKSHEET A-8-3,
PARTS V-VI

Check applicable box:	☐ Occupational	☐ Physical	☐ Respiratory	☐ Speech Pathology
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PART V - OVERTIME COMPUTATION

	Therapists 1	Assistants 2	Aides 3	Trainees 4	Total 5
47	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)				47
48	Overtime rate (see instructions)				48
49	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)				49
	CALCULATION OF LIMIT				
50	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked in column 5, line 47)				50
51	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)				51
	DETERMINATION OF OVERTIME ALLOWANCE				
52	Adjusted hourly salary equivalency amount (see instructions)				52
53	Overtime cost limitation (line 51 times line 52)				53
54	Maximum overtime cost (enter the lesser of line 49 or line 53)				54
55	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)				55
56	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)				56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	Salary equivalency amount (from line 23)		57
58	Travel allowance and expense - provider site (from lines 33, 34, or 35))		58
59	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)		59
60	Overtime allowance (from column 5, line 56)		60
61	Equipment cost (see instructions)		61
62	Supplies (see instructions)		62
63	Total allowance (sum of lines 57-62)		63
64	Total cost of outside supplier services (from provider records)		64
65	Excess over limitation (line 64 minus line 63; if negative, enter zero)		65

COST ALLOCATION - GENERAL SERVICE COSTS

PERIOD:
FROM _____
TO _____

PROVIDER CCN: _____

WORKSHEET B,
PART I

COST CENTER DESCRIPTIONS	NET EXPENSES FOR COST ALLOCATION (from Wkst. A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS 4	SUBTOTAL (cols. 0-4) 4A	ADMINIS- TRATIVE & GENERAL 5	MAIN- TENANCE & REPAIRS 6	OPERATION OF PLANT 7
		BLDGS. & FIXTURES 1	MOVABLE EQUIPMENT 2					
GENERAL SERVICE COST CENTERS								
1 Capital Related Costs-Buildings and Fixtures								1
2 Capital Related Costs-Movable Equipment								2
4 Employee Benefits								4
5 Administrative and General								5
6 Maintenance and Repairs								6
7 Operation of Plant								7
8 Laundry and Linen Service								8
9 Housekeeping								9
10 Dietary								10
11 Cafeteria								11
12 Maintenance of Personnel								12
13 Nursing Administration								13
14 Central Services and Supply								14
15 Pharmacy								15
16 Medical Records & Medical Records Library								16
17 Social Service								17
18 Other General Service (specify)								18
19 Nonphysician Anesthetists								19
20 Nursing School								20
21 Intern & Res. Service-Salary & Fringes (Approved)								21
22 Intern & Res. Other Program Costs (Approved)								22
23 Paramedical Education Program (specify)								23
INPATIENT ROUTINE SERVICE COST CENTERS								
30 Adults and Pediatrics (General Routine Care)								30
31 Intensive Care Unit								31
32 Coronary Care Unit								32
33 Burn Intensive Care Unit								33
34 Surgical Intensive Care Unit								34
35 Other Special Care Unit (specify)								35
40 Subprovider IPF								40
41 Subprovider IRF								41
42 Subprovider (specify)								42
43 Nursery								43
44 Skilled Nursing Facility								44
45 Nursing Facility								45
46 Other Long Term Care								46

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B,
PART IPERIOD:
FROM _____
TO _____

PROVIDER CCN: _____

COST CENTER DESCRIPTIONS	NET EXPENSES FOR COST ALLOCATION (from Wkst. A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS 4	SUBTOTAL (cols. 0-4) 4A	ADMINIS- TRATIVE & GENERAL 5	MAIN- TENANCE & REPAIRS 6	OPERATION OF PLANT 7
		BLDGS. & FIXTURES 1	MOVABLE EQUIPMENT 2					
ANCILLARY SERVICE COST CENTERS								
50 Operating Room								50
51 Recovery Room								51
52 Labor Room and Delivery Room								52
53 Anesthesiology								53
54 Radiology-Diagnostic								54
55 Radiology-Therapeutic								55
56 Radioisotope								56
57 Computed Tomography (CT) Scan								57
58 Magnetic Resonance Imaging (MRI)								58
59 Cardiac Catheterization								59
60 Laboratory								60
61 PBP Clinical Laboratory Services-Program Only								61
62 Whole Blood & Packed Red Blood Cells								62
63 Blood Storing, Processing, & Trans.								63
64 Intravenous Therapy								64
65 Respiratory Therapy								65
66 Physical Therapy								66
67 Occupational Therapy								67
68 Speech Pathology								68
69 Electrocardiology								69
70 Electroencephalography								70
71 Medical Supplies Charged to Patients								71
72 Implantable Devices Charged to Patients								72
73 Drugs Charged to Patients								73
74 Renal Dialysis								74
75 ASC (Non-Distinct Part)								75
76 Other Ancillary (specify)								76
OUTPATIENT SERVICE COST CENTERS								
88 Rural Health Clinic (RHC)								88
89 Federally Qualified Health Center (FQHC)								89
90 Clinic								90
91 Emergency								91
92 Observation Beds								92
93 Other Outpatient Service (specify)								93

COST ALLOCATION - GENERAL SERVICE COSTS

PERIOD:
FROM _____
TO _____

PROVIDER CCN: _____

WORKSHEET B,
PART I

COST CENTER DESCRIPTIONS	NET EXPENSES FOR COST ALLOCATION (from Wkst. A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS 4	SUBTOTAL (cols. 0-4) 4A	ADMINIS- TRATIVE & GENERAL 5	MAIN- TENANCE & REPAIRS 6	OPERATION OF PLANT 7	
		BLDGS. & FIXTURES 1	MOVABLE EQUIPMENT 2						
OTHER REIMBURSABLE COST CENTERS									
94 Home Program Dialysis									94
95 Ambulance Services									95
96 Durable Medical Equipment-Rented									96
97 Durable Medical Equipment-Sold									97
98 Other Reimbursable (specify)									98
99 Outpatient Rehabilitation Provider (specify)									99
100 Intern-Resident Service (not appvd. tching. prgm.)									100
101 Home Health Agency									101
SPECIAL PURPOSE COST CENTERS									
105 Kidney Acquisition									105
106 Heart Acquisition									106
107 Liver Acquisition									107
108 Lung Acquisition									108
109 Pancreas Acquisition									109
110 Intestinal Acquisition									110
111 Islet Acquisition									111
112 Other Organ Acquisition (specify)									112
115 Ambulatory Surgical Center (Distinct Part)									115
116 Hospice									116
117 Other Special Purpose (specify)									117
118 SUBTOTALS (sum of lines 1-117)									118
NONREIMBURSABLE COST CENTERS									
190 Gift, Flower, Coffee Shop, & Canteen									190
191 Research									191
192 Physicians' Private Offices									192
193 Nonpaid Workers									193
194 Other Nonreimbursable (specify)									194
200 Cross Foot Adjustments									200
201 Negative Cost Centers									201
202 TOTAL (sum lines 118-201)									202

COST ALLOCATION - GENERAL SERVICE COSTS

 PERIOD:
 FROM _____
 TO _____

PROVIDER CCN: _____

WORKSHEET B,
PART I

COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	MAIN- TENANCE OF PERSONNEL	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE
	8	9	10	11	12	13	14	15	16	17
GENERAL SERVICE COST CENTERS										
1 Capital Related Costs-Buildings and Fixtures										1
2 Capital Related Costs-Movable Equipment										2
4 Employee Benefits										4
5 Administrative and General										5
6 Maintenance and Repairs										6
7 Operation of Plant										7
8 Laundry and Linen Service										8
9 Housekeeping										9
10 Dietary										10
11 Cafeteria										11
12 Maintenance of Personnel										12
13 Nursing Administration										13
14 Central Services and Supply										14
15 Pharmacy										15
16 Medical Records & Medical Records Library										16
17 Social Service										17
18 Other General Service (specify)										18
19 Nonphysician Anesthetists										19
20 Nursing School										20
21 Intern & Res. Service-Salary & Fringes (Approved)										21
22 Intern & Res. Other Program Costs (Approved)										22
23 Paramedical Education Program (specify)										23
INPATIENT ROUTINE SERVICE COST CENTERS										
30 Adults and Pediatrics (General Routine Care)										30
31 Intensive Care Unit										31
32 Coronary Care Unit										32
33 Burn Intensive Care Unit										33
34 Surgical Intensive Care Unit										34
35 Other Special Care Unit (specify)										35
40 Subprovider IPF										40
41 Subprovider IRF										41
42 Subprovider (specify)										42
43 Nursery										43
44 Skilled Nursing Facility										44
45 Nursing Facility										45
46 Other Long Term Care										46

FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4020)

COST ALLOCATION - GENERAL SERVICE COSTS

 PERIOD:
 FROM _____
 TO _____
WORKSHEET B,
PART I

COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	MAIN- TENANCE OF PERSONNEL	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE
	8	9	10	11	12	13	14	15	16	17
ANCILLARY SERVICE COST CENTERS										
50 Operating Room										50
51 Recovery Room										51
52 Labor Room and Delivery Room										52
53 Anesthesiology										53
54 Radiology-Diagnostic										54
55 Radiology-Therapeutic										55
56 Radioisotope										56
57 Computed Tomography (CT) Scan										57
58 Magnetic Resonance Imaging (MRI)										58
59 Cardiac Catheterization										59
60 Laboratory										60
61 PPP Clinical Laboratory Services-Program Only										61
62 Whole Blood & Packed Red Blood Cells										62
63 Blood Storing, Processing, & Trans.										63
64 Intravenous Therapy										64
65 Respiratory Therapy										65
66 Physical Therapy										66
67 Occupational Therapy										67
68 Speech Pathology										68
69 Electrocardiology										69
70 Electroencephalography										70
71 Medical Supplies Charged to Patients										71
72 Implantable Devices Charged to Patients										72
73 Drugs Charged to Patients										73
74 Renal Dialysis										74
75 ASC (Non-Distinct Part)										75
76 Other Ancillary (specify)										76
OUTPATIENT SERVICE COST CENTERS										
88 Rural Health Clinic (RHC)										88
89 Federally Qualified Health Center (FQHC)										89
90 Clinic										90
91 Emergency										91
92 Observation Beds										92
93 Other Outpatient Service (specify)										93

COST ALLOCATION - GENERAL SERVICE COSTS

 PERIOD: FROM _____ TO _____
 WORKSHEET B, PART I

COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	MAIN- TENANCE OF PERSONNEL	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE
	8	9	10	11	12	13	14	15	16	17
OTHER REIMBURSABLE COST CENTERS										
94 Home Program Dialysis										94
95 Ambulance Services										95
96 Durable Medical Equipment-Rented										96
97 Durable Medical Equipment-Sold										97
98 Other Reimbursable (specify)										98
99 Outpatient Rehabilitation Provider (specify)										99
100 Intern-Resident Service (not appvd. tchg. prgm.)										100
101 Home Health Agency										101
SPECIAL PURPOSE COST CENTERS										
105 Kidney Acquisition										105
106 Heart Acquisition										106
107 Liver Acquisition										107
108 Lung Acquisition										108
109 Pancreas Acquisition										109
110 Intestinal Acquisition										110
111 Islet Acquisition										111
112 Other Organ Acquisition (specify)										112
115 Ambulatory Surgical Center (Distinct Part)										115
116 Hospice										116
117 Other Special Purpose (specify)										117
118 SUBTOTALS (sum of lines 1-117)										118
NONREIMBURSABLE COST CENTERS										
190 Gift, Flower, Coffee Shop, & Canteen										190
191 Research										191
192 Physicians' Private Offices										192
193 Nonpaid Workers										193
194 Other Nonreimbursable (specify)										194
200 Cross Foot Adjustments										200
201 Negative Cost Centers										201
202 TOTAL (sum lines 118-201)										202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B,
PART IPERIOD:
FROM _____
TO _____

PROVIDER CCN: _____

COST CENTER DESCRIPTIONS	OTHER GENERAL SERVICE	NON- PHYSICIAN ANES- THETISTS	NURSING SCHOOL	INTERNS & RESIDENTS SALARY AND FRINGES	INTERNS & RESIDENTS PROGRAM COSTS	PARAMEDICAL EDUCATION (SPECIFY)	SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS	TOTAL	
	18	19	20	21	22	23	24	25		
GENERAL SERVICE COST CENTERS										
1	Capital Related Costs-Buildings and Fixtures									1
2	Capital Related Costs-Movable Equipment									2
4	Employee Benefits									4
5	Administrative and General									5
6	Maintenance and Repairs									6
7	Operation of Plant									7
8	Laundry and Linen Service									8
9	Housekeeping									9
10	Dietary									10
11	Cafeteria									11
12	Maintenance of Personnel									12
13	Nursing Administration									13
14	Central Services and Supply									14
15	Pharmacy									15
16	Medical Records & Medical Records Library									16
17	Social Service									17
18	Other General Service (specify)									18
19	Nonphysician Anesthetists									19
20	Nursing School									20
21	Intern & Res. Service-Salary & Fringes (Approved)									21
22	Intern & Res. Other Program Costs (Approved)									22
23	Paramedical Education Program (specify)									23
INPATIENT ROUTINE SERVICE COST CENTERS										
30	Adults and Pediatrics (General Routine Care)									30
31	Intensive Care Unit									31
32	Coronary Care Unit									32
33	Burn Intensive Care Unit									33
34	Surgical Intensive Care Unit									34
35	Other Special Care Unit (specify)									35
40	Subprovider IPF									40
41	Subprovider IRF									41
42	Subprovider (specify)									42
43	Nursery									43
44	Skilled Nursing Facility									44
45	Nursing Facility									45
46	Other Long Term Care									46

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B,
PART IPERIOD:
FROM _____
TO _____

PROVIDER CCN: _____

COST CENTER DESCRIPTIONS	OTHER GENERAL SERVICE	NON- PHYSICIAN ANES- THETISTS	NURSING SCHOOL	INTERNS & RESIDENTS SALARY AND FRINGES	INTERNS & RESIDENTS PROGRAM COSTS	PARAMEDICAL EDUCATION (SPECIFY)	TOTAL	
	18	19	20	21	22	23	SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS
24								
25								
26								
27								
28								
29								
30								
31								
32								
33								
34								
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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B,
PART IPERIOD:
FROM _____
TO _____

PROVIDER CCN: _____

COST CENTER DESCRIPTIONS										TO			
OTHER REIMBURSABLE COST CENTERS													
OTHER GENERAL SERVICE	NON- PHYSICIAN ANES- THETISTS	NURSING SCHOOL	INTERNS & RESIDENTS SALARY AND FRINGES	INTERNS & RESIDENTS PROGRAM COSTS	PARAMEDICAL EDUCATION (SPECIFY)	SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS			TOTAL			
18	19	20	21	22	23	24	25			26			

ALLOCATION OF CAPITAL-RELATED COSTS

 PERIOD:
FROM _____
TO _____

PROVIDER CCN: _____

WORKSHEET B,
PART II

COST CENTER DESCRIPTIONS	DIRECTLY ASSIGNED NEW CAPITAL RELATED COSTS	CAPITAL RELATED COSTS		SUBTOTAL (sum of cols. 0-2)	EMPLOYEE BENEFITS	ADMINIS- TRATIVE & GENERAL	MAIN- TENANCE & REPAIRS	OPERATION OF PLANT
		BLDGS. & FIXTURES	MOVABLE EQUIPMENT					
GENERAL SERVICE COST CENTERS								
1 Capital Related Costs-Buildings and Fixtures								1
2 Capital Related Costs-Movable Equipment								2
4 Employee Benefits								4
5 Administrative and General								5
6 Maintenance and Repairs								6
7 Operation of Plant								7
8 Laundry and Linen Service								8
9 Housekeeping								9
10 Dietary								10
11 Cafeteria								11
12 Maintenance of Personnel								12
13 Nursing Administration								13
14 Central Services and Supply								14
15 Pharmacy								15
16 Medical Records & Medical Records Library								16
17 Social Service								17
18 Other General Service (specify)								18
19 Nonphysician Anesthetists								19
20 Nursing School								20
21 Intern & Res. Service-Salary & Fringes (Approved)								21
22 Intern & Res. Other Program Costs (Approved)								22
23 Paramedical Education Program (specify)								23
INPATIENT ROUTINE SERVICE COST CENTERS								
30 Adults and Pediatrics (General Routine Care)								30
31 Intensive Care Unit								31
32 Coronary Care Unit								32
33 Burn Intensive Care Unit								33
34 Surgical Intensive Care Unit								34
35 Other Special Care Unit (specify)								35
40 Subprovider IPF								40
41 Subprovider IRF								41
42 Subprovider (specify)								42
43 Nursery								43
44 Skilled Nursing Facility								44
45 Nursing Facility								45
46 Other Long Term Care								46

ALLOCATION OF CAPITAL-RELATED COSTS

 PERIOD:
 FROM _____
 TO _____

PROVIDER CCN: _____

WORKSHEET B,
PART II

COST CENTER DESCRIPTIONS	DIRECTLY ASSIGNED NEW CAPITAL RELATED COSTS 0	CAPITAL RELATED COSTS		SUBTOTAL (sum of cols. 0-2) 2A	EMPLOYEE BENEFITS 4	ADMINIS- TRATIVE & GENERAL 5	MAIN- TENANCE & REPAIRS 6	OPERATION OF PLANT 7
		BLDGS. & FIXTURES 1	MOVABLE EQUIPMENT 2					
ANCILLARY SERVICE COST CENTERS								
50 Operating Room								50
51 Recovery Room								51
52 Labor Room and Delivery Room								52
53 Anesthesiology								53
54 Radiology-Diagnostic								54
55 Radiology-Therapeutic								55
56 Radioisotope								56
57 Computed Tomography (CT) Scan								57
58 Magnetic Resonance Imaging (MRI)								58
59 Cardiac Catheterization								59
60 Laboratory								60
61 PBP Clinical Laboratory Services-Program Only								61
62 Whole Blood & Packed Red Blood Cells								62
63 Blood Storing, Processing, & Trans.								63
64 Intravenous Therapy								64
65 Respiratory Therapy								65
66 Physical Therapy								66
67 Occupational Therapy								67
68 Speech Pathology								68
69 Electrocardiology								69
70 Electroencephalography								70
71 Medical Supplies Charged to Patients								71
72 Implantable Devices Charged to Patients								72
73 Drugs Charged to Patients								73
74 Renal Dialysis								74
75 ASC (Non-Distinct Part)								75
76 Other Ancillary (specify)								76
OUTPATIENT SERVICE COST CENTERS								
88 Rural Health Clinic (RHC)								88
89 Federally Qualified Health Center (FQHC)								89
90 Clinic								90
91 Emergency								91
92 Observation Beds								92
93 Other Outpatient Service (specify)								93

ALLOCATION OF CAPITAL-RELATED COSTS

 PERIOD:
FROM _____
TO _____

PROVIDER CCN: _____

WORKSHEET B,
PART II

COST CENTER DESCRIPTIONS	DIRECTLY ASSIGNED NEW CAPITAL RELATED COSTS 0	CAPITAL RELATED COSTS		SUBTOTAL (sum of cols. 0-2) 2A	EMPLOYEE BENEFITS 4	ADMINIS- TRATIVE & GENERAL 5	MAIN- TENANCE & REPAIRS 6	OPERATION OF PLANT 7
		BLDGS. & FIXTURES 1	MOVABLE EQUIPMENT 2					
OTHER REIMBURSABLE COST CENTERS								
94 Home Program Dialysis								94
95 Ambulance Services								95
96 Durable Medical Equipment-Rented								96
97 Durable Medical Equipment-Sold								97
98 Other Reimbursable (specify)								98
99 Outpatient Rehabilitation Provider (specify)								99
100 Intern-Resident Service (not appvd. tching. prgm.)								100
101 Home Health Agency								101
SPECIAL PURPOSE COST CENTERS								
105 Kidney Acquisition								105
106 Heart Acquisition								106
107 Liver Acquisition								107
108 Lung Acquisition								108
109 Pancreas Acquisition								109
110 Intestinal Acquisition								110
111 Islet Acquisition								111
112 Other Organ Acquisition (specify)								112
115 Ambulatory Surgical Center (Distinct Part)								115
116 Hospice								116
117 Other Special Purpose (specify)								117
118 SUBTOTALS (sum of lines 1-117)								118
NONREIMBURSABLE COST CENTERS								
190 Gift, Flower, Coffee Shop, & Canteen								190
191 Research								191
192 Physicians' Private Offices								192
193 Nonpaid Workers								193
194 Other Nonreimbursable (specify)								194
200 Cross Foot Adjustments								200
201 Negative Cost Centers								201
202 TOTAL (sum lines 118-201)								202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B,
PART IIPERIOD:
FROM _____
TO _____

PROVIDER CGN: _____

COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	MAIN- TENANCE OF PERSONNEL	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE
	8	9	10	11	12	13	14	15	16	17
GENERAL SERVICE COST CENTERS										
1 Capital Related Costs-Buildings and Fixtures										1
2 Capital Related Costs-Movable Equipment										2
4 Employee Benefits										4
5 Administrative and General										5
6 Maintenance and Repairs										6
7 Operation of Plant										7
8 Laundry and Linen Service										8
9 Housekeeping										9
10 Dietary										10
11 Cafeteria										11
12 Maintenance of Personnel										12
13 Nursing Administration										13
14 Central Services and Supply										14
15 Pharmacy										15
16 Medical Records & Medical Records Library										16
17 Social Service										17
18 Other General Service (specify)										18
19 Nonphysician Anesthetists										19
20 Nursing School										20
21 Intern & Res. Service-Salary & Fringes (Approved)										21
22 Intern & Res. Other Program Costs (Approved)										22
23 Paramedical Education Program (specify)										23
INPATIENT ROUTINE SERVICE COST CENTERS										
30 Adults and Pediatrics (General Routine Care)										30
31 Intensive Care Unit										31
32 Coronary Care Unit										32
33 Burn Intensive Care Unit										33
34 Surgical Intensive Care Unit										34
35 Other Special Care Unit (specify)										35
40 Subprovider IPF										40
41 Subprovider IRF										41
42 Subprovider (specify)										42
43 Nursery										43
44 Skilled Nursing Facility										44
45 Nursing Facility										45
46 Other Long Term Care										46

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B,
PART IIPERIOD:
FROM _____
TO _____

PROVIDER CGN: _____

COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	MAIN- TENANCE OF PERSONNEL	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE
	8	9	10	11	12	13	14	15	16	17
ANCILLARY SERVICE COST CENTERS										
50 Operating Room										50
51 Recovery Room										51
52 Labor Room and Delivery Room										52
53 Anesthesiology										53
54 Radiology-Diagnostic										54
55 Radiology-Therapeutic										55
56 Radioisotope										56
57 Computed Tomography (CT) Scan										57
58 Magnetic Resonance Imaging (MRI)										58
59 Cardiac Catheterization										59
60 Laboratory										60
61 PBP Clinical Laboratory Services-Program Only										61
62 Whole Blood & Packed Red Blood Cells										62
63 Blood Storing, Processing, & Trans.										63
64 Intravenous Therapy										64
65 Respiratory Therapy										65
66 Physical Therapy										66
67 Occupational Therapy										67
68 Speech Pathology										68
69 Electrocardiology										69
70 Electroencephalography										70
71 Medical Supplies Charged to Patients										71
72 Implantable Devices Charged to Patients										72
73 Drugs Charged to Patients										73
74 Renal Dialysis										74
75 ASC (Non-Distinct Part)										75
76 Other Ancillary (specify)										76
OUTPATIENT SERVICE COST CENTERS										
88 Rural Health Clinic (RHC)										88
89 Federally Qualified Health Center (FQHC)										89
90 Clinic										90
91 Emergency										91
92 Observation Beds										92
93 Other Outpatient Service (specify)										93

ALLOCATION OF CAPITAL-RELATED COSTS						PROVIDER CGN:		PERIOD: FROM _____ TO _____		WORKSHEET B, PART II						
COST CENTER DESCRIPTIONS						LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	CAFETERIA 11	MAIN- TENANCE OF PERSONNEL 12	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	
OTHER REIMBURSABLE COST CENTERS																
94	Home Program Dialysis															94
95	Ambulance Services															95
96	Durable Medical Equipment-Rented															96
97	Durable Medical Equipment-Sold															97
98	Other Reimbursable (specify)															98
99	Outpatient Rehabilitation Provider (specify)															99
100	Intern-Resident Service (not appvd. tchg. prgm.)															100
101	Home Health Agency															101
SPECIAL PURPOSE COST CENTERS																
105	Kidney Acquisition															105
106	Heart Acquisition															106
107	Liver Acquisition															107
108	Lung Acquisition															108
109	Pancreas Acquisition															109
110	Intestinal Acquisition															110
111	Islet Acquisition															111
112	Other Organ Acquisition (specify)															112
115	Ambulatory Surgical Center (Distinct Part)															115
116	Hospice															116
117	Other Special Purpose (specify)															117
118	SUBTOTALS (sum of lines 1-117)															118
NONREIMBURSABLE COST CENTERS																
190	Gift, Flower, Coffee Shop, & Canteen															190
191	Research															191
192	Physicians' Private Offices															192
193	Nonpaid Workers															193
194	Other Nonreimbursable (specify)															194
200	Cross Foot Adjustments															200
201	Negative Cost Centers															201
202	TOTAL (sum lines 118-201)															202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B,
PART IIPERIOD:
FROM _____
TO _____

PROVIDER CCN: _____

COST CENTER DESCRIPTIONS	OTHER GENERAL SERVICE	NON- PHYSICIAN ANES- THETISTS	NURSING SCHOOL	INTERNS & RESIDENTS SALARY AND FRINGES	INTERNS & RESIDENTS PROGRAM COSTS	PARAMEDICAL EDUCATION (SPECIFY)	SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS	TOTAL
	18	19	20	21	22	23	24	25	26
GENERAL SERVICE COST CENTERS									
1 Capital Related Costs-Buildings and Fixtures									1
2 Capital Related Costs-Movable Equipment									2
4 Employee Benefits									4
5 Administrative and General									5
6 Maintenance and Repairs									6
7 Operation of Plant									7
8 Laundry and Linen Service									8
9 Housekeeping									9
10 Dietary									10
11 Cafeteria									11
12 Maintenance of Personnel									12
13 Nursing Administration									13
14 Central Services and Supply									14
15 Pharmacy									15
16 Medical Records & Medical Records Library									16
17 Social Service									17
18 Other General Service (specify)									18
19 Nonphysician Anesthetists									19
20 Nursing School									20
21 Intern & Res. Service-Salary & Fringes (Approved)									21
22 Intern & Res. Other Program Costs (Approved)									22
23 Paramedical Education Program (specify)									23
INPATIENT ROUTINE SERVICE COST CENTERS									
30 Adults and Pediatrics (General Routine Care)									30
31 Intensive Care Unit									31
32 Coronary Care Unit									32
33 Burn Intensive Care Unit									33
34 Surgical Intensive Care Unit									34
35 Other Special Care Unit (specify)									35
40 Subprovider IPF									40
41 Subprovider IRF									41
42 Subprovider (specify)									42
43 Nursery									43
44 Skilled Nursing Facility									44
45 Nursing Facility									45
46 Other Long Term Care									46

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B,
PART II

COST CENTER DESCRIPTIONS		OTHER GENERAL SERVICE 18	NON- PHYSICIAN ANES- THETISTS 19	NURSING SCHOOL 20	INTERNS & RESIDENTS SALARY AND FRINGES 21	INTERNS & RESIDENTS PROGRAM COSTS 22	PARAMEDICAL EDUCATION (SPECIFY) 23	TO		TOTAL
								SUBTOTAL 24	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS 25	
ANCILLARY SERVICE COST CENTERS										
50	Operating Room									50
51	Recovery Room									51
52	Labor Room and Delivery Room									52
53	Anesthesiology									53
54	Radiology-Diagnostic									54
55	Radiology-Therapeutic									55
56	Radioisotope									56
57	Computed Tomography (CT) Scan									57
58	Magnetic Resonance Imaging (MRI)									58
59	Cardiac Catheterization									59
60	Laboratory									60
61	PBP Clinical Laboratory Services-Program Only									61
62	Whole Blood & Packed Red Blood Cells									62
63	Blood Storing, Processing, & Trans.									63
64	Intravenous Therapy									64
65	Respiratory Therapy									65
66	Physical Therapy									66
67	Occupational Therapy									67
68	Speech Pathology									68
69	Electrocardiology									69
70	Electroencephalography									70
71	Medical Supplies Charged to Patients									71
72	Implantable Devices Charged to Patients									72
73	Drugs Charged to Patients									73
74	Renal Dialysis									74
75	ASC (Non-Distinct Part)									75
76	Other Ancillary (specify)									76
	OUTPATIENT SERVICE COST CENTERS									
88	Rural Health Clinic (RHC)									88
89	Federally Qualified Health Center (FQHC)									89
90	Clinic									90
91	Emergency									91
92	Observation Beds									92
93	Other Outpatient Service (specify)									93

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B,
PART IIPERIOD:
FROM _____
TO _____

PROVIDER CCN:

	COST CENTER DESCRIPTIONS	OTHER GENERAL SERVICE	NON- PHYSICIAN ANES- THETISTS	NURSING SCHOOL	INTERNS & RESIDENTS SALARY AND FRINGES	INTERNS & RESIDENTS PROGRAM COSTS	PARAMEDICAL EDUCATION (SPECIFY)	SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS	TOTAL
	OTHER REIMBURSABLE COST CENTERS	18	19	20	21	22	23	24	25	26
94	Home Program Dialysis									94
95	Ambulance Services									95
96	Durable Medical Equipment-Rented									96
97	Durable Medical Equipment-Sold									97
98	Other Reimbursable (specify)									98
99	Outpatient Rehabilitation Provider (specify)									99
100	Intern-Resident Service (not appvd. tching. prgm.)									100
101	Home Health Agency									101
	SPECIAL PURPOSE COST CENTERS									
105	Kidney Acquisition									105
106	Heart Acquisition									106
107	Liver Acquisition									107
108	Lung Acquisition									108
109	Pancreas Acquisition									109
110	Intestinal Acquisition									110
111	Islet Acquisition									111
112	Other Organ Acquisition (specify)									112
115	Ambulatory Surgical Center (Distinct Part)									115
116	Hospice									116
117	Other Special Purpose (specify)									117
118	SUBTOTALS (sum of lines 1-117)									118
	NONREIMBURSABLE COST CENTERS									
190	Gift, Flower, Coffee Shop, & Canteen									190
191	Research									191
192	Physicians' Private Offices									192
193	Nonpaid Workers									193
194	Other Nonreimbursable (specify)									194
200	Cross Foot Adjustments									200
201	Negative Cost Centers									201
202	TOTAL (sum lines 118-201)									202

COST ALLOCATION - STATISTICAL BASIS

PERIOD: FROM _____ TO _____

WORKSHEET B-1

PROVIDER CCN: _____

COST CENTER DESCRIPTIONS	CAPITAL RELATED COST		EMPLOYEE BENEFITS (GROSS SALARIES)	RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUM. COST)		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)
	BLDGS. & FIXTURES (SQUARE FEET)	MOVABLE EQUIPMENT (DOLLAR VALUE)						
	1	2	4	5A	5	6	7	
GENERAL SERVICE COST CENTERS								
1 Capital Related Costs-Buildings and Fixtures								1
2 Capital Related Costs-Movable Equipment								2
4 Employee Benefits								4
5 Administrative and General								5
6 Maintenance and Repairs								6
7 Operation of Plant								7
8 Laundry and Linen Service								8
9 Housekeeping								9
10 Dietary								10
11 Cafeteria								11
12 Maintenance of Personnel								12
13 Nursing Administration								13
14 Central Services and Supply								14
15 Pharmacy								15
16 Medical Records & Medical Records Library								16
17 Social Service								17
18 Other General Service (specify)								18
19 Nonphysician Anesthetists								19
20 Nursing School								20
21 Intern & Res. Service-Salary & Fringes (Approved)								21
22 Intern & Res. Other Program Costs (Approved)								22
23 Paramedical Education Program (specify)								23
INPATIENT ROUTINE SERVICE COST CENTERS								
30 Adults and Pediatrics (General Routine Care)								30
31 Intensive Care Unit								31
32 Coronary Care Unit								32
33 Burn Intensive Care Unit								33
34 Surgical Intensive Care Unit								34
35 Other Special Care Unit (specify)								35
40 Subprovider IPF								40
41 Subprovider IRF								41
42 Subprovider (specify)								42
43 Nursery								43
44 Skilled Nursing Facility								44
45 Nursing Facility								45
46 Other Long Term Care								46

COST ALLOCATION - STATISTICAL BASIS

PERIOD:
FROM _____
TO _____

PROVIDER CCN: _____

WORKSHEET B-1

COST CENTER DESCRIPTIONS	CAPITAL RELATED COST		EMPLOYEE BENEFITS (GROSS SALARIES)	RECONCILIATION	ADMINIS-TRATIVE & GENERAL (ACCUM. COST)	MAIN-TENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)
	BLDGS. & FIXTURES (SQUARE FEET)	MOVABLE EQUIPMENT (DOLLAR VALUE)					
	1	2	4	5A	5	6	7
ANCILLARY SERVICE COST CENTERS							
50 Operating Room							50
51 Recovery Room							51
52 Labor Room and Delivery Room							52
53 Anesthesiology							53
54 Radiology-Diagnostic							54
55 Radiology-Therapeutic							55
56 Radioisotope							56
57 Computed Tomography (CT) Scan							57
58 Magnetic Resonance Imaging (MRI)							58
59 Cardiac Catheterization							59
60 Laboratory							60
61 PBP Clinical Laboratory Services-Program Only							61
62 Whole Blood & Packed Red Blood Cells							62
63 Blood Storing, Processing, & Trans.							63
64 Intravenous Therapy							64
65 Respiratory Therapy							65
66 Physical Therapy							66
67 Occupational Therapy							67
68 Speech Pathology							68
69 Electrocardiology							69
70 Electroencephalography							70
71 Medical Supplies Charged to Patients							71
72 Implantable Devices Charged to Patients							72
73 Drugs Charged to Patients							73
74 Renal Dialysis							74
75 ASC (Non-Distinct Part)							75
76 Other Ancillary (specify)							76
OUTPATIENT SERVICE COST CENTERS							
88 Rural Health Clinic (RHC)							88
89 Federally Qualified Health Center (FQHC)							89
90 Clinic							90
91 Emergency							91
92 Observation Beds							92
93 Other Outpatient Service (specify)							93

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

PERIOD:
FROM _____
TO _____

PROVIDER CCN: _____

COST CENTER DESCRIPTIONS	CAPITAL RELATED COST			EMPLOYEE BENEFITS (GROSS SALARIES)	RECONCIL- IATION	ADMINIS- TRATIVE & GENERAL (ACCUM. COST)	MAIN- TENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)							
	BLDGS. & FIXTURES (SQUARE FEET)	MOVABLE EQUIPMENT (DOLLAR VALUE)													
									1	2	4	5A	5	6	7
OTHER REIMBURSABLE COST CENTERS															
94	Home Program Dialysis							94							
95	Ambulance Services							95							
96	Durable Medical Equipment-Rented							96							
97	Durable Medical Equipment-Sold							97							
98	Other Reimbursable (specify)							98							
99	Outpatient Rehabilitation Provider (specify)							99							
100	Intern-Resident Service (not appvd. tching. prgm.)							100							
101	Home Health Agency							101							
SPECIAL PURPOSE COST CENTERS															
105	Kidney Acquisition							105							
106	Heart Acquisition							106							
107	Liver Acquisition							107							
108	Lung Acquisition							108							
109	Pancreas Acquisition							109							
110	Intestinal Acquisition							110							
111	Islet Acquisition							111							
112	Other Organ Acquisition (specify)							112							
115	Ambulatory Surgical Center (Distinct Part)							115							
116	Hospice							116							
117	Other Special Purpose (specify)							117							
118	SUBTOTALS (sum of lines 1-117)							118							
NONREIMBURSABLE COST CENTERS															
190	Gift, Flower, Coffee Shop, & Canteen							190							
191	Research							191							
192	Physicians' Private Offices							192							
193	Nonpaid Workers							193							
194	Other Nonreimbursable (specify)							194							
200	Cross foot adjustments							200							
201	Negative cost centers							201							
202	Cost to be allocated (per Worksheet B, Part I)							202							
203	Unit cost multiplier (Worksheet B, Part I)							203							
204	Cost to be allocated (per Worksheet B, Part II)							204							
205	Unit cost multiplier (Worksheet B, Part II)							205							

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

PERIOD:
FROM _____
TO _____

PROVIDER CGN:

COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSE- KEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	MAIN- TENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINIS- TRATION (DIRECT NURS. HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
GENERAL SERVICE COST CENTERS											
1 Capital Related Costs-Buildings and Fixtures											1
2 Capital Related Costs-Movable Equipment											2
4 Employee Benefits											4
5 Administrative and General											5
6 Maintenance and Repairs											6
7 Operation of Plant											7
8 Laundry and Linen Service											8
9 Housekeeping											9
10 Dietary											10
11 Cafeteria											11
12 Maintenance of Personnel											12
13 Nursing Administration											13
14 Central Services and Supply											14
15 Pharmacy											15
16 Medical Records & Medical Records Library											16
17 Social Service											17
18 Other General Service (specify)											18
19 Nonphysician Anesthetists											19
20 Nursing School											20
21 Intern & Res. Service-Salary & Fringes (Approved)											21
22 Intern & Res. Other Program Costs (Approved)											22
23 Paramedical Education Program (specify)											23
INPATIENT ROUTINE SERVICE COST CENTERS											
30 Adults and Pediatrics (General Routine Care)											30
31 Intensive Care Unit											31
32 Coronary Care Unit											32
33 Burn Intensive Care Unit											33
34 Surgical Intensive Care Unit											34
35 Other Special Care Unit (specify)											35
40 Subprovider IPF											40
41 Subprovider IRF											41
42 Subprovider (specify)											42
43 Nursery											43
44 Skilled Nursing Facility											44
45 Nursing Facility											45
46 Other Long Term Care											46

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSE- KEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	MAIN- TENANCE OF PERSONNEL (NUMBER HOUSED)	PROVIDER CGN:				PERIOD:		SOCIAL SERVICE (TIME SPENT)	
						NURSING ADMINIS- TRATION (DIRECT NURS. HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	FROM	TO		
ANCILLARY SERVICE COST CENTERS													
50 Operating Room													50
51 Recovery Room													51
52 Labor Room and Delivery Room													52
53 Anesthesiology													53
54 Radiology-Diagnostic													54
55 Radiology-Therapeutic													55
56 Radioisotope													56
57 Computed Tomography (CT) Scan													57
58 Magnetic Resonance Imaging (MRI)													58
59 Cardiac Catheterization													59
60 Laboratory													60
61 PBP Clinical Laboratory Services-Program Only													61
62 Whole Blood & Packed Red Blood Cells													62
63 Blood Storing, Processing, & Trans.													63
64 Intravenous Therapy													64
65 Respiratory Therapy													65
66 Physical Therapy													66
67 Occupational Therapy													67
68 Speech Pathology													68
69 Electrocardiology													69
70 Electroencephalography													70
71 Medical Supplies Charged to Patients													71
72 Implantable Devices Charged to Patients													72
73 Drugs Charged to Patients													73
74 Renal Dialysis													74
75 ASC (Non-Distinct Part)													75
76 Other Ancillary (specify)													76
OUTPATIENT SERVICE COST CENTERS													
88 Rural Health Clinic (RHC)													88
89 Federally Qualified Health Center (FQHC)													89
90 Clinic													90
91 Emergency													91
92 Observation Beds													92
93 Other Outpatient Service (specify)													93

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSE- KEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	MAIN- TENANCE OF PERSONNEL (NUMBER HOUSED)	PROVIDER CGN:				PERIOD: FROM _____ TO _____		SOCIAL SERVICE (TIME SPENT)
						NURSING ADMINIS- TRATION (DIRECT NURS. HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)			
	8	9	10	11	12	13	14	15	16	17		
OTHER REIMBURSABLE COST CENTERS												
94 Home Program Dialysis												94
95 Ambulance Services												95
96 Durable Medical Equipment-Rented												96
97 Durable Medical Equipment-Sold												97
98 Other Reimbursable (specify)												98
99 Outpatient Rehabilitation Provider (specify)												99
100 Intern-Resident Service (not appvd. tching. prgm.)												100
101 Home Health Agency												101
SPECIAL PURPOSE COST CENTERS												
105 Kidney Acquisition												105
106 Heart Acquisition												106
107 Liver Acquisition												107
108 Lung Acquisition												108
109 Pancreas Acquisition												109
110 Intestinal Acquisition												110
111 Islet Acquisition												111
112 Other Organ Acquisition (specify)												112
115 Ambulatory Surgical Center (Distinct Part)												115
116 Hospice												116
117 Other Special Purpose (specify)												117
118 SUBTOTALS (sum of lines 1-117)												118
NONREIMBURSABLE COST CENTERS												
190 Gift, Flower, Coffee Shop, & Canteen												190
191 Research												191
192 Physicians' Private Offices												192
193 Nonpaid Workers												193
194 Other Nonreimbursable (specify)												194
200 Cross foot adjustments												200
201 Negative cost centers												201
202 Cost to be allocated (per Worksheet B, Part I)												202
203 Unit cost multiplier (Worksheet B, Part I)												203
204 Cost to be allocated (per Worksheet B, Part II)												204
205 Unit cost multiplier (Worksheet B, Part II)												205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

PERIOD: FROM _____ TO _____

PROVIDER CCN: _____

COST CENTER DESCRIPTIONS	OTHER GENERAL SERVICE (SPECIFY)	NON- PHYSICIAN ANES- THETISTS (ASGND TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS		PARA- MEDICAL EDUCATION (ASSIGNED TIME)	SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS	TOTAL
				SALARY AND FRINGES (ASSIGNED TIME)	PROGRAM COSTS (ASSIGNED TIME)				
GENERAL SERVICE COST CENTERS									
1 Capital Related Costs-Buildings and Fixtures	18	19	20	21	22	23	24	25	26
2 Capital Related Costs-Movable Equipment									
4 Employee Benefits									
5 Administrative and General									
6 Maintenance and Repairs									
7 Operation of Plant									
8 Laundry and Linen Service									
9 Housekeeping									
10 Dietary									
11 Cafeteria									
12 Maintenance of Personnel									
13 Nursing Administration									
14 Central Services and Supply									
15 Pharmacy									
16 Medical Records & Medical Records Library									
17 Social Service									
18 Other General Service (specify)									
19 Nonphysician Anesthetists									
20 Nursing School									
21 Intern & Res. Service-Salary & Fringes (Approved)									
22 Intern & Res. Other Program Costs (Approved)									
23 Paramedical Education Program (specify)									
INPATIENT ROUTINE SERVICE COST CENTERS									
30 Adults and Pediatrics (General Routine Care)									
31 Intensive Care Unit									
32 Coronary Care Unit									
33 Burn Intensive Care Unit									
34 Surgical Intensive Care Unit									
35 Other Special Care Unit (specify)									
40 Subprovider IPF									
41 Subprovider IRF									
42 Subprovider (specify)									
43 Nursery									
44 Skilled Nursing Facility									
45 Nursing Facility									
46 Other Long Term Care									

COST ALLOCATION - STATISTICAL BASIS

PERIOD: FROM _____ TO _____

PROVIDER CCN: _____

WORKSHEET B-1

COST CENTER DESCRIPTIONS	OTHER GENERAL SERVICE (SPECIFY)	NON- PHYSICIAN ANES- THETISTS (ASGND TIME)	NURSING SCHOOL (ASSIGNED TIME)	SALARY AND FRINGES (ASSIGNED TIME)	PROVIDER CCN:		SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS	TOTAL
					INTERNS & RESIDENTS	PARA- MEDICAL EDUCATION (ASSIGNED TIME)			
	18	19	20	21	22	23	24	25	26
ANCILLARY SERVICE COST CENTERS									
50 Operating Room									50
51 Recovery Room									51
52 Labor Room and Delivery Room									52
53 Anesthesiology									53
54 Radiology-Diagnostic									54
55 Radiology-Therapeutic									55
56 Radioisotope									56
57 Computed Tomography (CT) Scan									57
58 Magnetic Resonance Imaging (MRI)									58
59 Cardiac Catheterization									59
60 Laboratory									60
61 PBP Clinical Laboratory Services-Program Only									61
62 Whole Blood & Packed Red Blood Cells									62
63 Blood Storing, Processing, & Trans.									63
64 Intravenous Therapy									64
65 Respiratory Therapy									65
66 Physical Therapy									66
67 Occupational Therapy									67
68 Speech Pathology									68
69 Electrocardiology									69
70 Electroencephalography									70
71 Medical Supplies Charged to Patients									71
72 Implantable Devices Charged to Patients									72
73 Drugs Charged to Patients									73
74 Renal Dialysis									74
75 ASC (Non-Distinct Part)									75
76 Other Ancillary (specify)									76
OUTPATIENT SERVICE COST CENTERS									
88 Rural Health Clinic (RHC)									88
89 Federally Qualified Health Center (FQHC)									89
90 Clinic									90
91 Emergency									91
92 Observation Beds									92
93 Other Outpatient Service (specify)									93

COST ALLOCATION - STATISTICAL BASIS

PERIOD: FROM _____ TO _____

PROVIDER CCN: _____

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	OTHER GENERAL SERVICE (SPECIFY)	NON- PHYSICIAN ANES- THETISTS (ASGND TIME)	NURSING SCHOOL (ASSIGNED TIME)	SALARY AND FRINGES (ASSIGNED TIME)	PROVIDER CCN:		SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS	TOTAL
						INTERNS & RESIDENTS	PARA- MEDICAL EDUCATION (ASSIGNED TIME)			
		18	19	20	21	22	23	24	25	26
	OTHER REIMBURSABLE COST CENTERS									
94	Home Program Dialysis									94
95	Ambulance Services									95
96	Durable Medical Equipment-Rented									96
97	Durable Medical Equipment-Sold									97
98	Other Reimbursable (specify)									98
99	Outpatient Rehabilitation Provider (specify)									99
100	Intern-Resident Service (not appvd. tching. prgm.)									100
101	Home Health Agency									101
	SPECIAL PURPOSE COST CENTERS									
105	Kidney Acquisition									105
106	Heart Acquisition									106
107	Liver Acquisition									107
108	Lung Acquisition									108
109	Pancreas Acquisition									109
110	Intestinal Acquisition									110
111	Islet Acquisition									111
112	Other Organ Acquisition (specify)									112
115	Ambulatory Surgical Center (Distinct Part)									115
116	Hospice									116
117	Other Special Purpose (specify)									117
118	SUBTOTALS (sum of lines 1-117)									118
	NONREIMBURSABLE COST CENTERS									
190	Gift, Flower, Coffee Shop, & Canteen									190
191	Research									191
192	Physicians' Private Offices									192
193	Nonpaid Workers									193
194	Other Nonreimbursable (specify)									194
200	Cross foot adjustments									200
201	Negative cost centers									201
202	Cost to be allocated (per Worksheet B, Part I)									202
203	Unit cost multiplier (Worksheet B, Part I)									203
204	Cost to be allocated (per Worksheet B, Part II)									204
205	Unit cost multiplier (Worksheet B, Part II)									205

POST STEPDOWN ADJUSTMENTS		PROVIDER CCN:	PERIOD: FROM _____ TO _____	WORKSHEET B-2	
	DESCRIPTION	WORKSHEET		AMOUNT	
		PART	LINE NO.		
	1	2	3	4	
1	Adjustment for EPO costs in Renal Dialysis cost center	1	74		1
2	Adjustment for EPO costs in Home Program Dialysis cost center	1	94		2
3	Adjustment for ARANESP costs in Renal Dialysis cost center	1	74		3
4	Adjustment for ARANESP costs in Home Program Dialysis cost center	1	94		4
5					5
6					6
7					7
8					8
9					9
10					10
11					11
12					12
13					13
14					14
15					15
16					16
17					17
18					18
19					19
20					20
21					21
22					22
23					23
24					24
25					25
26					26
27					27
28					28
29					29
30					30
31					31
32					32
33					33
34					34
35					35
36					36
37					37
38					38
39					39
40					40
41					41
42					42
43					43
44					44
45					45
46					46
47					47
48					48
49					49
50					50
51					51
52					52
53					53
54					54
55					55
56					56
57					57
58					58
59					59

COMPUTATION OF RATIO OF COSTS TO CHARGES

PERIOD:
FROM _____
TO _____

PROVIDER CCN: _____

WORKSHEET C
PART I

COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			Inpatient	Charges		Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio
			Total Costs	RCE Dis- allowance	Total Costs		Outpatient	Total (column 6 + column 7)			
	1	2	3	4	5	6	7	8	9	10	11
INPATIENT ROUTINE SERVICE COST CENTERS											
30 Adults and Pediatrics (General Routine Care)											
31 Intensive Care Unit											30
32 Coronary Care Unit											31
33 Burn Intensive Care Unit											32
34 Surgical Intensive Care Unit											33
35 Other Special Care (specify)											34
40 Subprovider IPF											35
41 Subprovider IRF											40
42 Subprovider (Specify)											41
43 Nursery											42
44 Skilled Nursing Facility											43
45 Nursing Facility											44
46 Other Long Term Care											45
ANCILLARY SERVICE COST CENTERS											
50 Operating Room											46
51 Recovery Room											
52 Labor Room and Delivery Room											50
53 Anesthesiology											51
54 Radiology-Diagnostic											52
55 Radiology-Therapeutic											53
56 Radioisotope											54
57 Computed Tomography (CT) Scan											55
58 Magnetic Resonance Imaging (MRI)											56
59 Cardiac Catheterization											57
60 Laboratory											58
61 PBP Clinical Laboratory Services-Prgm. Only											59
62 Whole Blood & Packed Red Blood Cells											60
63 Blood Storing, Processing, & Trans.											61
64 Intravenous Therapy											62
65 Respiratory Therapy											63
66 Physical Therapy											64
67 Occupational Therapy											65
68 Speech Pathology											66
											67
											68

COMPUTATION OF RATIO OF COSTS TO CHARGES

 PERIOD:
FROM _____
TO _____

PROVIDER CCN: _____

WORKSHEET C
PART I

COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio
			Total Costs	RCE Dis- allowance	Total Costs	Inpatient	Outpatient	Total (column 6 + column 7)			
69 Electrocardiology	1	2	3	4	5	6	7	8	9	10	11
70 Electroencephalography											69
71 Medical Supplies Charged to Patients											70
72 Implantable Devices Charged to Patients											71
73 Drugs Charged to Patients											72
74 Renal Dialysis											73
75 ASC (Non-Distinct Part)											74
76 Other Ancillary (specify)											75
OUTPATIENT SERVICE COST CENTERS											76
88 Rural Health Clinic (RHC)											88
89 Federally Qualified Health Center (FQHC)											89
90 Clinic											90
91 Emergency											91
92 Observation Beds (see instructions)											92
93 Other Outpatient Service (specify)											93
OTHER REIMBURSABLE COST CENTERS											
94 Home Program Dialysis											94
95 Ambulance Services											95
96 Durable Medical Equipment-Rented											96
97 Durable Medical Equipment-Sold											97
98 Other Reimbursable (specify)											98
99 Outpatient Rehabilitation Provider (specify)											99
100 Intern-Resident Service (not appvd. tchnlg. prgm.)											100
101 Home Health Agency											101
SPECIAL PURPOSE COST CENTERS											
105 Kidney Acquisition											105
106 Heart Acquisition											106
107 Liver Acquisition											107
108 Lung Acquisition											108
109 Pancreas Acquisition											109
110 Intestinal Acquisition											110
111 Islet Acquisition											111
112 Other Organ Acquisition (specify)											112
115 Ambulatory Surgical Center (Distinct Part)											115
116 Hospice											116
117 Other Special Purpose (specify)											117
200 Subtotal (see instructions)											200
201 Less Observation Beds											201
202 Total (see instructions)											202

CALCULATION OF OUTPATIENT SERVICE COST TO
CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

☐ Title V
☐ Title XIX

PROVIDER CCN: _____

PERIOD:
FROM _____
TO _____

WORKSHEET C,
PART II

Cost Center Descriptions	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst B, Part II, col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 ÷ col. 7)
	1	2	3	4	5	6	7	8
ANCILLARY SERVICE COST CENTERS								
50 Operating Room								
51 Recovery Room								50
52 Labor Room and Delivery Room								51
53 Anesthesiology								52
54 Radiology-Diagnostic								53
55 Radiology-Therapeutic								54
56 Radioisotope								55
57 Computed Tomography (CT) Scan								56
58 Magnetic Resonance Imaging (MRI)								57
59 Cardiac Catheterization								58
60 Laboratory								59
61 PBP Clinical Laboratory Services-Prgm. Only								60
62 Whole Blood & Packed Red Blood Cells								61
63 Blood Storing, Processing, & Trans.								62
64 Intravenous Therapy								63
65 Respiratory Therapy								64
66 Physical Therapy								65
67 Occupational Therapy								66
68 Speech Pathology								67
69 Electrocardiology								68
70 Electroencephalography								69
71 Medical Supplies Charged to Patients								70
72 Implantable Devices Charged to Patients								71
73 Drugs Charged to Patients								72
74 Renal Dialysis								73
75 ASC (Non-Distinct Part)								74
76 Other Ancillary (specify)								75
								76

4090 (Cont.)		FORM CMS-2552-10				PERIOD: FROM _____ TO _____		WORKSHEET C. PART II (CONT.)	
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY		[] Title V [] Title XIX		PROVIDER CCN:					
Cost Center Descriptions		Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst B, Part II, col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Operating Cost Reduction Amount	Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 ÷ col. 7)	
		1	2	3	5	6	7	8	
OUTPATIENT SERVICE COST CENTERS									
88	Rural Health Clinic (RHC)								88
89	Federally Qualified Health Center (FQHC)								89
90	Clinic								90
91	Emergency								91
92	Observation Beds (see instructions)								92
93	Other Outpatient Service (specify)								93
OTHER REIMBURSABLE COST CENTERS									
94	Home Program Dialysis								94
95	Ambulance Services								95
96	Durable Medical Equipment-Rented								96
97	Durable Medical Equipment-Sold								97
98	Other Reimbursable (specify)								98
99	Outpatient Rehabilitation Provider (specify)								99
100	Intern-Resident Service (not appvd. chng. prgm.)								100
101	Home Health Agency								101
105	Kidney Acquisition								105
106	Heart Acquisition								106
107	Liver Acquisition								107
108	Lung Acquisition								108
109	Pancreas Acquisition								109
110	Intestinal Acquisition								110
111	Islet Acquisition								111
112	Other Organ Acquisition (specify)								112
115	Ambulatory Surgical Center (Distinct Part)								115
116	Hospice								116
117	Other Special Purpose (specify)								117
200	Subtotal (sum of lines 50 thru 199)								200
201	Less Observation Beds								201
202	Total (line 200 minus line 201)								202

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS				PROVIDER CCN:		PERIOD: FROM _____ TO _____		WORKSHEET D, PART I	
Check applicable boxes:		☐ Title V ☐ Title XVIII, Part A ☐ Title XIX		☐ PPS ☐ TEFRA					
(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
	INPATIENT ROUTINE SERVICE COST CENTERS								
	Adults & Pediatrics (General Routine Care)								30
30									
31	Intensive Care Unit								31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care Unit (specify)								35
40	Subprovider IPF								40
41	Subprovider IRF								41
42	Subprovider (Other)								42
43	Nursery								43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)								200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		PROVIDER CCN: _____	PERIOD: FROM _____ TO _____		WORKSHEET D, PART II	
Check applicable boxes:		☐ Title V ☐ Title XVIII, Part A ☐ Title XIX	☐ Hospital ☐ IPF ☐ IRF	☐ Subprovider (Other)	☐ PPS ☐ TEFRA	
(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)
	ANCILLARY SERVICE COST CENTERS					
50	Operating Room					50
51	Recovery Room					51
52	Labor Room and Delivery Room					52
53	Anesthesiology					53
54	Radiology-Diagnostic					54
55	Radiology-Therapeutic					55
56	Radioisotope					56
57	Computed Tomography (CT) Scan					57
58	Magnetic Resonance Imaging (MRI)					58
59	Cardiac Catheterization					60
60	Laboratory					60
61	PBP Clinical Laboratory Services-Prgm. Only					61
62	Whole Blood & Packed Red Blood Cells					62
63	Blood Storing, Processing, & Transfusing					63
64	Intravenous Therapy					64
65	Respiratory Therapy					65
66	Physical Therapy					66
67	Occupational Therapy					67
68	Speech Pathology					68
69	Electrocardiology					69
70	Electroencephalography					70
71	Medical Supplies Charged to Patients					71
72	Implantable Devices Charged to Patients					72
73	Drugs Charged to Patients					73
74	Renal Dialysis					74
75	ASC (Non-Distinct Part)					75
76	Other Ancillary (specify)					76
88	Rural Health Clinic (RHC)					88
89	Federally Qualified Health Center (FQHC)					89
90	Clinic					90
91	Emergency					91
92	Observation Beds					92
93	Other Outpatient Service (specify)					93
	OTHER REIMBURSABLE COST CENTERS					
94	Home Program Dialysis					94
95	Ambulance Services					95
96	Durable Medical Equipment-Rented					96
97	Durable Medical Equipment-Sold					97
98	Other Reimbursable (specify)					98
200	Total (sum of lines 50 through 199)					200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE
SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D,
PART III

PROVIDER CCN: _____

PERIOD:
FROM _____
TO _____

Check applicable boxes:	☐ Title V ☐ Title XVIII, Part A ☐ Title XIX	☐ PPS ☐ TEFRA		Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)
		2	3									
(A)	Cost Center Description	1	2	3	4	5	6	7	8	9		
	INPATIENT ROUTINE SERVICE COST CENTERS											
30	Adults & Pediatrics (General Routine Care)											30
31	Intensive Care Unit											31
32	Coronary Care Unit											32
33	Burn Intensive Care Unit											33
34	Surgical Intensive Care Unit											34
35	Other Special Care Unit (specify)											35
40	Subprovider IPF											40
41	Subprovider IRF											41
42	Subprovider (Other)											42
43	Nursery											43
44	Skilled Nursing Facility											44
45	Nursing Facility											45
200	Total (sum of lines 30-199)											200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY
SERVICE OTHER PASS THROUGH COSTS

PROVIDER CCN: _____

PERIOD:
FROM _____
TO _____WORKSHEET D,
PART IV

COMPONENT CCN: _____

Check applicable boxes:	☐ Title V ☐ Title XVIII, Part A ☐ Title XIX	☐ Hospital ☐ IPF ☐ IRF	☐ Subprovider (Other) ☐ SNF ☐ NF	☐ ICF/MR	☐ PPS ☐ TEFRA			
(A)	Cost Center Description	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
51	Recovery Room							51
52	Labor room and Delivery Room							52
53	Anesthesiology							53
54	Radiology-Diagnostic							54
55	Radiology-Therapeutic							55
56	Radioisotope							56
57	Computed Tomography (CT) Scan							57
58	Magnetic Resonance Imaging (MRI)							58
59	Cardiac Catheterization							59
60	Laboratory							60
61	PBP Clinical Laboratory Serv.-Prgm. Only							61
62	Whole Blood & Packed Red Blood Cells							62
63	Blood Storing, Processing, & Transfusing							63
64	Intravenous Therapy							64
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
69	Electrocardiology							69
70	Electroencephalography							70
71	Medical Supplies Charged To Patients							71
72	Implantable Devices Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis							74
75	ASC (Non-Distinct Part)							75
76	Other Ancillary (specify)							76
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic (RHC)							88
89	Federally Qualified Health Center (FQHC)							89
90	Clinic							90
91	Emergency							91
92	Observation Beds							92
93	Other Outpatient Service (specify)							93
	OTHER REIMBURSABLE COST CENTERS							
94	Home Program Dialysis							94
95	Ambulance Services							95
96	Durable Medical Equipment-Rented							96
97	Durable Medical Equipment-Sold							97
98	Other Reimbursable (specify)							98
200	Total (sum of lines 50 through 199)							200

(A) Worksheet A line numbers

**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY
SERVICE OTHER PASS THROUGH COSTS**

PROVIDER CCN: _____

PERIOD:

FROM _____

WORKSHEET D,
PART IV (Cont.)

COMPONENT CCN: _____

TO _____

Check
applicable
boxes:
☐ Title V
☐ Title XVIII, Part A
☐ Title XIX

☐ Hospital
☐ IPF
☐ IRF

☐ Subprovider (Other)
☐ SNF
☐ NF

☐ ICF/MR
☐ PPS
☐ TEFRA

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass- Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass- Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room								50
51	Recovery Room								51
52	Delivery Room and Labor Room								52
53	Anesthesiology								53
54	Radiology-Diagnostic								54
55	Radiology-Therapeutic								55
56	Radioisotope								56
57	Computed Tomography (CT) Scan								57
58	Magnetic Resonance Imaging (MRI)								58
59	Cardiac Catheterization								59
60	Laboratory								60
61	PBP Clinical Laboratory Serv.-Prgm. Only								61
62	Whole Blood & Packed Red Blood Cells								62
63	Blood Storing, Processing, & Transfusing								63
64	Intravenous Therapy								64
65	Respiratory Therapy								65
66	Physical Therapy								66
67	Occupational Therapy								67
68	Speech Pathology								68
69	Electrocardiology								69
70	Electroencephalography								70
71	Medical Supplies Charged To Patients								71
72	Implantable Devices Charged to Patients								72
73	Drugs Charged to Patients								73
74	Renal Dialysis								74
75	ASC (Non-Distinct Part)								75
76	Other Ancillary (specify)								76
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic (RHC)								88
89	Federally Qualified Health Center (FQHC)								89
90	Clinic								90
91	Emergency								91
92	Observation Beds								92
93	Other Outpatient Service (specify)								93
	OTHER REIMBURSABLE COST CENTERS								
94	Home Program Dialysis								94
95	Ambulance Services								95
96	Durable Medical Equipment-Rented								96
97	Durable Medical Equipment-Sold								97
98	Other Reimbursable (specify)								98
200	Total (sum of lines 50 through 199)								200

(A) Worksheet A line numbers

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS			PROVIDER CCN: _____		PERIOD: FROM _____	WORKSHEET D, PART V
			COMPONENT CCN: _____		TO _____	
Check applicable boxes:	☐ Title V - O/P ☐ Title XVIII, Part B ☐ Title XIX - O/P	☐ Hospital ☐ IPF ☐ IRF	☐ Subprovider (Other) ☐ SNF ☐ NF	☐ Swing Bed SNF ☐ Swing Bed NF ☐ ICF/MR		

PART V - APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

(A)	Cost Center Description	Cost to Charge Ratio from Worksheet C, Part I, col. 9 1	Program Charges			Program Cost			
			PPS Reimbursed Services (see inst.) 2	Cost Reimbursed Services Subject to Ded. & Coins. (see inst.) 3	Cost Reimbursed Services Not Subject to Ded. & Coins. (see inst.) 4	PPS Services (see inst.) 5	Cost Reimbursed Services Subject to Ded. & Coins. (see inst.) 6	Cost Reimbursed Services Not Subject to Ded. & Coins. (see inst.) 7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room								50
51	Recovery Room								51
52	Labor & Delivery Room								52
53	Anesthesiology								53
54	Radiology-Diagnostic								54
55	Radiology-Therapeutic								55
56	Radioisotope								56
57	Computed Tomography (CT) Scan								57
58	Magnetic Resonance Imaging (MRI)								58
59	Cardiac Catheterization								59
60	Laboratory								60
61	PBP Clinical Laboratory Serv.-Prgm. Only								61
62	Whole Blood & Packed Red Blood Cells								62
63	Blood Storing, Processing, & Transfusing								63
64	Intravenous Therapy								64
65	Respiratory Therapy								65
66	Physical Therapy								66
67	Occupational Therapy								67
68	Speech Pathology								68
69	Electrocardiology								69
70	Electroencephalography								70
71	Medical Supplies Charged To Patients								71
72	Implantable Devices Charged to Patients								72
73	Drugs Charged to Patients								73
74	Renal Dialysis								74
75	ASC (Non-Distinct Part)								75
76	Other Ancillary (specify)								76
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic (RHC)								88
89	Federally Qualified Health Center (FQHC)								89
90	Clinic								90
91	Emergency								91
92	Observation Bed								92
93	Other Outpatient Service (specify)								93
	OTHER REIMBURSABLE COST CENTERS								
94	Home Program Dialysis								94
95	Ambulance								95
96	Durable Medical Equipment-Rented								96
97	Durable Medical Equipment-Sold								97
98	Other Reimbursable Cost Center								98
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

COMPUTATION OF INPATIENT OPERATING COST		PROVIDER CCN.: _____	PERIOD: FROM _____ TO _____	WORKSHEET D-1, PART I
		COMPONENT CCN.: _____		
Check applicable boxes:	☐ Title V - I/P ☐ Title XVIII, Part A ☐ Title XIX - I/P	☐ Hospital ☐ IPF ☐ IRF	☐ Subprovider (other) ☐ SNF	☐ ICF/MR ☐ PPS ☐ TEFRA ☐ Other

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	Inpatient days (including private room days and swing-bed days, excluding newborn)		1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)		2
3	Private room days (excluding swing-bed and observation bed days). <i>If you have only private room days, do not complete this line.</i>		3
4	Semi-private room days (excluding swing-bed and observation bed days)		4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions).		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period.		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the Program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16
SWING BED ADJUSTMENT			
17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)		21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	General inpatient routine service charges (excluding swing-bed <i>and observation bed</i> charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		37

COMPUTATION OF INPATIENT OPERATING COST		PROVIDER CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET D-1, PART II
Check applicable boxes:		COMPONENT CCN: _____		
☐ Title V - I/P ☐ Title XVIII, Part A ☐ Title XIX - I/P		☐ Hospital ☐ IPF ☐ IRF	☐ Subprovider (other) ☐ PPS ☐ TEFRA ☐ Other	

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS						1		
38	Adjusted general inpatient routine service cost per diem (see instructions)							38
39	Program general inpatient routine service cost (line 9 x line 38)							39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)							40
41	Total Program general inpatient routine service cost (line 39 + line 40)							41
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)			
	1	2	3	4	5			
42	Nursery (title V & XIX only)							42
Intensive Care Type Inpatient Hospital Units								
43	Intensive Care Unit							43
44	Coronary Care Unit							44
45	Burn Intensive Care Unit							45
46	Surgical Intensive Care Unit							46
47	Other Special Care Unit (specify)							47
						1		
48	Program inpatient ancillary service cost (Worksheet D-3, column 3, line 200)							48
49	Total Program inpatient costs (sum of lines 41 through 48) (see instructions)							49

PASS-THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Worksheet D, sum of Parts I and III)		50
51	Pass through costs applicable to Program inpatient ancillary services (from Worksheet D, sum of Parts II and IV)		51
52	Total Program excludable cost (sum of lines 50 and 51)		52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist, and medical education costs (line 49 minus line 52)		53

TARGET AMOUNT AND LIMIT COMPUTATION

54	Program discharges		54
55	Target amount per discharge		55
56	Target amount (line 54 x line 55)		56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57
58	Bonus payment (see instructions)		58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket		59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket		60
61	If line 53 ÷ line 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)		61
62	Relief payment (see instructions)		62
63	Allowable Inpatient cost plus incentive payment (see instructions)		63

PROGRAM INPATIENT ROUTINE SWING BED COST

64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (see instructions) (title XVIII only)		64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (see instructions) (title XVIII only)		65
66	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (Title XVIII only. For CAH, see instructions.)		66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69

COMPUTATION OF INPATIENT OPERATING COST		PROVIDER CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET D-1, PARTS III & IV
COMPONENT CCN: _____				
Check applicable boxes:	☐ Title V - I/P ☐ Title XVIII, Part A ☐ Title XIX - I/P	☐ Hospital ☐ IPF ☐ IRF	☐ Subprovider (other) ☐ SNF ☐ NF	☐ ICF/MR ☐ PPS ☐ TEFRA ☐ Other

PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICT/MR ONLY

70	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		70
71	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71
72	Program routine service cost (line 9 x line 71)		72
73	Medically necessary private room cost applicable to Program (line 14 x line 35)		73
74	Total Program general inpatient routine service costs (line 72 + line 73)		74
75	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Parts II, column 26, line 45)		75
76	Per diem capital-related costs (line 75 ÷ line 2)		76
77	Program capital-related costs (line 9 x line 76)		77
78	Inpatient routine service cost (line 74 minus line 77)		78
79	Aggregate charges to beneficiaries for excess costs (from provider records)		79
80	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80
81	Inpatient routine service cost per diem limitation		81
82	Inpatient routine service cost limitation (line 9 x line 81)		82
83	Reasonable inpatient routine service costs (see instructions)		83
84	Program inpatient ancillary services (see instructions)		84
85	Utilization review - physician compensation (see instructions)		85
86	Total Program inpatient operating costs (sum of lines 83 through 85)		86

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)		87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)		88
89	Observation bed cost (line 87 x line 88) (see instructions)		89

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

		Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass-Through Cost (col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School cost						91
92	Allied Health cost						92
93	All other Medical Education						93

APPORTIONMENT OF COST OF
 SERVICES RENDERED BY
 INTERNS AND RESIDENTS

PROVIDER CCN:

PERIOD:

FROM _____
TO _____WORKSHEET D-2,
PARTS I-III**PART I - NOT IN APPROVED TEACHING PROGRAM**

Cost Centers		Percent of Assigned Time	Expense Allocation	Total Inpatient Days All Patients	
		1	2	3	
1	Total cost of services rendered	100.00			1
Hospital Inpatient Routine Services:					
2	Adults & pediatrics (general routine care)				2
3	Intensive care unit				3
4	Coronary care unit				4
5	Burn Intensive Care Unit				5
6	Surgical Intensive Care Unit				6
7	Other Special Care (specify)				7
8	Nursery				8
9	Subtotal (sum of lines 2 through 8)				9
10	IPF - Inpatient routine service				10
11	IRF - Inpatient routine service				11
12	Subprovider (Other) - Inpatient routine service				12
13	Skilled Nursing Facility				13
14	Nursing Facility				14
15	Other Long Term Care				15
16	Home Health Agency				16
17	Outpatient Rehabilitation Providers				17
18	Ambulatory Surgical Center				18
19	Hospice				19
20	Subtotal (sum of lines 9 through 19)				20
				Total Charges (from Worksheet C, Part I, column 8, lines 88 through 93)	
Hospital Outpatient Services:					
21	Rural Health Clinic (RHC)				21
22	Federally Qualified Health Center (FQHC)				22
23	Clinic				23
24	Emergency				24
25	Observation beds				25
26	Other Outpatient Service (specify)				26
27	Subtotal (sum of lines 21 through 26)				27
28	Total (sum of lines 20 and 27)	100.00			28

PART II - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT ROUTINE COSTS ONLY)

		Expenses Allocated to cost centers on Worksheet B, Part I columns 21 and 22	Swing Bed Amount	Net Cost (column 1 plus column 2)	
		1	2	3	
Hospital Inpatient Routine Services:					
29	Adults & Pediatrics (general routine care)				29
30	Swing Bed - SNF				30
31	Swing Bed - NF				31
32	Intensive care unit				32
33	Coronary care unit				33
34	Burn Intensive Care Unit				34
35	Surgical Intensive Care Unit				35
36	Other Special Care (specify)				36
37	Subtotal (sum of lines 28, and 29 through 36)				37
38	IPF - Inpatient routine service				38
39	IRF - Inpatient routine service				39
40	Subprovider (Other)- Inpatient routine service				40
41	Skilled Nursing Facility				41
42	Total (sum of lines 37 through 41)				42

PART III - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH PARTS I AND II ARE USED)

		Not In Approved Teaching Program (from Part I)		
		1	Amount	
Hospital				
43	Inpatient	column 9, line 9		43
44	Outpatient	column 9, line 27		44
45	Total Hospital (sum of lines 43 and 44)			45
46	IPF - Inpatient routine service	column 9, line 10		46
47	IRF - Inpatient routine service	column 9, line 11		47
48	Subprovider (Other)- Inpatient routine service	column 9, line 12		48
49	Skilled Nursing Facility	column 9, line 13		49

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS	PROVIDER CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET D-2, PARTS I-III (Cont.)
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PART I - NOT IN APPROVED TEACHING PROGRAM

	Average Cost Per Day 4	Health Care Program Inpatient Days			Title V (col. 4 x col. 5) 8	Title XVIII (col. 4 x col. 6) 9	Title XIX (col. 4 x col. 7) 10	
		Title V 5	Title XVIII, Part B 6	Title XIX 7				
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20

	Ratio of Cost to Charges (column 2 ÷ column 3)	Titles V and XIX Outpatient and Title XVIII Part B Charges			Titles V and XIX Outpatient and Title XVIII Part B Cost			
		Title V 5	Title XVIII Part B 6	Title XIX 7	Title V 8	Title XVIII Part B 9	Title XIX 10	
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28

PART II - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT ROUTINE COSTS ONLY)

	Total Inpatient Days - All Patients 4	Average Cost Per Day (column 3 ÷ column 4) 5	Title XVIII Part B Inpatient Days 6	Expenses Applicable to Title XVIII (col. 5 x col. 6) 7				
29								29
30								30
31								31
32								32
33								33
34								34
35								35
36								36
37								37
38								38
39								39
40								40
41								41
42								42

PART III - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH PARTS I AND II ARE USED)

	In Approved Teaching Program		Total Title XVIII Costs					
	(from Part II, col. 7)	Amount	(to Wkst. E, Part B)	(col. 2 + col. 4)				
	3	4	5	6				
43	line 37							43
44								44
45			line 2					45
46	line 38		line 2					46
47	line 39		line 2					47
48	line 40		line 2					48
49	line 41		line 2					49

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			PROVIDER CCN: _____ COMPONENT CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET D-3
Check applicable boxes:	☐ Title V ☐ Title XVIII, Part A ☐ Title XIX	☐ Hospital ☐ IPF ☐ IRF	☐ Subprovider (other) ☐ SNF ☐ NF	☐ Swing-Bed SNF ☐ Swing-Bed NF ☐ ICF/MR	☐ PPS ☐ TEFRA ☐ Other

COST CENTER DESCRIPTION		Ratio of Cost to Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)		1	2	3	
INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults and Pediatrics (General Routine Care)				30
31	Intensive Care Unit				31
32	Coronary Care Unit				32
33	Burn Intensive Care Unit				33
34	Surgical Intensive Care Unit				34
35	Other Special Care (specify)				35
40	Subprovider IPF				40
41	Subprovider IRF				41
42	Subprovider (Specify)				42
43	Nursery				43
ANCILLARY SERVICE COST CENTERS					
50	Operating Room				50
51	Recovery Room				51
52	Labor Room and Delivery Room				52
53	Anesthesiology				53
54	Radiology-Diagnostic				54
55	Radiology-Therapeutic				55
56	Radioisotope				56
57	Computed Tomography (CT) Scan				57
58	Magnetic Resonance Imaging (MRI)				58
59	Cardiac Catheterization				59
60	Laboratory				60
61	PBP Clinical Laboratory Services-Prgm. Only				61
62	Whole Blood & Packed Red Blood Cells				62
63	Blood Storing, Processing, & Trans.				63
64	Intravenous Therapy				64
65	Respiratory Therapy				65
66	Physical Therapy				66
67	Occupational Therapy				67
68	Speech Pathology				68
69	Electrocardiology				69
70	Electroencephalography				70
71	Medical Supplies Charged to Patients				71
72	Implantable Devices Charged to Patients				72
73	Drugs Charged to Patients				73
74	Renal Dialysis				74
75	ASC (Non-Distinct Part)				75
76	Other Ancillary (specify)				76
OUTPATIENT SERVICE COST CENTERS					
88	Rural Health Clinic (RHC)				88
89	Federally Qualified Health Center (FQHC)				89
90	Clinic				90
91	Emergency				91
92	Observation Beds (see instructions)				92
93	Other Outpatient Service (specify)				93
OTHER REIMBURSABLE COST CENTERS					
94	Home Program Dialysis				94
95	Ambulance Services				95
96	Durable Medical Equipment-Rented				96
97	Durable Medical Equipment-Sold				97
98	Other Reimbursable (specify)				98
200	Total (sum of lines 50-94 and 96-98)				200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)				202

(A) Worksheet A line numbers

COMPUTATION OF ORGAN ACQUISITION COSTS AND CHARGES
FOR HOSPITALS WHICH ARE CERTIFIED TRANSPLANT CENTERS

PROVIDER CCN: _____

PERIOD:

FROM _____

TO _____

WORKSHEET D-4,
PART ICheck
applicable box:☐ HEART☐ LIVER☐ PANCREAS☐ ISLET☐ KIDNEY☐ LUNG☐ INTESTINE☐ OTHER (specify) _____**PART I - COMPUTATION OF ORGAN ACQUISITION COSTS (INPATIENT ROUTINE AND ANCILLARY SERVICES)**

Computation of Inpatient Routine Service Costs Applicable to Organ Acquisition		Inpatient Routine Organ Charges	Per Diem Costs (from Wkst. D-1, Part II)		Organ Acquisition Days	Cost (col. 2 x col. 3)	
		1	D	2	3	4	
1	Adults and Pediatrics		38				1
2	Intensive Care		43				2
3	Coronary Care		44				3
4	Burn Intensive Care Unit		45				4
5	Surgical Intensive Care Unit		46				5
6	Other Special Care (specify)		47				6
7	TOTAL (sum of lines 1-6)						7

Computation of Ancillary Service Costs Applicable to Organ Acquisition		Ratio of Cost to Charges (from Wkst. C)		Organ Acquisition Ancillary Charges	Organ Acquisition Ancillary Costs	
		C	1	2	3	
8	Operating Room	50				8
9	Recovery Room	51				9
10	Labor Room & Delivery Room	52				10
11	Anesthesiology	53				11
12	Radiology-Diagnostic	54				12
13	Radiology-Therapeutic	55				13
14	Radioisotope	56				14
15	Computed Tomography (CT) Scan	57				15
16	Magnetic Resonance Imaging (MRI)	58				16
17	Cardiac Catheterization	59				17
18	Laboratory	60				18
19	PBP Clinical Laboratory Services-Program Only	61				19
20	Whole Blood & Packed Red Blood Cells	62				20
21	Blood Storage, Processing, & Transfusing	63				21
22	IV Therapy	64				22
23	Respiratory Therapy	65				23
24	Physical Therapy	66				24
25	Occupational Therapy	67				25
26	Speech Pathology	68				26
27	Electrocardiology	69				27
28	Electroencephalography	70				28
29	Medical Supplies Charged to Patients	71				29
30	Implantable Devices Charged to Patients	72				30
31	Drugs Charged to Patients	73				31
32	Renal Dialysis	74				32
33	ASC (non-distinct part)	75				33
34	Other Ancillary (specify)	76				34
35	Rural Health Clinic (RHC)	88				35
36	Federally Qualified Health Center (FQHC)	89				36
37	Clinic	90				37
38	Emergency Room	91				38
39	Observation Beds	92				39
40	Other Outpatient Service (specify)	93				40
41	TOTAL (sum of lines 8-40)					41

C = Worksheet C line numbers

D = Worksheet D-1 line numbers

COMPUTATION OF ORGAN ACQUISITION COSTS AND CHARGES FOR HOSPITALS WHICH ARE CERTIFIED TRANSPLANT CENTERS		PROVIDER CCN: _____ OPO CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET D-4, PART II
Check applicable box:	☐ HEART ☐ KIDNEY	☐ LIVER ☐ LUNG	☐ PANCREAS ☐ INTESTINE	☐ ISLET ☐ OTHER (specify)

**PART II - COMPUTATION OF ORGAN ACQUISITION COSTS (OTHER THAN INPATIENT ROUTINE AND
ANCILLARY SERVICE COSTS)**

Computation of the Cost of Inpatient Services of Interns and Residents Not In Approved Teaching Program		Average Cost Per Day (from Wkst. D-2, Part I, col. 4)		Organ Acquisition Days	Organ Acquisition Costs (col. 1 x col. 2)	
		D	1			
42	Adults & Pediatrics (General routine care)	2		2		42
43	Intensive Care Unit	3				43
44	Coronary Care Unit	4				44
45	Burn Intensive Care Unit	5				45
46	Surgical Intensive Care Unit	6				46
47	Other Special Care (specify)	7				47
48	TOTAL (sum of lines 42 through 47)					48

Computation of the Cost of Outpatient Services of Interns and Residents Not In Approved Teaching Program		Organ Charges (see instructions)		Ratio of Cost to Charges from Wkst. D-2, Part I, col. 4)		Organ Acquisition Costs (col. 1 x col. 2)	
		1	D	2	3		
49	Rural Health Clinic (RHC)		21				49
50	Federally Qualified Health Center (FQHC)		22				50
51	Clinic		23				51
52	Emergency		24				52
53	Observation Beds		25				53
54	Other Outpatient Service (specify)		26				54
55	TOTAL (sum of lines 49 through 54)						55

D = Worksheet D-2, Part I, line numbers

COMPUTATION OF ORGAN ACQUISITION COSTS AND CHARGES
FOR HOSPITALS WHICH ARE CERTIFIED TRANSPLANT CENTERS

PROVIDER CCN:

OPO CCN:

PERIOD:

FROM _____
TO _____WORKSHEET D-4,
PARTS III & IVCheck
applicable box:☐ HEART☐ LIVER☐ PANCREAS☐ ISLET☐ KIDNEY☐ LUNG☐ INTESTINE☐ OTHER (specify)

PART III - SUMMARY OF COSTS AND CHARGES

		Cost		Charges		
		Part A	Part B	Part A	Part B	
		1	2	3	4	
56	Routine and Ancillary from Part I					56
57	Interns and Residents (inpatient)					57
58	Interns and Residents (outpatient)					58
59	Direct Organ Acquisition (see instructions)					59
60	Cost of Services of Teaching Physicians (Wkst. D-5, Part II)					60
61	Total (sum of lines 56 thru 60)					61
62	Total Usable Organs (see instructions)					62
63	Medicare Usable Organs (see instructions)					63
64	Ratio of Medicare Usable Organs to Total Usable Organs (line 63 ÷ line 62)					64
65	Medicare Cost/Charges (see instructions)					65
66	Revenue for Organs Sold					66
67	Subtotal (line 65 minus line 66)					67
68	Organs Furnished Part B					68
69	Net Organ Acquisition Cost and Charges (see instructions)					69

PART IV - STATISTICS

		Living Related	Cadaveric	Revenue	
		1	2	3	
70	Organs Excised in Provider (1)				70
71	Organs Purchased from Other Transplant Hospitals (2)				71
72	Organs Purchased from Non-Transplant Hospitals				72
73	Organs Purchased from OPOs				73
74	Total (sum of lines 70 thru 73)				74
75	Organs Transplanted				75
76	Organs Sold to Other Hospitals				76
77	Organs Sold to OPOs				77
78	Organs Sold to Transplant Hospitals				78
79	Organs Sold to Military or VA Hospitals				79
80	Organs Sold Outside the U.S.				80
81	Organs Sent Outside the U.S. (no revenue received)				81
82	Organs Used for Research				82
83	Unusable/Discarded Organs				83
84	Total (sum of lines 75 through 83 should equal line 74)				84

(1) Organs procured outside your center by a procurement team from your center are not included in the count.

(2) Organs procured outside your center by a procurement team are included in the count.

APPORTIONMENT OF COST FOR THE SERVICES OF TEACHING PHYSICIANS

WORKSHEET D-5,

PART I

Check applicable box: ☐ Hospital Staff ☐ Medical Staff

PART I - REASONABLE COMPENSATION EQUIVALENT COMPUTATION

Line No.	Specialty Description/Physician Identifier	Total Remuneration	Professional Component	RCE Amount	Physician/ Professional Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit
1	2	3	4	5	6	7	8
1	General Practitioner Family Practice						1
2	Internal Medicine						2
3	Surgery						3
4	Pediatrics						4
5	Obstetrics-Gynecology						5
6	Radiology						6
7	Psychiatry						7
8	Anesthesiology						8
9	Pathology						9
10	All Other						10
11	Total						11

Line No.	Specialty Description/Physician Identifier	Cost of Membership & Continuing Education	Professional Component Share of col. 11	Cost of Physician Malpractice Insurance	Professional Component Share of col. 13	Adjusted RCE Limit	Adjust Cost of Physician's Direct Medical & Surgical Services
9	10	11	12	13	14	15	16
1	General Practitioner Family Practice						1
2	Internal Medicine						2
3	Surgery						3
4	Pediatrics						4
5	Obstetrics-Gynecology						5
6	Radiology						6
7	Psychiatry						7
8	Anesthesiology						8
9	Pathology						9
10	All Other						10
11	Total (transfer the amount in column 16, line 11, to Part II, line 1, column 1 or 2, as appropriate)						11

APPORTIONMENT OF COST FOR THE SERVICES OF TEACHING PHYSICIANS		PROVIDER CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET D-5, PART II
Check applicable box:	☐ Hospital ☐ IRF	☐ IPF ☐ Subprovider (other)		

PART II - APPORTIONMENT OF COST FOR THE SERVICES OF TEACHING PHYSICIANS

		Hospital Staff	Medical School Faculty	Total (col 1 + col 2)	
		1	2	3	
1	Adjusted Cost of Physician's Direct Medical and Surgical Services				1
2	Total Inpatient Days and Outpatient Visit Days				2
3	Average Per Diem (line 1 ÷ line 2)				3

HEALTH CARE PROGRAM REIMBURSABLE DAYS

4	Title V - Inpatient				4
5	Title V - Outpatient				5
6	Title XVIII - Part A				6
7	Title XVIII - Part B				7
8	Title XIX - Inpatient				8
9	Title XIX - Outpatient				9
10	Inpatient and Outpatient Kidney Acquisition				10
11	Inpatient and Outpatient Liver Acquisition				11
12	Inpatient and Outpatient Heart Acquisition				12
13	Inpatient and Outpatient Lung Acquisition				13
14	Inpatient and Outpatient Pancreas Acquisition				14
15	Inpatient and Outpatient Intestine Acquisition				15
16	Inpatient and Outpatient Islet Acquisition				16
17	Other Organ Acquisition				17

HEALTH CARE PROGRAM REIMBURSABLE COST

18	Title V - Inpatient (line 3 x line 4)				18
19	Title V - Outpatient (line 3 x line 5)				19
20	Title XVIII - Part A (line 3 x line 6)				20
21	Title XVIII - Part B (line 3 x line 7)				21
22	Title XIX - Inpatient (line 3 x line 8)				22
23	Title XIX - Outpatient (line 3 x line 9)				23
24	Inpatient and Outpatient Kidney Acquisition (line 3 x line 10)				24
25	Inpatient and Outpatient Liver Acquisition (line 3 x line 11)				25
26	Inpatient and Outpatient Heart Acquisition (line 3 x line 12)				26
27	Inpatient and Outpatient Lung Acquisition (line 3 x line 13)				27
28	Inpatient and Outpatient Pancreas Acquisition (line 3 x line 14)				28
29	Inpatient and Outpatient Intestine Acquisition (line 3 x line 15)				29
30	Inpatient and Outpatient Islet Acquisition (line 3 x line 16)				30
31	Inpatient and Outpatient Other Organ Acquisition (line 3 x line 17)				31

Transfer the amounts in column 3 as follows:

- Add lines 18 and 19, and transfer to Worksheet E-3, Part VII
- Line 20 to Worksheet E, Part A, or Worksheet E-3, Part I to **IV** as appropriate
- Line 21 to Worksheet E, Part B
- Add lines 22 and 23, and transfer to Worksheet E-3, Part VII, as appropriate
- Sum of lines 24 through 31 to Worksheet D-4, Part III, line 60

CALCULATION OF REIMBURSEMENT SETTLEMENT		PROVIDER CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET E, PART A
Check applicable box:	☐ Hospital ☐ Subprovider (Other)			

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

1	DRG amounts other than outlier payments		1
2	Outlier payments for discharges (see instructions)		2
2.01	<i>Outlier reconciliation amount</i>		2.01
3	Managed care simulated payments		3
4	Bed days available divided by number of days in the cost reporting period (see instructions)		4
Indirect Medical Education Adjustment Calculation for Hospitals			
5	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996 (see instructions)		5
6	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		6
7	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		7
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		7.01
8	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.		8
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		8.02
9	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line 8 plus lines (8.01 and 8.02) (see instructions)		9
10	FTE count for allopathic and osteopathic programs in the current year from your records		10
11	FTE count for residents in dental and podiatric programs		11
12	Current year allowable FTE (see instructions)		12
13	Total allowable FTE count for the prior year		13
14	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		14
15	Sum of lines 12 through 14 divided by 3		15
16	Adjustment for residents in initial years of the program		16
17	Adjustment for residents displaced by program or hospital closure		17
18	Adjusted rolling average FTE count		18
19	Current year resident to bed ratio (line 18 divided by line 4)		19
20	Prior year resident to bed ratio (see instructions)		20
21	Enter the lesser of lines 19 or 20 (see instructions)		21
22	IME payment adjustment (see instructions)		22
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA			
23	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		23
24	IME FTE resident count over cap (see instructions)		24
25	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		25
26	Resident to bed ratio (divide line 25 by line 4)		26
27	IME payments adjustment (see instructions)		27
28	IME Adjustment (see instructions)		28
29	Total IME payment (sum of lines 22 and 28)		29
Disproportionate Share Adjustment			
30	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		30
31	Percentage of Medicaid patient days to total days reported on Worksheet S-2, Part I, line 24. (see instructions)		31
32	Sum of lines 30 and 31		32
33	Allowable disproportionate share percentage (see instructions)		33
34	Disproportionate share adjustment (see instructions)		34

CALCULATION OF REIMBURSEMENT SETTLEMENT		PROVIDER CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET E, PART A (Cont.)
Check applicable box:	☐ Hospital ☐ IRF	☐ IPF ☐ Subprovider (other)		

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

Additional payment for high percentage of ESRD beneficiary discharges			
40	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		40
41	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		41
42	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		42
43	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		43
44	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		44
45	Average weekly cost for dialysis treatments (see instructions)		45
46	Total additional payment (line 45 times line 44 times line 41)		46
47	Subtotal (see instructions)		47
48	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only (see instructions)		48
49	Total payment for inpatient operating costs SCH and MDH only (see instructions)		49
50	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		50
51	Exception payment for inpatient program capital (Worksheet L, Part III) (see instructions)		51
52	Direct graduate medical education payment (from Worksheet E-4, line 49) (see instructions).		52
53	Nursing and allied health managed care payment		53
54	Special add-on payments for new technologies		54
55	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)		55
56	Cost of teaching physicians (Worksheet D-5, Part II, col. 3, line 20)		56
57	Routine service other pass through costs (from <i>Wkst D, Part III, column 9, lines 30-35</i>).		57
58	Ancillary service other pass through costs Worksheet D, Part IV, col. 11 line 200)		58
59	Total (sum of amounts on lines 49 through 58)		59
60	Primary payer payments		60
61	Total amount payable for program beneficiaries (line 59 minus line 60)		61
62	Deductibles billed to program beneficiaries		62
63	Coinsurance billed to program beneficiaries		63
64	Allowable bad debts (see instructions)		64
65	Adjusted reimbursable bad debts (see instructions)		65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)		66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)		67
68	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)		68
69	Outlier payments reconciliation (<i>Sum of lines 93, 95 and 96</i>).(For SCH see instructions)		69
70	Other adjustments (specify) (see instructions)		70
70.95	<i>Recovery of Accelerated depreciation</i>		70.95
70.96	<i>Low Volume Adjustment for Federal Fiscal year 2011</i>		70.96
70.97	<i>Low Volume Adjustment for Federal Fiscal year 2012</i>		70.97
71	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		71
72	Interim payments		72
73	Tentative settlement (for contractor use only)		73
74	Balance due provider (Program) (line 71 minus the sum of lines 72 and 73)		74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		75

TO BE COMPLETED BY CONTRACTOR

90	Operating outlier amount from Worksheet E, Part A line 2 (<i>see instructions</i>).		90
91	Capital outlier from Worksheet L, Part I, line 2		91
92	Operating outlier reconciliation adjustment amount (see instructions)		92
93	Capital outlier reconciliation adjustment amount (see instructions)		93
94	The rate used to calculate the Time Value of Money (see instructions)		94
95	Time Value of Money for operating expenses (see instructions)		95
96	Time Value of Money for capital related expenses (see instructions)		96

CALCULATION OF REIMBURSEMENT SETTLEMENT		PROVIDER CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET E, PART B
Check applicable box: ☐ Hospital ☐ IPF ☐ IRF ☐ Subprovider (Other) ☐ SNF				
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1	Medical and other services (see instructions)			1
2	Medical and other services reimbursed under OPPS (see instructions).			2
3	PPS payments			3
4	Outlier payment (see instructions)			4
5	Enter the hospital specific payment to cost ratio (see instructions)			5
6	Line 2 times line 5			6
7	Sum of line 3 and line 4 divided by line 6			7
8	Transitional corridor payment (see instructions)			8
9	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200			9
10	Organ acquisition			10
11	Total cost (sum of lines 1 and 10) (see instructions)			11
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12	Ancillary service charges			12
13	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)			13
14	Total reasonable charges (sum of lines 12 and 13)			14
Customary charges				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis			15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)			17
18	Total customary charges (see instructions)			18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			20
21	Lesser of cost or charges (line 11 minus line 20) (for CAH, see instructions)			21
22	Interns and residents (see instructions)			22
23	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, §2148)			23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)			24
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)			25
26	Deductibles and Coinsurance relating to amount on line 24 (see instructions)			26
27	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (see instructions)			27
28	Direct graduate medical education payments (from Worksheet E-4, line 50)			28
29	ESRD direct medical education costs (from Worksheet E-4, line 36)			29
30	Subtotal (sum of lines 27 through 29)			30
31	Primary payer payments			31
32	Subtotal (line 30 minus line 31)			32
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	Composite rate ESRD (from Worksheet I-5, line 11)			33
34	Allowable bad debts (see instructions)			34
35	Adjusted reimbursable bad debts (see instructions)			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)			36
37	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)			37
38	MSP-LCC reconciliation amount from PS&R			38
39	Other adjustments (specify) (see instructions)			39
40	Subtotal (line 37 plus or minus lines 39 minus 38)			40
41	Interim payments			41
42	Tentative settlement (for contractors use only)			42
43	Balance due provider/program (line 40 minus the sum of lines 41, and 42)			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			44

CALCULATION OF
REIMBURSEMENT SETTLEMENTPROVIDER CCN: _____
COMPONENT CCN: _____PERIOD:
FROM _____
TO _____WORKSHEET E,
PART B (Cont.)Check applicable box ☐ Hospital ☐ IPF ☐ IRF ☐ Subprovider(Other) ☐ SNF**PART B - MEDICAL AND OTHER HEALTH SERVICES****TO BE COMPLETED BY CONTRACTOR**

90	Original outlier amount (see instructions)		90
91	Outlier reconciliation adjustment amount (see instructions)		91
92	The rate used to calculate the Time Value of Money		92
93	Time Value of Money (see instructions)		93
94	Total (sum of lines 91 and 93)		94

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		PROVIDER CCN: _____ COMPONENT CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET E-1, PART I
Check applicable box:	☐ Hospital ☐ IPF ☐ IRF	☐ Subprovider (Other) ☐ SNF ☐ Swing-Bed SNF		
Description				
1	Total interim payments paid to provider			
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			
	Program to Provider	.01		
		.02		
		.03		
		.04		
		.05		
		.50		
		.51		
		.52		
		.53		
		.54		
	Subtotal (sum of lines 3.01- 3.49 minus sum of lines 3.50-3.98)	.99		
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)			
TO BE COMPLETED BY CONTRACTOR				
5	Program to Provider	.01		
		.02		
		.03		
		.50		
		.51		
		.52		
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50 -5.98)	.99		
6	Determined net settlement amount (balance due) based on the cost report (1)	.01		
7	Total Medicare program liability (see instructions)	.02		
8	Name of Contractor	(Contractor Number)		
			NPR	Date (Month/Day/Year)
				8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.

CALCULATION OF REIMBURSEMENT
SETTLEMENT FOR HIT

PROVIDER CCN:

PERIOD:

FROM _____

COMPONENT CCN:

TO _____

WORKSHEET E-1,
PART II

Check

☐ Hospital

☐ CAH

Applicable box:

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I, line 14, column 15		1
2	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12		2
3	Medicare HMO days from Wkst S-3, Part I, column 6, line 2		3
4	Total inpatient <i>days</i> from S-3, Part I, column 8 sum of lines 1, 8-12		4
5	Total hospital charges from Wkst C, Part I, column 8 line 200		5
6	Total hospital charity care charges from Wkst S-10, column 3 line 20		6
7	CAH only - The reasonable cost incurred for the purchase of certified HIT technology from Worksheet S-2, Part I line 168		7
8	Calculation of the HIT incentive payment (see instructions)		8

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

30	Initial/interim HIT payment(s).		30
31	<i>Initial/interim HIT payment adjustments (see instructions)</i>		31
32	Balance due provider (line 8 minus line 30 <i>and</i> line 31)		32

CALCULATION OF REIMBURSEMENT
SETTLEMENT - SWING BEDS

PROVIDER CCN: _____

PERIOD:

FROM _____

WORKSHEET E-2

COMPONENT CCN: _____

TO _____

Check
applicable
boxes:☐ Title V
☐ Title XVIII
☐ Title XIX☐ Swing Bed - SNF
☐ Swing Bed - NF

COMPUTATION OF NET COST OF COVERED SERVICES		PART A	PART B	
		1	2	
1	Inpatient routine services - swing bed-SNF (see instructions)			1
2	Inpatient routine services - swing bed-NF (see instructions)			2
3	Ancillary services (from Wkst. D-3, column 3, line 200 for Part A, and sum of Wkst. D, Part V, columns 5 and 7, line 202 for Part B) (For CAH, see instructions)			3
4	Per diem cost for interns and residents not in approved teaching program (see instructions)			4
5	Program days			5
6	Interns and residents not in approved teaching program (see instructions)			6
7	Utilization review - physician compensation - SNF optional method only			7
8	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)			8
9	Primary payer payments (see instructions)			9
10	Subtotal (line 8 minus line 9)			10
11	Deductibles billed to program patients (exclude amounts applicable to physician professional services)			11
12	Subtotal (line 10 minus line 11)			12
13	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)			13
14	80% of Part B costs (line 12 x 80%)			14
15	Subtotal (enter the lesser of line 12 minus line 13, or line 14)			15
16	Other adjustments (specify) (see instructions)			16
17	Reimbursable bad debts (see instructions)			17
18	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			18
19	Total (sum of lines 15 and 17, plus/minus line 16)			19
20	Interim payments			20
21	Tentative settlement (for contractor use only)			21
22	Balance due provider/program (line 19 minus the sum of lines 20 and 21)			22
23	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			23

CALCULATION OF REIMBURSEMENT SETTLEMENT

PROVIDER CCN: _____

PERIOD:

FROM _____

COMPONENT CCN: _____

TO _____

WORKSHEET E-3,
PART I

PART I - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER - TEFRA

1	Inpatient hospital services (see instructions)		1
2	Organ acquisition		2
3	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)		3
4	Subtotal (sum of lines 1 thru 3)		4
5	Primary payer payments		5
6	Subtotal (line 4 less line 5).		6
7	Deductibles		7
8	Subtotal (line 6 minus line 7)		8
9	Coinsurance		9
10	Subtotal (line 8 minus line 9)		10
11	Allowable bad debts (exclude bad debts for professional services) (see instructions)		11
12	Adjusted reimbursable bad debts (see instructions)		12
13	Allowable bad debts for dual eligible beneficiaries (see instructions)		13
14	Subtotal (sum of lines 10 and 12)		14
15	Direct graduate medical education payments (from Worksheet E-4, line 49)		15
16	Other pass through costs (see instructions). DO NOT USE THIS LINE.		16
17	Other adjustments (specify) (see instructions)		17
18	Total amount payable to the provider (see instructions)		18
19	Interim payments		19
20	Tentative settlement (for contractor use only)		20
21	Balance due provider/program (line 18 minus the sum lines 19 and 20)		21
22	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		22

CALCULATION OF REIMBURSEMENT SETTLEMENT

PROVIDER CCN:

PERIOD:

WORKSHEET E-3,

COMPONENT CCN:

FROM _____
TO _____

PART II

Check
applicable
box:☐ Hospital
☐ Subprovider IPF

PART II - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IPF PPS

1	Net Federal IPF PPS payment (excluding outlier, ECT, and medical education payments)		1
2	Net IPF PPS Outlier payment		2
3	Net IPF PPS ECT payment		3
4	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004 (see instructions)		4
4.01	<i>Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)</i>		4.01
5	New teaching program adjustment (see instructions)		5
6	Current year unweighted FTE count of I&R other than FTEs in the first 3 years of a "new teaching program" (see instructions)		6
7	Current year unweighted I&R FTE count for residents within the first 3 years of a "new teaching program" (see instructions)		7
8	Intern and resident count for IPF PPS medical education adjustment (see instructions)		8
9	Average daily census (see instructions)		9
10	Medical Education Adjustment Factor $\{((1 + (\text{line } 8/\text{line } 9)) \text{ raised to the power of } .5150 - 1)\}$.		10
11	Medical Education Adjustment (line 1 multiplied by line 10).		11
12	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)		12
13	Nursing and allied health managed care payment (see instruction)		13
14	Organ acquisition		14
15	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)		15
16	Subtotal (see instructions)		16
17	Primary payer payments		17
18	Subtotal (line 16 less line 17).		18
19	Deductibles		19
20	Subtotal (line 18 minus line 19)		20
21	Coinurance		21
22	Subtotal (line 20 minus line 21)		22
23	Allowable bad debts (exclude bad debts for professional services) (see instructions)		23
24	Adjusted reimbursable bad debts (see instructions)		24
25	Allowable bad debts for dual eligible beneficiaries (see instructions)		25
26	Subtotal (sum of lines 22 and 24)		26
27	Direct graduate medical education payments (from Worksheet E-4, line 49) <i>(For freestanding IPF only)</i>		27
28	Other pass through costs (see instructions)		28
29	Outlier payments reconciliation		29
30	Other adjustments (specify) (see instructions)		30
31	Total amount payable to the provider (see instructions)		31
32	Interim payments		32
33	Tentative settlement (for contractor use only)		33
34	Balance due provider/program (line 31 minus the sum lines 32 and 33)		34
35	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		35

TO BE COMPLETED BY CONTRACTOR

50	Original outlier amount from Worksheet E-3, Part II, line 2 (see instructions)		50
51	Outlier reconciliation adjustment amount (see instructions)		51
52	The rate used to calculate the Time Value of Money (see instructions)		52
53	Time Value of Money (see instructions)		53

CALCULATION OF REIMBURSEMENT SETTLEMENT		PROVIDER CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET E-3, PART III
Check applicable box:	☐ Hospital ☐ Subprovider IRF			

PART III - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IRF PPS

1	Net Federal PPS payment (see instructions)		1
2	Medicare SSI ratio (IRF PPS only) (see instructions)		2
3	Inpatient Rehabilitation LIP payments (see instructions)		3
4	Outlier payments		4
5	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)		5
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under §412.424(d)(1)(iii)(F)(1) or (2)		5.01
6	New teaching program adjustment (see instructions)		6
7	Current year unweighted FTE count of I&R other than FTEs in the first 3 years of a "new teaching program" (see instructions)		7
8	Current year unweighted I&R FTE count for residents within the first 3 years of a "new teaching program" (see instructions)		8
9	Intern and resident count for IRF PPS medical education adjustment (see instructions)		9
10	Average daily census (see instructions)		10
11	Medical Education Adjustment Factor $\{(1 + (\text{line 9}/\text{line 10})) \text{ raised to the power of } .6876 - 1\}$.		11
12	Medical Education Adjustment (line 1 multiplied by line 11).		12
13	Total PPS Payment (sum of lines 1, 3, 4 and 12)		13
14	Nursing and Allied Health Managed Care payment (see instructions)		14
15	Organ acquisition		15
16	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)		16
17	Subtotal (see instructions)		17
18	Primary payer payments		18
19	Subtotal (line 17 less line 18).		19
20	Deductibles		20
21	Subtotal (line 19 minus line 20)		21
22	Coinsurance		22
23	Subtotal (line 21 minus line 22)		23
24	Allowable bad debts (exclude bad debts for professional services) (see instructions)		24
25	Adjusted reimbursable bad debts (see instructions)		25
26	Allowable bad debts for dual eligible beneficiaries (see instructions)		26
27	Subtotal (sum of lines 23 and 25)		27
28	Direct graduate medical education payments (from Worksheet E-4, line 49) (For free standing IRF only).		28
29	Other pass through costs (see instructions)		29
30	Outlier payments reconciliation		30
31	Other adjustments (specify) (see instructions)		31
32	Total amount payable to the provider (see instructions)		32
33	Interim payments		33
34	Tentative settlement (for contractor use only)		34
35	Balance due provider/program (line 32 minus the sum lines 33 and 34)		35
36	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		36

TO BE COMPLETED BY CONTRACTOR

50	Original outlier amount from Worksheet E-3, Part III, line 4 (see instructions)		50
51	Outlier reconciliation adjustment amount (see instructions)		51
52	The rate used to calculate the Time Value of Money (see instructions)		52
53	Time Value of Money (see instructions)		53

CALCULATION OF REIMBURSEMENT SETTLEMENT

PROVIDER CCN:

PERIOD:

WORKSHEET E-3,

COMPONENT CCN:

FROM _____
TO _____

PART IV

Check
applicable
box:☐ Hospital
☐ Subprovider (Other)

PART IV - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER LTCH PPS

1	Net Federal PPS payment (see instructions)		1
2	Outlier payments		2
3	Total PPS payments (sum of lines 1 and 2)		3
4	Nursing and allied health managed care payments (see instructions)		4
5	Organ acquisition		5
6	Cost of teaching physicians		6
7	Subtotal (see instructions)		7
8	Primary payer payments		8
9	Subtotal (line 7 less line 8).		9
10	Deductibles		10
11	Subtotal (line 9 minus line 10)		11
12	Coinsurance		12
13	Subtotal (line 11 minus line 12)		13
14	Allowable bad debts (exclude bad debts for professional services) (see instructions)		14
15	Adjusted reimbursable bad debts (see instructions)		15
16	Allowable bad debts for dual eligible beneficiaries (see instructions)		16
17	Subtotal (sum of lines 13 and 15)		17
18	Direct graduate medical education payments (from Worksheet E-4, line 49 <i>(for freestanding LTCH only)</i>)		18
19	Other pass through costs (see instructions)		19
20	Outlier payments reconciliation		20
21	Other adjustments (specify) (see instructions)		21
22	Total amount payable to the provider (see instructions)		22
23	Interim payments		23
24	Tentative settlement (for contractor use only)		24
25	Balance due provider/program (line 22 minus the sum lines 23 and 24)		25
26	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		26

TO BE COMPLETED BY CONTRACTOR

50	Original PPS payment and outlier amount from Worksheet E-3, Part IV, line 3 (see instructions)		50
51	Outlier reconciliation adjustment amount (see instructions)		51
52	The rate used to calculate the Time Value of Money (see instructions)		52
53	Time Value of Money (see instructions)		53

CALCULATION OF REIMBURSEMENT SETTLEMENT		PROVIDER CCN: _____	PERIOD: FROM _____	WORKSHEET E-3, PART V
		COMPONENT CCN: _____	TO _____	

PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)

1	Inpatient services		1
2	Nursing and allied health managed care payment (see instruction)		2
3	Organ acquisition		3
4	Subtotal (sum of lines 1 thru 3)		4
5	Primary payer payments		5
6	Total cost (line 4 less line 5) (For CAH, see instructions)		6
COMPUTATION OF LESSER OF COST OR CHARGES			
Reasonable charges			
7	Routine service charges		7
8	Ancillary service charges		8
9	Organ acquisition charges, net of revenue		9
10	Total reasonable charges		10
Customary charges			
11	Aggregate amount actually collected from patients liable for payment for services on a charge basis		11
12	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		12
13	Ratio of line 11 to line 12 (not to exceed 1.000000)		13
14	Total customary charges (see instructions)		14
15	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		15
16	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		16
17	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)		17
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
18	Direct graduate medical education payments (from Worksheet E-4, line 49)		18
19	Cost of covered services (sum of lines 6 and 17)		19
20	Deductibles (exclude professional component)		20
21	Excess reasonable cost (from line 16)		21
22	Subtotal (line 19 minus line 20)		22
23	Coinsurance		23
24	Subtotal (line 22 minus line 23)		24
25	Allowable bad debts (exclude bad debts for professional services) (see instructions)		25
26	Adjusted reimbursable bad debts (see instructions)		26
27	Allowable bad debts for dual eligible beneficiaries (see instructions)		27
28	Subtotal (sum of lines 24 and 25 or 26)		28
29	Other adjustments (specify) (see instructions)		29
30	Subtotal (line 28, plus or minus line 29)		30
31	Interim payments		31
32	Tentative settlement (for contractor use only)		32
33	Balance due provider/program (line 30 minus the sum of lines 31, and 32)		33
34	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		34

CALCULATION OF REIMBURSEMENT SETTLEMENT

PROVIDER CCN: _____

PERIOD:

FROM _____

COMPONENT CCN.: _____

TO _____

WORKSHEET E-3,
PART VIPART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR
TITLE XVIII PART A PPS SNF SERVICES

PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1	Resource Utilization Group (RUGS) payment	1
2	Routine service other pass through costs	2
3	Ancillary service other pass through costs	3
4	Subtotal (sum of lines 1 through 3)	4
COMPUTATION OF NET COST OF COVERED SERVICES		
5	Medical and other services. <i>Do not use this line (see instructions).</i>	5
6	Deductibles	6
7	Coinsurance	7
8	Allowable bad debts (see instructions)	8
9	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	9
10	Allowable reimbursable bad debts (see instructions)	10
11	Utilization review	11
12	Subtotal (Sum of lines 4, 5 minus 6 & 7 plus 10 and 11) (see instructions)	12
13	Inpatient primary payer payments	13
14	Other adjustments (specify) (see instructions)	14
15	Subtotal (line 12 minus 13 ± lines 14)	15
16	Interim payments	16
17	Tentative settlement (for contractor use only)	17
18	Balance due provider/program (line 15 minus the sum of lines 16 and 17)	18
19	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	19

CALCULATION OF REIMBURSEMENT SETTLEMENT			PROVIDER CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET E-3, PART VII
			COMPONENT CCN: _____		
Check applicable boxes:	☐ Title V ☐ Title XIX	☐ Hospital ☐ Subprovider ☐ SNF	☐ NF ☐ ICF/MR	☐ PPS ☐ TEFRA ☐ Other	

PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES

COMPUTATION OF NET COST OF COVERED SERVICES		Inpatient Title V or Title XIX	Outpatient Title V or Title XIX	
1	Inpatient hospital/SNF/NF services			1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)			4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)			7
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8	Routine service charges			8
9	Ancillary service charges			9
10	Organ acquisition charges, net of revenue			10
11	Incentive from target amount computation			11
12	Total reasonable charges (sum of lines 8 through 11)			12
CUSTOMARY CHARGES				
13	Amount actually collected from patients liable for payment for services on a charge basis			13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)			15
16	Total customary charges (see instructions)			16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)			17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)			18
19	Interns and residents (see instructions)			19
20	Cost of teaching physicians (see instructions)			20
21	Cost of covered services (enter the lesser of line 4 or line 16)			21
PROSPECTIVE PAYMENT AMOUNT				
22	Other than outlier payments			22
23	Outlier payments			23
24	Program capital payments			24
25	Capital exception payments (see instructions)			25
26	Routine and ancillary service other pass through costs			26
27	Subtotal (sum of lines 22 through 26)			27
28	Customary charges (title V or XIX PPS covered services only)			28
29	Titles V or XIX (sum of lines 21 and 27)			29
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30	Excess of reasonable cost (from line 18)			30
31	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)			31
32	Deductibles			32
33	Coinsurance			33
34	Allowable bad debts (see instructions)			34
35	Utilization review			35
36	Subtotal (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)			36
37	Other adjustments (specify) (see instructions)			37
38	Subtotal (line 36 ± line 37)			38
39	Direct graduate medical education payments (from Worksheet E-4)			39
40	Total amount payable to the provider (sum of lines 38 and 39)			40
41	Interim payments			41
42	Balance due provider/program (line 40 minus 41)			42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2			43

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		PROVIDER CCN:	PERIOD: FROM _____ TO _____	WORKSHEET E-4
Check applicable box:	☐ Title V ☐ Title XVIII ☐ Title XIX			
COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996			1
2	Unweighted FTE - resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			2
3	Amount of reduction to Direct GME cap under § 422 of MMA			3
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			3.01
4	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			4
4.01	ACA §5503 increase to the direct GME FTE cap (see instructions for cost reporting periods straddling 7/1/2011)			4.01
4.02	ACA §5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			4.02
5	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus line 4.01 plus line 4.02 plus applicable subscripts)			5
6	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			6
7	Enter the lesser of line 5 or line 6			7
		Primary Care	Other	Total
		1	2	3
8	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year			8
9	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6			9
10	Weighted dental and podiatric resident FTE count for the current year			10
11	Total weighted FTE count			11
12	Total weighted resident FTE count for the prior cost reporting year (see instructions)			12
13	Total weighted resident FTE count for the penultimate cost reporting year (see instr.)			13
14	Rolling average FTE count (sum of lines 11 through 13 divided by 3)			14
15	Adjustment for residents in initial years of new programs			15
16	Adjustment for residents displaced by program or hospital closure			16
17	Adjusted rolling average FTE count			17
18	Per resident amount			18
19	Approved amount for resident costs			19
20	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			20
21	Direct GME FTE unweighted resident count over cap (see instructions)			21
22	Allowable additional direct GME FTE resident count (see instructions)			22
23	Enter the locality adjustment national average per resident amount (see instructions)			23
24	Multiply line 22 time line 23			24
25	Total direct GME amount (sum of lines 19 and 24)			25
COMPUTATION OF PROGRAM PATIENT LOAD		Inpatient Part A	Managed Care	
26	Inpatient days			26
27	Total inpatient days (see instructions)			27
28	Ratio of inpatient days to total inpatient days			28
29	Program direct GME amount			29
30	Reduction for direct GME payments for Medicare managed care			30
31	Net Program direct GME amount			31
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32	Renal dialysis direct medical education costs (from Worksheet B, Part I, sum of columns 20 and 23, lines 74 and 94)			32
33	Renal dialysis and home dialysis total charges (Worksheet C, Part I, column 8, sum of lines 74 and 94)			33
34	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)			34
35	Medicare outpatient ESRD charges (see instructions)			35
36	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)			36

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		PROVIDER CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET E-4 (Cont.)
Check applicable box:	☐ Title V ☐ Title XVIII ☐ Title XIX			
APPORTIONMENT OF MEDICARE REASONABLE COST OF GME				
Part A Reasonable Cost				
37	Reasonable cost (see instructions)			37
38	Organ acquisition costs (Worksheet D-4, Part III, column 1, line 69)			38
39	Cost of teaching physicians (Worksheet D-5, Part II, column 3, line 20)			39
40	Primary payer payments (see instructions)			40
41	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			41
Part B Reasonable Cost				
42	Reasonable cost (see instructions)			42
43	Primary payer payments (see instructions)			43
44	Total Part B reasonable cost (line 42 minus line 43)			44
45	Total reasonable cost (sum of lines 41 and 44)			45
46	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			46
47	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			47
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48	Total program GME payment (line 31)			48
49	Part A Medicare GME payment (line 46 x 48)(Title XVIII only) (see instructions)			49
50	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)			50

BALANCE SHEET

(If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

PROVIDER CCN: _____

 PERIOD:
 FROM _____
 TO _____

WORKSHEET G

	Assets (Omit cents)	General Fund 1	Specific Purpose Fund 2	Endowment Fund 3	Plant Fund 4	
CURRENT ASSETS						
1	Cash on hand and in banks					1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable					4
5	Other receivables					5
6	Allowances for uncollectible notes and accounts receivable					6
7	Inventory					7
8	Prepaid expenses					8
9	Other current assets					9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)					11
FIXED ASSETS						
12	Land					12
13	Land improvements					13
14	Accumulated depreciation					14
15	Buildings					15
16	Accumulated depreciation					16
17	Leasehold improvements					17
18	Accumulated depreciation					18
19	Fixed equipment					19
20	Accumulated depreciation					20
21	Automobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment					23
24	Accumulated depreciation					24
25	Minor equipment depreciable					25
26	Accumulated depreciation					26
27	HIT designated Assets					27
28	Accumulated depreciation					28
29	Minor equipment-nondepreciable					29
30	Total fixed assets (sum of lines 12-29)					30
OTHER ASSETS						
31	Investments					31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets					34
35	Total other assets (sum of lines 31-34)					35
36	Total assets (sum of lines 11, 30, and 35)					36

BALANCE SHEET

(If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

PROVIDER CCN:

PERIOD:

FROM _____
TO _____WORKSHEET G
(CONT.)

Liabilities and Fund Balances (Omit cents)		General Fund 1	Specific Purpose Fund 2	Endowment Fund 3	Plant Fund 4	
CURRENT LIABILITIES						
37	Accounts payable					37
38	Salaries, wages, and fees payable					38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)					40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities					44
45	Total current liabilities (sum of lines 37 thru 44)					45
LONG TERM LIABILITIES						
46	Mortgage payable					46
47	Notes payable					47
48	Unsecured loans					48
49	Other long term liabilities					49
50	Total long term liabilities (sum of lines 46 thru 49)					50
51	Total liabilities (sum of lines 45 and 50)					51
CAPITAL ACCOUNTS						
52	General fund balance					52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted					54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					56
57	Plant fund balance - invested in plant					57
58	Plant fund balance - reserve for plant improvement, replacement, and expansion					58
59	Total fund balances (sum of lines 52 thru 58)					59
60	Total liabilities and fund balances (sum of lines 51 and 59)					60

STATEMENT OF CHANGES IN FUND BALANCES

PROVIDER CCN: _____

PERIOD:
FROM _____
TO _____

WORKSHEET G-1

	GENERAL FUND			SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND		
	1	2	3	4	5	6	7	8
1 Fund balances at beginning of period								
2 Net income (loss) (from Worksheet G-3, line 29)								
3 Total (sum of line 1 and line 2)								
4 Additions (credit adjustments) (specify)								
5								
6								
7								
8								
9								
10 Total additions (sum of lines 4-9)								
11 Subtotal (line 3 plus line 10)								
12 Deductions (debit adjustments) (specify)								
13								
14								
15								
16								
17								
18 Total deductions (sum of lines 12-17)								
19 Fund balance at end of period per balance sheet (line 11 minus line 18)								

STATEMENT OF PATIENT REVENUES
AND OPERATING EXPENSES

PROVIDER CCN:

PERIOD:

FROM _____
TO _____WORKSHEET G-2,
PARTS I & II

PART I - PATIENT REVENUES

REVENUE CENTER		INPATIENT	OUTPATIENT	TOTAL	
		1	2	3	
GENERAL INPATIENT ROUTINE CARE SERVICES					
1	Hospital				1
2	Subprovider IPF				2
3	Subprovider IRF				3
4	Subprovider (Other)				4
5	Swing bed - SNF				5
6	Swing bed - NF				6
7	Skilled nursing facility				7
8	Nursing facility				8
9	Other long term care				9
10	Total general inpatient care services (sum of lines 1-9)				10
INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES					
11	Intensive care unit				11
12	Coronary care unit				12
13	Burn intensive care unit				13
14	Surgical intensive care unit				14
15	Other special care (specify)				15
16	Total intensive care type inpatient hospital services (sum of lines 11-15)				16
17	Total inpatient routine care services (sum of lines 10 and 16)				17
18	Ancillary services				18
19	Outpatient services				19
20	Rural Health Clinic (RHC)				20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency				22
23	Ambulance				23
24	Outpatient rehabilitation providers				24
25	ASC				25
26	Hospice				26
27	Other (specify)				27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)				28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Wkst. A, column 3, line 200)			29
30	Add (specify)			30
31				31
32				32
33				33
34				34
35				35
36	Total additions (sum of lines 30-35)			36
37	Deduct (specify)			37
38				38
39				39
40				40
41				41
42	Total deductions (sum of lines 37-41)			42
43	Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)			43

STATEMENT OF REVENUES
AND EXPENSES

PROVIDER CCN:

PERIOD:

FROM _____

TO _____

WORKSHEET G-3

Description		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	1
2	Less contractual allowances and discounts on patients' accounts	2
3	Net patient revenues (line 1 minus line 2)	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	4
5	Net income from service to patients (line 3 minus line 4)	5

OTHER INCOME

6	Contributions, donations, bequests, etc	6
7	Income from investments	7
8	Revenues from telephone and <i>other miscellaneous communication services</i>	8
9	Revenue from television and radio service	9
10	Purchase discounts	10
11	Rebates and refunds of expenses	11
12	Parking lot receipts	12
13	Revenue from laundry and linen service	13
14	Revenue from meals sold to employees and guests	14
15	Revenue from rental of living quarters	15
16	Revenue from sale of medical and surgical supplies to other than patients	16
17	Revenue from sale of drugs to other than patients	17
18	Revenue from sale of medical records and abstracts	18
19	Tuition (fees, sale of textbooks, uniforms, etc.)	19
20	Revenue from gifts, flowers, coffee shops, and canteen	20
21	Rental of vending machines	21
22	Rental of hospital space	22
23	Governmental appropriations	23
24	Other (specify)	24
25	Total other income (sum of lines 6-24)	25
26	Total (line 5 plus line 25)	26
27	Other expenses (specify)	27
28	Total other expenses (sum of line 27 and subscripts)	28
29	Net income (or loss) for the period (line 26 minus line 28)	29

ANALYSIS OF PROVIDER-BASED
HOME HEALTH AGENCY COSTS

PROVIDER CCN: _____

PERIOD:
FROM _____
TO _____

WORKSHEET H

COST CENTER DESCRIPTIONS (omit cents)	SALARIES	EMPLOYEE BENEFITS	TRANSPOR- TATION (see instructions)	CONTRACTED/ PURCHASED SERVICES	OTHER COSTS	TOTAL (sum of cols. 1 thru 5)	RECLASS- IFICATIONS	RECLASSIFIED TRIAL BALANCE (col. 6 + col. 7)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 8 + col. 9)
	1	2	3	4	5	6	7	8	9	10
GENERAL SERVICE COST CENTERS										
1 Capital Related-Bldgs. and Fixtures										1
2 Capital Related-Movable Equipment										2
3 Plant Operation & Maintenance										3
4 Transportation (see instructions)										4
5 Administrative and General										5
HHA REIMBURSABLE SERVICES										
6 Skilled Nursing Care										6
7 Physical Therapy										7
8 Occupational Therapy										8
9 Speech Pathology										9
10 Medical Social Services										10
11 Home Health Aide										11
12 Supplies (see instructions)										12
13 Drugs										13
14 DME										14
HHA NONREIMBURSABLE SERVICES										
15 Home Dialysis Aide Services										15
16 Respiratory Therapy										16
17 Private Duty Nursing										17
18 Clinic										18
19 Health Promotion Activities										19
20 Day Care Program										20
21 Home Delivered Meals Program										21
22 Homemaker Service										22
23 All Others										23
24 Total (sum of lines 1-23)										24

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST

 PROVIDER CCN: _____
 HHA CCN: _____

 PERIOD:
 FROM _____
 TO _____

 WORKSHEET H-1
 PART I

	NET EXPENSES FOR COST ALLOCATION (from Wkst. H, col. 10)	CAPITAL RELATED COSTS		PLANT OPERATION & MAINTENANCE	TRANS- PORTATION	SUBTOTAL (cols. 0-4)	ADMINIS- TRATIVE & GENERAL	TOTAL (cols. 4a + 5)
		BLDGS. & FIXTURES	MOVABLE EQUIPMENT					
		0	1			2	3	4
GENERAL SERVICE COST CENTERS								
1								1
2								2
3								3
4								4
5								5
HHA REIMBURSABLE SERVICES								
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
HHA NONREIMBURSABLE SERVICES								
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24	Totals (sum of lines 1-23)							24

COST ALLOCATION - HHA STATISTICAL BASIS

 PROVIDER CCN: _____
 HHA CCN: _____

 PERIOD:
 FROM _____
 TO _____
WORKSHEET H-1,
PART II

		CAPITAL RELATED COSTS					PLANT OPERATION & MAINTENANCE (SQUARE FEET)	TRANSPORTATION (MILEAGE)	RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		BLDGS. & FIXTURES (SQUARE FEET)		MOVABLE EQUIPMENT (DOLLAR VALUE)	3	4					5a
		1	2								
GENERAL SERVICE COST CENTERS											
1	Capital Related-Bldgs. and Fixtures										1
2	Capital Related-Movable Equipment										2
3	Plant Operation & Maintenance										3
4	Transportation (see instructions)										4
5	Administrative and General										5
HHA REIMBURSABLE SERVICES											
6	Skilled Nursing Care										6
7	Physical Therapy										7
8	Occupational Therapy										8
9	Speech Pathology										9
10	Medical Social Services										10
11	Home Health Aide										11
12	Supplies (see instructions)										12
13	Drugs										13
14	DME										14
HHA NONREIMBURSABLE SERVICES											
15	Home Dialysis Aide Services										15
16	Respiratory Therapy										16
17	Private Duty Nursing										17
18	Clinic										18
19	Health Promotion Activities										19
20	Day Care Program										20
21	Home Delivered Meals Program										21
22	Homemaker Service										22
23	All Others										23
24	Total (sum of lines 1-23)										24
25	Cost To Be Allocated (per Worksheet H-1, Part I)										25
26	Unit Cost Multiplier										26

ALLOCATION OF GENERAL SERVICE
COSTS TO HHA COST CENTERS

PROVIDER CCN: _____

PERIOD:
FROM _____

TO _____

WORKSHEET H-2,
PART I

HHA CCN: _____

HHA COST CENTER (omit cents)	From Wkst. H-1 Part I, col. 6, line	HHA TRIAL BALANCE (1)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS	SUBTOTAL (cols. 0-4)	ADMINIS- TRATIVE & GENERAL	MAIN- TENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE
			BLDGS. & FIXTURES	MOVABLE EQUIPMENT							
		0	1	2	4	4A	5	6	7	8	
1 Administrative and General	5										1
2 Skilled Nursing Care	6										2
3 Physical Therapy	7										3
4 Occupational Therapy	8										4
5 Speech Pathology	9										5
6 Medical Social Services	10										6
7 Home Health Aide	11										7
8 Supplies	12										8
9 Drugs	13										9
10 DME	14										10
11 Home Dialysis Aide Services	15										11
12 Respiratory Therapy	16										12
13 Private Duty Nursing	17										13
14 Clinic	18										14
15 Health Promotion Activities	19										15
16 Day Care Program	20										16
17 Home Delivered Meals Program	21										17
18 Homemaker Service	22										18
19 All Others	23										19
20 Totals (sum of lines 1-19) (2)											20
21 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.											21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE
COSTS TO HHA COST CENTERSWORKSHEET H-2,
PART I (CONT.)PERIOD:
FROM _____
TO _____PROVIDER CCN: _____
HHA CCN: _____

	HHA COST CENTER (omit cents)	HOUSE KEEPING	DIETARY	CAFETERIA	MAIN- TENANCE OF PERSONNEL	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE	NON- PHYSICIAN ANES- THETISTS
		9	10	11	12	13	14	15	16	17	18	19
1	Administrative and General											1
2	Skilled Nursing Care											2
3	Physical Therapy											3
4	Occupational Therapy											4
5	Speech Pathology											5
6	Medical Social Services											6
7	Home Health Aide											7
8	Supplies											8
9	Drugs											9
10	DME											10
11	Home Dialysis Aide Services											11
12	Respiratory Therapy											12
13	Private Duty Nursing											13
14	Clinic											14
15	Health Promotion Activities											15
16	Day Care Program											16
17	Home Delivered Meals Program											17
18	Homemaker Service											18
19	All Others											19
20	Totals (sum of lines 1-19) (2)											20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.											21

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS				PROVIDER CCN: _____ HHA CCN: _____		PERIOD: FROM _____ TO _____		WORKSHEET H-2, PART I (CONT.)		
HHA COST CENTER (omit cents)		NURSING SCHOOL	INTERNS AND SALARY AND FRINGES	PROGRAM COSTS	PARAMEDICAL EDUCATION (SPECIFY)	SUBTOTAL (sum of cols. 4a-23)	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS	SUBTOTAL (cols. 23 ± 24)	ALLOCATED HHA A&G (see Part II)	TOTAL HHA COSTS
		20	21	22	23	24	25	26	27	28
1	Administrative and General									
2	Skilled Nursing Care									
3	Physical Therapy									
4	Occupational Therapy									
5	Speech Pathology									
6	Medical Social Services									
7	Home Health Aide									
8	Supplies									
9	Drugs									
10	DME									
11	Home Dialysis Aide Services									
12	Respiratory Therapy									
13	Private Duty Nursing									
14	Clinic									
15	Health Promotion Activities									
16	Day Care Program									
17	Home Delivered Meals Program									
18	Homemaker Service									
19	All Others									
20	Totals (sum of lines 1-19) (2)									
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.									

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS				PROVIDER CCN: _____ HHA CCN: _____		PERIOD: FROM _____ TO _____		WORKSHEET H-2, PART II	
HHA COST CENTER		CAPITAL RELATED COST		EMPLOYEE BENEFITS (GROSS SALARIES)	RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	
		BLDG. & FIXTURES (SQUARE FEET)	MOVABLE EQUIPMENT (DOLLAR VALUE)						
1	2	3	4	5	6	7	8	9	
1	Administrative and General							1	
2	Skilled Nursing Care							2	
3	Physical Therapy							3	
4	Occupational Therapy							4	
5	Speech Pathology							5	
6	Medical Social Services							6	
7	Home Health Aide							7	
8	Supplies							8	
9	Drugs							9	
10	DME							10	
11	Home Dialysis Aide Services							11	
12	Respiratory Therapy							12	
13	Private Duty Nursing							13	
14	Clinic							14	
15	Health Promotion Activities							15	
16	Day Care Program							16	
17	Home Delivered Meals Program							17	
18	Homemaker Service							18	
19	All Others							19	
20	Totals (sum of lines 1-19)							20	
21	Total cost to be allocated							21	
22	Unit Cost Multiplier							22	

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS							PROVIDER CCN: _____ HHA CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET H-2, PART II (CONT.)							
HHA COST CENTER							LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSE-KEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	MAIN-TENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NURS. HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
							8	9	10	11	12	13	14	15	16	
1	Administrative and General															1
2	Skilled Nursing Care															2
3	Physical Therapy															3
4	Occupational Therapy															4
5	Speech Pathology															5
6	Medical Social Services															6
7	Home Health Aide															7
8	Supplies															8
9	Drugs															9
10	DME															10
11	Home Dialysis Aide Services															11
12	Respiratory Therapy															12
13	Private Duty Nursing															13
14	Clinic															14
15	Health Promotion Activities															15
16	Day Care Program															16
17	Home Delivered Meals Program															17
18	Homemaker Service															18
19	All Others															19
20	Totals (sum of lines 1-19)															20
21	Total cost to be allocated															21
22	Unit Cost Multiplier															22

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS		PROVIDER CCN: _____		PERIOD: FROM _____ TO _____		WORKSHEET H-2, PART II (CONT.)		
HHA COST CENTER		SOCIAL SERVICE (TIME SPENT)	OTHER GENERAL SERVICE (SPECIFY)	NON- PHYSICIAN ANES- THETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SALARY & FRINGES (ASSIGNED TIME)	PROGRAM COSTS (ASSIGNED TIME)	PARA- MEDICAL EDUCATION (SPECIFY) (ASSIGNED TIME)
		17	18	19	20	21	22	23
1	Administrative and General							1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
20	Totals (sum of lines 1-19)							20
21	Total cost to be allocated							21
22	Unit Cost Multiplier							22

APPORTIONMENT OF PATIENT SERVICE COSTS Check applicable box: ☐ Title V ☐ Title XVIII ☐ Title XIX	PROVIDER CCN: _____ HHA CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET H-3, Parts I & II
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PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

Cost Per Visit Computation		From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	Program Visits			Cost of Services				
								Part A	Part B		Part A	Part B		Total Program Cost (sum of cols. 9-10)	
									Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
Patient Services															
1	Skilled Nursing Care	2													1
2	Physical Therapy	3													2
3	Occupational Therapy	4													3
4	Speech Pathology	5													4
5	Medical Social Service	6													5
6	Home Health Aide	7													6
7	Total (sum of lines 1-6)														7

Limitation Cost Computation		CBSA No. (1)	Program Visits			
			Part A	Part B		
				Not Subject to Deductibles & Coinsurance		Subject to Deductibles & Coinsurance
Patient Services		1	2	3	4	
8	Skilled Nursing Care					8
9	Physical Therapy					9
10	Occupational Therapy					10
11	Speech Pathology					11
12	Medical Social Services					12
13	Home Health Aide					13
14	Total (sum of lines 8-13)					14

Supplies and Drugs Cost Computations		From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I) 1	Shared Ancillary Costs (from Part II) 2	Total HHA Costs (cols. 1 + 2) 3	Total Charges from HHA (Record) 4	Ratio (col. 3 ÷ col. 4) 5	Program Covered Charges			Cost of Services			
								Part A 6	Part B		Part A 9	Part B		
									Not Subject to Deductibles & Coinsurance 7	Subject to Deductibles & Coinsurance 8		Not Subject to Deductibles & Coinsurance 10	Subject to Deductibles & Coinsurance 11	
15	Cost of Medical Supplies	8												15
16	Cost of Drugs	9												16

PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS

		From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio 1	Total HHA Charges (from provider records) 2	HHA Shared Ancillary Costs (col. 1 x col. 2) 3	Transfer to Part I as Indicated 4	
1	Physical Therapy	66				col. 2, line 2	1
2	Occupational Therapy	67				col. 2, line 3	2
3	Speech Pathology	68				col. 2, line 4	3
4	Cost of Medical Supplies	71				col. 2, line 15	4
5	Cost of Drugs	73				col. 2, line 16	5

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT	PROVIDER CCN: _____ HHA CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET H-4, Parts I & II
Check applicable box: ☐ Title V ☐ Title XVIII ☐ Title XIX			

PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES

Description		Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		1	2	3	
Reasonable Cost of Part A & Part B Services					
1	Reasonable cost of services (see instructions)				1
2	Total charges				2
Customary Charges					
3	Amount actually collected from patients liable for payment for services on a charge basis (from your records)				3
4	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(b)				4
5	Ratio of line 3 to line 4 (not to exceed 1.000000)				5
6	Total customary charges (see instructions)				6
7	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)				7
8	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)				8
9	Primary payer amounts				9

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

Description		Part A Services	Part B Services	
		1	2	
10	Total reasonable cost (see instructions)			10
11	Total PPS Reimbursement - Full Episodes without Outliers			11
12	Total PPS Reimbursement - Full Episodes with Outliers			12
13	Total PPS Reimbursement - LUPA Episodes			13
14	Total PPS Reimbursement - PEP Episodes			14
15	Total PPS Outlier Reimbursement - Full Episodes with Outliers			15
16	Total PPS Outlier Reimbursement - PEP Episodes			16
17	Total Other Payments			17
18	DME Payments			18
19	Oxygen Payments			19
20	Prosthetic and Orthotic Payments			20
21	Part B deductibles billed to Medicare patients (exclude coinsurance)			21
22	Subtotal (sum of lines 10 thru 20 minus line 21)			22
23	Excess reasonable cost (from line 8)			23
24	Subtotal (line 22 minus line 23)			24
25	Coinsurance billed to program patients (from your records)			25
26	Net cost (line 24 minus line 25)			26
27	Reimbursable bad debts (from your records)			27
28	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			28
29	Total costs - current cost reporting period (line 26 plus line 27)			29
30	Other adjustments (see instructions) (specify)			30
31	Subtotal (line 29 plus/minus line 30)			31
32	Interim payments (see instructions)			32
33	Tentative settlement (for contractor use only)			33
34	Balance due provider/program (line 31 minus lines 32 and 33)			34
35	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			35

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES				PROVIDER CCN: _____ HHA CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET H-5		
Description				Part A		Part B		
				mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
				1	2	3	4	
1	Total interim payments paid to provider						1	
2	Interim payments payable on individual bills either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write "NONE" or enter a zero.						2	
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero.(1)	Program to Provider	.01				3.01	
.02						3.02		
.03						3.03		
.04						3.04		
.05						3.05		
		Provider to Program	.50				3.50	
			.51				3.51	
			.52				3.52	
			.53				3.53	
			.54				3.54	
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			.99			3.99	
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)						4	
TO BE COMPLETED BY INTERMEDIARY								
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	Program to Provider	.01				5.01	
			.02				5.02	
			.03				5.03	
			.50				5.50	
			.51				5.51	
		Provider to Program	.52				5.52	
			Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			.99		5.99
6			Determine net settlement amount (balance due) based on the cost report (see instructions)	Program to Provider	.01			
		Provider to Program	.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)						7	
8	Name of Contractor	Contractor Number		NPR Date: Month, Day, Year			8	

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment, even though total repayment is not accomplished until a later date.

ANALYSIS OF RENAL DIALYSIS DEPARTMENT COSTS		PROVIDER CCN:	PERIOD: FROM _____ TO _____	WORKSHEET I-1	
Check applicable box:		☐ Renal Dialysis Department ☐ Home Program Dialysis			
	TOTAL COSTS	BASIS	STATISTICS	FTEs per 2080 Hours	
	1	2	3	4	
1	Registered Nurses	Hours of Service			1
2	Licensed Practical Nurses	Hours of Service			2
3	Nurses Aides	Hours of Service			3
4	Technicians	Hours of Service			4
5	Social Workers	Hours of Service			5
6	Dieticians	Hours of Service			6
7	Physicians	Accumulated Cost			7
8	Non-patient Care Salary	Accumulated Cost			8
9	Subtotal (sum of lines 1-8)				9
10	Employee Benefits	Salary			10
11	Capital Related Costs-Bldgs. & Fixtures	Square Feet			11
12	Capital Related Costs-Mov. Equip.	Percentage of Time			12
13	Machine Costs & Repairs	Percentage of Time			13
14	Supplies	Requisitions			14
15	Drugs	Requisitions			15
16	Other	Accumulated Cost			16
17	Subtotal (sum of lines 9-16)*				17
18	Capital Related Costs-Bldgs. & Fixtures	Square Feet			18
19	Capital Related Costs-Mov. Equip.	Percentage of Time			19
20	Employee Benefits	Salary			20
21	Administrative and General	Accumulated Cost			21
22	Maint./Repairs-Operation-Housekeeping	Square Feet			22
23	Medical Education Program Costs				23
24	Central Services & Supplies	Requisitions			24
25	Pharmacy	Requisitions			25
26	Other Allocated Costs	Accumulated Cost			26
27	Subtotal (sum of lines 17-26)*				27
28	Laboratory (see instructions)	Charges			28
29	Respiratory Therapy (see instructions)	Charges			29
30	Other (see instructions)	Charges			30
31	Total costs (sum of lines 27-30)				31

* Line 17, column 1 should agree with Worksheet A, column 7 for line 74 or line 94 as appropriate,
and line 27, column 1 should agree with Worksheet B, Part I, column 26 for line 74 or line 94 as appropriate.

ALLOCATION OF RENAL DEPARTMENT COSTS TO TREATMENT MODALITIES

WORKSHEET 1-2

PROVIDER CCN: _____

PERIOD: FROM _____ TO _____

OUTPATIENT SERVICES COMPOSITE PAYMENT RATE	[] Renal Dialysis Department [] Home Program Dialysis										ROUTINE ANCILLARY SERVICES	SUBTOTAL (sum of cols. 1-8)	OVERHEAD	TOTAL (col. 9 + col. 10)
	CAPITAL AND RELATED COSTS		DIRECT PATIENT CARE SALARY		EMPLOYEE BENEFITS	DRUGS	MEDICAL SUPPLIES	7	8	9				
	BUILDING	EQUIPMENT	RNs	OTHER										
1 Total Renal Department Costs	1	2	3	4	5	6	7	8	9	10	11			
MAINTENANCE														
2 Hemodialysis														
3 Intermittent Peritoneal														
TRAINING														
4 Hemodialysis														
5 Intermittent Peritoneal														
6 CAPD														
7 CDDP														
HOME														
8 Hemodialysis														
9 Intermittent Peritoneal														
10 CAPD														
11 CDDP														
OTHER BILLABLE SERVICES														
12 Inpatient Dialysis														
13 Method II Home Patient														
14 EPO (included in Renal Department)														
15 ARENESE (included in Renal Department)														
16 Other														
17 Total (sum of lines 2-16)														
18 Medical Educational Program Costs														
19 Total Renal Costs (line 17 + line 18)														

DIRECT AND INDIRECT RENAL DIALYSIS COST ALLOCATION -
STATISTICAL BASIS

PROVIDER CCN: _____

PERIOD:
FROM _____
TO _____

WORKSHEET 1-3

Check applicable box:

☐ Renal Dialysis Department☐ Home Program Dialysis

Check applicable box:		[] Renal Dialysis Department		[] Home Program Dialysis											
COMPOSITE PAYMENT SERVICES		CAPITAL AND RELATED COSTS		DIRECT PATIENT CARE SALARY		EMPLOYEE BENEFITS (SALARY)	DRUGS (REQUIST.)	MEDICAL SUPPLIES (REQUIST.)	ROUTINE ANCILLARY SERVICES (CHARGES)	SUB-TOTAL	OVERHEAD (ACCUM. COST)				
		BUILDING (SQUARE FEET)	EQUIPMENT (% OF TIME)	RN's (HOURS)	OTHERS (HOURS)										
1			2	3	4	5	6	7	8	9	10				
1	Total Renal Department Costs														
	MAINTENANCE														
2	Hemodialysis														
3	Intermittent Peritoneal TRAINING														
4	Hemodialysis														
5	Intermittent Peritoneal														
6	CAPD														
7	CCDP														
	HOME														
8	Hemodialysis														
9	Intermittent Peritoneal														
10	CAPD														
11	CCDP														
	OTHER BILLABLE SERVICES														
12	Inpatient Dialysis Treatments														
13	Method II Home Patient														
14	EPO														
15	ARENESP														
16	Other														
17	Total Statistical Basis														
18	Unit Cost Multiplier (line 1 ÷ line 17)														

COMPUTATION OF AVERAGE COST PER TREATMENT
FOR OUTPATIENT RENAL DIALYSIS

WORKSHEET I-4

Check applicable box:		PROVIDER CCN: _____		PERIOD: FROM _____ TO _____				
☐ Renal Dialysis Department		☐ Home Program Dialysis						
		Number of Total Treatments	Total Cost (from Wkst. 1-2, col. 11)	Average Cost of Program Treatments (col. 2 ÷ col. 1)	Number of Program Treatments	Total Program Expenses (col. 4 x col. 3)	Total Program Payment	Average Payment Rate (col. 6 ÷ col. 4)
		1	2	3	4	5	6	7
1	Maintenance - Hemodialysis							1
2	Maintenance - Peritoneal Dialysis							2
3	Training - Hemodialysis							3
4	Training - Peritoneal Dialysis							4
5	Training - Continuous Ambulatory Peritoneal Dialysis							5
6	Training - Continuous Cycling Peritoneal Dialysis							6
7	Home Program - Hemodialysis							7
8	Home Program - Peritoneal Dialysis				Patient Weeks			8
9	Home Program - Continuous Ambulatory Peritoneal Dialysis							9
10	Home Program - Continuous Cycling Peritoneal Dialysis							10
11	Totals (sum of lines 1-8, columns 1 and 4) (sum of lines 1-10, columns 2, 5, and 7)							11

CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B	PROVIDER CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET I-5
---	------------------------	-----------------------------------	---------------

Description

1	Total expenses related to care of program beneficiaries (see instructions)		1
2	Total payment (from Worksheet I-4, column 6, line 11)		2
3	Deductibles billed to Medicare (Part B) patients		3
4	Coinsurance billed to Medicare (Part B) patients		4
5	Bad debts for deductibles and coinsurance, net of bad debt recoveries		5
6			6
7	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		7
8	Net deductibles and coinsurance billed to Medicare (Part B) patients (sum of lines 3 and 4 less line 5)		8
9	Program payment (line 2 less line 3, times 80 percent)		9
10	Unrecovered from Medicare (Part B) patients (<i>line 1 minus the sum of lines 8 and 9</i>) (if negative, enter zero and do not complete line 11)		10
11	Reimbursable bad debts (lesser of line 10 or line 5) (transfer to Worksheet E, Part B, line 33)		11

ALLOCATION OF GENERAL SERVICE COSTS TO COMMUNITY MENTAL HEALTH CENTERS	PROVIDER CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET J-1, PART I
	COMPONENT CCN: _____		

PART I - ALLOCATION OF GENERAL SERVICE COSTS TO COMMUNITY MENTAL HEALTH CENTER COST CENTERS

COMPONENT COST CENTER (omit cents)	NET EXPENSES FOR COST ALLOCATION (see instru.)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	SUBTOTAL (cols. 0-4)	ADMINIS- TRATIVE & GENERAL	MAIN- TENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE
		BLDG. & FIXTURES	MOVABLE EQUIPMENT						
		0	1	2	4	4A	5	6	7
1 Administrative and General									1
2 Skilled Nursing Care									2
3 Physical Therapy									3
4 Occupational Therapy									4
5 Speech Pathology									5
6 Medical Social Services									6
7 Respiratory Therapy									7
8 Psychiatric/Psychological Services									8
9 Individual Therapy									9
10 Group Therapy									10
11 Individualized Activity Therapies									11
12 Family Counseling									12
13 Diagnostic Services									13
14 Approved Patient Training & Education									14
15 Prosthetic and Orthotic Devices									15
16 Drugs and Biologicals									16
17 Medical Supplies									17
18 Medical Appliances									18
19 Durable Medical Equipment-Rented									19
20 Durable Medical Equipment-Sold									20
21 All Others									21
22 Totals (sum of lines 1-21)(1)									22
23 Unit Cost Multiplier (see instructions)									23

(1) Columns 0 through 26, line 22 must agree with the corresponding columns of Wkst. B, Part I, lines as appropriate. See instructions.

ALLOCATION OF GENERAL SERVICE COSTS TO
COMMUNITY MENTAL HEALTH CENTERS

PROVIDER CCN: _____

PERIOD:

FROM _____

TO _____

WORKSHEET J-1,
PART I (CONT.)COMPONENT COST CENTER
(omit cents)

COMPONENT CCN: _____

PART I - ALLOCATION OF GENERAL SERVICE COSTS TO COMMUNITY MENTAL HEALTH CENTER COST CENTERS

	HOUSE- KEEPING 9	DIETARY 10	CAFETERIA 11	MAIN- TENANCE OF PERSONNEL 12	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	OTHER GENERAL SERVICE 18	NON- PHYSICIAN ANES- THETISTS 19	
1 Administrative and General												1
2 Skilled Nursing Care												2
3 Physical Therapy												3
4 Occupational Therapy												4
5 Speech Pathology												5
6 Medical Social Services												6
7 Respiratory Therapy												7
8 Psychiatric/Psychological Services												8
9 Individual Therapy												9
10 Group Therapy												10
11 Individualized Activity Therapies												11
12 Family Counseling												12
13 Diagnostic Services												13
14 Approved Patient Training & Education												14
15 Prosthetic and Orthotic Devices												15
16 Drugs and Biologicals												16
17 Medical Supplies												17
18 Medical Appliances												18
19 Durable Medical Equipment-Rented												19
20 Durable Medical Equipment-Sold												20
21 All Others												21
22 Totals (sum of lines 1-21)(1)												22
23 Unit Cost Multiplier (see instructions)												23

(1) Columns 0 through 26, line 22 must agree with the corresponding columns of Wkst. B, Part I, lines as appropriate. See instructions.

ALLOCATION OF GENERAL SERVICE COSTS TO COMMUNITY MENTAL HEALTH CENTERS	PROVIDER CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET J-1, PART I (CONT.)
	COMPONENT CCN: _____		

PART I - ALLOCATION OF GENERAL SERVICE COSTS TO COMMUNITY MENTAL HEALTH CENTER COST CENTERS

COMPONENT COST CENTER (omit cents)	NURSING SCHOOL	INTERNS & RESIDENTS		PARA- MEDICAL EDUCATION (SPECIFY)	SUBTOTAL (sum of cols. 4A-23)	INTERN & RESIDENT COST & POST STEPPDOWN ADJ.	SUBTOTAL (sum of cols. 24 ± 25)	ALLOCATED COMPONENT A&G (see Part II) (2)	TOTAL (sum of cols. 26 ± 27)
		SALARY & FRINGES	PROGRAM COSTS						
1 Administrative and General	20	21	22	23	24	25	26	27	28
2 Skilled Nursing Care									1
3 Physical Therapy									2
4 Occupational Therapy									3
5 Speech Pathology									4
6 Medical Social Services									5
7 Respiratory Therapy									6
8 Psychiatric/Psychological Services									7
9 Individual Therapy									8
10 Group Therapy									9
11 Individualized Activity Therapies									10
12 Family Counseling									11
13 Diagnostic Services									12
14 Approved Patient Training & Education									13
15 Prosthetic and Orthotic Devices									14
16 Drugs and Biologicals									15
17 Medical Supplies									16
18 Medical Appliances									17
19 Durable Medical Equipment-Rented									18
20 Durable Medical Equipment-Sold									19
21 All Others									20
22 Totals (sum of lines 1-21)(1)									21
23 Unit Cost Multiplier (see instructions)									22
									23

(1) Columns 0 through 26, line 22 must agree with the corresponding columns of Wkst. B, Part I, lines as appropriate. See instructions.

ALLOCATION OF GENERAL SERVICE COSTS TO
COMMUNITY MENTAL HEALTH CENTERS

PROVIDER CCN: _____

PERIOD:
FROM _____

TO _____

WORKSHEET J-1,
PART II

COMPONENT CCN: _____

PART II - ALLOCATION OF GENERAL SERVICE COSTS TO COMMUNITY MENTAL HEALTH CENTER COST CENTERS - STATISTICAL BASIS

	CMHC COST CENTER (omit cents)	CAPITAL RELATED COST				EMPLOYEE BENEFITS (GROSS SALARIES)	RECONCILI- ATION	ADMINIS- TRATIVE & GENERAL (ACCUM. COST)	MAIN- TENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)
		BLDG & FIXTURES (SQUARE FEET)	MOVABLE EQUIPMENT (SQUARE FEET)	0	1	2	4	5	6	7	8
1	Administrative and General										
2	Skilled Nursing Care										
3	Physical Therapy										
4	Occupational Therapy										
5	Speech Pathology										
6	Medical Social Services										
7	Respiratory Therapy										
8	Psychiatric/Psychological Services										
9	Individual Therapy										
10	Group Therapy										
11	Individualized Activity Therapies										
12	Family Counseling										
13	Diagnostic Services										
14	Approved Patient Training & Education										
15	Prosthetic and Orthotic Devices										
16	Drugs and Biologicals										
17	Medical Supplies										
18	Medical Appliances										
19	Durable Medical Equipment-Rented										
20	Durable Medical Equipment-Sold										
21	All Others										
22	Totals (sum of lines 1-21)										
23	Total Cost to be Allocated										
24	Unit Cost Multiplier (see instructions)										

ALLOCATION OF GENERAL SERVICE COSTS TO
COMMUNITY MENTAL HEALTH CENTERS

PROVIDER CCN: _____

PERIOD:
FROM _____TO _____
WORKSHEET J-1,
PART II (CONT.)

COMPONENT CCN: _____

PART II - ALLOCATION OF GENERAL SERVICE COSTS TO COMMUNITY MENTAL HEALTH CENTER COST CENTERS - STATISTICAL BASIS

	CORE COST CENTER (omit cents)	HOUSE- KEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	MAIN- TENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINIS- TRATION (DIRECT NURS. HRS)*	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	OTHER GENERAL SERVICE (SPECIFY)	NON- PHYSICIAN ANES- THETISTS (ASSIGNED TIME)
		9	10	11	12	13	14	15	16	17	18	19
1	Administrative and General											1
2	Skilled Nursing Care											2
3	Physical Therapy											3
4	Occupational Therapy											4
5	Speech Pathology											5
6	Medical Social Services											6
7	Respiratory Therapy											7
8	Psychiatric/Psychological Services											8
9	Individual Therapy											9
10	Group Therapy											10
11	Individualized Activity Therapies											11
12	Family Counseling											12
13	Diagnostic Services											13
14	Approved Patient Training & Education											14
15	Prosthetic and Orthotic Devices											15
16	Drugs and Biologicals											16
17	Medical Supplies											17
18	Medical Appliances											18
19	Durable Medical Equipment-Rented											19
20	Durable Medical Equipment-Sold											20
21	All Others											21
22	Totals (sum of lines 1-21)											22
23	Total Cost to be Allocated											23
24	Unit Cost Multiplier (see instructions)											24

ALLOCATION OF GENERAL SERVICE COSTS TO
COMMUNITY MENTAL HEALTH CENTERS

PROVIDER CCN: _____

PERIOD:

FROM _____

TO _____

WORKSHEET J-1,
PART II (CONT.)

COMPONENT CCN: _____

PART II - ALLOCATION OF GENERAL SERVICE COSTS TO COMMUNITY MENTAL HEALTH CENTER COST CENTERS - STATISTICAL BASIS

CORF COST CENTER (omit cents)	NURSING SCHOOL (ASSIGNED TIME) 20	INTERNS & RESIDENTS		PARA- MEDICAL EDUCATION (SPECIFY) (ASSIGNED TIME) 23	24	25	26	27	28	
		SALARY & FRINGES (ASSIGNED TIME) 21	PROGRAM COSTS (ASSIGNED TIME) 22							
1 Administrative and General										1
2 Skilled Nursing Care										2
3 Physical Therapy										3
4 Occupational Therapy										4
5 Speech Pathology										5
6 Medical Social Services										6
7 Respiratory Therapy										7
8 Psychiatric/Psychological Services										8
9 Individual Therapy										9
10 Group Therapy										10
11 Individualized Activity Therapies										11
12 Family Counseling										12
13 Diagnostic Services										13
14 Approved Patient Training & Education										14
15 Prosthetic and Orthotic Devices										15
16 Drugs and Biologicals										16
17 Medical Supplies										17
18 Medical Appliances										18
19 Durable Medical Equipment-Rented										19
20 Durable Medical Equipment-Sold										20
21 All Others										21
22 Totals (sum of lines 1-21)										22
23 Total Cost to be Allocated										23
24 Unit Cost Multiplier (see instructions)										24

COMPUTATION OF COMMUNITY MENTAL HEALTH CENTER PROVIDER COSTS

PROVIDER CCN: _____

PERIOD:
FROM _____
TO _____WORKSHEET J-2,
PART I

PART I - APPORTIONMENT OF CMHC COST CENTERS

COMPONENT CCN: _____

	(From Wkst. J-1, Part I, col. 28)	Total Component Charges	Ratio of Costs to Charges (col. 1 ÷ col. 2)	Title V Component Charges	Title V Component Costs (col. 3 x col. 4)	Title XVIII Component Charges	Title XVIII Component Costs (col. 3 x col. 6)	Title XIX Component Charges	Title XIX Component Costs (col. 3 x col. 8)	
1	Administrative and General									1
2	Skilled Nursing Care									2
3	Physical Therapy									3
4	Occupational Therapy									4
5	Speech Pathology									5
6	Medical Social Services									6
7	Respiratory Therapy									7
8	Psychiatric/Psychological Services									8
9	Individual Therapy									9
10	Group Therapy									10
11	Individualized Activity Therapy									11
12	Family Counseling									12
13	Diagnostic Services									13
14	Approved Patient Training & Education									14
15	Prosthetic and Orthotic Devices									15
16	Drugs and Biologicals									16
17	Medical Supplies									17
18	Medical Appliances									18
19	All Others (1)									19
20	Totals (sum of lines 1-19)									20

(1) Enter amount in column 1 from Worksheet J-1, Part I, column 28, line 21.

COMPUTATION OF COMMUNITY MENTAL HEALTH CENTER PROVIDER COSTS

WORKSHEET J-2,

PART II

PROVIDER CCN: _____

PERIOD:

FROM _____

TO _____

COMPONENT CCN: _____

PART II - APPORTIONMENT OF COST OF CMHC PROVIDER SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS

	(From Wkst. J-1, Part I, col. 29)	Total Component Charges	Ratio of Costs to Charges (1)	Title V Component Charges (2)	Title V Component costs (col. 3 x col. 4)	Title XVIII Component Charges (2)	Title XVIII Component costs (col. 3 x col. 6)	Title XIX Component Charges (2)	Title XIX Component costs (col. 3 x col. 8)	
21	1	2	3	4	5	6	7	8	9	21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
Total (sum of lines 21-28)										
Total component costs. Add the amount from Part I, line 20										
and the amounts from line 28, columns 5, 7, and 9. (3)										

(1) From Worksheet C, Part I, column 9, lines as appropriate

(2) Charges for columns **4 and 8** are obtained from your records.

(3) Transfer the amounts on line 28, columns 5, 7, and 9, as appropriate, to Worksheet J-3, line 1.

CALCULATION OF REIMBURSEMENT SETTLEMENT COMMUNITY
MENTAL HEALTH CENTER PROVIDER SERVICES

PROVIDER CCN: _____

PERIOD:

FROM _____

WORKSHEET J-3

COMPONENT CCN: _____

TO _____

Check
applicable
boxes:☐ Title V☐ Title XVIII☐ Title XIX

		PROGRAM COST	
1	Cost of component services (from Worksheet J-2, Part II, line 29)		1
2	PPS payments received excluding outliers		2
3	Outlier payments		3
4	Primary payer payments		4
5	Total reasonable cost (see instructions)		5
6	Total charges for program services		6
	CUSTOMARY CHARGES		
7	Aggregate amount actually collected from patients liable for services on a charge basis		7
8	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		8
9	Ratio of line 7 to line 8 (not to exceed 1.000000) (see instructions)		9
10	Total customary charges (see instructions)		10
11	Excess of customary charges over reasonable cost (see instructions)		11
12	Excess of reasonable cost over customary charges (see instructions)		12
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
13	Total reasonable cost (from line 5)		13
14	Part B deductible billed to program patients		14
15	Net cost (line 13 minus line 14)		15
16	Excess of reasonable cost over customary charges (from line 12)		16
17	Subtotal (line 15 minus line 16)		17
18	80 percent of costs (80% of line 17) (see instructions)		18
19	Actual coinsurance billed to program patients (from provider records)		19
20	Net cost less actual billed coinsurance (line 17 minus line 19)		20
21	Reimbursable bad debts (from provider records) (see instructions)		21
22			22
23	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		23
24	Net reimbursable amount (see instructions)		24
25	Other adjustments (see instructions) (specify)		25
26	Total cost (line 24 plus or minus line 25)		26
27	Interim payments (see instructions)		27
28	Tentative settlement (for contractor use only)		28
29	Balance due component/program (line 26 minus lines 27 and 28)		29
30	Protested amounts (nonallowable cost report items in accordance with CMS Pub. 15-II, section 115.2)		30

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED COMMUNITY MENTAL HEALTH
CENTER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

PROVIDER CCN:

COMPONENT CCN:

PERIOD:

FROM _____

TO _____

WORKSHEET J-4

Check
applicable
boxes:

[] Title XVIII

DESCRIPTION				Part B		
				1	2	
				mm/dd/yyyy	Amount	
1	Total interim payments paid to providers					1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary, for services rendered in the cost reporting periods. If none, write "NONE", or enter zero.					2
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE", or enter zero (1). Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	Program to Provider	.01			3.01
			.02			3.02
			.03			3.03
			.04			3.04
			.05			3.05
		Provider to Program	.50			3.50
			.51			3.51
			.52			3.52
			.53			3.53
			.54			3.54
			.99			3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet J-3, line 27)					4

TO BE COMPLETED BY INTERMEDIARY

5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE," or enter zero (1). Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	Program to	.01			5.01
			.02			5.02
		Provider	.03			5.03
			.50			5.50
		Provider to	.51			5.51
			.52			5.52
			.99			5.99
6	Determine net settlement amount (balance due) based on the cost report (see instructions). (1)	Program to				
		Provider	.01			6.01
		to Program	.02			6.02
7	Total Medicare liability (see instructions)					7
8	Name of Contractor	Contractor Number	NPR Date (Month, Day, Year)			8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which you agree to the amount of repayment, even though the total repayment is not accomplished until a later date.

ANALYSIS OF PROVIDER-BASED

HOSPICE COSTS

WORKSHEET K

PROVIDER CCN: _____

PERIOD:

FROM _____

TO _____

HOSPICE CCN: _____

COST CENTER DESCRIPTIONS	SALARIES (from Wkst. K-1)	EMPLOYEE BENEFITS (from Wkst. K-2)	TRANSPOR- TATION (see inst.)	CONTRACTED SERVICES (from Wkst. K-3)	OTHER	TOTAL (cols. 1-5)	RECLASSI- FICATION	SUBTOTAL (col. 6 ± col. 7)	ADJUST- MENTS	TOTAL (col. 8 ± col. 9)
	1	2	3	4	5	6	7	8	9	10
GENERAL SERVICE COST CENTERS										
1 Capital Related Costs-Bldg and Fixt.										1
2 Capital Related Costs-Movable Equip.										2
3 Plant Operation and Maintenance										3
4 Transportation - Staff										4
5 Volunteer Service Coordination										5
6 Administrative and General										6
INPATIENT CARE SERVICE										
7 Inpatient - General Care										7
8 Inpatient - Respite Care										8
VISITING SERVICES										
9 Physician Services										9
10 Nursing Care										10
11 Nursing Care-Continuous Home Care										11
12 Physical Therapy										12
13 Occupational Therapy										13
14 Speech/ Language Pathology										14
15 Medical Social Services										15
16 Spiritual Counseling										16
17 Dietary Counseling										17
18 Counseling - Other										18
19 Home Health Aide and Homemaker										19
20 HH Aide & Homemaker - Cont. Home Care										20
21 Other										21
OTHER HOSPICE SERVICE COSTS										
22 Drugs, Biological and Infusion Therapy										22
23 Analgesics										23
24 Sedatives / Hypnotics										25
25 Other - Specify										25
26 Durable Medical Equipment/Oxygen										26
27 Patient Transportation										27
28 Imaging Services										28
29 Labs and Diagnostics										29
30 Medical Supplies										30
31 Outpatient Services (including E/R Dept.)										31
32 Radiation Therapy										32
33 Chemotherapy										33
34 Other										34
HOSPICE NONREIMBURSABLE SERVICE										
35 Bereavement Program Costs										35
36 Volunteer Program Costs										36
37 Fundraising										37
38 Other Program Costs										38
39 Total (sum of lines 1 thru 38)										39

HOSPICE COMPENSATION ANALYSIS
SALARIES AND WAGES

WORKSHEET K-1

PERIOD:
FROM _____
TO _____

PROVIDER CCN: _____

HOSPICE CCN: _____

COST CENTER DESCRIPTIONS (omit cents)	ADMINIS- TRATOR	DIRECTOR	MEDICAL SOCIAL WORKERS	SUPER- VISORS	NURSES	TOTAL THERAPISTS	AIDES	ALL OTHER	TOTAL (1)
	1	2	3	4	5	6	7	8	9
GENERAL SERVICE COST CENTERS									
1 Capital Related Costs-Bldg and Fixt.									1
2 Capital Related Costs-Movable Equip.									2
3 Plant Operation and Maintenance									3
4 Transportation - Staff									4
5 Volunteer Service Coordination									5
6 Administrative and General									6
INPATIENT CARE SERVICE									
7 Inpatient - General Care									7
8 Inpatient - Respite Care									8
VISITING SERVICES									
9 Physician Services									9
10 Nursing Care									10
11 Nursing Care-Continuous Home Care									11
12 Physical Therapy									12
13 Occupational Therapy									13
14 Speech/ Language Pathology									14
15 Medical Social Services									15
16 Spiritual Counseling									16
17 Dietary Counseling									17
18 Counseling - Other									18
19 Home Health Aide and Homemaker									19
20 HH Aide & Homemaker - Cont. Home Care									20
21 Other									21
OTHER HOSPICE SERVICE COSTS									
22 Drugs, Biological and Infusion Therapy									22
23 Analgesics									23
24 Sedatives / Hypnotics									24
25 Other - Specify									25
26 Durable Medical Equipment/Oxygen									26
27 Patient Transportation									27
28 Imaging Services									28
29 Labs and Diagnostics									29
30 Medical Supplies									30
31 Outpatient Services (including E/R Dept.)									31
32 Radiation Therapy									32
33 Chemotherapy									33
34 Other									34
HOSPICE NONREIMBURSABLE SERVICE									
35 Bereavement Program Costs									35
36 Volunteer Program Costs									36
37 Fundraising									37
38 Other Program Costs									38
39 Total (sum of lines 1 thru 38)									39

(1) Transfer the amount in column 9 to Wkst. K, column 1

HOSPICE COMPENSATION ANALYSIS EMPLOYEE
BENEFITS (PAYROLL RELATED)PERIOD:
FROM _____
TO _____

PROVIDER CCN: _____

HOSPICE CCN: _____

WORKSHEET K-2

COST CENTER DESCRIPTIONS (omit cents)	ADMINIS- TRATOR	DIRECTOR	MEDICAL SOCIAL WORKERS	SUPER- VISORS	NURSES	TOTAL THERAPISTS	AIDES	ALL OTHER	TOTAL (1)
	1	2	3	4	5	6	7	8	9
GENERAL SERVICE COST CENTERS									
1 Capital Related Costs-Bldg and Fixt.									1
2 Capital Related Costs-Movable Equip.									2
3 Plant Operation and Maintenance									3
4 Transportation - Staff									4
5 Volunteer Service Coordination									5
6 Administrative and General									6
INPATIENT CARE SERVICE									
7 Inpatient - General Care									7
8 Inpatient - Respite Care									8
VISITING SERVICES									
9 Physician Services									9
10 Nursing Care									10
11 Nursing Care-Continuous Home Care									11
12 Physical Therapy									12
13 Occupational Therapy									13
14 Speech/ Language Pathology									14
15 Medical Social Services									15
16 Spiritual Counseling									16
17 Dietary Counseling									17
18 Counseling - Other									18
19 Home Health Aide and Homemaker									19
20 HH Aide & Homemaker - Cont. Home Care									20
21 Other									21
OTHER HOSPICE SERVICE COSTS									
22 Drugs, Biological and Infusion Therapy									22
23 Analgesics									23
24 Sedatives / Hypnotics									24
25 Other - Specify									25
26 Durable Medical Equipment/Oxygen									26
27 Patient Transportation									27
28 Imaging Services									28
29 Labs and Diagnostics									29
30 Medical Supplies									30
31 Outpatient Services (including E/R Dept.)									31
32 Radiation Therapy									32
33 Chemotherapy									33
34 Other									34
HOSPICE NONREIMBURSABLE SERVICE									
35 Bereavement Program Costs									35
36 Volunteer Program Costs									36
37 Fundraising									37
38 Other Program Costs									38
39 Total (sum of lines 1 thru 38)									39

(1) Transfer the amount in column 9 to Wkst. K, column 2

HOSPICE COMPENSATION ANALYSIS
CONTRACTED SERVICES/PURCHASED SERVICES

WORKSHEET K-3

PERIOD:
FROM _____
TO _____PROVIDER CCN: _____
HOSPICE CCN: _____

COST CENTER DESCRIPTIONS (omit cents)	ADMINIS- TRATOR	DIRECTOR	MEDICAL SOCIAL WORKERS	SUPER- VISORS	NURSES	TOTAL THERAPISTS	AIDES	ALL OTHER	TOTAL (1)
	1	2	3	4	5	6	7	8	9
GENERAL SERVICE COST CENTERS									
1 Capital Related Costs-Bldg and Fixt.									1
2 Capital Related Costs-Movable Equip.									2
3 Plant Operation and Maintenance									3
4 Transportation - Staff									4
5 Volunteer Service Coordination									5
6 Administrative and General									6
INPATIENT CARE SERVICE									
7 Inpatient - General Care									7
8 Inpatient - Respite Care									8
VISITING SERVICES									
9 Physician Services									9
10 Nursing Care									10
11 Nursing Care-Continuous Home Care									11
12 Physical Therapy									12
13 Occupational Therapy									13
14 Speech/ Language Pathology									14
15 Medical Social Services									15
16 Spiritual Counseling									16
17 Dietary Counseling									17
18 Counseling - Other									18
19 Home Health Aide and Homemaker									19
20 HH Aide & Homemaker - Cont. Home Care									20
21 Other									21
OTHER HOSPICE SERVICE COSTS									
22 Drugs, Biological and Infusion Therapy									22
23 Analgesics									23
24 Sedatives / Hypnotics									24
25 Other - Specify									25
26 Durable Medical Equipment/Oxygen									26
27 Patient Transportation									27
28 Imaging Services									28
29 Labs and Diagnostics									29
30 Medical Supplies									30
31 Outpatient Services (including E/R Dept.)									31
32 Radiation Therapy									32
33 Chemotherapy									33
34 Other									34
HOSPICE NONREIMBURSABLE SERVICE									
35 Bereavement Program Costs									35
36 Volunteer Program Costs									36
37 Fundraising									37
38 Other Program Costs									38
39 Total (sum of lines 1 thru 38)									39

(1) Transfer the amount in column 9 to Wkst. K, column 4

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

 PROVIDER CCN: _____
 HOSPICE CCN: _____

 PERIOD:
 FROM _____
 TO _____

 WORKSHEET K-4,
 PART I

COST CENTER DESCRIPTIONS	NET EXPENSES FOR COST ALLOCATION	CAPITAL RELATED COST		PLANT OPERATION & MAINT.	TRANS- PORTATION	VOLUNTEER SERVICES COORDI- NATOR	SUBTOTAL (cols. 0 - 5)	ADMINIS- TRATIVE & GENERAL	TOTAL (col. 5 ± col. 6)
		BUILDINGS & FIXTURES	MOVABLE EQUIPMENT						
GENERAL SERVICE COST CENTERS	0	1	2	3	4	5	5A	6	7
1 Capital Related Costs-Bldg and Fixt.									1
2 Capital Related Costs-Movable Equip.									2
3 Plant Operation and Maintenance									3
4 Transportation - Staff									4
5 Volunteer Service Coordination									5
6 Administrative and General									6
INPATIENT CARE SERVICE									
7 Inpatient - General Care									7
8 Inpatient - Respite Care									8
VISITING SERVICES									
9 Physician Services									9
10 Nursing Care									10
11 Nursing Care-Continuous Home Care									11
12 Physical Therapy									12
13 Occupational Therapy									13
14 Speech/ Language Pathology									14
15 Medical Social Services									15
16 Spiritual Counseling									16
17 Dietary Counseling									17
18 Counseling - Other									18
19 Home Health Aide and Homemaker									19
20 HH Aide & Homemaker - Cont. Home Care									20
21 Other									21
OTHER HOSPICE SERVICE COSTS									
22 Drugs, Biological and Infusion Therapy									22
23 Analgesics									23
24 Sedatives / Hypnotics									24
25 Other - Specify									25
26 Durable Medical Equipment/Oxygen									26
27 Patient Transportation									27
28 Imaging Services									28
29 Labs and Diagnostics									29
30 Medical Supplies									30
31 Outpatient Services (including E/R Dept.)									31
32 Radiation Therapy									32
33 Chemotherapy									33
34 Other									34
HOSPICE NONREIMBURSABLE SERVICE									
35 Bereavement Program Costs									35
36 Volunteer Program Costs									36
37 Fundraising									37
38 Other Program Costs									38
39 Total (sum of lines 1 thru 38)									39

COST ALLOCATION - HOSPICE STATISTICAL BASIS

WORKSHEET K-4,
PART II

COST CENTER DESCRIPTIONS	CAPITAL RELATED COST		HOSPICE CCN: _____		PERIOD: FROM _____ TO _____		ADMINIS- TRATIVE & GENERAL (ACC. COST)
	BUILDINGS & FIXTURES (SQ. FT.)	MOVABLE EQUIPMENT (\$ VALUE)	PLANT OPERATION & MAINT. (SQ. FT.)	TRANS- PORTATION (MILEAGE)	VOLUNTEER SERVICES COORDINATOR (HOURS)	RECONCIL- IATION	
GENERAL SERVICE COST CENTERS							
1 Capital Related Costs-Bldg and Fixt.							1
2 Capital Related Costs-Movable Equip.							2
3 Plant Operation and Maintenance							3
4 Transportation - Staff							5
5 Volunteer Service Coordination							5
6 Administrative and General							6
INPATIENT CARE SERVICE							
7 Inpatient - General Care							7
8 Inpatient - Respite Care							8
VISITING SERVICES							
9 Physician Services							9
10 Nursing Care							10
11 Nursing Care-Continuous Home Care							11
12 Physical Therapy							12
13 Occupational Therapy							13
14 Speech/ Language Pathology							14
15 Medical Social Services							15
16 Spiritual Counseling							16
17 Dietary Counseling							17
18 Counseling - Other							18
19 Home Health Aide and Homemaker							19
20 HH Aide & Homemaker - Cont. Home Care							20
21 Other							21
OTHER HOSPICE SERVICE COSTS							
22 Drugs, Biological and Infusion Therapy							22
23 Analgesics							23
24 Sedatives / Hypnotics							24
25 Other - Specify							25
26 Durable Medical Equipment/Oxygen							26
27 Patient Transportation							27
28 Imaging Services							28
29 Labs and Diagnostics							29
30 Medical Supplies							30
31 Outpatient Services (including E/R Dept.)							31
32 Radiation Therapy							32
33 Chemotherapy							33
34 Other							34
HOSPICE NONREIMBURSABLE SERVICE							
35 Bereavement Program Costs							35
36 Volunteer Program Costs							36
37 Fundraising							37
38 Other Program Costs							38
39 Cost To be Allocated (per Wkst. K-4, Part I)							39
40 Unit Cost Multiplier							40

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

PROVIDER CCN: _____ PERIOD: FROM _____ TO _____ WORKSHEET K-5, PART I

HOSPICE CCN: _____

PART I - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

HOSPICE COST CENTER (omit cents)	From Wkst. K-4 Part I, col. 7, line	HOSPICE TRIAL BALANCE (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	SUBTOTAL (cols. 0-4)	ADMINIS- TRATIVE & GENERAL	MAIN- TENANCE & REPAIRS	OPERATION OF PLANT
			BLDGS. & FIXTURES	MOVABLE EQUIPMENT					
		0	1	2	4	4A	5	6	7
1	Administrative and General								1
2	Inpatient - General Care								2
3	Inpatient - Respite Care								3
4	Physician Services								4
5	Nursing Care								5
6	Nursing Care-Continuous Home Care								6
7	Physical Therapy								7
8	Occupational Therapy								8
9	Speech/ Language Pathology								9
10	Medical Social Services								10
11	Spiritual Counseling								11
12	Dietary Counseling								12
13	Counseling - Other								13
14	Home Health Aide and Homemaker								14
15	HH Aide & Homemaker - Cont. Home Care								15
16	Other								16
17	Drugs, Biological and Infusion Therapy								17
18	Analgesics								18
19	Sedatives / Hypnotics								19
20	Other - Specify								20
21	Durable Medical Equipment/Oxygen								21
22	Patient Transportation								22
23	Imaging Services								23
24	Labs and Diagnostics								24
25	Medical Supplies								25
26	Outpatient Services (including E/R Dept.)								26
27	Radiation Therapy								27
28	Chemotherapy								28
29	Other								29
30	Bereavement Program Costs								30
31	Volunteer Program Costs								31
32	Fundraising								32
33	Other Program Costs								33
34	Totals (sum of lines 1-33) (2)								34
35	Unit Cost Multiplier (see instructions)								35

(1) Column 0, line 34 must agree with Wkst. A, column 7, line 116.

(2) Columns 0 through 25, line 34 must agree with the corresponding columns of Wkst. B, Part I, line 116.

FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4062.1)

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

WORKSHEET K-5,
PART I (Cont.)PROVIDER CCN: _____
HOSPICE CCN: _____
PERIOD:
FROM _____
TO _____

PART I - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

HOSPICE COST CENTER (omit cents)	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	MAIN- TENANCE OF PERSONNEL	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
1 Administrative and General	8	9	10	11	12	13	14	15	16	17	1
2 Inpatient - General Care											2
3 Inpatient - Respite Care											3
4 Physician Services											4
5 Nursing Care											5
6 Nursing Care-Continuous Home Care											6
7 Physical Therapy											7
8 Occupational Therapy											8
9 Speech/ Language Pathology											9
10 Medical Social Services											10
11 Spiritual Counseling											11
12 Dietary Counseling											12
13 Counseling - Other											13
14 Home Health Aide and Homemaker											14
15 HH Aide & Homemaker - Cont. Home Care											15
16 Other											16
17 Drugs, Biological and Infusion Therapy											17
18 Analgesics											18
19 Sedatives / Hypnotics											19
20 Other - Specify											20
21 Durable Medical Equipment/Oxygen											21
22 Patient Transportation											22
23 Imaging Services											23
24 Labs and Diagnostics											24
25 Medical Supplies											25
26 Outpatient Services (including E/R Dept.)											26
27 Radiation Therapy											27
28 Chemotherapy											28
29 Other											29
30 Bereavement Program Costs											30
31 Volunteer Program Costs											31
32 Fundraising											32
33 Other Program Costs											33
34 Totals (sum of lines 1-33) (2)											34
35 Unit Cost Multiplier (see instructions)											35

(1) Column 0, line 34 must agree with Wkst. A, column 7, line 116.

(2) Columns 0 through 25, line 34 must agree with the corresponding columns of Wkst. B, Part I, line 116.

FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4062.1)

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS				PROVIDER CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET K-5, PART I (Cont.)
				HOSPICE CCN: _____		

PART I - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

HOSPICE COST CENTER (omit cents)	OTHER GENERAL SERVICE	NON- PHYSICIAN ANES- THETISTS	NURSING SCHOOL	INTERNS & RESIDENTS		PARA- MEDICAL EDUCATION (SPECIFY)	SUBTOTAL (cols. 4a-23)	INTERN & RESIDENT COST & POST STEPDOWN ADJUST.	SUBTOTAL (cols. 24 ± 25)	ALLOCATED HOSPICE A&G (see Part II)	TOTAL HOSPICE COSTS (cols. 26 ± 27)
				SALARY & FRINGES	PROGRAM COSTS						
1 Administrative and General	8	19	20	21	22	23	24	25	26	27	28
2 Inpatient - General Care											1
3 Inpatient - Respite Care											2
4 Physician Services											3
5 Nursing Care											4
6 Nursing Care-Continuous Home Care											5
7 Physical Therapy											6
8 Occupational Therapy											7
9 Speech/ Language Pathology											8
10 Medical Social Services											9
11 Spiritual Counseling											10
12 Dietary Counseling											11
13 Counseling - Other											12
14 Home Health Aide and Homemaker											13
15 HH Aide & Homemaker - Cont. Home Care											14
16 Other											15
17 Drugs, Biological and Infusion Therapy											16
18 Analgesics											17
19 Sedatives / Hypnotics											18
20 Other - Specify											19
21 Durable Medical Equipment/Oxygen											20
22 Patient Transportation											21
23 Imaging Services											22
24 Labs and Diagnostics											23
25 Medical Supplies											24
26 Outpatient Services (including E/R Dept.)											25
27 Radiation Therapy											26
28 Chemotherapy											27
29 Other											28
30 Bereavement Program Costs											29
31 Volunteer Program Costs											30
32 Fundraising											31
33 Other Program Costs											32
34 Totals (sum of lines 1-33) (2)											33
35 Unit Cost Multiplier (see instructions)											34
											35

(1) Column 0, line 34 must agree with Wkst. A, column 7, line 116.

(2) Columns 0 through 25, line 34 must agree with the corresponding columns of Wkst. B, Part I, line 116.

FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4062.1)

ALLOCATION OF GENERAL SERVICE COSTS TO
HOSPICE COST CENTERS STATISTICAL BASISPROVIDER CCN: _____
HOSPICE CCN: _____PERIOD:
FROM _____
TO _____WORKSHEET K-5,
PART II

PART II - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS - STATISTICAL BASIS

HOSPICE COST CENTER	CAPITAL RELATED COST			EMPLOYEE BENEFITS (GROSS SALARIES)	RECONCIL- IATION	ADMINIS- TRATIVE & GENERAL (ACCUM. COST)	MAIN- TENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)
	BLDG. & FIXTURES (SQUARE FEET)	MOVABLE EQUIPMENT (DOLLAR VALUE)						
	1	2		4	5 A	5	6	7
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34								34
35								35
36								36

FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4062.2)

ALLOCATION OF GENERAL SERVICE COSTS TO
HOSPICE COST CENTERS STATISTICAL BASIS

PROVIDER CCN: _____

PERIOD:
FROM _____TO _____
WORKSHEET K-5,
PART II (Cont.)

HOSPICE CCN: _____

PART II - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS - STATISTICAL BASIS

HOSPICE COST CENTER	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSE- KEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	MAIN- TENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINIS- TRATION (DIRECT NURS. HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)
	8	9	10	11	12	13	14	15	16
1 Administrative and General									1
2 Inpatient - General Care									2
3 Inpatient - Respite Care									3
4 Physician Services									4
5 Nursing Care									5
6 Nursing Care-Continuous Home Care									6
7 Physical Therapy									7
8 Occupational Therapy									8
9 Speech/ Language Pathology									9
10 Medical Social Services									10
11 Spiritual Counseling									11
12 Dietary Counseling									12
13 Counseling - Other									13
14 Home Health Aide and Homemaker									14
15 HH Aide & Homemaker - Cont. Home Care									15
16 Other									16
17 Drugs, Biological and Infusion Therapy									17
18 Analgesics									18
19 Sedatives / Hypnotics									19
20 Other - Specify									20
21 Durable Medical Equipment/Oxygen									21
22 Patient Transportation									22
23 Imaging Services									23
24 Labs and Diagnostics									24
25 Medical Supplies									25
26 Outpatient Services (including E/R Dept.)									26
27 Radiation Therapy									27
28 Chemotherapy									28
29 Other									29
30 Bereavement Program Costs									30
31 Volunteer Program Costs									31
32 Fundraising									32
33 Other Program Costs									33
34 Totals (sum of lines 1-33) (2)									34
35 Total cost to be allocated									35
36 Unit Cost Multiplier (see instructions)									36

FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4062.2)

ALLOCATION OF GENERAL SERVICE COSTS TO
HOSPICE COST CENTERS STATISTICAL BASIS

PROVIDER CCN: _____ PERIOD:
FROM _____ TO _____
HOSPICE CCN: _____

WORKSHEET K-5,
PART II (Cont.)

PART II - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS - STATISTICAL BASIS

	HOSPICE COST CENTER	SOCIAL SERVICE (TIME SPENT)	OTHER GENERAL SERVICE (SPECIFY)	NON- PHYSICIAN ANES- THETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS		PARA- MEDICAL EDUCATION (SPECIFY) (ASSIGNED TIME)
						SALARY & FRINGES (ASSIGNED TIME)	PROGRAM COSTS (ASSIGNED TIME)	
1	Administrative and General	17	18	19	20	21	22	23
2	Inpatient - General Care							1
3	Inpatient - Respite Care							2
4	Physician Services							3
5	Nursing Care							4
6	Nursing Care-Continuous Home Care							5
7	Physical Therapy							6
8	Occupational Therapy							7
9	Speech/ Language Pathology							8
10	Medical Social Services							9
11	Spiritual Counseling							10
12	Dietary Counseling							11
13	Counseling - Other							12
14	Home Health Aide and Homemaker							13
15	HH Aide & Homemaker - Cont. Home Care							14
16	Other							15
17	Drugs, Biological and Infusion Therapy							16
18	Analgesics							17
19	Sedatives / Hypnotics							18
20	Other - Specify							19
21	Durable Medical Equipment/Oxygen							20
22	Patient Transportation							21
23	Imaging Services							22
24	Labs and Diagnostics							23
25	Medical Supplies							24
26	Outpatient Services (including E/R Dept.)							25
27	Radiation Therapy							26
28	Chemotherapy							27
29	Other							28
30	Bereavement Program Costs							29
31	Volunteer Program Costs							30
32	Fundraising							31
33	Other Program Costs							32
34	Totals (sum of lines 1-33) (2)							33
35	Total cost to be allocated							34
36	Unit Cost Multiplier (see instructions)							35
								36

FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4062.2)

APPORTIONMENT OF HOSPICE SHARED SERVICES

PROVIDER CCN: _____

PERIOD:

FROM _____

HOSPICE CCN: _____

TO _____

WORKSHEET K-5,
PART III

PART III - COMPUTATION OF TOTAL HOSPICE SHARED COSTS

COST CENTER		Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total Hospice Charges (Provider Records)	Hospice Shared Ancillary Costs (cols. 1 x 2)	
		0	1	2	3	
ANCILLARY SERVICE COST CENTERS						
1	Physical Therapy	66				1
2	Occupational Therapy	67				2
3	Speech/ Language Pathology	68				3
4	Drugs, Biological and Infusion Therapy	73				4
5	Durable Medical Equipment/Oxygen	96				5
6	Labs and Diagnostics	60				6
7	Medical Supplies	71				7
8	Outpatient Services (including E/R Dept.)	93				8
9	Radiation Therapy	55				9
10	Other	76				10
11	Totals (sum of lines 1-10)					11

CALCULATION OF HOSPICE PER DIEM COST

PROVIDER CCN: _____

PERIOD:
FROM _____
TO _____

WORKSHEET K-6

HOSPICE CCN: _____

COMPUTATION OF PER DIEM COST		TITLE XVIII	TITLE XIX	OTHER	TOTAL	
		1	2	3	4	
1	Total cost (see instructions)					1
2	Total unduplicated days (Worksheet S-9, column 6, line 5)					2
3	Average cost per diem (line 1 divided by line 2)					3
4	Unduplicated Medicare days (Worksheet S-9, column 1, line 5)					4
5	Aggregate Medicare cost (line 3 times line 4)					5
6	Unduplicated Medicaid days (Worksheet S-9, column 2, line 5)					6
7	Aggregate Medicaid cost (line 3 times line 6)					7
8	Unduplicated SNF days (Worksheet S-9, column 3, line 5)					8
9	Aggregate SNF cost (line 3 times line 8)					9
10	Unduplicated NF days (Worksheet S-9, column 4, line 5)					10
11	Aggregate NF cost (line 3 times line 10)					11
12	Other Unduplicated days (Worksheet S-9, column 5, line 5)					12
13	Aggregate cost for other days (line 3 times line 12)					13

Note: The data for the SNF and NF on lines 8 through 11 are included in the Medicare and Medicaid lines 4 through 7.

CALCULATION OF CAPITAL PAYMENT		PROVIDER CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET L
		COMPONENT CCN: _____		
Check applicable boxes:	☐ Title V ☐ Title XVIII, Part A ☐ Title XIX	☐ Hospital ☐ Subprovider (other)	☐ PPS ☐ Cost Method	

PART I - FULLY PROSPECTIVE METHOD

CAPITAL FEDERAL AMOUNT		
1	Capital DRG other than outlier	1
2	Capital DRG outlier payments	2
3	Total inpatient days divided by number of days in the cost reporting period (see instructions)	3
4	Number of interns & residents (see instructions)	4
5	Indirect medical education percentage (see instructions)	5
6	Indirect medical education adjustment (line 1 times line 5)	6
7	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, Part A line 30) (see instructions)	7
8	Percentage of Medicaid patient days to total days (see instructions)	8
9	Sum of lines 7 and 8	9
10	Allowable disproportionate share percentage (see instructions)	10
11	Disproportionate share adjustment (line 10 times lines 1)	11
12	Total prospective capital payments (sum of lines 1-2, 6 and 11)	12

PART II - PAYMENT UNDER REASONABLE COST

1	Program inpatient routine capital cost (see instructions)	1
2	Program inpatient ancillary capital cost (see instructions)	2
3	Total inpatient program capital cost (line 1 plus line 2)	3
4	Capital cost payment factor (see instructions)	4
5	Total inpatient program capital cost (line 3 x line 4)	5

PART III - COMPUTATION OF EXCEPTION PAYMENTS

1	Program inpatient capital costs (see instructions)	1
2	Program inpatient capital costs for extraordinary circumstances (see instructions)	2
3	Net program inpatient capital costs (line 1 minus line 2)	3
4	Applicable exception percentage (see instructions)	4
5	Capital cost for comparison to payments (line 3 x line 4)	5
6	Percentage adjustment for extraordinary circumstances (see instructions)	6
7	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	7
8	Capital minimum payment level (line 5 plus line 7)	8
9	Current year capital payments (from Part I, line 12 as applicable)	9
10	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	10
11	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	11
12	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	12
13	Current year exception payment (if line 12 is positive, enter the amount on this line)	13
14	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	14
15	Current year allowable operating and capital payment (see instructions)	15
16	Current year operating and capital costs (see instructions)	16
17	Current year exception offset amount (see instructions)	17

ALLOCATION OF ALLOWABLE COSTS FOR
EXTRAORDINARY CIRCUMSTANCESPROVIDER CCN: _____
PERIOD: FROM _____ TO _____
PART IWORKSHEET L-1,
PART I

Cost Center Descriptions	EXTRA-ORDINARY CAPITAL RELATED COSTS 0	CAPITAL RELATED COSTS		SUBTOTAL (sum of cols. 0-2) 2A	EMPLOYEE BENEFITS 4	ADMINIS-TRATIVE & GENERAL 5	MAIN-TENANCE & REPAIRS 6	OPERATION OF PLANT 7
		BLDGS. & FIXTURES 1	MOVABLE EQUIPMENT 2					
GENERAL SERVICE COST CENTERS								
1 Capital Related Costs-Buildings and Fixtures								1
2 Capital Related Costs-Movable Equipment								2
4 Employee Benefits								4
5 Administrative and General								5
6 Maintenance and Repairs								6
7 Operation of Plant								7
8 Laundry and Linen Service								8
9 Housekeeping								9
10 Dietary								10
11 Cafeteria								11
12 Maintenance of Personnel								12
13 Nursing Administration								13
14 Central Services and Supply								14
15 Pharmacy								15
16 Medical Records & Medical Records Library								16
17 Social Service								17
18 Other General Service (specify)								18
19 Nonphysician Anesthetists								19
20 Nursing School								20
21 Intern & Res. Service-Salary & Fringes (Approved)								21
22 Intern & Res. Other Program Costs (Approved)								22
23 Paramedical Ed. Program (specify)								23
INPATIENT ROUTINE SERVICE COST CENTERS								0
30 Adults and Pediatrics (General Routine Care)								30
31 Intensive Care Unit								31
32 Coronary Care Unit								32
33 Burn Intensive Care Unit								33
34 Surgical Intensive Care Unit								34
35 Other Special Care Unit (specify)								35
40 Subprovider IPF								40
41 Subprovider IRF								41
42 Subprovider								42
43 Nursery								43
44 Skilled Nursing Facility								44
45 Nursing Facility								45
46 Other Long Term Care								46

ALLOCATION OF ALLOWABLE COSTS FOR
EXTRAORDINARY CIRCUMSTANCES
 PROVIDER CCN: _____
 PERIOD: FROM _____ TO _____
 WORKSHEET L-1,
 PART I (Cont.)

Cost Center Descriptions	EXTRA-ORDINARY CAPITAL RELATED COSTS	CAPITAL RELATED COSTS		SUBTOTAL (sum of cols. 0-2) 2A	EMPLOYEE BENEFITS 4	ADMINIS-TRATIVE & GENERAL 5	MAIN-TENANCE & REPAIRS 6	OPERATION OF PLANT 7
		BLDGS. & FIXTURES 1	MOVABLE EQUIPMENT 2					
	0	1	2	2A	4	5	6	7
ANCILLARY SERVICE COST CENTERS								
50 Operating Room								50
51 Recovery Room								51
52 Labor Room and Delivery Room								52
53 Anesthesiology								53
54 Radiology-Diagnostic								54
55 Radiology-Therapeutic								55
56 Radioisotope								56
57 Computed Tomography (CT) Scan								57
58 Magnetic Resonance Imaging (MRI)								58
59 Cardiac Catheterization								59
60 Laboratory								60
61 PBP Clinical Laboratory Service-Program Only								61
62 Whole Blood & Packed Red Blood Cells								62
63 Blood Storing, Processing, & Trans.								63
64 Intravenous Therapy								64
65 Respiratory Therapy								65
66 Physical Therapy								66
67 Occupational Therapy								67
68 Speech Pathology								68
69 Electrocardiology								69
70 Electroencephalography								70
71 Medical Supplies Charged to Patients								71
72 Implantable Devices Charged to Patients								72
73 Drugs Charged to Patients								73
74 Renal Dialysis								74
75 ASC (Non-Distinct Part)								75
76 Other Ancillary (specify)								76
OUTPATIENT SERVICE COST CENTERS								
88 Rural Health Clinic (RHC)								0
89 Federally Qualified Health Center (FQHC)								88
90 Clinic								89
91 Emergency								90
92 Observation Beds								91
93 Other Outpatient (specify)								92
								93

ALLOCATION OF ALLOWABLE COSTS FOR
EXTRAORDINARY CIRCUMSTANCES
 PROVIDER CCN: _____
 PERIOD: FROM _____ TO _____
 WORKSHEET L-1,
 PART I (Cont.)

Cost Center Descriptions	EXTRA-ORDINARY CAPITAL RELATED COSTS	CAPITAL RELATED COSTS		SUBTOTAL (sum of cols. 0-4)	EMPLOYEE BENEFITS	ADMINIS-TRATIVE & GENERAL	MAIN-TENANCE & REPAIRS	OPERATION OF PLANT
		BLDGS. & FIXTURES	MOVABLE EQUIPMENT					
OTHER REIMBURSABLE COST CENTERS								
94 Home Program Dialysis								
95 Ambulance Services								94
96 Durable Medical Equipment-Rented								95
97 Durable Medical Equipment-Sold								96
98 Other Reimbursable (specify)								97
99 Outpatient Rehabilitation Provider (specify)								98
100 Intern-Resident Service (not appvd. tching. prgm.)								99
101 Home Health Agency								100
SPECIAL PURPOSE COST CENTERS								
105 Kidney Acquisition								101
106 Heart Acquisition								0
107 Liver Acquisition								105
108 Lung Acquisition								106
109 Pancreas Acquisition								107
110 Intestinal Acquisition								108
111 Islet Acquisition								109
112 Other Organ Acquisition (specify)								110
115 Ambulatory Surgical Center (Distinct Part)								111
116 Hospice								112
117 Other Special Purpose (specify)								115
118 SUBTOTALS (sum of lines 1-117)								116
NONREIMBURSABLE COST CENTERS								
190 Gift, Flower, Coffee Shop, & Canteen								117
191 Research								118
192 Physicians' Private Offices								0
193 Nonpaid Workers								190
194 Other Nonreimbursable (specify)								191
200 Gross Foot Adjustments								192
201 Negative Cost Centers								193
202 Total (sum of line 118 and lines190-201)								194
203 Total Statistical Basis								200
204 Unit Cost Multiplier								201

ALLOCATION OF ALLOWABLE COSTS FOR
EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1,
PART I (Cont.)

Cost Center Descriptions	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	MAIN- TENANCE OF PERSONNEL	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PERIOD:		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE
								FROM	TO		
	8	9	10	11	12	13	14	15	16	17	
GENERAL SERVICE COST CENTERS											
1 Capital Related Costs-Buildings and Fixtures											1
2 Capital Related Costs-Movable Equipment											2
4 Employee Benefits											4
5 Administrative and General											5
6 Maintenance and Repairs											6
7 Operation of Plant											7
8 Laundry and Linen Service											8
9 Housekeeping											9
10 Dietary											10
11 Cafeteria											11
12 Maintenance of Personnel											12
13 Nursing Administration											13
14 Central Services and Supply											14
15 Pharmacy											15
16 Medical Records & Medical Records Library											16
17 Social Service											17
18 Other General Service (specify)											18
19 Nonphysician Anesthetists											19
20 Nursing School											20
21 Intern & Res. Service-Salary & Fringes (Approved)											21
22 Intern & Res. Other Program Costs (Approved)											22
23 Paramedical Ed. Program (specify)											23
0 INPATIENT ROUTINE SERVICE COST CENTERS											
30 Adults and Pediatrics (General Routine Care)											30
31 Intensive Care Unit											31
32 Coronary Care Unit											32
33 Burn Intensive Care Unit											33
34 Surgical Intensive Care Unit											34
35 Other Special Care Unit (specify)											35
40 Subprovider IPF											40
41 Subprovider IRF											41
42 Subprovider											42
43 Nursery											43
44 Skilled Nursing Facility											44
45 Nursing Facility											45
46 Other Long Term Care											46

ALLOCATION OF ALLOWABLE COSTS FOR
EXTRAORDINARY CIRCUMSTANCESWORKSHEET L-1,
PART I (Cont.)

Cost Center Descriptions	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	MAIN- TENANCE OF PERSONNEL	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE
	8	9	10	11	12	13	14	15	16	17
ANCILLARY SERVICE COST CENTERS										
50	Operating Room									50
51	Recovery Room									51
52	Labor Room and Delivery Room									52
53	Anesthesiology									53
54	Radiology-Diagnostic									54
55	Radiology-Therapeutic									55
56	Radioisotope									56
57	Computed Tomography (CT) Scan									57
58	Magnetic Resonance Imaging (MRI)									58
59	Cardiac Catheterization									59
60	Laboratory									60
61	PBP Clinical Laboratory Service-Program Only									61
62	Whole Blood & Packed Red Blood Cells									62
63	Blood Storing, Processing, & Trans.									63
64	Intravenous Therapy									64
65	Respiratory Therapy									65
66	Physical Therapy									66
67	Occupational Therapy									67
68	Speech Pathology									68
69	Electrocardiology									69
70	Electroencephalography									70
71	Medical Supplies Charged to Patients									71
72	Implantable Devices Charged to Patients									72
73	Drugs Charged to Patients									73
74	Renal Dialysis									74
75	ASC (Non-Distinct Part)									75
76	Other Ancillary (specify)									76
0	OUTPATIENT SERVICE COST CENTERS									
88	Rural Health Clinic (RHC)									88
89	Federally Qualified Health Center (FQHC)									89
90	Clinic									90
91	Emergency									91
92	Observation Beds									92
93	Other Outpatient (specify)									93

ALLOCATION OF ALLOWABLE COSTS FOR
EXTRAORDINARY CIRCUMSTANCESWORKSHEET L-1,
PART I (Cont.)PERIOD:
FROM _____
TO _____

PROVIDER CCN: _____

Cost Center Descriptions

	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	MAIN- TENANCE OF PERSONNEL	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE
	8	9	10	11	12	13	14	15	16	17
OTHER REIMBURSABLE COST CENTERS										
94 Home Program Dialysis										
95 Ambulance Services										
96 Durable Medical Equipment-Rented										
97 Durable Medical Equipment-Sold										
98 Other Reimbursable (specify)										
99 Outpatient Rehabilitation Provider (specify)										
100 Intern-Resident Service (not appvd. tching. prgm.)										
101 Home Health Agency										
0 SPECIAL PURPOSE COST CENTERS										
105 Kidney Acquisition										
106 Heart Acquisition										
107 Liver Acquisition										
108 Lung Acquisition										
109 Pancreas Acquisition										
110 Intestinal Acquisition										
111 Islet Acquisition										
112 Other Organ Acquisition (specify)										
115 Ambulatory Surgical Center (Distinct Part)										
116 Hospice										
117 Other Special Purpose (specify)										
118 SUBTOTALS (sum of lines 1-117)										
NONREIMBURSABLE COST CENTERS										
190 Gift, Flower, Coffee Shop, & Canteen										
191 Research										
192 Physicians' Private Offices										
193 Nonpaid Workers										
194 Other Nonreimbursable (specify)										
200 Gross Foot Adjustments										
201 Negative Cost Centers										
202 Total (sum of line 118 and lines 190-201)										
203 Total Statistical Basis										
204 Unit Cost Multiplier										

ALLOCATION OF ALLOWABLE COSTS FOR
EXTRAORDINARY CIRCUMSTANCESPROVIDER CCN: _____
PERIOD: FROM _____ TO _____
WORKSHEET L-1,
PART 1 (Cont.)

Cost Center Descriptions	OTHER GENERAL SERVICE	NON- PHYSICIAN ANES- THETISTS	NURSING SCHOOL	INTERNS & RESIDENTS SALARY & FRINGES	INTERNS & RESIDENTS PROGRAM COSTS	PARA- MEDICAL EDUCATION (SPECIFY)	TOTAL	
	18	19	20	21	22	23	SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS
							24	25
GENERAL SERVICE COST CENTERS								
1 Capital Related Costs-Buildings and Fixtures								
2 Capital Related Costs-Movable Equipment								
4 Employee Benefits								
5 Administrative and General								
6 Maintenance and Repairs								
7 Operation of Plant								
8 Laundry and Linen Service								
9 Housekeeping								
10 Dietary								
11 Cafeteria								
12 Maintenance of Personnel								
13 Nursing Administration								
14 Central Services and Supply								
15 Pharmacy								
16 Medical Records & Medical Records Library								
17 Social Service								
18 Other General Service (specify)								
19 Nonphysician Anesthetists								
20 Nursing School								
21 Intern & Res. Service-Salary & Fringes (Approved)								
22 Intern & Res. Other Program Costs (Approved)								
23 Paramedical Ed. Program (specify)								
INPATIENT ROUTINE SERVICE COST CENTERS								
30 Adults and Pediatrics (General Routine Care)								
31 Intensive Care Unit								
32 Coronary Care Unit								
33 Burn Intensive Care Unit								
34 Surgical Intensive Care Unit								
35 Other Special Care Unit (specify)								
40 Subprovider IPF								
41 Subprovider IRF								
42 Subprovider								
43 Nursery								
44 Skilled Nursing Facility								
45 Nursing Facility								
46 Other Long Term Care								

ALLOCATION OF ALLOWABLE COSTS FOR
EXTRAORDINARY CIRCUMSTANCES

ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES					PROVIDER CCN:			PERIOD: FROM _____ TO _____		WORKSHEET L-1, PART 1 (Cont.)	
Cost Center Descriptions	OTHER GENERAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	INTERNS & RESIDENTS SALARY AND FRINGES	INTERNS & RESIDENTS PROGRAM COSTS	PARAMEDICAL EDUCATION (SPECIFY)	SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS	TOTAL		
	18	19	20	21	22	23	24	25	26		
ANCILLARY SERVICE COST CENTERS											
50 Operating Room											50
51 Recovery Room											51
52 Labor Room and Delivery Room											52
53 Anesthesiology											53
54 Radiology-Diagnostic											54
55 Radiology-Therapeutic											55
56 Radioisotope											56
57 Computed Tomography (CT) Scan											57
58 Magnetic Resonance Imaging (MRI)											58
59 Cardiac Catheterization											59
60 Laboratory											60
61 PBP Clinical Laboratory Service-Program Only											61
62 Whole Blood & Packed Red Blood Cells											62
63 Blood Storing, Processing, & Trans.											63
64 Intravenous Therapy											64
65 Respiratory Therapy											65
66 Physical Therapy											66
67 Occupational Therapy											67
68 Speech Pathology											68
69 Electrocardiology											69
70 Electroencephalography											70
71 Medical Supplies Charged to Patients											71
72 Implantable Devices Charged to Patients											72
73 Drugs Charged to Patients											73
74 Renal Dialysis											74
75 ASC (Non-Distinct Part)											75
76 Other Ancillary (specify)											76
OUTPATIENT SERVICE COST CENTERS											
88 Rural Health Clinic (RHC)											0
89 Federally Qualified Health Center (FQHC)											88
90 Clinic											89
91 Emergency											90
92 Observation Beds											91
93 Other Outpatient (specify)											92
											93

ALLOCATION OF ALLOWABLE COSTS FOR
EXTRAORDINARY CIRCUMSTANCESWORKSHEET L-1,
PART 1 (Cont.)

Cost Center Descriptions	PROVIDER CCN:					PERIOD:		TOTAL
	OTHER GENERAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	INTERNS & RESIDENTS SALARY AND FRINGES	INTERNS & RESIDENTS PROGRAM COSTS	PARAMEDICAL EDUCATION (SPECIFY)	SUBTOTAL	
	18	19	20	21	22	23	24	25
OTHER REIMBURSABLE COST CENTERS								
94 Home Program Dialysis								
95 Ambulance Services								
96 Durable Medical Equipment-Rented								
97 Durable Medical Equipment-Sold								
98 Other Reimbursable (specify)								
99 Outpatient Rehabilitation Provider (specify)								
100 Intern-Resident Service (not appvd. tching. prgm.)								
101 Home Health Agency								
SPECIAL PURPOSE COST CENTERS								
105 Kidney Acquisition								
106 Heart Acquisition								
107 Liver Acquisition								
108 Lung Acquisition								
109 Pancreas Acquisition								
110 Intestinal Acquisition								
111 Islet Acquisition								
112 Other Organ Acquisition (specify)								
115 Ambulatory Surgical Center (Distinct Part)								
116 Hospice								
117 Other Special Purpose (specify)								
118 SUBTOTALS (sum of lines 1-117)								
NONREIMBURSABLE COST CENTERS								
190 Gift, Flower, Coffee Shop, & Canteen								
191 Research								
192 Physicians' Private Offices								
193 Nonpaid Workers								
194 Other Nonreimbursable (specify)								
200 Cross Foot Adjustments								
201 Negative Cost Centers								
202 Total (sum of line 118 and lines 190-201)								
203 Total Statistical Basis								
204 Unit Cost Multiplier								

COMPUTATION OF PROGRAM INPATIENT ROUTINE SERVICE
CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES

PROVIDER CCN: _____

PERIOD:
FROM _____
TO _____WORKSHEET L-1,
PART II

Check applicable box:	☐ Title V ☐ Title XVIII, Part A ☐ Title XIX			Capital Cost for Extraordinary Circumstances (from Wkst. L-1, Part I, col. 26)	Swing Bed Adjustment 2	Reduced Capital Cost for Extraordinary Circumstances (col. 1 - col. 2) 3	Total Patient Days 4	Per Diem (col. 3 ÷ col. 4) 5	Inpatient Program Days 6	Inpatient Program Capital Cost (col. 5 x col. 6) 7
	Cost Center Description	1								
(A)	INPATIENT ROUTINE SERVICE COST CENTERS									
30	Adults & Pediatrics (General Routine Care)									30
31	Intensive Care Unit									31
32	Coronary Care Unit									32
33	Burn Intensive Care Unit									33
34	Surgical Intensive Care Unit									34
35	Other Special Care Unit (specify)									35
40	Subprovider IPF									40
41	Subprovider IRF									41
42	Subprovider (Other)									42
43	Nursery									43
200	Total (sum of lines 30-199)									200

(A) Worksheet A line numbers

COMPUTATION OF PROGRAM INPATIENT ANCILLARY SERVICE
CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCESWORKSHEET L-1,
PART III

Check applicable boxes:	☐ Hospital ☐ Subprovider	☐ Title V ☐ Title XVIII, Part A ☐ Title XIX	PROVIDER CCN: _____	PERIOD: FROM _____ TO _____	Worksheet L-1, Part III				
					COMPONENT CCN: _____				
Cost Center Description			1	2	3	4	5		
			Capital Cost for Extraordinary Circumstances (from Wkst. L-1, Part I, col. 26)	Total Charges (from Wkst. C, Part I, col. 6)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Program Extraordinary Capital Cost (col. 3 x col. 4)		
(A)			ANCILLARY SERVICE COST CENTERS						
50			Operating Room						
51			Recovery Room						
52			Labor Room and Delivery Room						
53			Anesthesiology						
54			Radiology-Diagnostic						
55			Radiology-Therapeutic						
56			Radioisotope						
57			Computed Tomography (CT) Scan						
58			Magnetic Resonance Imaging (MRI)						
59			Cardiac Catheterization						
60			Laboratory						
61			PPB Clinical Laboratory Service-Program Only						
62			Whole Blood & Packed Red Blood Cells						
63			Blood Storing, Processing, & Trans.						
64			Intravenous Therapy						
65			Respiratory Therapy						
66			Physical Therapy						
67			Occupational Therapy						
68			Speech Pathology						
69			Electrocardiology						
70			Electroencephalography						
71			Medical Supplies Charged to Patients						
72			Implantable Devices Charged to Patients						
73			Drugs Charged to Patients						
74			Renal Dialysis						
75			ASC (Non-Distinct Part)						
76			Other Ancillary (specify)						

(A) Worksheet A line numbers

COMPUTATION OF PROGRAM INPATIENT ANCILLARY SERVICE
CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCESWORKSHEET L-1,
PART III (CONT.)

Check applicable boxes:	☐ Hospital ☐ Subprovider	☐ Title V ☐ Title XVIII, Part A ☐ Title XIX	PROVIDER CCN: _____ COMPONENT CCN: _____	PERIOD: FROM _____ TO _____	
Cost Center Description	Capital Cost for Extraordinary Circumstances (from Wkst. L-1, Part I, col. 26)	Total Charges (from Wkst. C, Part I, col. 6)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Program Extraordinary Capital Cost (col. 3 x col. 4)
(A)	1	2	3	4	5
OUTPATIENT SERVICE COST CENTERS					
88	Rural Health Clinic (RHC)				88
89	Federally Qualified Health Center (FQHC)				89
90	Clinic				90
91	Emergency				91
92	Observation Beds				92
93	Other Outpatient (specify)				93
OTHER REIMBURSABLE COST CENTERS					
94	Home Program Dialysis				94
95	Ambulance Services				95
96	Durable Medical Equipment-Rented				96
97	Durable Medical Equipment-Sold				97
98	Other Reimbursable (specify)				98
200	Total (sum of lines 50 through 199)				200

(A) Worksheet A line numbers

GHHK8EHEN

The net expenses for cost allocation on Worksheet A for the RHC/FQHC cost center line must equal the total facility costs in column 7 line 32 of this worksheet.

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES	PROVIDER CCN: _____	PERIOD: FROM _____	WORKSHEET M-2
	COMPONENT CCN: _____	TO _____	

Check applicable box:	☐ RHC	☐ FQHC
-----------------------	------------------------------	-------------------------------

VISITS AND PRODUCTIVITY

	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
Positions	1	2	3	4	5	
1 Physicians						1
2 Physician Assistants						2
3 Nurse Practitioners						3
4 Subtotal (sum of lines 1-3)						4
5 Visiting Nurse						5
6 Clinical Psychologist						6
7 Clinical Social Worker						7
7.01 Medical Nutrition Therapist (FQHC only)						7.01
7.02 Diabetes Self Management Training (FQHC only)						7.02
8 Total FTEs and Visits (sum of lines 4-7)						8
9 Physician Services Under Agreements						9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10	Total costs of health care services (from Worksheet M-1, column 7, line 22)		10
11	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)		11
12	Cost of all services (excluding overhead) (sum of lines 10 and 11)		12
13	Ratio of RHC/FQHC services (line 10 divided by line 12)		13
14	Total facility overhead (from Worksheet M-1, column 7, line 31)		14
15	Parent provider overhead allocated to facility (see instructions)		15
16	Total overhead (sum of lines 14 and 15)		16
17	Allowable Direct GME overhead (see instructions)		17
18	Subtract line 17 from line 16		18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)		19
20	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)		20

- (1) The productivity standard for physicians is 4,200 and 2,100 for physician assistants and nurse practitioners. If an exception to the standard has been granted (Worksheet S-8, line 12 equals "Y"), column 3, lines 1 thru 3 of this worksheet should contain, at a minimum, one element that is different than the standard.

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	PROVIDER CCN: _____ COMPONENT CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET M-3
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Check applicable boxes:	☐ RHC ☐ FQHC	☐ Title V ☐ Title XVIII	☐ Title XIX
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DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1	Total allowable cost of RHC/FQHC services (from Worksheet M-2, line 20)		1
2	Cost of vaccines and their administration (from Worksheet M-4, line 15)		2
3	Total allowable cost excluding vaccine (line 1 minus line 2)		3
4	Total visits (from Worksheet M-2, column 5, line 8)		4
5	Physicians visits under agreement (from Worksheet M-2, column 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)		
				Prior to January 1	On or after January 1	
				1	2	
8	Per visit payment limit (from CMS Pub. 27, Sec. 505 or your contractor)					8
9	Rate for Program covered visits (see instructions)					9

CALCULATION OF SETTLEMENT			
10	Program covered visits excluding mental health services (from contractor records)		10
11	Program cost excluding costs for mental health services (line 9 x line 10)		11
12	Program covered visits for mental health services (from contractor records)		12
13	Program covered cost from mental health services (line 9 x line 12)		13
14	Limit adjustment for mental health services (see instructions)		14
15	Graduate Medical Education pass-through cost (see instructions)		15
16	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3)		16
16.01	Total program charges (see instructions)(from contractor's records)		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		16.02
16.03	Total program preventive costs (<i>see instructions</i>)		16.03
16.04	Total program non-preventive costs (<i>see instructions</i>)		16.04
16.05	Total program cost (see instructions)		16.05
17	Primary payer amounts		17
18	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		18
19	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		19
20	Net Medicare cost excluding vaccines (see instructions)		20
21	Program cost of vaccines and their administration (from Worksheet M-4, line 16)		21
22	Total reimbursable Program cost (line 20 plus line 21)		22
23	Reimbursable bad debts (see instructions)		23
24	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		24
25	Other adjustments (specify) (see instructions)		25
26	Net reimbursable amount (lines 22 plus 23 plus or minus line 25)		26
27	Interim payments		27
28	Tentative settlement (for contractor use only)		28
29	Balance due component/program (line 26 minus lines 27 and 28)		29
30	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, section 115.2		30

(1) Lines 8 through 14: Fiscal year providers use columns 1 & 2, calendar year providers use column 2 only.

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA
VACCINE COST

PROVIDER CCN: _____

PERIOD:

FROM _____

WORKSHEET M-4

COMPONENT CCN: _____

TO _____

Check

applicable boxes:

☐ RHC☐ FQHC☐ Title V☐ Title XVIII☐ Title XIX

		PNEUMOCOCCAL	INFLUENZA	
		1	2	
1	Health care staff cost (from Worksheet M-1, column 7, line 10)			1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time			2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)			3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)			4
5	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)			5
6	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)			6
7	Total overhead (from Worksheet M-2, line 16)			7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)			8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)			9
10	Total pneumococcal and influenza vaccine costs and their administration costs (sum of lines 5 and 9)			10
11	Total number of pneumococcal and influenza vaccine injections (from your records)			11
12	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)			12
13	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries			13
14	Program cost of pneumococcal and influenza vaccines and their administration costs (line 12 x line 13)			14
15	Total cost of pneumococcal and influenza vaccines and their administration costs (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2)			15
16	Total Program cost of pneumococcal and influenza vaccines and their administration costs (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21)			16

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	PROVIDER CCN: _____ COMPONENT CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET M-5
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Check applicable box: ☐ RHC ☐ FQHC

DESCRIPTION		Part B		
		1	2	
		mm/dd/yyyy	Amount	
1	Total interim payments paid to providers			1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary, for services rendered in the cost reporting periods. If none, write "NONE", or enter zero.			2
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE", or enter zero (1).	Program to Provider	.01 .02 .03 .04 .05 .50 .51 .52 .53 .54 .99	3.01 3.02 3.03 3.04 3.05 3.50 3.51 3.52 3.53 3.54 3.99
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			4

TO BE COMPLETED BY CONTRACTOR

5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE," or enter zero (1).	Program to Provider Provider to Program	.01 .02 .03 .50 .51 .52 .99	5.01 5.02 5.03 5.50 5.51 5.52 5.99
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			
6	Determine net settlement amount (balance due) based on the cost report (see instructions). (1)	Program to Provider Provider to Program	.01 .02	6.01 6.02
7	Total Medicare liability (see instructions)			7
8	Name of Contractor	Contractor Number	Date (Month/Day/Year)	8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which you agree to the amount of repayment, even though the total repayment is not accomplished until a later date.